



MARCH 2008, No. 29

FROM THE PRESIDENT'S DESK

Greetings Dear Friends,

Welcome to another edition of the Counselling Association of South Australia Newsletter. I trust that you are well and that this edition finds you enthusiastic and energized for the coming months. At least if nothing else, it will be cooler!

Last weekend saw the mid-year PACFA council meeting in Melbourne and one of the primary concerns facing the council was the issue which we presented to you at the beginning of the year, where the Federal Government was asking for a decision about a joint and national register.

Whilst the final outcome is still to be decided, it was the decision of the CASA Executive to vote to set up multiple registers whilst maintaining the PACFA Register. Multiple registers would be created for those eligible to belong to Member Associations, eligibility comprising: education, supervision and professional standards, training and accreditation for PACFA in 2009.

It is hoped that individuals on these separate registers for other psychotherapists and counsellors, when meeting State and Federal governmental requirements, would be eligible for Allied Health Professional status.

Whilst it was recognised that the Federal Government is seeking a single conglomerate national register comprising different skill levels (see above), it was also considered important that PACFA maintain an independent register, given that historically this indicates a level of professional excellence.

It is now necessary for this information to be taken back to the government and for

further talks to be entered into as to how this is best created. It is envisaged that the PACFA register will remain as an individual identity, and that further negotiation will occur with ACA in order to achieve the national register that will meet government expectations. Please be assured that information pertinent to this matter will be passed on to the membership.

In our own back yard, the Executive is looking to the rest of the year, with the conference coming up in June, and with an excellent range of Professional Development days on offer.



Pamela Brear (Secretary) and a working party comprising of Judy Headley and Fiona Griffith have been diligently considering the standard required by CASA for a person to be formally recognised as a supervisor. This is extremely important as it requires skill, knowledge, practice and considerable expertise as a practitioner to be able to sit with other counsellors in a supervisory mode. It is also necessary for the credibility of the profession that we are seen to be setting and maintaining a professional stance in regard to these matters. These standards will sit equally with PACFA standards, and as such will continue to build a national standard as well as a state one.

It was with sadness we as a committee also acknowledged the resignation of Diana Capaldo early this year due to personal issues. Diana is known to many of you as both the Membership Convenor, and Conference Convenor. In these and other roles in the past, Diana has selflessly devoted her time and energy to

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CASA and the promotion of the counselling as a profession. She has imbued her style and grace to her work, and her gift to the membership of CASA was a considerable one. I would like to publicly acknowledge both her, in her diligence, and her work in its excellence, and thank her sincerely from the Executive Committee.

All the best Diana!

Viv Cheesman has agreed to take over the role of Membership Convenor, and we thank her for stepping up to this position in her already busy life, especially as she already carries the positions of Editor (of this fine document and of the Email News) and of Ethics Convenor.

It is with pleasure that I announce to the member-

ship the election to the committee of Carol Longmire, who has agreed to join us in our endeavors to serve the CASA membership. Carol will, I have no doubt, bring graciousness and wisdom to her role, and please acknowledge her for this step when you see her at the Professional Development days. As we have said before, it takes time and commitment to take up a position with any board, and CASA is no different. However the benefits in learning, understanding and serving are real and our time is given willingly. If you are interested in being on the Executive, please speak to one of the Executive Members – we'd love to have you on board.

Keep well and kind regards,

Joy Anasta, President

Have Your Say in the Newsletter

We had planned to start a "Grass Roots" column in this edition of the CASA Newsletter, but unfortunately had no response from the membership. We continue to invite your comment and contributions.

We are very keen to receive articles for publication. To make a worthwhile contribution in this manner, it is not necessary to be a "high flyer" in the counselling community. On the contrary - we all benefit from the wisdom, knowledge and insights of our peers, gathered from various sources. In this way **YOU** can help to nurture and progress counselling as a community and as a profession in South Australia. Please support your fellow counsellors by sharing your experience with all of us.

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Editorial

CASA, as part of the flag statement, is committed to best practice counselling for clients and the provision of professional support for counsellors. One of the ways in which this is actioned is by fostering the ongoing education of members. This educational function is performed in part by the written word, as in the Newsletter, and also through the Professional Development program and the annual CASA Conferences. I would like to sincerely thank those who have contributed articles to this edition of the CASA Newsletter. Their contributions add to our counselling knowledge.

Ann Wilson, Tracey Bone and Shane O'Dea explore different aspects of disenfranchised grief in

their articles. Disenfranchised grief refers to the social aspect of grief, whereby the griever and / or the loss are not socially recognised. Understandably, this lack of community recognition and support potentially has a cascade effect, creating further issues, losses and difficulties for grievers. These articles are relevant to our practice as counsellors, as a great deal of the work of counselling is around assisting clients to adjust to changed life circumstances.

Rob Brodie, by granting an interview, has again generously given his time and expertise to CASA, progressing our understanding of Psychodrama and Sociometry. Viv Maitland and her team, by

organising our Professional Development days, likewise make a significant educational contribution. The Counselling Calendar in this issue will help keep you up to date on the upcoming events, as will Viv's periodic e-mail reminders.

Work continues in the Executive on the next annual Conference. You will notice that there is now a new conference date - with the best will in the world, the Executive was unable to make the previous date "work".

I hope that you find this edition of the Newsletter both stimulating and useful to your practice.

Viv Cheesman, Editor

Interview with Rob Brodie by Viv Cheesman

Rob Brodie, Director of the Psychodrama Training Institute of South Australia, was the final Presenter at the CASA Professional Development Day, in October, 2007. Our thanks go to Rob, for so skilfully guiding our process at the end of what for many was an intense day of Professional Development, and also for his generous sharing of time and expertise during this interview.

Following the event, it was interesting to discover how few people at the PD day (myself included) have a clear understanding of what psychodrama is and how it "works". Consequently, I approached Rob in an effort to get a thumbnail sketch of what Psychodrama is about to share with Newsletter readers. This was the first indication of how very little I understood about psycho-drama. Rob

gently corrected me, making it clear that Psychodrama is a holistic approach, which cannot be readily reduced into a "thumbnail sketch".

During the interview, he expressed his concerns about the dominance of the medical model, which is strongly intellectual. While he sees medicine as obviously having an important place, he considered reliance upon that model to be reductionistic and inconsistent with holistic principles. By comparison, Rob explained that within the paradigm of psychodrama, action is seen as the primary expression of the whole self and that the psychodramatist works with thoughts, feelings and behaviours in a specific situation or context. Within this modality, aspects of the self arise, these being aspects which are expressed neither by language or image. He saw the popular concepts of "right brain / left brain" as reductionistic versions of this concept.

We talked at length about the psychodrama concept of "warm up". He explained that this concept

applies in many areas of life, and that athletes and cars "warm up" before action. I was probably looking a little fuzzy at that point, so to explain further, he used a case in point: our interview. My warm up was seen to be arriving, ringing the bell, shaking hands and having an initial conversation about the environment and then a further one about facilities for group therapy. The warm up in this case was seen to have social, behavioural, ritualistic and affective aspects.

