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Call for papers in Counselling Psychology

Dr Mary Watts (City University, London) and Dr Stephen Palmer (Centre for Stress Management, London) have joined the Editorial Team of the *British Journal of Medical Psychology* in order to develop a new section devoted to Counselling Psychology.

The new section aims to promote theoretical and research developments in the field of counselling psychology. A broad theoretical and methodological base, combined with academic rigour will be maintained. Client studies will be considered where they illustrate unusual or original theoretical or conceptual perspectives, or innovative forms of counselling psychology interventions which carry important theoretical implications.

You are invited to submit appropriate counselling papers (4 copies) to the Counselling Psychology Section Editors, British Journal of Medical Psychology, BPS Journals Office, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK.

The **British Journal of Medical Psychology** (ISSN 0007-1129) is published quarterly and edited by Dr Frank Margison (Central Manchester Healthcare NHS Trust) and Dr Duncan Cramer (Loughborough University). Volume 70 (1997) is still available at £117 (US$222); price of Volume 71 (1998) £126 (US$235).

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Editorial

Looking through the back copies of *Counselling Psychology Review* I noticed we have had very few submissions about the practice of counselling psychology overseas.

In fact, only three articles have been received in the last two years. In 1996, Glyn Hudson-Allez wrote about her experience of training professionals in Hong Kong (vol. 11, no. 4), the next year Charles Chen from Canada addressed the issue of supervision by novice supervisors (vol. 12, no. 1) and in this issue Dr. Stephen Palmer interviews two key staff members of a women's counselling service in Beijing, China.

So, bearing in mind, *Counselling Psychology Review* is received by 53 members living abroad and I trust read by many more, I would like to take this opportunity to encourage our overseas readers, as well as psychologists travelling abroad to work, to submit articles and letters and share their experiences. I hope this will enrich our understanding of working in different cultures and settings.

So please put pen to paper as soon as possible!

Kasia Szymanska encourages submissions to ***CPR*** from overseas.

Early unwanted sexual experiences, obsessionality & eating disorders

Irit Levy & Bryan D. Adams

This article is based on a paper presented at the First International Conference of Counselling Psychology, May 1997.

This study proposes that obsessionality develops as a result of early unwanted sexual experiences, and that this obsessionality can predispose individuals to eating disorders. A group of 74 young female undergraduates was used to study these relationships. Significant correlations were found amongst the variables but were insufficiently robust to support the proposed model.

The link between obsessionality and eating disorders was initially put forward by Palmer and Jones (1939), and supported by Rothenberg (1988). Obsessive-compulsive symptoms were found in a quarter of anorexics studied. Smart *et al* (1976) also investigated and noted this link. Johnson and Holloway (1988) noted that bulimic patients score higher on obsessionality than both anorexics and controls. This relationship however is still poorly understood (Fahy, 1991). Freud (1962) argued that sexual abuse was an antecedent of hysteria, which she regarded as a key feature of anorexia. Halmi and Crisp (1980) maintain that anorexia reflects an association between oral and sexual gratification and impregnation. Calam and Slade (1987, 1989) reported a relationship between unwanted sexual experiences and eating disorders in a subclinical group. Significant correlations were found between various subscales of sexual experiences, obsessionality and eating disorders. However, these were not found to be discriminative features across the operationally defined groups of eating disorders. Suggestions are made for improvements to the research design and clinical implications for counselling psychologists are addressed.

Anorexia Nervosa defined

Anorexia Nervosa (AN), introduced by Gull (1874), refers to a nervous loss of appetite. Since 1874, several other definitions have been offered. Amongst the most commonly cited is that of Bruch (1974), "the relentless pursuit of thinness", and Russell (1977) "fear of fatness". The theme of fear was reoffered by Crisp *et al* (1980) who called it a "phobia of weight gain". As yet no single definition has been accepted above others.

What are the characteristic features of Anorexia Nervosa?

