

THE MEANING OF ‘FAMILY’ & ‘INDIVIDUAL’ IN SELECTED SOCIAL POLICIES: revisiting assumptions about age, gender and parental obligation

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Introduction

This paper arises from my reflections on experiences of ‘care’ with adult family members: both those living in shared households and those living elsewhere. I am concerned both with the implications for policy and related policy practices by health and human services personnel. I will explore the contradictions in family and family-related policies and practices as they impede democracy and co-operation within family groups and networks. The paper will explore selected examples of two sets of assumptions influential in family policies: definitions of ‘family’ and ‘individual’ in private health insurance policies and in Federal social security arrangements.

First, I will be concerned with assumptions which are related **to age and parental obligation.**

Family and family-related policies concerned with ‘care’ and ‘co-operation’ between resident family groups, especially involving adults, and non-resident family networks concerned with inter-generational caring are fraught with contradictions and barriers to co-operation. For example, adults over 18 years are treated as individuals, in spite of increasing numbers of young people being at least partially dependent on parents for longer periods. Related adult family members living together are considered ‘individuals’ for purposes such as health insurance, regardless of ‘who pays?’ and ‘who can afford to pay?’ Similarly, adult family members of non-resident ‘care’ networks have no particular rights to information or support, in spite of implicit expectations, from themselves, as well as from service providers, that they will be ‘active carers’. Such contradictions demand a revisiting of assumptions about ‘individuals’ and ‘family’.

Second, the paper will briefly consider **gender assumptions**, as they are implicitly present in a hierarchy of needs and imputed rights, antagonistic to co-operation and democratic meeting of needs of women, men and children. Using Eichler's (1984) framework, my paper will revisit and reconsider, sixteen years later, how individualism and familism operate in Australian family policies.

Eichler's (1984) models of 'family' in social policies:

Family policy makers have long debated the extent to which policies do and should treat citizens as 'individual units' or as 'family units'. Margrit Eichler's (1984) key note address at the International Seminar on 'Social Change and Family Policies', auspiced by the Australian Institute of Family Studies, in Melbourne 19-24 th August, 1984, addressed this issue. In the context of examining the contradictions of income support and child support policies for one parent families, Eichler pointed out the impossible situation where men, as major income providers, were expected to carry the economic costs of children from serial families. Based primarily on Canadian experience, but with international significance for all the Westernised nations, she identified

'the two most important characteristics for social policy purposes of contemporary families in highly industrialised countries as:

- (1) a significant discrepancy between household and family memberships and
- (2) the co-existence of one-earner and two-earner families' (p431)

Both of these claims are relevant for contemporary Australian family policy and practice, although typically in Australian policy 'family' and 'household' have been treated as synonymous.

Eichler argued that

'First, the family is taken as the administrative unit for economic and social welfare policies, while we are, second, faced with a diversity of families with respect to their composition and economic structure, and where, third, the family is seen as the major economic support structure for its members, we will necessarily run into administrative and social justice problems which may, in extreme cases, even produce the effects that specific policies were aimed to alleviate the negative consequences of.'"(p431)

All three elements of her argument appear to me to be borne out in contemporary Australia. For this reason, I am drawing on Eichler's excellent paper as a starting point and framework, and wish to use it as a point of evaluation to tease out 'how far we have come' in Australia in our recognition of assumptions about 'individuals', 'families', 'age' and 'gender' in the sixteen years since that seminar.

Eichler made a theoretical contribution in that paper by proposing that there were three models of family policy in westernised industrial nations.