Rob described the PD day as having created strong warm ups for many people, and that some enactment to complete the warm up was needed. Still grappling with the concept of incomplete warm ups, I asked him what a completed warm up would look like. He gave the following example: "If it's a hot day and you feel thirsty and want a drink, and then you drink a bottle of beer, and then you're not thirsty any more, and are satisfied. That's a completed warm up."

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Given my unfamiliarity with psychodrama, Rob explained some of the central tenets. Action is seen as often coming first (not thought, as in some psychologies), and our actions are strongly influenced by previous life experiences. These previous experiences, "old memories" called conserved roles, can act in such a way that they limit our vision and reduce the possibilities in responding to new circumstances. Within psychodrama, working with warm ups and the untangling of previous life experience and allows for reworking of the experience, thereby facilitating self display.

In our culture, Rob believes that we are brought up to hide some vital aspects of our selves, and that we are often mistreated if we do not. I disclosed to Rob my considerable discomfort when standing before a group, and using this as an example, he said that working with warm ups enables frozenness to become untangled and self display more complete. In psychodrama this is called spontaneity. Spontaneity is seen to be greater than impulsiveness, encompassing creative self-expression. Rob said spontaneity before groups may be reduced. I was intrigued to find that within Psychodrama, work is done to maintain spontaneity, and further, that spontaneity is trainable! The more frequently we rise to "things" or events, the greater our spontaneity becomes.

In psychodrama, the influence of past experiences may be brought alive, re-experienced and re-worked in the present moment. It encompasses cognitive, affective, and behavioural aspects of past experiences, in addition to social aspects

of the self as a "social atom" such as the original family system, for example. The concept of social atom was new to me, and I subsequently found an interesting article by Professor Rory Remer explaining it (see below), within the context of Sociometry. It consists of all the individuals who are significant in our lives at a particular moment.

Rob explained to me that at the PD day, he identified a sense of isolation as individual practitioners to be a consistent theme within the group, and part of our warm-up. He then addressed it using practices known as Sociometry, which measured the patterns of connection between people there.

He had us sit in a circle, with the stage being the empty area between us at the centre of the circle. The stage was empty so that it held the maximum projective potential, enabling totally subjective experiences for each individual present to be projected. This meant that we were able to explore our own individual worlds, allowing us to bring unconscious material into consciousness. Rob acted as both our Director and Producer, and looked for a protagonist from us. This person was one who talked of her experience of isolation and seemed to embody the group's experience of isolation. Auxiliaries, the secondary actors, were those others who also expressed their experiences around isolation.

To demonstrate patterns of connectedness, Rob then explained how he used Sociometry when asking us to place ourselves in the room where we considered where we stood in relationship to our protagonist. Within psychodrama, the produced experience of response is

instrumental in building a different culture. In our situation, the new culture was one of connection, as opposed to the earlier culture of isolation.

Following our session, at Rob's suggestion, I did some internet research, and found the following web pages to be helpful.

Rob's psychodrama page is <http://psychodrama.tk>, and his home page is at <http://www.users.on.net/~iam/>

The Psychodrama Training Institute of South Australia can be found at <http://anzpa.org/ptisa>

The Australian and New Zealand Psychodrama Association Incorporated (<http://anzpa.org>) is, like CASA, a member organisation of [the Psychotherapy and Counselling Federation of Australia](http://www.psychotherapyandcounselling.org.au). A flag statement explaining psychodrama can be found there.

An interesting paper entitled "Social Atom Theory Revisited: SAT Redux", by Professor Rory Remer, Ph.D, Department of Educational and Counseling Psychology, University of Kentucky may be viewed at: <http://www.uky.edu/~rremers/sociometry/SATRDY.DOC>

Dr Adam Blatner, (prominent US psychiatrist and author), has published a large number of his papers on-line. He has broadly classified them under the headings of Psychotherapy and General Psychology, Psychodrama, Philosophy and Spirituality, and "Other Topics". His paper on the theory of psychodrama is at: <http://www.blatner.com/adam/pdntbk/pdtheory.htm>

All his on-line papers may be accessed from: <http://www.blatner.com/adam/papers.html>

Training and Development

Psychodrama Weekend Workshop

Workshop Friday 4 - Sunday 6 April 2008

Fri 7.30pm - 10pm, Sat 10am-6pm; Sun 11th 10am-5.00pm

Venue on Glen Osmond Rd, Myrtle Bank

More information <http://anzpa.org/ptisa/>

\$385 early bird fee for \$150 deposit paid by 28 March; \$415 full fee

Contact Rob Brodie iam@internode.on.net or tel (08) 8271 6023





Where Does My Grief Fit? A Personal Narrative of Disenfranchised Grief and Adaptation

by Ann Wilson.

This paper is a personal reflection on the disenfranchised and ambiguous loss I have experienced since my husband's accident in 1996. I will examine this situation from my perspective of wife/mother/carer as it relates to my own personal development, as well as my professional development as a teacher and counsellor.

Eleven years ago my husband was cycling when he was struck by a speeding drink driver. He was in a medically induced coma for two weeks. His condition was critical for the first week, and then he slowly began to improve (see addendum).

The initial trauma was so surreal - I felt like I was in a parallel universe. Everything was in slow motion; I was numb and afraid. We had 3 children (aged 4, 8 and 10) and the thought of him dying was so painful. Then there were the fears that he may live - in a vegetative state, as a quadriplegic, that he may never be able to come home, that we would never finish the mud-brick house we had been building, that we would lose the house as my husband was the sole income earner... The 'what ifs' were never ending.

Remarkably, he survived. After weeks in intensive care, the spinal unit, and the Julia Farr Centre for rehabilitation, he came home. And the grief began... From the fear of his dying, to the elation of his survival, people around me who had been such a wonderful support gradually fell away. It was 'expected' that, apart from the court cases (criminal charges against the driver, then civil case for compensation), our struggle was over. I, on the other hand, was reeling from the impact of his injuries. He was not the man I knew. He looked pretty much the same, but that was it. We had been together for 17 years, and

now he was a stranger. If I brought this up with friends/family, I got the usual replies "At least you've still got him", "It could have been so much worse" and the occasional, incredibly upsetting, "At least you'll get plenty of compensation"!

Doka defines this as disenfranchised grief: 'the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported.' He speaks of 'psychosocial death in which the persona of someone has changed so significantly...that significant others perceive the person as he or she previously existed as dead. In all of these cases, spouses and others may experience a profound sense of loss, but that loss cannot be publicly acknowledged for the person is still biologically alive' (1993, pp. 2&4). Self-disenfranchised grief occurs where 'the source is one's own lack of acknowledgement and recognition of it. The specific psychological phenomenon operating in disenfranchised grief is shame' (Doka, 1989, p. 25). I identify with this - the reactions of others to my expressions of grief had been very negative, so I quickly learnt that these feelings of mine were not sanctioned, and therefore unacceptable.

