



# THE WEST AUSTRALIAN SOCIAL WORKER

## OPERATION SAFE HAVEN LEEUWIN BARRACKS A FCS PERSPECTIVE OF INTERVENTION WITH THE KOSOVARS

### Introduction

The war in Kosova resulted in many refugees fleeing and being placed in refugee camps in Macedonia and Albania. The pressure placed on these camps led the United Nations High Commission for Refugees to take the unprecedented step of relocating the displaced persons around the world, including Australia.

Australia agreed to accept 4,000 refugees and accommodate them in safe havens across Australia. On 27 May 1999 Leeuwin Army Barracks in Western Australia received 384 Kosovar men, women and children.

The group represented a diverse amalgam of people in terms of religion, beliefs, values, attitudes and experiences. The Kosova people experienced the practice termed 'ethnic cleansing'. Many witnessed the murder, torture and rape of family, friends and community members. They were denied the rights of their homeland and watched the burning and destruction of their villages and communities. They were forced to flee their homes and relocate to Macedonia and other countries. In some instances people were separated and isolated from family and community members.

To accommodate the Kosova people in Western Australia, the Leeuwin Barracks Safe Haven was established with the Australian Defence Force and Department of Immigration and Multicultural Affairs (DIMA) as lead agencies. Other agencies included the WA Police Service, Hospital and Allied Health Services, Association for Services to Torture and Trauma Survivors (ASeTTS), West Coast College of Education, Red Cross and Salvation Army. Family and Children's Services was invited to participate as a result of its involvement in the state emergency management advisory committee.

The department's main involvement was to assess the needs of the Kosova people and provide appropriate family and individual support.

### Methods

Family and Children's Services selected a multidisciplinary team of professionals from diverse cultures and disciplines including clinical psychologists, social workers, education officers, children's services officers, community development officers and administrative staff.

Other criteria included knowledge and experience in dealing with crisis situations and working in culturally diverse communities. Some staff were chosen for their language skills and experience in interpreting and translation services.

The initial briefing provided by DIMA before the arrival of the Kosovars set the scene for the department's contact with the Kosova people. As a result of this briefing there was an understanding that the Kosovars were of strict Muslim faith and followed rigid gender divisions.

It was envisaged that this group of people, most of whom had not met one another previously, would become a small, largely self governing community. It was also anticipated that the Kosova people would require services such as education, health, accommodation, counselling, transport, security, interpreters and recreation activities.

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## THE WEST AUSTRALIAN SOCIAL WORKER

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The Family and Children's Services team employed the broad principles of community development with sensitivity to cross cultural issues.

*"The aim of community development is to empower a particular community or group of communities, and therefore the individuals within it, to address their needs. It involves a focus on issues such as access, equity and participation, and as such, has particular relevance for marginalised groups and individuals within the wider community."* (McGorry, 1995, p467).

In line with procedures outlined by the Australian Emergency Management Institute (1996) and community development literature, staff began the process of assessing the needs of the community by forming and developing relationships and gaining acceptance and trust. A literature review was undertaken focussing on Albanian history and culture, models of community development and models of practice in working with survivors of torture and trauma. Demographic information of the Kosova people was obtained from DIMA and Defence.

Staff conducted a cross sectional needs analysis to ascertain the Kosova people's requirements while living within the Leeuwin Barracks Safe Haven. The needs analysis was conducted by dividing the team into pairs which focussed on key groups of Kosovar people. These key groups were zero to six year old children, young people aged 12 to 25 and parents of young children. The needs analysis was conducted via formal and informal consultations and observations and examined areas including education, recreation, safety, health, and emotional and psychological wellbeing.

The needs analysis illustrated that this group of people represented a cross section of the Kosova population and were by no means a cohesive group. The diverse characteristics of the community were demonstrated by their varying levels of education, social, economic and religious backgrounds. There was also a distinct rural-urban dichotomy.

### Other findings

It was apparent that there were no appropriate facilities or structured activities for children under the age of seven years. Many adults indicated a strong desire to improve their English speaking skills but some were limited in attending classes due to lack of child care. The young women expressed a desire to have access to their own meeting area. The men in the community requested participation in activities to support their traditional roles.

These findings showed that staff needed to overcome cultural and language differences so that they could work effectively with the Kosova people. Staff were also required to work collaboratively with the other agencies. This involved participating in regular morning briefings at which critical information was disseminated, agency roles clarified, tasks and activities negotiated, and a fortnightly calendar of events endorsed. This forum then linked into regular meetings attended by DIMA and Defence with the Kosova's own elected management council.

Family and Children's Services undertook to provide the following services:

- early education - providing a safe environment in which children aged four to seven years could have educational input and give parents time out for their own needs including attending English classes;
- advocacy and support;
- Recreational and social activities;
- counselling - one to one informal basic counselling and psychological therapy related to child behaviour management and post trauma support; and
- child protection.