The characteristics of AN are as much psychological as physical and arguably weight loss is secondary to the psychological symptoms. Certain cognitive processes usually lead to the weight loss, which may be regarded as the manifestation of these initiating symptoms. Bruch (1982) was the first to suggest that a perceptual disorder is "pathognomic" of anorexia. Since then

others, e.g. Garner and Garfinkel (1980), have produced models to demonstrate how self perception contributes to the development of AN. Essentially, what all such models propose is that it is distorted body image that "sets the ball rolling", leading to dieting which may get out of control. Two types of AN have been documented clinically; Garfinkel and Garner (1982) differentiate between Anorexia Nervosa Restricting (AN-R), and Anorexia Nervosa Bulimic (AN-B) subtypes. Restricting anorectics, which conform to the layman's stereotype, rigidly restrict food intake; bulimic anorectics are closer to the bulimia category and go through bouts of bingeing, followed by elimination (diuretics/laxatives/purging etc). Bulimics typically retain their normal weight; bulimic anorectics lose weight.

Bulimia and Anorexia Nervosa

Bulimia Nervosa (BN) is characterized by the consumption of vast amounts of food in a relatively short period of time, followed by elimination (usually vomiting). BN has several distinctive features not seen in AN, such as unchanged weight. BN is more common (a frequency of 1-3 per cent (Yates, 1989) compared with 0.5-1.0 per cent of AN).

The difficulty in diagnosing BN is that individuals maintain "usual" body weight, and are physically unchanged. But there are tell tale signs: the disappearance of great amounts of food, changes to nails and teeth, the formation of callouses on hands. Privacy is a hallmark of this disorder, presumably as a result of the individual's shame over their lack of self-control. ANs usually pride themselves on the control they have achieved; BNs are often disconcerted with their inability to control their urges. It is possible for a recovered anorexic, who has eased control, to lose it completely, becoming bulimic.

The issue of control

Control is fundamental to both AN and BN. BN is characterized by a subjective feeling of loss of control; AN may be experienced as either mastery or loss of control depending on the subtype. The literature considers the topic of control mostly in reference to AN.

Ironically, most anorectics will continue to crave the foods eliminated from their diet. Cooper and Miller (1988) remark that the term *Anorexia Nervosa* (implying loss of appetite) is a "misnomer"; in the majority of cases appetite persists. The extent of control in eating disorders implies that AN has an obsessional component. Many of the cardinal symptoms of anorexia the pursuit of thinness, calorie counting, repeated weight checking – all resemble the obsessional symptoms described in the diagnosis of OCD. They are excessive, recurrent, persistent, and unsurpassable. In turn, weight loss and the avoidance of "fattening" foods constitute the compulsions. As the disorder unfolds the obsessional symptoms become increasingly prominent and potent. Although AN may be conceptualized as a form of OCD (Rothenberg, 1986) it is an open question as to whether obsessionality is cause or consequence.

An Obsessive Compulsive Hypothesis

The hypothesis that AN is a manifestation of OCD was first proposed by Palmer and Jones (1939). Ten years later, DuBois (1949) suggested renaming AN "compulsion neurosis with cachexia". He argued that "the imperative, regularly recurring, and persistent thoughts of food conform with the typical pattern of obsessive thinking in the same way that the imperative urges to avoid food in a repetitive, illogical and uncontrolled way conform with the typical pattern of compulsive eating". Empirical support for these hypotheses were presented in 1988 by Rothenberg in a review of 11 AN patients. Rothenberg noted that depression and obsessive compulsive symptoms were reported by 55 per cent and 27 per cent respectively. Earlier, Rothenberg had argued that the link between depressive symptoms and AN may be secondary to that between OCD and AN; when obsessive compulsive defences break down, depressive symptoms arise.

Garner and Garfinkel (1980), citing Keys *et al* (1950), caution that starvation plays a crucial role in the genesis of some obsessional traits. They suggest that low self-esteem, central to the phenomenology of AN, may lead to a distorted self image; patients perceive themselves as fat and unattractive. In turn ruminating, enhanced by avoidance (Wardle, 1987), ritualizing and starvation, perpetuate the disorder. Positive reinforcement, i.e. temporary relief from anxiety, may be experienced with excessive exercise, or purging behaviour and weight loss (Garner and Bemis, 1982). Thus AN becomes a self perpetuating cycle, where starvation fuels psychopathology.

Studies comparing personality profiles of eating disorder sufferers and non sufferers have proved fruitful. Using Eysenck's Personality Inventory (EPI), Leyton Obsessionality Inventory (LOI) and Cattell's Personality Factor Questionnaire (16PF), Smart *et al* (1976) showed that anorectics score significantly higher on measures of neuroticism, introversion, anxiety and independence. More importantly, anorectics score higher on the LOI, yet slightly lower than OCDs. These traits are not completely abolished by weight restoration (Stonehill & Crisp, 1977). This may indicate that obsessionality is deeply rooted (premorbid) in the personalities of those developing eating disorders.