My inability to grieve was complicated by my husband's ongoing daily needs, the demands of being a mother of three, and the legal case for compensation (which was not resolved for 6 years) - we had no income and had to fight every three months for a cheque to cover wages. Doka, discussing economic and legal problems in relation to death, states: 'A surviving partner, as well as surviving children may have been financially dependent on the deceased in this type of relationship... this would add to the burden of the loss... and legal difficulties can complicate grief and make recovery difficult for all concerned in this type of relationship' (1989, p. 263). The same applies to those dealing with trauma and disability. Losses abound in our scenario.

Weenolsen (1988, cited in Bull, 1991) notes that losses are both direct and indirect. I found his categories are strong themes in my loss situation - loss of the 'person', loss of sharing, loss of contact, loss of family unity, loss of way of life, and loss of role functioning.

My husband lost his career, hobbies, his entire life style. I've lost my partner, my teaching career, my freedom. The children have lost a father. They lost me for a long time too - from my grief and because I spent so much time on the 6 year legal case. They lost a significant male role model, the innocence of childhood, and the structure of our family. The extended family lost a son, son-in-law, brother, brother-in-law, uncle. He is no longer asked to do the speeches at family celebrations, to be the wit at parties, to help people move house, join in anything physically or mentally demanding - all the things he loved to do. We had lost a whole lifestyle, yet, to outsiders, we looked the same.

The hardest thing to cope with is that this is never ending. Every day there are reminders of the losses. My husband is plagued by fatigue. Our lives revolve around his rest and activity times. His memory deficits require us to 'fill in the blanks', and he gets very frustrated by this. His decision making and problem solving skills have been badly affected. These used to be his strong points. He needs help working out tasks, and cannot be relied on for the simplest things, much less a crisis! He gets stuck in a way of thinking or acting (called perseveration), and needs someone around to help him to move on: e.g. he'll make 4 cups of tea one after the other, when what he actually wants is breakfast; he'll go over and over talking about a problem, unable to shift his thinking.

As a result of his brain injury, he developed bipolar disorder. His condition gradually worsened in the 18 months following the accident, with rapidly increasing cycles of depression and mania, until he attempted





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suicide. He was detained in a psychiatric ward for a month, and, after many months of counselling (which wasn't very successful because he has trouble remembering, making decisions and self monitoring) we managed to get his medication and daily routine right. He needs careful monitoring because any change in routine can upset the balance. It doesn't take much to set him in a flurry.

The children and I have adopted many of his former roles, while also trying to include him where possible. The family system has had to change. So, I am a widow who still has a husband. I am the mother of three who has four. Three of them are growing up and moving on, one will always be dependent. Boss talks about one type of ambiguous loss as 'a person is perceived as physically present but psychologically absent' and says it 'is illustrated in the extreme by people with...chronic mental illnesses. It can also occur when a person experiences serious head trauma, first becoming comatose and then waking up a different person.' 'Unlike death, an ambiguous loss may never allow people to achieve the detachment that is necessary for normal closure. ...People can't start grieving because the situation is indeterminate. It feels like a loss but it is not *really* one. This confusion freezes the grieving process' (2000, p. 9). This concept of frozen grief had a big impact on me – I feel validated.

Boss' book describes my experiences well. The confusion and distress, the helplessness, anxiety and depression, the physical and emotional exhaustion, the lack of resolution and the trauma, the living 'in a gray zone of ambiguity' (2000, p.48), the conflicts with extended family, the realization that 'devastation wrought by unresolved grief is only intensified when no one validates it' (2000, p. 59), the anger and the guilt that follows it, with her

many other examples of ambivalence.

To outsiders, this may seem completely hopeless and overwhelming. There have been many times when I have felt that way, when I have been at rock bottom. Yet there has been real power in those times. 'In the Greek language, crisis means turning point' (Boss 2000, p. 106). I continually discover good things that have come from my loss. Although I wouldn't wish the pain of this journey on anyone else, I am a better, more intuitive person. I am stronger, more empathic, more centred and, in many ways, happier. I'm a better parent because I am aware that anything could happen, and my children and I may not have each other as long as we might wish. I've gained sensitivity to others' pain and challenges. Hughes puts it well: 'Probably one of the best things that has come out of my loss... is learning to have faith in something (like healing or risking loving new people), even when I can't see the end result...there are no guarantees in life – we can't look into a crystal ball and know our futures. But we can take our losses and the good and the bad things that have come out of them and live the best lives we can' (2005, p.166).

In the first few months after the accident, I had brilliant support. The local community organised rosters for meals, ironing, handyman jobs, and help with the children. My family put their lives on hold, helping with everything they could. My husband's colleagues embraced us with financial and moral support. The most valuable thing they did was allow me to be me – not a mother, wife, or daughter, but an adult who needed to be listened to and 'vent', without judgment. They organized legal counsel, buffered me from media demands, and, when I was at a very low point, took me to a psychologist. I was reluctant to go ("I was fine"), but this was one of the best things I have ever done. His empathy, listening skills, and guidance put me on a road to self discovery which I may never

have found, had the accident not occurred. I learnt to shut the door on the 'what ifs', have confidence in my own abilities, to stand up for myself and my family (quite an achievement in the face of the legal and medical systems). He also helped me acknowledge and express my feelings. Viorst explains, '...acknowledged feelings are easier to control than those we deny' (1998, p. 281). He constantly encouraged me, and now I am empowered, I can say no without feeling guilty, I choose to self care without feeling selfish, and I take full responsibility for my life choices. My feelings are well stated by Tatlbaum: 'Recovery from grief is the restoration of our capacity for living a full life and enjoying life without feelings of guilt, shame, sorrow, or regret. We have recovered when we once again feel able to cope with our feelings and our environment, and when we can face reality and accept our loss on a gut level, not just intellectually (1993, p. 94)'.

Some medical staff also helped me adjust to my losses. They empathized with our situation, offered techniques to aid our daily coping, and supported us in the legal case. Some transcended their job descriptions, coming to our home, seeing the daily challenges, supporting and facilitating further help. Education about brain injury and bipolar disorder was also helpful. 'The act of seeking information eases the stress of ambiguity...and helps people conclude, 'We have done all that we can'' (Boss 2000, p. 112). Ritual has also helped. We renewed our wedding vows 2½ years after the accident. As we both felt we were different people, we wanted to recommit. This also helped the children and our 200 guests to recognize and accept the changes. Unfortunately, with my husband's bipolar disorder, our relationship has since deteriorated.

I have felt very alone at times during the past 12 years. For a while I went to a support group for brain injury, but found it hard to relate to people who were caring for severely





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physically handicapped relatives.