These services were provided via consultation and involvement of community members (for example, consulting parents and the elected Kosova Council) thereby empowering and enabling the Kosovars to make their own informed decisions.

*"The approach followed emphasises the importance of 'therapeutic presence' instead of imposing formal psychotherapy, and is characterised by an avoidance of psychologising the evil nature of war atrocities and pathologising political dimensions."* (Papadopoulos, 1999).

To support staff, debriefings were provided on a daily and weekly basis. Daily briefings involved peer support such as sharing information, experiences and events which occurred during the day, and planning for the next day's activities and events.

Weekly debriefings were conducted by a department senior clinical psychologist and involved providing information on appropriate self care, self monitoring for level of distress and signs of vicarious trauma. The structure of the debriefing sessions was informal, flexible and sensitive to the team's issues and concerns and often involved an interweaving of personal and procedural issues.

### Results

#### Early education

There were a number of positive outcomes and achievements in the area of early education including:

- acquisition of appropriate infrastructure and resources to run an early education service;
- delivery of two modified education programs sensitive to the children's level of development, linguistic abilities and psychological health;
- regular attendance of 16 to 23 children in the kindy (4 and 5 year olds) and 16 (6 year olds) in the preschool;
- parents had the option of leaving children in a supervised education environment while they attended adult English classes;
- parents commented on their children's enjoyment in attending and the benefits to the whole family when the children were occupied in a positive way;

- children's development improved such as their ability to share and interact with others, gross and fine motor skills, communication skills, increased attention and concentration span;
- flow down effect of children's learning to other family members, especially language skills; and
- parents were able seek advice on child management issues and staff were able provide positive role models in parenting.

#### ***Advocacy and support***

The Family and Children's Services team provided extensive advocacy and support services to the Kosovars and personnel from other agencies. This included:

- raising of Kosovar issues and concerns to appropriate agencies and engaging them in services to best assist them in having these needs met and issues addressed;
- appropriate referral of people to relevant agencies;
- follow up with Kosovars and agencies to check on adequacy of service provision;
- acquisition of resources for staff and the Kosova people; and
- effective and open communication to ensure the community understood the role of Family and Children's Services (done via the daily Safe Haven bulletin [in both English and Albanian] and distribution of notices to relevant Kosova groups).

#### ***Recreational and social activities***

Family and Children's Services was involved in planning, organising and implementing recreational and social activities. Staff actively participated in the majority of events. This involved:

- recognition of existing skills of the young people and assisting them to develop new skills;
- increase in the cohesiveness of the group of Kosova people through participation in events organised by both the community and agencies;
- provision of informal and non threatening settings in which the Kosova people felt comfortable to disclose and discuss their experiences;
- breakdown of formal barriers which existed between agencies and between the agencies and Kosovars;
- help in containing post trauma symptoms;
- provision of opportunities to support parents in appropriate and positive interactions with their children; and
- recognition, invitation and involvement with the Kosovars in significant celebrations such as the Kosova Flag Day celebrations and the double wedding.

#### ***Counselling***

Counselling comprised a major part of the work done by Family and Children's Services and included:

- provision of informal counselling to the majority of the Kosova people - initially this comprised active listening, summarising and reflection while subsequent discussions involved ongoing active listening;

- reinforcement and modelling of positive and preventive parenting, appropriate anger management, valuing of individual's characteristics and current status;
- promotion and assistance in developing assertiveness and positive self esteem skills in children, young people and parents;
- creation of an environment which reinforced appropriate communication and interactions between the children; and
- incidental learning particularly within the early education forum.

#### ***Child protection***

Child protection is a statutory responsibility of the department and as such was an important component of Family and Children's Services intervention.

Following the mandate of the department and remaining sensitive to cultural issues of the Kosova people, Family and Children's Services effectively assessed and intervened on several child protection matters. The department also ensured the safety of the community, particularly the children, via discussion with lead agencies about appropriate child safety procedures, and the development of rules and routines.

### **Discussion**

Family and Children's Services work at Leeuwin Barracks has been unique in that the department was the only state government agency invited to provide services.

Working with refugees is complex and requires creative strategies. The primary objective of the department's involvement was to provide family and individual support to the Kosova people. In meeting this objective, the team assessed the current needs of the people and provided services appropriate to these needs.

The work undertaken by the team was mindful of community development models; cross cultural models and issues of sensitivity; and empowerment and the need to create a supportive and safe environment. The approach was activity based and consisted of programs which promoted resilience within the Kosovar people. Activities focused on recognising existing skills and developing new skills. The approach was deliberately competency based as opposed to analysing deficits within the community.

While not formally assessed, the value of the activities undertaken by the team has been acknowledged by the lead agencies in the operation, other state organisations and by the Kosovars themselves.

The team benefited from not being expected to engage in the work of 'therapy' as this was provided by a contracted non government service (ASeTTS). Team members were free to encounter the Kosovar people as a 'therapeutic presence' rather than as clients with whom therapy was a service which had to be provided.