Both Patton (1988) and King (1963) found premorbid obsessionality to be a risk factor for eating disorders. Norris (1979) stated that 60 per cent of his anorexic patients were described as obsessionally premorbid.

Such retrospective studies appear to indicate that obsessionality is more likely to be the cause than the effect of AN. Holden (1990) concluded that premorbid personality traits are "over represented" in the anorectic population and that starvation exaggerates obsessional traits. The genetic and epidemiological evidence also indicates some overlap between the two disorders.

Fahy *et al* (1993) assessed the prevalence of eating disorders in a sample of 105 female patients with OCD. They found that 11 per cent had a history of disordered eating. This confirmed Kasvikis *et al* (1986). More importantly, this was significantly greater than that found in a non-clinical, or even neurotic, population (Kasvikis *et al*, 1986). Fahy *et al* (1993) argued this may be an underestimate as individuals with comorbid AN and OCD may have attended eating disorder clinics alone. The substantial comorbidity and similar age of onset noted suggest a specific relationship does exist.

Fahy *et al* (1993) advise that food related OC stimuli may sensitise the patient to develop the full anorexic pathology. Likewise, women with a history of AN were found to have an earlier onset of OCD than those with no such history (17.4 years of age compared with 22.1). Johnson and Holloway (1988) also suggest that individuals with eating disorder have increased obsessional symptoms, concreteness, rigidity and dichotomous thinking. All these, facilitated by OCD symptoms, may invite AN.

The case for sexual abuse

The link between sexual dynamics and eating disorders is well documented. Freud (1962) proposed the seduction hypothesis. She considered early sexual abuse significant to the aetiology of hysterical symptomatology, and to be characteristic of anorexia. Halmi and Crisp (1980) maintain that anorectics renounce guilt through the rejection of food associated with "oral and sexual gratification identified with early fantasies of impregnation". Similarly, Andersen (1984) noted that eating disorders are often preceded by sexual conflicts.

In comparing the psychological problems of sexual abuse victims and AN sufferers, Sloan and Leichner (1986) concluded that sexual abuse is aetiologically important. Goldfarb (1987) submitted three case reports of disordered eating, bulimia, anorexia and compulsive eating, all of which were preceded by sexual abuse (one of incest). Goldfarb concluded that eating disorders are used to "starve off" painful memories, whilst providing a false sense of control. Calam and Slade

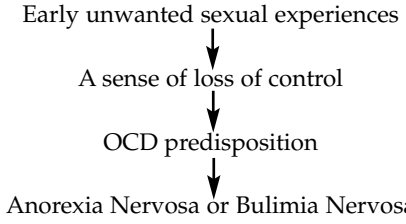
(1989) studied the relationship between eating disorders and unwanted sexual experiences in 130 female university students. The results confirmed Calam and Slade's hypothesis that anorexia forms an overt means of regaining control within the family, whereas bulimia/compulsive eating may arise when the individual is in no position to regain any kind of control.

Palmer, Oppennheimer, Dignon, Chaloner and Howells (1990) attempted to replicate Calam and Slade's (1989) findings and found that about a third of anorexics report unwanted early sexual experiences and concluded that sexual abuse was one of several risk factors in the development of eating disorders.

The present study

This study attempted to show that sexual abuse/unwanted early sexual experiences may lead to a subjective, yet strong, sense of loss of control and contamination. An individual may try to regain control in another area in life. This obsessive compulsive energy may be manifested in regaining control (with AN-R subjects) or repeated failed attempts (Bulimics and AN-P). See Figure 1 for a summary of this process.

Figure 1 Proposed model for the aetiology of eating disorder



Method

Subjects: seventy-four female subjects participated in the study, 85 per cent of whom were not taking any psychology courses.

Procedure: one hundred subjects were approached by the researcher or a representative briefed to follow the same procedure. Seventy-four completed questionnaires were returned. Each questionnaire was presented in an envelope; subjects could deposit the completed questionnaire in a pigeon hole, assuring anonymity. Interested subjects (who left a name and address at the end of the questionnaire) were subsequently briefed about the outcome of the study.

Measures: the questionnaire had four constituents:

1. General information

Subjects were asked for: age, sex, weight, height, marital status, ethnicity, religion. Age and height information were used to calculate Body Mass Index.