Everyone was so focused on the physical challenges of brain injury; there was little emphasis on the psychological challenge. There were many problems with my husband's family, who denied that he had difficulties. This created conflicts which added stress and trauma to our situation. Denial 'is harmful when it invalidates or renders people powerless.' 'It is the combination of optimism and realistic thinking that allows people to move ahead in spite of ambiguous loss' (Boss 2000, pp. 84, 92). I have found that by accepting what has been lost (what I can't change), and changing what I can (e.g. my role from 'wife' to 'carer'), I no longer feel helpless and overwhelmed. Keeping a Gratitude Journal helped me to stay positive. Woolfett says 'Think of all you have to be thankful for. This is not to deny the hurt... But it may help to consider the things that make your life worth living too' (2003, p. 77).

I was interested to note in Boss' cyclical model, her six guidelines for resiliency while having to live with ambiguous loss. They are: 'Finding Meaning, Tempering Mastery, Reconstructing Identity, Normalizing Ambivalence, Revisiting Attachment, Discovering Hope' (n.d.). Unknowingly, that's what I have done during

Conclusion

Having disenfranchised and ambiguous loss named, described and validated has made an immense difference to how I feel and think about my grief, and therefore, myself and life. My journey in and through grief will continue. However, I am able to face it with courage, strength and a sense of gratitude, knowing that I am not alone.

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Addendum

Police investigations found that the driver was doing 117km/hr in a 60km/hr zone, and had a blood alcohol level of .212% (over four times the legal limit). The helmet my husband had been wearing absorbed the initial impact, but broke. It was found on an embankment, behind a fallen tree, 8 metres away from where his body had landed.

My husband had a closed head injury, with 3 skull fractures (both temporal bones and a major basal skull fracture), a bleed in the cerebellum, 2 neck fractures (C6 & C7), ruptured eardrum, liver damage, and a fractured fibula and ankle with compartment syndrome leading to the loss of blood supply to his lower leg. His head injury was the main concern for doctors, as his brain was swelling rapidly. The normal range for brain pressure is 5-15mm/Hg. By Day 3, his pressure was 44mm/Hg, and I was told by his doctors that they did not think he would survive. But, after weeks of hospital treatment and Julia Farr rehabilitation, he came home.

His outpatient rehabilitation continued for two years.

The court case for compensation

Infertility and Grief by Shane O'Dea



Introduction

Anyone with a sex life knows fertility control is an issue for every heterosexual relationship. According to research by Business and Professional Women SA (n.d.), healthy couples in their mid-20s having regular sex have a one-in-four chance of achieving pregnancy in any given month. Consequently, it is easy to under-

stand why fertility control is primarily focused upon preventing pregnancy. Most couples want to plan when they have children; but what if they want a child and conception does not happen?

A large part of my practice is with families from an upper middle class socioeconomic background in their thirties and forties. Many marry in their early to mid thirties, and may wait a few years further before attempting to begin a family. I regularly encounter couples (mainly

the female partner) who are experiencing difficulty conceiving, and most of these couples delay starting a family until well into their thirties.

There are many reasons for infertility. Most couples think they will conceive almost immediately after they cease contraception. In reality, one-in-six couples (about 17 per cent) experience infertility. Infertility is defined as a failure to conceive after 12 months of regular un-protected intercourse (Cook 1987).

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The likelihood of conceiving at age 35 is half that at age 30. By age forty, the chance is reduced to half that at age 35. For men, fertility declines from age 35. Whilst *in-vitro fertilisation* (IVF) and other forms of medically assisted reproduction can help some couples, they cannot "fix" old eggs. Even with assisted reproduction technology, the likelihood of conceiving (not the likelihood of a take home baby) is less than 40 percent (DiGirolamo 2007). Five percent of infertile couples experience childlessness resulting from sexual dysfunction, with some couples having a poor understanding of the biology of conception (Read 2004).

Nature of the loss

Two groups of couples experiencing loss from infertility are:

- those who have significant difficulty conceiving but eventually successfully give birth to a child (often with the aid of medical technology), and
- those who, despite some years of tests, procedures and various treatments, fail to conceive.

For the purpose of this paper, I will address the loss of infertility in a general manner. However, it is important to note that experiences of infertility differ, and that well over 50% of couples experiencing infertility are unlikely to ever become parents. Additional similarities and significant differences between feminine and masculine experiences of infertility (Peterson, Gold & Feingold 2007) are not explored in this paper. Furthermore, the grief associated with infertility as experienced by parents, families and friends of childless couples is not addressed here.

Characteristically, infertile couples are often in crisis, and become increasingly anxious to conceive. However, not all couples view infertility as a crisis, nor will both members of the couple necessarily respond to the infertility experience in the same manner. Typically the

infertile woman presents with the most overt emotional distress, whereas the infertile man's distress is often less overt and may be more difficult to assess (Daniluk 1991).

Social stigma surrounding infertility means that few people are available with whom the couple can share their experience or receive support. Couples may experience sexual dysfunction, marital discord, clinical depression, and emotional, physical, spiritual or financial stress. The woman's monthly menstrual period can bring with it feelings of despair, isolation, anger, frustration, fear, tears and heartache.

Each individual's or couple's experience is unique, and may differ widely from the experiences of others. Losses experienced may be different, may be experienced on many levels, and people are likely to experience fluctuating levels of emotional intensity. The losses may include:

- the loss of being "normal", being able to conceive or have children, of *potential* for pregnancy, childbirth, and parenting children navigating various developmental stages
- the loss of the pleasurable and unifying aspects of sex in their relationship
- the loss of purpose in the couple's relationship (since its purpose can be reduced to conceiving a child)
- the loss of sexual identity
- the loss of self-esteem
- the loss of communication patterns
- the loss of genetic continuity (continuing the family tree)
- the loss of dreams and plans that may be central to the reason why the couple married
- the loss of the ability to provide grandchildren
- the loss of value to their partner
- powerful experiences of isolation

and loneliness from exclusion from the "parenting club" (Peterson, Gold & Feingold 2007). Infertile couples lose community with other mothers (or couples) when the focus of the lives of their friends/siblings become directed towards caring for children

- the loss of belief in the goodness of God. They may see their difficulty conceiving as "punishment" for past sexual sins or a previous abortion (Daniluk 1997)
- for women for whom the expectation of motherhood is central to their self-identities, difficulties conceiving can be devastating as conceiving a child becomes their central focus in life
- the loss of future life choices including friendships that couples may have developed with other parents.

Impact of the loss on those involved

Anne Woollett (1985) found that couples facing childlessness were trying to cope with:

- recognition of disruption in their lives caused by infertility, and attempts to reassert control (particularly by seeking medical assistance)
- education in fertility issues, particularly their own infertility
- dealing with the negative identity of childlessness in intrapersonal and interpersonal domains
- coping with loss
- attempts to develop a positive identity
- reviewing reasons for wanting to have children
- considering life beyond infertility to a life without children
- re-assessment of life goals and ways of getting their needs met.