The team's multidisciplinary composition proved to be suc-

successful in meeting the project's overall objectives and complemented the tireless, committed efforts of the other agencies in a truly collaborative process.

The generosity of the Western Australian community cannot be overlooked in the overwhelming offers of goods and services which clearly made a difference to the Kosovars quality of life. The obvious barrier of language proved to be a vehicle for bringing staff and Kosovars together through a mutual need to understand one another and in particular the Kosovars eagerness to learn English.

Overall the Family and Children's Services team measured its success by the fact that the Kosovar parents entrusted their children into its care for activities on and off the base. Ultimately the joint efforts of all service agencies did indeed create a safe haven where individuals could begin to come to terms with their tragic circumstances.

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# Letters

**Dr Ruth Shean**  
**Chief Executive Officer**  
**Disability Services Commission**

Dear Dr Shean

A very concerning matter has been brought to my notice. Since 1991 there has been a steady decline in the number of social workers employed within the Disability Services Commission. I am reliably informed that in 1991 there were some 28 social workers employed within the Commission. This comprised 23 employed as social workers, 4 as supervisors and 1 as a Principal Social Worker. Since 1991 of course there have been a number of re-structures as with all government organisations. It is my understanding that following the recent re-structure the number of social workers will be reduced to 11 full time equivalent positions. Comprising 8 social workers, 2 supervisors and 1 principal. As of the 6<sup>th</sup> April the FTE numbered 15.

This is concerning, particularly in view of your assurances in a previous correspondence to me of support for the profession and

its ongoing need to maintain its supervision of social work students from the Universities.

It would seem that the reduction in the number of social work positions is directly related to the employment of local area coordinators. This is probably linked with the notion of a brokerage model of service and a move away from direct service provision.

I bring this matter of concern to you and would appreciate entering some discourse on the issue. It is worrying that on the one hand notional support for the profession is expressed and that on the other, in practical terms, position numbers are diminishing.

Yours sincerely  
Brian Wooller, Branch President  
9 August 1999

**Mr Brian Wooller**  
**Branch President**

Dear Mr Wooller

Thank you for your letter dated 9 August 1999 concerning the reduction in the number of social workers employed by the Disability Services Commission.

Since 1992, the Commission has been implementing the Local Area Co-ordination program throughout the metropolitan area and the Five Year Business Plan has made provision for complete statewide coverage by July 2000. The Commission's Corporate Executive has approved a set of interface principles that serve to rationalise existing staff roles in those areas where a Local Area Co-ordinator is placed. Particular areas of duplication have been found to be individualised consumer funding, community development and service co-ordination, and as it is necessary to focus all available resources on effective and efficient service delivery, there have been changes to the mix of staff resources to reflect areas of highest priority.

The current social work staffing level is 11.6 FTE (including two Social Work Supervisors), plus the Principal Consultant, Social Work. Once the current restructure is fully implemented and the Commission has full Local Area Co-ordination coverage (July 2000), it is expected that there will be a total of 10 FTE (including two Social Work Supervisors) plus the Principal Consultant, Social Work.

The restructures does, however, provide a clear opportunity for the resultant Specialist Senior Social Worker role to be both strengthened and better supported through increased provision for all professional staff in areas of professional development, information technology support and equipment.

Professional supervision standards and clinical specialist positions will continue to be supported and there will be clearer specification of available services and target clients as part of the Commission's move to put its own provider directorates onto a similar basis to funded non government agencies.

As part of the planned new service provision arrangements within the Commission, it is expected that there will be an annual review of both the services provided and their effectiveness, as well as the mix of staff and service strategies.

I do believe that a clear focus for the specialist role of social work within the Commission, as well as increased support for all professional staff, will lead to overall improvement in the way things have been in recent years.

Yours sincerely  
Dr Ruth Shean  
Chief Executive Officer, Disability Services Commission  
1 September 1999

**Mr Paul Schapper**  
**Executive Director, Contract and Management Services**

Dear Mr Schapper

The matter of tender for the provision of expert witnesses to the Family Court in Western Australia has been brought to my attention. It is my understanding that there has been considerable negotiation to ensure that the compliance criteria A.4.1.3 should include within it social workers who are members of the Australian Association of Social Workers who have achieved 'accredited social worker' status.

The exclusion of social workers from acceptance as appropriate to offer their services as expert witnesses from this tender arrangement in Western Australia is clearly anti-competitive and discriminatory.

It is hoped that this can be rectified and that social workers be included to accord them the opportunity to offer their expertise under contract for this purpose.

In other parts of Australia, it is my understanding that social workers are accepted for this purpose. The Australian Association of Social Workers is the only recognised professional body representing social workers in Australia. They currently have a continuing professional education requirement that members who participate in, and achieve compliance with, are accorded accredited social work status within their membership.

I do hope this matter can be dealt with.