- The **patriarchal model** (pp439-447) in which household and family are treated as synonymous or congruent, husband is equated with father, and income earner; mother is equated with wife and responsible for household work and child care
- The **equalitarian or egalitarian model** (p 447-454) in which either the husband or wife are responsible for income earning, household work and child care. If they are sole parents, it is likely that they will be required to do all of this.
- The **emancipated model** (p454 ff) which occurs 'when policies, by treating people administratively as members of families rather than as individuals, inadvertently or advertently discriminate against some types of families' (p454) This model was presented as an 'ideal type' not yet implemented, presented for prescriptive policy discussion. She suggested it would show the following features:
 - '(1) Every adult is considered responsible for his or her own economic well-being. If a person is unable to support him or herself, the support would shift to the state, not a family member.
 - (2) When an adult needs care, be it for permanent or temporary illness or handicap (including senility), it is the responsibility of the state (not a family member) to pay the costs of such care.
 - (3) The cost for raising children is shared by father, mother and the state, irrespective of the marital status of the parents.' (p455)

Looking back, this prescription has been relevant to the developing policies for child support in both one and two parent families, although both economic and social provisions have been difficult and fraught with hazard. Family violence, violence at separation, child abuse in two-parent families & even on officially recognised access visits after parental separation, sporadic and uneven child care arrangements (from supervised access visits through to full-time custodial care or residence, after family separation) have yet to be prevented by family policies or practices in Australia – and remain far from positively promoting democratic and co-operative familial and social relationships.

Eichler's emancipated model does not speak to other forms of care related to inter-generational relationships with aged parents or relatives. Clearly, in the sixteen intervening years, the rise of pro-family policies by Conservative and new right governments has seen the element of 'state support' in retreat, rather than expanded. 'State support' has remained, at best a minimal safety net. Regarding family support services, in Australia the churches and non-Government sector have been required to provide housing, care, nursing help, handyman services and all manner of 'family substitute' care provisions, to supplement state provisions. Non-government agencies simultaneously sought Federal 'Strengthening Families' funds, as well as sold off their properties and sought donations in order to increase their running costs to respond to demand. In short, contradictions between stated claims of compassion for families by the Federal Liberal-Coalition and actual policy practices at both federal and State levels were astounding..

The meaning of 'family' in contemporary social policy:

When the Howard Conservative Government introduced their '**Strengthening Families**' policies in 1996, we saw, in Australia, a strong ideological push toward what we used to think of as 'traditional families': that is, men as income earners in the public sphere, with full-time wives supporting them from the family home. It is this model which Eichler and other feminist analysts call patriarchal. With media co-operation, John and Jeanette Howard were presented to the Australian public as the 'ideal family couple', a projection of familism co-existing with possessive individualism (as discussed by Gillian Dalley, 1988, in *Ideologies of Care*). Not all of Australia's Prime Ministers have presented their wives and families as part of the leadership team. In fact Di Langmore (1992), in her wonderful account of Australia's *Prime Ministers' Wives* observed that it was not until Robert and Patti Menzies (1939-41; 1949-1965) that the Australian pattern of wifely public activity emulated the

model of the United States of America 'First Lady'. The husband/wife/leading couple image, adopted by the Howards added to Howard's populist words promising care to ordinary people, has presented a benevolent patriarchal image of national leadership. This provided a façade for a marked period of privatisation, punitive approaches to income support policies, and a moralistic stance about 'individual responsibility' to be required of ordinary citizens. Discussion of rights - the other side of the liberal expectation : 'responsibilities *and* rights' – retreated, and was replaced by the term 'mutual obligation'. In practice the emphasis was on the obligations of individuals. Market citizenship (a term coined by Anna Yeatman) ruled the day – rights became entirely dependent on what individuals and families could afford.

The statement accompanying the 1996-97 Budget, presented on 20th August 1996, by the Hon. Judi Moylan, Minister for Family Services, to the House of Representatives in Canberra, opened with the following belief statements and claims:

'The family is the core social unit in our society. For generations the family has endured as the primary and most effective provider of assistance and support for people of all ages and backgrounds. The Coalition is absolutely committed to ensuring that the needs of families remain at the centre of public policy. One of our highest priorities as a government is to relieve the financial pressures on low and middle income families bringing up children.'