2. Questions regarding eating attitudes and behaviour associated with AN

The EDI2 (Eating Disorder Inventory 2: Garner, 1990) was used. This assesses a range of attitudes and behaviours associated with AN. The EDI2 is an effective screening tool for identifying individuals with "subclinical" disorders, or those at risk of developing one. Of the 11 subscales which comprise the EDI2, three (with relatively high internal consistency) were selected to construct the first part of the identifying criteria. These were: Drive for Thinness (DFT), Bulimia (BULIMIA), and Body Dissatisfaction (BODDISS). The variable labels are given in brackets.

3. Unwanted sexual experiences/abuse

The Sexual Events Questionnaire 2 (SEQ2) (Calam & Slade, 1994) was used. This 14-item questionnaire was based on Russell's (1977) interview schedule.

Each item described an unwanted sexual experience. If a subject had experienced what was described, she indicated on a scale of 1 ("did not affect me at all") to 5 ("changed my life") its effect. Subjects were also asked to indicate other information about the experience, viz their age at the time and the perpetrator.

A total score (SEQTOT) and two specific scores were used in this study; one for events that took place within the family (referred to by variable label SEQFAM) and one for forced events (SEQFORCE). These two sets of experiences were identified by Calam and Slade as especially important and informative in reference to eating disorders.

4. Obsessive-compulsive tendencies

The final part of the questionnaire comprises the Padua Inventory (Sanavio, 1988),

Table 1 Demographic data of the whole sample and descriptive statistics for variables used

variable	*mean*	*s.d.*	*minimum*	*maximum*	valid N
BMI	21.30	3.68	12.8	31.95	71
EDI tot	18.31	14.34	0	59	74
DFT	5.10	5.38	0	18	74
BULIMIA	1.80	3.13	0	15	74
BODDISS	11.40	7.96	0	27	74
SEQtot	5.50	9.10	0	44	73
SEQforce	1.30	3.20	0	18	73
SEQfam	0.42	1.14	0	9	73
PADmot	0.37	0.50	0	2.29	74
PADimp	0.61	0.44	0	2.18	74
PADdirt	0.57	0.38	0	1.73	74
PADcheck	0.65	0.57	0	2.25	74

Table 2 Defining criteria for three eating disorder groups

EDISTATU	DFT	BULIMIA	BODDISS	No
AN-R	>=6	0	>=15	5
Bulimic	>=6	>=2	>=15	13
Symptom free	<=1	0	<=6	10
Sub-clinical	otherwise	otherwise	otherwise	41

Table 3 Correlation matrix of ED12 subscales and Padua and SEQ2 subscales

VARIABLE	BODDIS	BULIMIA	DFT
PADcheck	.056ns	.135ns	.643***
PADdirt	.274*	.310**	.416***
PADimp	.064ns	.106ns	.144ns
PADmot	.133ns	.171ns	.187ns
SEQchild	.009ns	.346**	.193ns
SEQfam	.032ns	.345**	.196ns
SEQforce	-.015ns	.317**	.166ns

ns = not significant ** = 0.001<p<0.01
* = 0.01<p<0.05 *** = p<0.001

a set of 60 obsessional thoughts and compulsive behaviours associated with OCD. Four factors are assessed: (i) impaired control over mental activities (PADimp); (ii) becoming contaminated (PADdirt); (iii) checking behaviours (PADcheck) and (iv) urges and worries of losing control over motor behaviours (PADmot). (See Sanavio, 1988, for details of scoring the Padua Inventory.)