Yours sincerely  
Brian Wooller Branch President  
6 September 1999

**Mr George Turnbull**  
**Director, Legal Aid Commission**

Dear Mr Turnbull

Please find attached my letter to Mr Paul Schapper regarding the inclusion of social workers under compliance criteria A.4.1.3

## Professionals and Self-Help Community Forum

3 November 1999, 6–8 pm  
Grace Vaughan House, 227 Stubbs Terrace,  
Shenton Park

With a view to exploring the role of professionals in self-help, WISH and the Health Consumers Council (HCC) WA are holding a community forum entitled *Professionals and Self-Help – Self-Help... Does it Help?*.

The forum is being conducted in a panel format with guest speakers from the Social Work Department of UWA, Divisions of General Practice, WA Association for Mental Health, HCC (WA) and several self-help groups including Parents of Children in Trauma (POCIT), The Spina Bifida Association (WA) and Obsessive Compulsive Disorder Self Help Group.

Question time will provide an excellent opportunity for professionals, students, service providers, self-help groups and interested community members to clarify any doubts and concerns or contribute to discussion.

RSVP: Call WISH on 9228 4488  
Light supper and refreshments will be provided.

for tender applications as expert witnesses to the Family Court.

I am sure it is merely an oversight that social workers have not been included in Western Australia and it is hoped that the matter can be resolved in line with, what my understanding is, of previous negotiations.

Yours sincerely  
Brian Wooller  
6 September 1999

**Mr Brian Wooller**  
**Branch President**

Dear Sir

Court Expert Tender

I acknowledge receipt of your letter to this office of 6 September 1999, which I have now had an opportunity to consider.

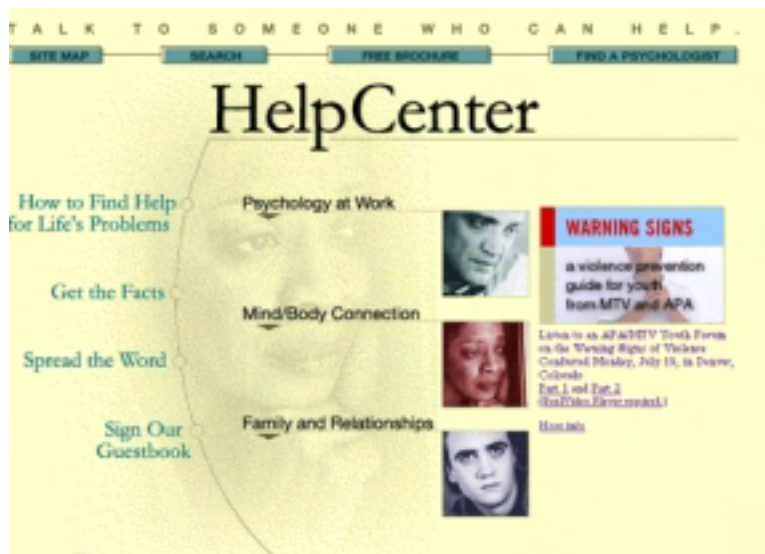
In Western Australia, unlike other States, there are only two categories of matters in which child representatives are appointed

*Continued on page 11*

# Net Watch

There has been requests from members for materials with recent information about responses to the growing problem of drug abuse in the community. The April 1999 edition of *The West Australian Social Worker* contained an article that dealt with the work undertaken by a West Australian Select Committee which reported to the Parliament in August 1999.

In this newsletter three texts are provided which highlight some of the issues and concerns that may face counsellors when assisting those persons who are conjointly involved in 12 step programs. Some of this material is available through an American Psychological Association web site, the Help Center [<http://helping.apa.org/>].



While the first article, *Integrating psychotherapy and 12-step programs*, was initially written for an audience of psychologists, it is a very helpful discussion that is readily applicable to social workers and other professions who counsel those who have engaged in abstinence oriented treatment and support services.

Following this article there are excerpts from a number of commentators who debate statements contained in a fact sheet, *Alcohol-related disorders: psychotherapy's role in effective treatment*, published on the APA's web site on working with those who are alcohol dependent. This debate is useful to social workers as it highlights a number of perspectives of those offering psychotherapy services vis a vis 12-step oriented programs. *ED*.

## 1. Integrating Psychotherapy and 12-Step Programs

by Marilyn Freimuth

Psychologists can expect to treat an increasing number of patients involved in some type of addiction recovery program. In AA alone, 60% of its membership seek some "treatment or counseling" (AA World Services, 1990). This paper considers some benefits and roadblocks to integrating psychotherapy and 12-step work. While the focus is on 12-step programs many of the issues are relevant to patients in other recovery programs.

Some psychotherapists view patients' 12-step involvement with neutrality or negativity. The latter has been true for those psychoanalytic clinicians who believe that addiction, as a symptom, will resolve only as dynamic issues are addressed (Berger, 1991).

Recently a number of addiction specialists have suggested that simultaneous involvement in psychotherapy and a 12-step program can be beneficial. These authors follow what can be called an adjunct model (e.g., Rosen, 1981; Zweben, 1987). By helping the patient cease substance abuse, 12-step involvement becomes a supportive adjunct to psychotherapy. A patient who actively works his/her program has a place to go and people to call whenever addiction related issues arise.