The Government recognises that providing an economic and social environment in which families can achieve their full potential is crucial to maintaining a strong, cohesive and compassionate society.' (Bolted , as in original publication)

In spite of this promised commitment to assist low & middle income families, in fact, since 1996 we have seen increasing economic inequalities; more young adults now living with their families of origin for economic purposes; 'work for the dole' and now a 'Fight-for-Dole Plan' (*The Age*, 2000, 24th July p 1), that is, the right to join the Army reserves, as an alternative to civil volunteer work while on unemployment assistance for the many young people who have been unable to secure a place in the full-time paid labour force.

Since 1996, Victoria has surpassed New South Wales and Tasmania as the Casino centre of the continent, under guidance of Jeff Kennett's negotiations with Crown Ptv Ltd . during his period as Premier.

Associated with the development of gambling, there have been dramatic increases in drug use. The recreational use of heroin, cocaine and ecstasy drugs, and resultant problems of addiction and death, have reached epidemic proportions in Victoria, just as use of drugs for competitive purposes in sport have commanded national and international attention. Yet the drug policies affecting families have not promoted more 'detox' facilities, more rehabilitation centres, more family support programs, pathways back into productive paid-work. Nor do drug policies address the supply of drugs, through importers and/or manufacturers in a multi-million dollar industry. In Victoria, we are stuck on a local debate about the pros and cons of 'safe injecting facilities'. In itself the essence of this proposal is about saving lives, and this motivation has driven the 'pro' case in the debate. What has been missing in the public debate is widespread discussion about a comprehensive prevention and rehabilitation approach to the abolition of drugs, offering opportunities to ex-drug addicts to regain a position of harmonious and productive social participation, and providing support to their families, before deaths by overdose or suicide occur.

Young people are more and more likely to be living longer with their families of origin, or returning to live with them if socio-economic circumstances require the need for cheaper living, or more personal, emotional, social or economic support. This means that households are likely to contain more co-resident adults, who, in policy categories, are treated as 'individuals', even if they are members of a biological or legal family. Much of this co-residence appears to be driven by economic circumstance. Credit or bank loans rely on individual economic capacity & credibility, although actual access to money, rent bonds or down-payments for housing, as well as 'recurrent' living costs will vary with family of origin circumstances and capacity for access to cash or credit.

Over the four years since 1996, as drug-related deaths, and deaths from suicide, have increased in Victoria, capacity for the young people & their family members to obtain help has been fraught with obstacles. Staff shortages and ill-equipped staff have been associated with punishing experiences for people seeking help. For example:

- If a person decided to seek help with drug addiction, a slow process of assessment occurred and then they were put on a waiting list. To receive help, the person has to be 'clean' or drug-free for seven days. Home detox was the most likely alternative to prison or hospital for becoming 'drug-free', prior to entering rehabilitation. This reflects the dire shortage of detox centres.

- Help in suicide or health crises has been difficult for families to obtain. For example, on one occasion a woman called the area Crisis Intervention team on a Saturday evening in 1998, worried that her adult son was at risk, with possible concussion following a mugging. The rather snappy, frantic person on the phone is reported as responding: 'We are dealing with 16 suicide attempts here, if you are worried, call an ambulance and get your son to the emergency department of your nearest hospital'. How a woman might lift a half-conscious adult male into a vehicle, or afford an ambulance if the prospective patient was not a member of the Ambulance Association was not information offered to the woman caller. In addition, given the crisis in the Ambulance service in Victoria in the Kennett period, and deaths imputed to be related to delayed response, it would have been hard for the woman to be confident that the Ambulance would come within minutes when called.
- Private hospitalisation has been offered as another route for drug addicted or suicidal young people. Those in the grips of drug addiction have usually sold all their belongings, sometimes some of their family belongings as well, be in debt, and, perhaps on sickness allowance. Sickness allowance does not fund treatment in private hospitals, so, again, the young person is dependant on family resources, and the very limited public detox and rehabilitation facilities.

Family private health insurance arrangements are a further barrier to obtaining assistance for adult family members with any health-related affliction, if they are not themselves covered by 'singles' insurance. Private family health insurance will not cover an adult 'individual' living with their parent or parents, as 'family' means dependant children under 18.