C.S. Lewis wrote: 'sorrow ... turns out not to be a state but a process' (1961, p. 50).

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Infertility and Grief

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Couples' responses to infertility can be understood both as crises and mourning processes. The Kübler-Ross model (1981) incorporating stages of loss may be applied to individuals' process associated with infertility (below).

Disbelief and surprise

Whatever the history or cause of a difficulty conceiving, few couples are prepared when conception becomes a problem for them (Cook 1987, p.467). The contraceptive mentality when avoiding pregnancy leads to unrealistic beliefs that our bodies can be controlled. Consequently, it can be a shock to discover that "control" is not always possible where conception is concerned.

Denial

Denial is a common response to infertility, associated with unevaluated beliefs that good, healthy people can conceive. For many, denial is the initial coping mechanism, potentially retarding their progress through mourning.

Anxiety

Anxiety frequently intensifies monthly with each possibility of conception. This pattern persists until all hope of pregnancy is finally exhausted. Likewise invasive, personal medical tests and treatments engender experiences of anxious vulnerability. Such anxiety can manifest through worry, restlessness, difficulty concentrating and fatigue, and is best treated by focusing on the underlying infertility rather than the anxiety symptoms themselves (Peterson, Gold & Feingold 2007).

Anger and Loss of Control

Infertile couples, together with family and friends, may feel cheated. Insensitive remarks, teasing and pressure to reproduce may provoke anger, potentially expressed directly or indirectly. Expressed anger can disguise intense emotional pain. Targets might include single mothers, child-

abusers, and significant others who are procreating. Anger, directed inward as depression with associated learned helplessness, or outwards through expression of rage and bitterness, can lead to emotional and/or social isolation. The expression of anger commonly is mixed with feelings of intense grief, guilt and somatic distress (Shapiro & Cornell 1982).

Additionally, couples may sense that they have lost control of their life, and their future. Other life and career issues may well be pushed aside as their sole focus becomes "making a baby" with a sense of inadequacy at having not been able to do so.

Isolation and Alienation

Infertile couples often suffer estrangement from other people. Rather than dealing with the developmental expectations of friends and family members about when they are going to have children, they isolate themselves often as a form of protection.

Isolation intended to protect from embarrassment, pity, unsolicited advice etc. can result in external support systems evaporating. Parties and gatherings skipped to avoid the pain of seeing someone else pregnant or with a young child. Another's fertility (celebrated in baby showers, Mother's Day, etc) reinforces feelings of incompleteness, leading to greater alienation. Couples may engage in secrecy to hide their shame of infertility from family and friends.

Additionally, couples may experience strained marital communication, limiting understanding. Their sexual relationship, once a celebration of unity and pleasure, may become a symbol of pain and failure, with evaporation of passion and spontaneity. This can lead to avoidance of sexual contact, especially mid-cycle, to minimise repeated monthly disappointments. Other couples may only have sexual relations mid-cycle in a mechanical fashion in hope of conceiving (Cook 1987). The quality of a couple's sexual relationship is inextricably

linked to the physical and emotional health of each partner and to the health of the relationship (Peterson, Gold & Feingold 2007). With questioning of self identity comes the questioning of role expectations within the relationship of the couple (Reed 1987).

Guilt, Inadequacy and Low Self Esteem

Pervasive negative feelings about oneself are common in this crisis. Infertility presents major challenges to individuals' sense of wholeness, and such feelings may generalise into other areas of life.

Eighty percent of medical issues surrounding infertility are linked to either the male (40%) or female (40%) partner. Whereas only ten percent of the medical issues related to "couple issues" and a further ten percent are unexplained causes. The partner, identified by medical practitioners as most contributing to infertility is likely to experience guilt, self accusation and low self esteem at a deeper level than their partner. Past actions such as masturbation, abortion(s) and sexual indiscretions may increase experiences of guilt. Both sense of self as a sexual being and gender identity become especially vulnerable.

Sometimes, where one partner has a clear medical problem resulting in the couple's infertility, that partner may seek to abandon the marriage in order to free their partner to form another relationship in which the likelihood of having children is higher.

Depression and Grief

Infertility involves many losses with associated grief, particularly following diagnoses of conclusive infertility. Grief is likely to be disenfranchised due to the private nature of infertility and lack of social recognition and support. Individuals are at risk of complicated grief, and may experience psychosomatic problems, detailed fantasies of their unborn children, and doubt their ability to accomplish anything of

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Infertility and Grief

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value in life despite past accomplishments. For those whose diagnosis remains inconclusive, the grief process is difficult as they remain on the rollercoaster of a possible future pregnancy. It can cause depression, with feelings of hopelessness, powerlessness and inadequacy. Depression is common in infertile women, with levels peaking between the second and third year of infertility. Women with higher depression levels experience lower pregnancy rates and are less committed to infertility treatment (Peterson, Gold & Feingold 2007).

Religious and / or Spiritual Challenges

Infertility can lead to people questioning their religious or spiritual beliefs upon which they previously relied for strength and meaning. If they cannot reconcile their belief structures with their experience, they may enter spiritual crises and have further self doubt, feelings of worthlessness and diminished self-esteem.

What helps?

For many, infertility signifies an extremely difficult time in their lives as individuals and as couples. People receive minimal recognition, understanding and support from their usual support structures. The healing task of counselling is to work with the infertile person/couple towards acceptance. Couples need to work through their powerful feelings and reactions, so as to continue with the rest of their lives in a meaningful and peaceful manner. They may need to redefine how they wish their future to be, and why. Interestingly, couples who successfully resolve these issues may complete a developmental task in their relationships that other couples address much later (Cook 1987).

Read (1995) suggests opening up the discussion with the couple with questions such as:

- Has anything changed in your relationship with your partner

since you have been trying to conceive?

- How have your fertility problems affected your relationship, including your sexual relationship?
- How have your relationships with your family and friends changed since you have been trying to conceive?

Wills (2003) suggests that the focus of counselling (where possible) be on the relationship between the couple and their social environment rather than focusing upon individual therapy. To reduce the tendency to place the blame or to promote feelings of guilt, it is important for couples to acknowledge infertility as being a couple's issue and not a problem of individual partners (Daniluk 1991).

The counsellor's role is to use their professional emphasis on empathic support, developmental perspectives, and individual decision-making processes with a view to assisting the couple to face the future with hopeful anticipation rather than exclusively focusing upon their lost options or regrets (Cook 1987 p. 468).

Anderson (1989) argues that as couples come to understand their intense feelings of anger, denial, depression and grief they may well be better able to cope with their experience of infertility, and its interference with normal adult developmental tasks. As couples come to terms their infertility, they may need to re-evaluate their beliefs about life, spirituality and parenthood. It is important that counsellors are alert to differences in beliefs possibly existing between the partners. Counsellor can assist in their exploration and understanding of these differences, to help them find a way forward together.