This extra-therapeutic support frees the therapist to address emotionally difficult issues with some comfort that the resulting stress will not lead to substance abuse. Likewise, psychotherapy is an important adjunct to the 12-step work. Therapy becomes a place to process complex and changing feelings about the 12-step experience (e.g., relationship to a sponsor). Thus, therapy supports continued program involvement and enhances benefits to the patient (Zweben, 1987).

The collaborative model of integration incorporates the adjunct model but is distinguished by the belief that the benefits of 12-step work extend beyond cessation of substance abuse to include therapeutic-like emotional growth. Flores (1988) illustrates this idea with reference to alcoholism: "The first step of the AA program is the only step that addresses drinking. The rest of the eleven steps of the 12-step program are dedicated exclusively to what AA calls 'the removal of character defects.' AA is commonly referred to by its members as a 'program for living'" (p. 213).

Numerous articles address the growth promoting effects of 12-step work (e.g. Bean, 1975; Brown, 1985; Dodes, 1988; Flores, 1988; Matano and Yalom, 1991; Tiebout, 1944). However, only a few authors (Brown, 1985; Freimuth, in press; Levin, 1985) emphasize that the 12-step experience can benefit the patient's progress in therapy. For example, a psychotherapist who seeks collaboration values a patient's intense attachment to a

sponsor or home group for two reasons: (a) it serves to support abstinence and (b) it may diffuse the patient's relationship to the therapist which, if too intimate, might provoke premature termination (Dodes, 1988). Those who do not value collaboration may view these intense attachments solely in terms of undue dependence.

While the benefits of collaborating with a 12-step program are recognized (Brown, 1985; Levin, 1985), existing literature fails to provide a model for putting this relationship into practice. Conjoint therapy provides such a model. Conjoint treatment "refers to the concurrent treatment of a patient in two different settings by two different analysts [therapists]. The analysts [therapists] work separately to resolve the patient's resistance, one in a group setting and the other in an individual setting" (Ormont & Ormont, 1986, p. 424). Typical conjoint therapy combines individual and group treatment. However, these authors note that a conjoint relationship can develop between a psychotherapist and any outside agent (p. 435)

Anyone who has worked conjointly knows there are distinct challenges to a successful alliance. Just as two psychotherapists working conjointly may not have the same theoretical orientation, so it is that values of a 12-step program and psychotherapy can conflict. The sources of conflict may arise from the therapist's personal experiences with such programs and addiction. Other differences will be conceptual (Matano & Yalom, 1991).

Is the goal abstinence or controlled drinking? Is a person always an addict even if he/she has been "sober" a long time? Can a patient have a strong attachment to a 12-step program without this being a substitute addiction? Still other differences arise from uncritical acceptance of certain "stereotypes":

12-step programs are religious. The spiritual dimension of 12-step philosophy (i.e., belief in a higher power as conceptualized by the individual) is mistakenly equated as religious (Humphreys, 1993).

12-step philosophy is against therapy and medication. Bill W., AA's founder, sought therapy twice after becoming sober (Levin, 1985). AA World Services publishes pamphlets which discuss the value of medication and psychotherapy.

12-step philosophy encourages people to abdicate responsibility. Rational Recovery is quite critical of AA on this point. Early recovery does emphasize the addict's "powerlessness" over addictive substances. This fits the program's position that addicts are not responsible for addiction (which is considered a disease). However, addicts are responsible for their recovery by attending meetings and following the steps such as four and eight where the addict is responsible to make a "searching and fearless moral inventory" and become "willing to make amends" (Matano & Yalom, 1991).

Strong negative emotions such as anger are discouraged (Bean, 1975; Levin, 1985). While members' anger toward the program is not accepted in meetings, there is no unilateral discouragement of negative affect. Only when anger threatens sobriety is it considered necessary to circumvent negative feelings. See Freimuth (1944) for further discussion of common misconceptions of 12-step philosophy.

The therapist who follows a conjoint model must become familiar with relevant recovery literature and attend open meetings. While conceptual differences will remain, as long as the therapist respects the program's position for the patient (e.g., abstinence over controlled drinking), a collaborative relationship can develop.

A second challenge to collaboration comes from the patient's resistances and the therapist's reactions to them. For example, an alcoholic with a year's sobriety begins psychotherapy by expressing disgruntlement with AA and praising the therapist's helpfulness. Kinney and Montgomery (1979) caution against being seduced by the patient's appeal to one's narcissism which can mask doubts about maintaining abstinence or fears about how to manage allegiances to both a 12-step group and therapy.

Other times, psychotherapy will be viewed as "less than." When a patient speaks enthusiastically about the alking with a sponsor or listening at meetings, the therapist can feel jealous ("Why didn't I come up with that observation?") or annoyed that similar reactions offered in therapy have been ignored. In light of these feelings, the program's value for the patient may not be recognized and the patient's enthusiasm interpreted merely as a veiled criticism of the therapy.