For example, HBA health Insurance describes Family membership as covering 'the member, a partner and any single children under 17 years and single full-time students under 25 years'. (National Mutual Health Insurance Pty Ltd - trading as HBA. *Health Insurance* Booklet 2000, p8)

Or

Medibank Private states 'Family memberships cover the contributor, spouse and dependent children until they turn 18. Unmarried student dependents attending an approved course of study at an educational

institution may be included on the family membership until the age of 25. (Medibank Private brochure, 1989.) Recent Medibank Private promotion materials are mostly geared to 'active singles'. The types of membership offered are: 'single membership covering one person only; couples membership covering the member and their spouse; single parent family membership covering the member and one or more dependant children; and family membership covering the member, spouse and one or more dependant children.' (Medibank Private, 1997, *Product Guide*. Melbourne.) Medibank Private offers a 'Family share and save' payment program, which allows family heads to pay excess 'similar to that on car and house insurance policies, to save on your contribution payments' (Payment Options Brochure, p6).

The restructure of the **social security system** and the formation of the Centrelink provider agency also provides examples of the implicit family support expected for social assistance recipients. For example:

- **Youth Allowance** was introduced on 1st July 1998, replacing Austudy for full-time students under the age of 25 years; youth training allowance, newstart allowance for under 21 year olds; Sickness allowance for under 21 year olds and Family Allowance for some secondary students aged 16-18 years old. (Commonwealth Department of Family & Community Services, *1999 Centrelink Helping Families*. Canberra, January 1999, page 51)

Nowhere in this list is there mention of the age of 18, the official age of adult citizenship. Students eligible for Austudy are also subject to the Higher Education Contribution Scheme (HECS) which leads to a sizeable debt, at the end of a period of education, increasing over-time now with interest of 12% per annum. Families who can afford to make the fee payments 'up front' are able to prevent their son or daughter accruing such a debt.

- **Parenting Payment** combined the former Sole parent Pension and Parenting Allowance into one payment and introduced a payment for the full-time carer in Partnered relationships. For a partnered parent, a dependant child is one 'under 16 years of age' or 'a child over 16 years of age who qualifies the person to receive Child Disability Allowance'. (ibid, p31)

- *Child Disability allowance* is for children with a disability under 16 years, or full-time students with a disability up until the age of 21 years. (ibid, p59)
- *Family Allowance*, that once universal payment to assist in raising children, is now assets and means tested, but does treat 18 years as the official end of childhood, as long as the children are in full-time schooling, otherwise the cut-off is 16 years.
- The *Family Tax Initiative* was introduced on 1st January 1997 to provide 'help to families with dependant children'. (ibid p18) This is geared to provide positive payment to low-income families, similar to the Canadian Child Tax Credit, which was more universal to parents with children under 18. The definition of dependant child in the Australian Family Tax Initiative is the same as for family allowance – 16, plus recognition of older students in full-time education.

From the point of view of Conservative government policy, young adults are variably treated as 'individual units' and 'family members'. Definitions of 'family' are not consistent with 'shared households' of related or unrelated adults, but rest on biological or legal family relationships with variable age cut-off points for eligibility. Co-residence is a lesser contributor to definitions of 'family'. Non-residential care and support provided by parents to young people or young adults, who are not independently established, goes unrecognised.

Since 1996, Governments have discovered 'anxiety' and 'depression' as emotional states experienced by at least one in four Australians at some time during their lives. Perhaps the peak of irony in Victoria is that former Premier Jeff Kennett has been appointed by Federal Minister Woolridge to head up the \$5 million National Centre for Depression. Any social science student of the links between structural conditions and personal emotional well-being will have readily made the connection between the casualisation of labour, higher interest rates, high price of everyday life in Victoria under Kennett and 'anxiety' and 'depression'. In fact, individual 'deficit' (leading to blame) and required 'individual responsibility' was perfected to such a degree in these years that mental health strategies virtually replaced debate about working conditions, fair remuneration, secure jobs which could support family housing, and planning families futures. Reith's policies of anti-unionisation and

‘individual responsibility’ were supported in Victoria with vigour, to the extent that anxiety and depression reached epidemic proportions, associated with alienation and a palpable sense of widespread hopelessness about the lack of future opportunities. Led by rural citizens’ anger, Kennett lost power in a landslide victory for the Labor Party in Victoria in 1999.