Many couples describe their experience as a rollercoaster ride of emotions and find it helpful to understand common reactions to infertility (Jacobs & O'Donohue 2007). The couple's experience may be normalised by informing them of the psychological aspects of infertility,

and creating space for expression of their feelings about the medical procedures involved. Couples may wish to plan a timetable for treatment, and decide when to cease treatment. Wherever possible, counsellors can facilitate couples to heighten their feelings of control over their life and over the treatment process. Exploring strategies to deal with the pressure and insensitivity from others can also be useful. Infertility support groups can be invaluable in providing knowledge and support, reducing isolation, minimising depression and assisting with information for decision-making.

Minimisation of negative experiences around infertility and its treatment helps couples increase their emotional wellbeing, as do positive experiences such as engagement in fun activities and sexual activities not involved with conception. It may be useful to invite them to a deeper appreciation of their sexuality as a unifying experience, rather than as primarily a means of conceiving.

It may be helpful to invite couples to explore the distinction between *having a baby* and *being a parent* to assist them to understand their motivation. Possibly some of their desires can be achieved in other ways. Some couples discover in exploring the childless life-style opportunities not previously considered.

Ultimately, the counsellor accompanies couples on a stressful, difficult journey with the aim of supporting them with compassionate empathy, to help find a way through their crisis and to proceed with the rest of their lives.

Conclusion

The experience of infertility is a form of ambiguous loss involving recurring disenfranchised grief. The grief is not as cut and dry as the physical death of a loved one. Couples mourn the loss of the baby that they may never know. Each month, despite how hard they try to prepare themselves for bad news, hope

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Infertility and Grief

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arises that a baby will be conceived after all. Then, when the bad news comes again; the grief washes over infertile couples anew. This process continues month after month, year after year. Additional stressors include the financial cost of treatments, the hormonal impact with associated effects upon women's emotional states and mood, and the invasive, embarrassing aspects of medical treatment. Almost inevitably, couples' sex lives are impacted, and their relationships may be under threat.

Resolution may occur in one of three ways:

- They will eventually conceive a baby.
- They will stop the infertility treatments and choose to live without children.
- They will find alternative ways to parent, such as by adopting a child, becoming foster parents, or taking on significant roles in the lives of siblings' or friends' children.

Reaching acceptance can take years, and the couple's fertile family

and friends often provide limited support during this process. The role of counsellors in providing sensitive support, helping couples engage with their experience and to make decisions (as necessary) can provide the couple with moments of hope, grace and peace that draws them out of despair, grief and isolation.

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In the Name of Love...The Hidden Grief of Navy Families by Tracey Bone

In this paper I will explore and reflect on the nature and effects of three types of loss, i.e. disenfranchised, ambiguous and anticipatory loss, and reflect upon my unresolved grief related to personal experience directly consequent of being a navy wife. The two specific aspects of navy life I will concentrate upon are the meaning of my husband's absence, and moving due to postings. I will explore how these two issues incorporate many different layers of loss. I will identify personal values of rituals, memorabilia and symbolism assisting me in these demanding times, along with various strategies enabling me to address loss and grief issues on a professional level.

Stuart and I met when we were sixteen and "fell in love". Like the fairytale princess. At that "precious" time I had no idea I would spend



most of my life apart from my husband and be bringing up our children as a single, but unavailable,

mother. When reflecting, hindsight thoughts kick in.

There is a huge range of benefits to being married to a sailor. It enables me to live in most States and Territories of Australia. I experienced the Sydney New Years Eve fireworks from the Navy vantage point, lived near and explored the Daintree, and made many special friends along the way. Friends and family liken it to a full time holiday, and often say, "You are so lucky".

While I love the excitement of moving to new places, there is a flip side. Loss. I am excited when I find out we have another posting - another adventure. I love staying in 5 star apartments, sitting by the

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pool with the kids, and dining out each night while people pack up our house. It is fabulous - what a life. It's a great feeling when people arrange furniture in my new house. I use the word house as opposed to home as 'achieving this (home) requires a positive attitude and hard work' (Parfitt 2007). I also experience loss of identity and security with the ambiguity of what "home" means. When I explore the new local shops, it's fun. But then it hits. Loss. I miss the rolls at my old deli, I miss my friends, and I miss the way the children's teachers used to greet them. Sadness hits. Then I do what I do best to avoid dealing with these feelings- I get busy. While this is a great distraction, I now realize I need to grieve the losses in some way.

When we were young, I didn't look back, only forward. Each place was a new adventure. This has become an inbuilt defence mechanism. "Don't look back, don't look back". It is increasingly difficult to tell myself this and believe. But I do it. In recent years I have found postings involve anticipatory loss. Now I start to consider the losses I will experience, but then excitement completely takes over. This ambiguous loss makes me feel ambivalent and exhausted. I realize I need to examine my defences and coping style in relation to unresolved grief before I can be of benefit on a professional level.

If there is one key word to survive the transition and turn it into a positive experience, that word is support. Support is what you leave behind and need so badly. Unfortunately, 'the very nature of the disenfranchised grief precludes social support' (Doka 1993, p. 6). Postings create a lack of social support when most needed. Through planning, you can take support with you, however. Maintaining contact with friends e.g. by email, is essential. It teaches your children that friends are not forgotten. While saying

goodbye is hard, there is no value in deciding to live without friends at every posting. Friendships are vital. If you learn to live without friends, children follow your lead, and living without closeness is isolating.

The hardest and most layered loss occurs when my husband goes to sea. For the past four years he has been at sea for months on end. The fairytale princess would not put up with that, nor live that way by choice. Huge anticipatory loss comes with deployment. The days before Daddy leaves should be time for loving goodbyes, but are not. Tension is huge, kids are in tears, my husband represses guilt and I become numb and busy. It is horrible. The family behaves irrationally during emotional intensity.

Once he leaves I am lonely, empty and often isolated. As a mother, and 'in a culture where self control is highly valued (I have to) maintain a façade of strength and independence' (Freeman 2005, p. 83), and internalize my grief, as I have two grieving children to care for. Consequently I sit with other people's grief whilst suspending my own process.

People, with exception of other navy wives, DO NOT understand. Help and support is essential to coping. Comments from outside the navy are often unhelpful and isolating. "Stop complaining. Look at the money you're getting" (Money means nothing at this point); "Why would you stay with him?" (What would be different if I left?); "We will have you around for dinner" (never happens until you are back as a couple); "He's out sailing around the world having fun and leaving you with the kids. What a life!" (Gee, thanks for pointing that out to me); "How do you do it? My husband was away for two nights and I couldn't cope. I wouldn't be able to do it". (Like I have a choice!); "Why would you want to live that way?" (I don't). So to not be seen as a whingeing navy wife, I say nothing, become numb, get on with life and cry myself to sleep at night. The loss is disenfranchised and 'the central theme in counselling the

disenfranchised grievers is to validate loss' (Doka 1993, p. 7). Navy wives, true friends and helpful family members have helped validate losses by listening empathically and by saying "I'll take the kids for the afternoon"; "Come for dinner Friday night"; "Lets go to the show together"; "Wine at 6 in the court. Kids invited". Some family members try to fix the problem and take over. This is unhelpful and plants seeds of self doubt that maybe you can't cope. You need support, empathy and understanding. You need someone to complain to without judgement (which is normally your husband). You need to vent and validate (Doka 1989). You need support with the children and not be made to feel inadequate in asking for help.