The therapist who uses a conjoint model values the benefits which arise from having multiple input from multiple settings. In traditional conjoint treatment, where multiple input involves group and individual therapy, each modality is seen to serve a different function. Through careful treatment planning, resistance is accepted in one setting and analyzed in another or feelings aroused in one setting are worked through in the other (Ormont & Ormont, 1986).

This allotment of responsibility seems impossible when collaborating with a leaderless 12-step group. However, like typical conjoint treatment, the patient develops distinct ways of relating to the psychotherapy and 12-step experiences. The differences is that responsibility for the treatment plan rests solely with the psychotherapist who must understand the psychic role played by the 12-step program and then provide the patient with the complementary experience.

For example, a patient's resistance to exploring the defensive functions of grandiosity is accepted knowing that the psychological dimensions of steps one, two and eleven will help the patient address this issue. Similarly an idealized transference to a 12-step

*"The therapist who uses a conjoint model values the benefits which arise from having multiple input from multiple settings. In traditional conjoint treatment, where multiple input involves group and individual therapy, each modality is seen to serve a different function. Through careful treatment planning, resistance is accepted in one setting and analyzed in another or feelings aroused in one setting are worked through in the other."*

program is recognized as meeting a need and helping support abstinence while, at the same time, the therapy setting is used to help the patient express anger and begin to integrate positive and negative feelings.

In sum, collaboration is based on a mutual respect for the processes of 12-step groups and psychotherapy and a recognition that both have a role to play in facilitating abstinence and emotional growth. Psychotherapy patients involved in a 12-step program who sense that the therapist values collaboration will feel safe to make both modalities a significant part of ongoing recovery.

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## 2. APA Fact Sheet

### Alcohol-Related Disorders: Psychotherapy's Role in Effective Treatment

For many people, drinking alcohol is nothing more than a pleasant way to relax. People with alcohol-related disorders drink to excess, endangering both themselves and those around them. This question-and-answer fact sheet explains how psychotherapy can help people recover from these potentially life-threatening disorders. When does drinking become a problem? What causes alcohol-related disorders? How do alcohol-related disorders affect people? When should someone seek help? How can a psychologist help? Does treatment really work? When does drinking become a problem? For most adults, moderate alcohol use, no more than two drinks a day for men and one for women and older people, is relatively harmless. (A "drink" consists of 1.5 ounces of spirits, 5 ounces of wine or 12 ounces of beer, which contain equal amounts of alcohol.) Moderate use, however, lies at one end of a continuum that moves through alcohol abuse to alcohol dependence.

Alcohol abuse is a drinking pattern that results in adverse consequences that are both significant and recurrent. Alcohol abusers may fail to fulfill major school, work or family obligations. They may have drinking-related legal problems, such as drunk driving arrests. They may have relationship problems related to their drinking.

People with alcoholism, technically known as alcohol dependence, have become compulsive in their alcohol use. Although they can control their drinking at times, they are often unable to stop once they start. As their tolerance increases, they may need more and more alcohol to achieve the same "high." Or they may become physically dependent on alcohol, suffering withdrawal symptoms such as nausea, sweating, restlessness, irritability, tremors and even hallucinations and convulsions when they stop after a period of heavy drinking. It doesn't matter what kind of alcohol someone drinks or even how much: alcohol dependent people simply lack reliable control over their drinking.

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), one in 13 American adults is an alcohol abuser or alcoholic at any given time. A 1997 government survey revealed that drinking problems are also common among younger Americans, despite the fact that most states outlaw drinking under age 21. Almost five million youths aged 12 to 20 engage in binge drinking, for example, with females downing at least four drinks on a single occasion and males at least five.

#### What causes alcohol-related disorders?

Problem drinking has multiple causes, with genetic, physiological, psychological and social factors all playing a role. For some alcohol abusers, psychological traits such as impulsiveness, low self-esteem and a need for approval prompt inappropriate drinking. Others drink as a way of coping with emotional pain. Still others use alcohol to "medicate" psychological disorders. Once people begin drinking excessively, the problem can perpetuate itself. Heavy drinking can cause physiological changes that make more drinking the only way to avoid discomfort.

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Genetic factors render some people especially vulnerable to alcohol dependence. (Contrary to myth, being able to “hold your liquor” means you’re probably more at risk, not less.) Yet a family history of alcoholism doesn’t mean that children of alcoholics will automatically grow up to become alcoholics themselves. Environmental factors such as peer pressure and the easy availability of alcohol can also play key roles. Although alcohol-related disorders can strike anyone, poverty and physical or sexual abuse also increase the odds.

### **How do alcohol-related disorders affect people?**

While small amounts of alcohol may have some beneficial physical effects, heavy drinking can cause serious health problems and even death. In fact, 100,000 Americans die from alcohol-related causes each year. Short-term effects include distorted perceptions, memory loss, hangovers and black-outs. Many problems are not apparent until they become serious, however.