Age related assumptions

After the age of 18, family members are technically ‘individual’ citizens, theoretically with the full rights and responsibilities of adulthood. Yet their economic circumstances, their ‘capacity to establish an autonomous household’ (Orloff, 1993) is extraordinarily inter-connected with their family fortunes. The above examples from Australian family policies illustrate the shifting ages which are considered relevant for providing adult citizen support, and for relieving families of their responsibility for children. Full adult rates on public transport, entry to picture theatres, capacity to decide on abortions and adoption of a child born out of wedlock continue to be much earlier. This has been the case for forty years and bespeaks the capacity of capital to maximise profits from young people, as well as a gap between the age of capacity to parent, following menstruation, and the age when it is possible to earn a living to raise children (See Weeks, 1969). The confusion about when adulthood begins, with its associated rights and responsibilities, is in marked contrast to cultures with clear initiation and transition moments.

At the other end of the life-cycle, adult family members gradually assume ‘care’ responsibilities for aged relatives, whether they do so on a non-residential or a residential basis. The type of care provided includes a wide range of supportive, everyday life type activities. Relatives take food and clothing into nursing homes, take clothing home to wash, and supplement officially paid-for ‘care’ with additional visiting, outings and at times advocacy around hazardous incidents in the ‘care’ facility. Relatives support older people in their own homes, with additional food and goods, support for decision-making and explorations of the alternative health and social programs advised or recommended by paid service providers (employed in either local government, State or Federal government agencies or charitable non-government agencies). The network of community infrastructure available for older people is quite extensive as a result of Home and Community Care programs. However, in fact, quality of provided goods varies, with food services frequently being mentioned as a problem. Also, standards of practice vary among employed service providers. Practices include older people being

inappropriately called by their first names, being patronised, being treated as needy and dependant, rather than offered respectful relationships in which their life-time of achievements are recognised and valued.

The practice of **confidentiality** by health and community service providers for people over 18 and sometimes earlier (as in medical requests for contraception or abortion), is based on individual's rights to privacy. Yet alongside this, in the vacuum of shared official health information, family members are required to provide support and care. This is most difficult, either with young adults or with older people, if the family care is residential, but can also be difficult in non-residential caring relationships. The family carers do not have the status of paid carers, and therefore must act without information, with no access to files, nor invitations to participate in assessment or 'case planning' meetings. If the 'cared for' person is willing to have the family carer present at interviews or appointments, and if their own work commitments allow them to attend, or if specific permission is obtained from the 'cared for' person, some information is likely to be shared. Official status as participant in planning meetings is perceived to be more difficult for service providers to offer family carers, without thwarting the autonomy of the designated 'patient' or 'service-user'.

Gender assumptions:

Gender assumptions continue to be contradictory. On the one hand, gender neutral and equal opportunity approaches to policy practice leads many service providers to treat and recognise either women or men as able to 'care', and as in 'need of care'. However, life-long gender practices, influenced by cultural history, are operative in families. The spoken word may not describe what actually occurs, so practitioners doing assessments based on interview and self-reports must remain sceptical that they have learned what actually happens. International, comparative time use studies show that women still predominate in cooking, household management, laundry and other forms of emotional caring (See Bittman and Pixley, 2000). This is particularly likely to be true in older cohorts. Bryson (2000, p241-2) notes that

A detailed consideration of the household contribution of women and men clearly shows that it remains women who are more likely to undertake those routine tasks which have the greatest propensity to be exploitive, that is, they still do the tasks that are much more likely to interfere with leisure, paid work and career advancement'.