I have developed enormous amounts of strengths including independence, resilience and high levels of coping. However, there are significant losses when your husband is away. Deployment covers the five levels of losses described by Weenolsen (1988). "Primary losses" include loss of companionship night after night, week after week, month after month. Limited contact means the loss of communication. "Secondary losses" include loss of security and safety of a male in the house. "Holistic losses" include loss of the family unit and loss of everyday events. "Self concept losses" include the increase of various roles and responsibilities with consequent losses of freedom, sexual partner, someone with whom to vent and frequently the loss of sanity. The "metaphorical loss" is numbing. What happened to the fairytale princess? It's hogwash. My dreams are dead. Before having children, I felt frustrated when navy wives with children complained about their husband's absence. I was intolerant of single parents. I now spend time helping the children cope with losing their father (worse in its anticipatory phase), as Dad is often very busy at work when preparing for deployment. It would help to take time out for myself to

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*In the name of love –The hidden grief of Navy Families
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reflect on both my losses and strengths. These strategies would likewise be helpful for clients in similar situations. I have learned through reflection, the importance of maintaining open-mindedness and flexibility when respecting individuals grieving processes.

When Stuart is away my two girls and I each have our own "dog tag" necklace which we wear. This has his basic identity - name, D.O.B., religion, blood group. He has to wear this while at sea, so it's a symbolic bond that keeps us together. When I feel angry at him for leaving, I hold the dog tag, remembering he is in a war zone. It somehow brings me out of the negativity (at least until the kids have another fight), and I feel proud of him defending our freedom in Australia. This allows me to normalise the situation.

We bought art works at some of the places we lived, to remind us of those places. At destinations where we didn't, I have an obsession to revisit them for a holiday, just to get a painting. I now realise this is an important part of my grief process. Revisiting is a ritual, and the art is a symbol of memory in my heart. In those places we didn't buy artwork, I become panicked, like I need something or I will forget those special places, and part of my identity will be lost. I know I won't stop obsessing over getting these artworks until achieving my goal. Then I can lay that place to rest in my heart and honour it as a unique and special time in my life. I reflect on the symbol with a sense of contentment, and value its place in making me who I am and shaping our family.

Having rituals and meaningful memorabilia help the grieving process. 'Counsellors can help clients plan and implement rituals to aid in their grieving process but stresses simplicity for sensitivity of over complication' (Doka 1993, p. 7). Rituals, such as sending

personal video of the occasion, lighting a candle, or saying a prayer for Dad, have helped us deal with STUG reactions triggered by birthdays etc. in his absence.

My husband is home now, and struggles to fit into "normal" life. He has experienced many losses, both similar and different to myself, but his homecoming creates further losses for him, and I recognise his struggle and need to grieve. We will move again at the end of this year. My daughter is eight and for the first time she has expressed feelings that she doesn't want to go. While she is excited about a new place, she doesn't want to leave her friends. This impacts me emotionally. I feel both positive about the move, and sad inside because I don't want to leave my friends either. We are planning a going away party with her close friends, a ceremony for her to mark the end of the old, so she can move contentedly to meeting new friends with the knowledge she won't forget or be forgotten. She will do scrapbook pages with photos of her friends in Adelaide so she can always reflect on the memories. My second daughter is five and is more excited than sad, but her turn will come when leaving friends. Scrap booking reminds us of things, places, people and events that have made us who we are. In this way, memories are held in high regard in a treasured medium. Creative expression helps people who are fearful of losing memories to emotionally relocate and move on. I write journals of the children's lives so they know where they come from and where they have been. My daughter is also beginning to journal.

Using the senses to remember is important. My daughter sleeps in Daddy's t-shirt "Cos it smells like Daddy". Music may help some people experience and express their loss. Creative expression is utilized by many cultures to facilitate grief. Children naturally do this when grieving 'to let off pressures that can be building up inside' (Stevenson 1995, p. 3). I

value this tool for grieving clients.

Before I can benefit people on a professional basis with grief and loss, I need to complete Worden's "four tasks of mourning" (1991). In my situation these are:

1. Accepting the reality of each post-ing loss through venting and validation
2. Working through the pain of grief through creative expression e.g. journaling, revisiting, rituals
3. Adjusting to a new environment by social support, and getting busy
4. Emotionally relocating loss and moving on by obtaining meaningful memorabilia pertaining to the loss, and experiencing its symbolic meaning when moving forward.

Conclusion

The experiences I have encountered and areas I have identified as helpful in relation to loss, give me many strengths in skills, knowledge and self awareness in the ability to guide others through their grief management. Skills and knowledge in children's grief contribute to my ability to guide grieving children and families. Before the UniSA course, I had no idea of the wide range of losses that I had experienced, as they were disenfranchised and ambiguous. I now understand my obsession with revisiting places and obtaining meaningful artworks. Rituals, memorabilia and appropriate social support in relation to posting and absence are much more important to me than I realized. I will take responsibility for rebuilding on my unresolved grief through self awareness as in Melanie Parry-Jones (2007) words, 'It's never too late to grieve'.

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Counselling Calendar

<p>Saturday, 5th April 2008</p> <p>2:00 pm - 5:00 pm</p>	<p>CASA Professional Development Seminar</p> <p>Acceptance Commitment Therapy: The Third Wave of Mindfulness, Metaphor and Magic</p> <p>Presenter: Peter Toman \$15 for Association Members & Full Time Students, \$35 for Non-Association Members (Pay by cash or cheque on the day)</p>	<p>Uniting Church, Unley, cnr. Unley Rd & Edmund St</p>	<p>Viv Maitland, PD Convenor, email profdev@casa.asn.au</p>
<p>Friday 4th - Sunday 6th April 2008</p>	<p>Psychodrama Weekend Workshop</p>	<p>Glen Osmond Rd, Myrtle Bank</p>	<p>Rob Brodie (08) 8271 6023 http://anzpa.org/ptisa/</p>
<p>Saturday 28th June 2008</p>	<p>CASA Annual Conference</p>	<p>Education Development Centre, Milner St, Hindmarsh</p>	<p>Booking details to be advised in Email News</p>
<p>Saturday 16th August 2008</p>	<p>CASA Professional Development Seminar: Choice Theory & Reality Therapy with Joan Hoogstad</p>	<p>Uniting Church, Unley, cnr. Unley Rd & Edmund St</p>	<p>Viv Maitland, PD Convenor, email profdev@casa.asn.au</p>
<p>Wednesday 3rd September 2008</p>	<p>CASA Annual General Meeting</p>	<p>Uniting Church, Unley, cnr. Unley Rd & Edmund St</p>	<p>Geoff Haynes Ph (08) 8331 2255 admin@casa.asn.au</p>





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In line with the purpose of this publication as a forum for information, communication and education, the advertising policy is as follows: all advertising material submitted will be published, or not, at the discretion of the Editorial Committee.