Over the long term, heavy drinking can cause impotence, stomach ailments, cardiovascular problems, cancer, central nervous system damage, serious memory loss and liver cirrhosis. It also increases the chances of dying from automobile accidents, homicide and suicide. Although men are much more likely than women to develop alcoholism, women’s health suffers more even at lower levels of consumption.

Although moderate drinking may result in relaxation and euphoria, heavy drinking also has a very negative impact on mental health. In fact, alcohol abuse and alcoholism can worsen existing conditions, such as depression or schizophrenia, or induce new problems, such as serious memory loss, depression or anxiety.

People with alcohol-related disorders don’t just hurt themselves, however. According to NIAAA, more than half of Americans have at least one close relative with a drinking problem. The results can be devastating. Spouses are more likely to face domestic violence. Children are more likely to develop psychological problems, suffer physical and sexual abuse and neglect and because of the combination of genetic vulnerability and social learning, grow up to be alcoholics. Women who drink during pregnancy run a serious risk of damaging their fetuses. It’s not just relatives who suffer. Heavy drinkers often kill strangers through accidents or homicide.

### **When should someone seek help?**

Because some in our society view alcohol-related disorders as a sign of moral weakness, individuals often hide their drinking or deny they have a problem. How can you tell if you or someone you know is in trouble? Signs of a possible problem include having friends or relatives express concern, being annoyed when people criticize your drinking, feeling guilty about your drinking and thinking that you should cut down but finding yourself unable to do so. Needing a morning drink to steady your nerves or relieve a hangover is another warning sign.

Alcoholics usually can’t stop drinking through willpower alone. Most need outside help. They may need medically supervised detoxification to avoid potentially life-threatening withdrawal symptoms such as seizures, for instance. Depending on the

problem’s severity, treatment can take place during office visits, hospital stays or residential treatment programs. Once people are stabilized, they need help resolving psychological issues that may be associated with problem drinking

### **How can a psychologist help?**

Psychologists play a vital role in the successful treatment of alcohol-related disorders, serving as integral members of the multidisciplinary team that may be required to provide care. Be sure to choose a psychologist who is experienced in working with alcohol-related disorders. To improve the chances of recovery, seek help early.

Using individual or group psychotherapy, psychologists can help people address psychological issues involved in their drinking. They can help people boost their motivation, identify situations that trigger drinking and learn new coping methods. They can also provide referrals to self-help groups such as Alcoholics Anonymous, a crucial part of any recovery program. The treatment process doesn’t end once drinking does, however. To help prevent relapses, psychologists typically keep working with people as they begin new lives. Even after formal treatment ends, many people seek additional support through continued involvement in self-help groups.

Treatment can’t occur in a vacuum. Because families influence both drinking and recovery, marital and family therapy are also key. Psychologists can help families repair relationships and navigate the complex transitions that occur as recovery begins. They can help families understand alcoholism and learn how to support family members in recovery. And they can refer family members to self-help groups such as Al-Anon and Alateen.

### **Does treatment really work?**

Yes. Evidence strongly suggests that many people, especially those with jobs, families and other forms of social stability, recover after their first attempt. Not everyone is so fortunate. Some cycle between relapse and recovery several times before achieving long-term sobriety. What’s important is for the person to stop drinking again and get additional support.

While alcoholism is treatable, so far no cure has been found. That means people remain susceptible to relapses even after they’ve been sober for a long time. Reducing alcohol consumption doesn’t work. Most experts agree that the goal should be complete avoidance of alcohol.

Alcohol-related disorders can severely impair people’s functioning and health. But the prospects for long-term recovery are good for people who seek help from appropriate sources. Qualified psychologists with experience in this area can help those who suffer from alcohol-related disorders stop drinking and start regaining control of their lives.

*Text is available from APA web site - <http://helping.apa.org/therapy/alcohol.html>.*

### 3. Debate about the Fact Sheet

The APA Practice Directorate has recently released a statement on “Psychotherapy’s role in effective treatment” of alcohol-related disorders that at least implicitly seems to recommend “psychotherapy” as a demonstrably effective treatment for alcohol use disorders. It is [perhaps characteristically] vague about exactly what such treatment should entail, but the message clearly espouses the view that a 12-step model is an indispensable part of any viable approach.

I do not doubt that psychologists have a lot to offer in the substance use disorder field (indeed, they have made some of the most important contributions to date), nor do I doubt that 12-step programs have helped a significant number of people suffering from alcoholism. However, the Practice Directorate message appears to be decidedly biased and seems to disregard a good bit of what science-based practice has to offer. It also neglects many promising options available to those affected by drinking problems. This does not appear to serve the public best.

#### AL LANG

The American Psychological Association’s Practice Directorate has sent a mailing to all clinical practitioners in the APA entitled “Alcohol-related Disorders: Psychotherapy’s Role in Effective Treatment” — this document is labeled “just the facts.” Rather than providing facts, the document represents a remarkably outdated testimonial to AA and standard treatment and ignores research on advances in psychological treatment. In fact, the document is antipsychological, antipsychologist, and antiscientific.