Results

The relationship between eating disorders, sexual abuse and OCD

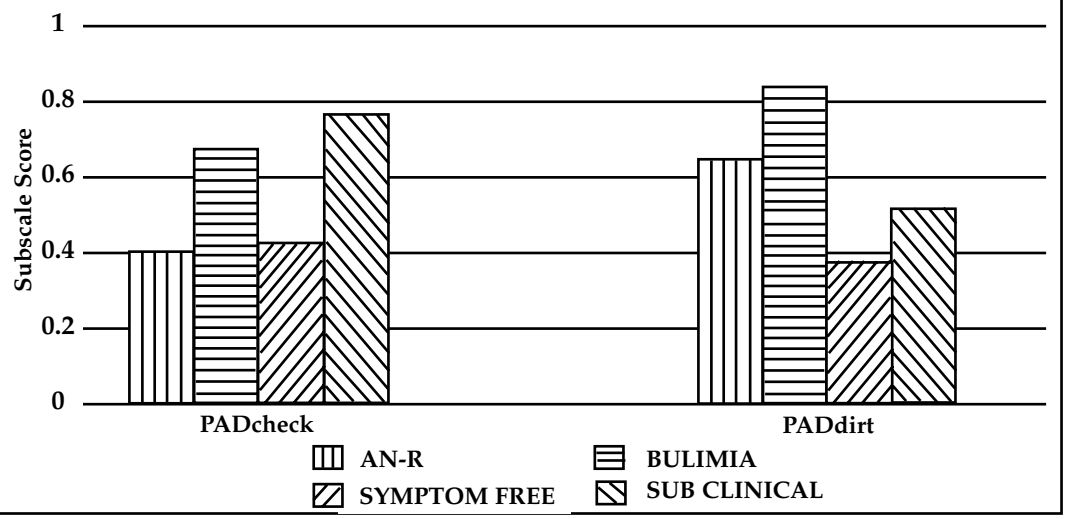
Associations between the subscales and scores were examined to test the hypotheses that unwanted early sexual experiences may lead to an obsessive compulsive tendency which may manifest as AN or BN. To specify the eating disorders, subjects were classified into three groups according to their scores on the three EDI 2 subscales. They were classified according to operationally defined criteria, chosen according to the subscale's association with the eating disorder, and the distribution of the data collected. The normative data in EDI 2 was not used; the aim was to use a criterion appropriate to the data in hand and stringent, thus avoiding false positives.

The discrete variable EDISTATU was constructed as follows; subjects were classified either AN-R, Bulimics, or Symptom Free. The rest of the population was classified as Sub-clinical.

A correlation matrix was calculated to explore the relationship among the three EDI 2 subscales, the four Padua subscales, and the three SEQ 2 subscales.

What is apparent is that the three subscales of the Sexual Events Questionnaire correlate significantly with the Bulimia subscale of the Eating Disorder Inventory but with no other subscale. These findings are broadly supported by Waller (1991). Also, the subscale PADdirt of the Padua Inventory correlates with all subscales of the Eating Disorder Inventory. The sole remaining significant correlation is between the subscale PADcheck and the DFT (drive for thinness) subscale of the Eating Disorder Inventory. This may represent the checking behaviour in AN and BN e.g. calorie counting, exercise regimes, etc. It should be noted that no significant correlation explains as much as half the variance, indicating that the genesis of eating disorders is inevitably multifaceted.

Figure 2 Group comparison on Padua subscales PADcheck and PADdirt, for the four defined groups

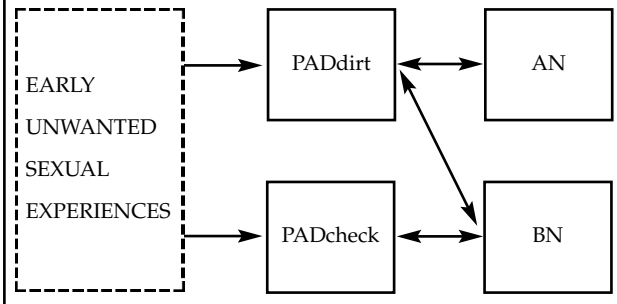


When comparisons were made within the four defined groups for scores on the SEQ2 and Padua Inventory, the only variables which the four groups discriminated amongst were PADcheck and PADdirt. These are shown in Figure 2.

The Symptom Free group recorded low subscale scores and the Bulimia group high subscale scores. However, the AN-R and Sub-clinical groups were not as reliably discriminated amongst with the Padua subscales.

A tentative refined model is suggested by these findings which is shown in Figure 3.

Figure 3 Revised model for the aetiology of eating disorder



Discussion

This study set out to investigate the relationships among sexual experiences, eating disorders and obsessionality. It was suggested that early unwanted sexual experiences instigate obsessive compulsive tendencies which may manifest as either AN or BN. The results indicated an association between eating disorders, obsessionality and unwanted sexual experiences but, even when significant, such findings were not sufficiently robust to support the proposed model. Despite the high proportion reporting unwanted sexual experiences, only bulimics showed an association between these experiences and eating disorders, such as proposed by Calam and Slade (1987, 1989). Later studies (Palmer *et al.*, 1990; Waller, 1991) have also failed to replicate Calam and Slade's findings. There are several potential explanations.