Assessing family violence and child abuse in families of any age are particularly difficult because of family members wish to protect their kin, and because of their general defensiveness about the intrusive state operating through employed service providers. In such situations wider family networks and family conferences are likely to be useful in care needs assessments.

The nature of widespread gender assumptions, and assumptions about women's emotionality, their responsibilities in families and the subsequent 'blame' attributed to them when they do not fulfil social expectations, means that such family practice interventions are themselves fraught. Collusion by workers and family members (residential or non-residential) can occur which confirms or leaves silent women's needs for care and support. Women's ambivalence about their own self-image of 'good wife' may be associated with their telling only part of the story to employed service providers, to protect their loved men.

The implications of this are that the general trend data about gendered patterns is always useful alongside individual or particular family assessments for service eligibility.

Implications for policies and practice:

Revisiting Eichler's proposals for emancipated families suggests that seeing family members as individuals can be as fraught as subsuming them into family units. In the arena of child support which Eichler was addressing, her proposals have borne fruit. But broadening her family models to other policy areas relies more heavily on state provision than the last decade of social policy has favoured. Since 1984, the sweeping Conservative trends to individualise eligibility and responsibility has demonstrated that families are assumed to supplement support, in addition to state provision. In the same era, in Australia, several rights based pensions and benefits have been restructured to be allowances and part-payments. Individuals are expected to supplement state support, as are their family members.

The distinction between policies for 'individuals' and 'families' does not foster co-operative family group or shared household arrangements. The distinction conceals the enormous costs – economic and emotional - expended by family members on their kin. The term 'individual' assumes

a capacity for independence and capacity to establish an autonomous household which eludes many young Australian adults.

What practical policy changes might be made to address the unsatisfactory use of ‘family’ and ‘individuals’, both in Government policies, and in other public usage?

Introducing the policy category of ‘household’:

It is suggested that the former assumption that family is usually synonymous with ‘household’ has outlived its usefulness. Rather, it would be useful to introduce the term ‘household’ as a new category into eligibility and policy determination. This could be elected for those shared activities and coverages where related or non-related adults are co-resident. That is, citizens could elect for coverage on the basis of ‘household’ or ‘shared household’ rather than family or individual. This would go some way to address the problem facing families of providing unrecognised support to young people still living with parents, and to older people living with adult children.

For example, ‘household’ coverage could be taken up in the areas of

- Medical insurance cover
- Ambulance cover, and membership in other health-related associations
- Government family payments might well, if tested, work better on a household basis, related to the economic unit of the household.
- Membership in a range of leisure associations
- Car ownership and car insurance, if households wished to share private transport arrangements
- Household & contents property insurance

Introducing the policy category of ‘designated residential and/or non-residential carer’:

A new category of family carer is required in policy discussion, particularly to address the experience of adult children of frail elderly parents, but also possibly useful for adult parents of young adults facing social and emotional difficulties while living with them, or living elsewhere. This is proposed in addition to greater use of the term ‘household’, on the basis that the concept of location and shared residence might be usefully separated from the person or persons assuming responsibility for informal care.

I suggest the term 'designated family carer' who would be defined as an elected or chosen person(s) responsible for providing care and support. The merit of a particular designation is status within the provider system of care, access to relevant information, and capacity to be consulted as a systematic practice by the health or community care providers. The naming of such people would also clarify responsibility in the family or household and community infrastructure widely acknowledged to be necessary when 'individual' citizens require additional or special care and support.

Conclusion:

Drawing on selected examples from private health insurance, the federal social security system and instances of health and community service delivery, I have explored the contemporary Australian usage of the terms 'family' and 'individual'. I have suggested that they are dysfunctional in a period when increasingly related or non-related adults are co-resident. As a way ahead, I have suggested the introduction and greater usage of two categories: first, 'household' and second, 'designated family carer(s)'. It is my assumption that this might move us toward Eichler's vision of 'emancipated families', without the pitfall of emphasis on 'individuals'. It may be a small lever to generate greater sharing, co-operation and democracy in families and communities of adult citizens.

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