To cite one example, the mailing claims that, “Using individual or group psychotherapy, psychologists can help people address psychological issues involved in their drinking. . . . They can also provide referrals to self-help groups such as Alcoholics Anonymous, a crucial part of any recovery program.”

There is a world of misinformation in this small excerpt. According to their 1995 meta-analysis of controlled research on alcoholism treatments, Miller and his colleagues found the cumulative evidence of the effectiveness of “psychotherapy” to be highly negative (Miller and Hester, in their earlier summary of evidence of alcoholism treatment effectiveness, listed “group therapy” and “individual counseling” under “treatment methods currently employed as standard practice in alcoholism programs” for which there was no evidence of effectiveness.) In their 1995 analysis, Miller et al. list Alcoholics Anonymous as the treatment modality with the most negative cumulative evidence score among treatment modalities with too few studies to evaluate conclusively.

The directorate’s mailing does not mention at all the treatments the Miller team found to be most effective, including brief interventions and motivational enhancement. While recommend-

ing support groups, the directorate’s mailing suggests only AA, Al-Anon, and Alateen, as though alternative groups such as Rational Recovery, SMART Recovery, and other non-12-step approaches didn’t exist. Nor is there any discussion in the directorate mailing of Alan Marlatt and his colleague’s thoroughgoing research on the benefits of a harm reduction approach of secondary prevention for college students with incipient drinking problems.

Finally, the directorate’s broadside indicates, “reducing alcohol consumption doesn’t work.” Yet reduced consumption is the primary benefit of the Marlatt team’s program and of brief interventions, as well as a choice allowed to individuals in motivational enhancement. The NIAAA’s recent Project MATCH trial of treatment with a highly dependent alcoholic population touted the success of its outcomes; these results were that on average alcoholics reduced drinking from 25 to 6 days per month and the amount they consumed on drinking days from 15 to 3 drinks.

That such a document should be presented by this official source as the standard for practice for psychologists in 1999 is shocking.

#### STANTON PEELE

*Continued from page 6*

by the Court, and which subsequently lead to the appointment of Court Experts. These matters generally involve allegations of physical, emotional and sexual abuse of children, and require some consideration of the psychological and/or psychiatric state of family members involved in the proceedings.

Court Experts are appointed by the Family Court, not Legal Aid. The Family Court of Western Australia has historically considered that psychologists and psychiatrists are appropriately qualified to act as Court Experts in these matters.

Social workers regularly give evidence in proceedings in the Family Court of Western Australia, however, their evidence usually arises out of particular aspects of the matter which relate to their professional involvement with the families in the proceedings.

As child representatives are appointed in a broader range of matters in other States, it is likely that there would be more occasions on which the evidence of social workers alone would be sufficient to address the issues before the Family Court in those States.

The recent Court Expert Tender of Legal Aid is a reflection of the current practice of the Family Court in this State.

It is important that your organisation be aware that:

(a) as part of the tender process, Legal Aid WA has reserved the right to, in appropriate circumstances, seek from the Family Court the appointment of a Court Expert not on the Preferred Panel;

(b) the tender process will be repeated in 12 months time, and the process and terms of the tender will be reviewed prior to the

advertisement of the next tender.

Yours faithfully  
George Turnbull, Director of Legal Aid  
20 September 1999

## Book Review



*One step beyond* by Warren McDonald. South Yarra, Hardie Grant Books, 1999

Although a small book (189 pages) this is a powerful account of Warren's fateful accident in April 1997 when the lower part of his body was crushed by a very large boulder dislodged by torrential rains. At the time Warren had nearly completed a rugged day long climb to the peak of Mount Bowen on Hinchinbrook Island. Subsequently he lost both legs and

this forced him on a long journey of rehabilitation and self discovery. His zest for adventure over a number of years had given him many rewards from being able to visit and travel to remote and exotic locations. He had also developed a deep appreciation of the need to retain the diminishing stock of unlogged forests in Tasmania and had learnt how to survive in adverse circumstances as an activist protesting against the destruction of the Tarkine.

Warren's experience is one that may resonate with many, especially young adults, about his journey after the accident involved forcing himself to succeed at many feats that require extraordinary strength. One such milestone was to re-climb Cradle Mountain - a very difficult place for those to hike and climb with the benefit of full mobility. The adjacent photo illustrates the sheer determination of this man to succeed against all odds.

In Warren's words *"We all face our own obstacles in life. Whether we rise to the challenge of overcoming them can only be decided by one person. Ourselves."* This book is well worth reading as a testimony of how to recognise and resolve the physical and psychological barriers to recovery after a severe trauma of this kind. A visit to Warren's web site <http://www.partanimal.com/> will provide you more recent information about this extraordinary man, including how he has become a respected guest speaker giving powerful motivational lectures.

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