Two kinds of advertising are available, namely calendar listings and advertisements.

- 1) Calendar listings provide information about forthcoming events such as conferences, public talks, seminars, workshops and courses run by groups, organisations or individuals. They may be submitted by all members and subscribers. Submissions must include the following minimum information only: event name, day(s), date(s), and time(s), venue, cost, contact name and details. Calendar listings are free of charge to members and subscribers.
- 2) Advertisements are charged according to the size of the advertisement (see examples below). This fee constitutes the purchasing of advertising space only. Layout, type-setting and artwork may be provided for an additional fee.

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Workshops, seminars, training courses, conferences and other events of interest to counsellors and subscribers in CASA's biannual calendar and periodic Email News. Events may also be advertised in the Newsletter (see our Advertising Policy). Editorial copy and articles related to events are also invited. Send details to Editor prior to the biannual deadline.

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2 columns x 5cm \$60	2 columns x 10cm \$90
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CASA Key Objectives

The key objectives of CASA are:

- to promote understanding and awareness of counselling in South Australia;
- to define, maintain and expand standards of practice, training and supervision;
- to foster an association which includes the wide range of counselling theories and therapeutic approaches and practice;
- to provide a supportive network for organisations, counsellors and other people using counselling skills;
- to represent counselling and counsellors at community, state, national and international levels;
- to contribute to the counselling profession by supporting research and education;
- to further the interests of counselling, clients and the community through pro-active socio-political activities.

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Membership:

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CASA is Important

For counsellors you can:

- have appropriate recognition of counselling training, skills and expertise;
- meet with colleagues;
- participate in professional development activities;
- keep informed of developments in your profession;
- voice issues that concern you and your clients;
- promote your services through the website directory, Email News and Newsletter;
- apply for inclusion on the national PACFA directory;
- contribute to the standing of counselling and psychotherapy in the community.

For the public and consumers, you can:

- identify a practitioner who has a recognised high standard of training and ethical practice;
- seek information on matters relating to counselling and psychotherapy;
- direct concerns about the professional practice or conduct of a member of the Association.

For the Government:

- CASA provides an interface between the professions of counselling and psychotherapy and government organisations, both at state and national levels.





Invitation to attend a workshop

Supporting those Experiencing Disenfranchised Grief

Friday, 9th May 2008 - Adelaide

Presented by Annie Cantwell-Bartl

This workshop will explore the topic of Disenfranchised Grief and the growing awareness of the types of loss that people can have grief experiences through. The workshop will discuss grieving styles and how they can impact of the disenfranchised nature of grief. The workshop will also look at effective strategies for professionals who are working with those experiencing Disenfranchised Grief.

Date

Friday, 9th May 2008

Time

9.30am – 4.30pm

Registration from 9.00am

Venue

The Royal Adelaide Hospital
Level 1

Eleanor Harrald Building
North Terrace

Adelaide SA 5000

Lecture Theatre 1.22

Cost (includes GST)

\$175.00

ACGB Member \$140.00

Morning tea, lunch and
afternoon tea provided

Limit

24

Registration closes

26th April 2008

Registration is essential

TO REGISTER CONTACT:

Australian Centre for Grief and
Bereavement
McCulloch House
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ABN: 22 038 903 478

Reg No. A0032503K

Designed for

Professionals working with those experiencing disenfranchised grief such as, teachers, counsellors, nurses, therapists, psychologists and other allied health professionals

Learning Outcomes

At the conclusion of the workshop participants will be able to:

- discuss the concept of Disenfranchised Grief and it's implications for the grief experience
- identify the range of experiences which can be disenfranchising for grieving people
- identify appropriate clinical interventions to assist those experiencing Disenfranchised Grief

Presenter Profile

Annie Cantwell-Bartl BA RN Grad Dip Counselling Master Counselling and Human Services MAPS

Annie Cantwell-Bartl has a professional background as a psychologist and a nurse. She works in private practice and is a consultant educator. Her area of speciality is grief and trauma and the impact of serious illness and disability on a family. She has lectured and researched in the area. At the present time she is completing a doctorate on the impact on parents of a child's disability. She has won awards for her work including the Pauline Toner University Award (2002) and the National Association for Loss and Grief, Media Award (2003). She is the author of *An Unrecognized Grief: Loss and Grief for Carers*. Published by the Carers Victoria.

A Practical Introduction to Working with Small Figures

with Dr John Barton
Adelaide, Friday 9th May, 2008

Learn how to use toy figures with counselling and therapy clients. Small figure work is a powerful and effective method of working with adults, adolescents and children.

This workshop will focus on working with adults in the one-to-one setting, This can be directly applied in couples and in family therapy, in supervision and in workplace/management settings.

Participants who work with children will need to modify the work to suit their clients.

Using small figures enables clients to:

- Express and understand their knowledge of the family and social systems they inhabit.
- Experience themselves and their stories from both internal and external perspectives.
- Connect with feelings and understanding that are held in nonverbal memory.
- Concretise and thus more fully experience their hopes and wishes for the future.

This workshop will cover:

General principles of combining small figure work with talk-based methods.

A specific way of using small figures to work with a client who has a difficult relationship.

A specific method for bringing to life the memories, feelings and actions of functional roles. This is particularly useful with depressed clients.

How to obtain small figures.



The workshop will be experiential.

Participants will have the opportunity to be both the client and the therapist. There will also be demonstration and discussion of practical and theoretical aspects of this work. The day is likely to be enjoyable and to heighten participants' appreciation of themselves.

Much of the content of this workshop was developed by Dr Carlos Raimundo as part of the "Play of Life" method.

John Barton is a psychotherapist and psychodramatist in Melbourne. He was a GP for over twenty years. He has taught small figure work in USA, Europe, Asia Australia, and New Zealand. He has a lighthearted teaching style which shows his enthusiasm for small figure work and his joy in the practice of psychotherapy.

Place: DIRC, 195 Gilles St, Adelaide.

Time: 9:00 am to 5pm, Friday 7th March. Morning and afternoon tea will be supplied and there will be a one hour lunch break.

Cost: \$ 140 (Concession \$90)

The workshop will be limited to 16 people.

For further information and to register contact John Barton.

email: jbarton@aapt.net.au

phone (61 3) 9480 6335.