Finn *et al.* (1986) and Button and Whitehouse (1981) report that sexual abuse and eating disorders both have relatively high prevalence rates. Thus it is plausible that a relationship may have been transcribed where none exists. This coincidence hypothesis (Pope & Hudson, 1982) points out that because sexual abuse and eating disorder share high prevalence rates and common schema, such a relationship is intuitively seductive.

Moreover, reasoning post hoc studies may represent judgmental bias (Finn *et al.* 1992).

A number of studies suggest that a substantial proportion of psychiatric patients report childhood sexual abuse (e.g .

Rosenfeld, 1979). Sexual abuse has been linked to many psychopathological phenomena such as depression and generalized anxiety. Thus, eating disorders may not be an inevitable consequence of sexual abuse in childhood, but rather one of a range of other potential outcomes.

Although studies have failed to prove a direct link between sexual abuse and eating disorders, it has been noted that certain unwanted sexual experiences are associated with the specific nature of eating disorders. For example, although Waller (1991) found a low rate of unwanted sexual experiences amongst AN-R women, a significantly higher rate was reported amongst bulimic women. More recently Calam and Slade, and Garner and Garfinkel, have come to view sexual abuse as a potential mediating factor for eating disorders rather than an absolute prerequisite.

There exist several methodological problems with all studies investigating sexual abuse, e.g. failure to disclose in questionnaire surveys; unreliability of retrospective information, etc.

This could explain the lack of consensus in different studies, and the even greater difficulty in concluding how much, if at all, sexual abuse contributes to the development of eating disorders.

This study could not conclusively demonstrate that eating disorders may represent, in some cases, manifestations of OCD, but it was interesting that scores on the eating disorder questionnaire correlated with obsessionality, and expressly with the subscale PADdirt. This needs investigating with larger clinical populations. It is suggested that a victim of sexual abuse may feel dirty afterwards, and go on to develop an obsession relating to cleanliness.

Although some studies have indicated that some relationship exists between obsessionality and eating disorders, none have looked at the potential interaction between sexual abuse, OCD and eating disorders. It is possible that a particular association occurs among the three, and that a robust one has not been found because researchers have been looking in the wrong place. The problem with looking at such a particular relationship is the lack of an appropriate scale. What is argued is that some cases of eating disorders are manifestations of obsessive compulsive tendencies, rather than that all eating disorders are cases of OCD.

At present, the only measures of OCD available are those specialized at detecting the most common types of OCD – cleaning, checking, etc. Thus researchers have to use tools that are not specialized to measure the specific manifestation investigated. What is required is a reliable measure of obsessionality that tailors questions to the specific focus of sexuality and food behaviour. In a study conducted by Fahy *et al.* (1993) patients with both anorexia and OCD were found to have more food focused OCD than the OCD group.

When assessing the relationship between eating disorders and obsessionality it is difficult to separate cause and effect. Fahy (1991) advises that the combination of cognitive distortions and obsessional rigidity associated with eating disorders (especially bulimia) may serve to perpetuate eating disorders. Conversely, Garfinkel and Garner (1982), have shown that obsessionality may be exacerbated by starvation states such as those caused by anorexia.

This study used a non-clinical population and subjects may be regarded as "survivors", or "resistors", of eating disorders. Any obsessionality noted may be a remainder of this experience. King (1963) reports that many who have suffered eating disorders often never get over the experience, nor a return to their premorbid state. This suggests that obsessionality may be augmented during eating disorders and may continue, to a lesser degree, after recovery. Like sexual abuse, OCD tendencies may serve as risk factors to the genesis of eating disorders, in those who have these tendencies and other promoting factors. One of the most striking findings of this study was that when subjects were categorized into the four eating status groups, over half of the subjects fell somewhere below the criteria for eating

disorder, but above the defined normal criterion. Only 10 met the symptom free criteri. This is probably due to the stringent definition criteria for eating disorders adopted to avoid false positives, which is essential with research on non-clinical populations. Had broader criteria been used a larger proportion of the population could have fallen into both the eating disorder and symptom free groups. It has been argued, however, that a significant number of subclinical cases of eating disorders exists in the population (Button and Whitehouse, 1981).

The recognition of such subclinical cases means better treatment prognosis (Morgan & Russell, 1975; Hsu, 1979). In addition, studying such cases, which may represent early stages of clinical eating disorder development, may shed light on the processes underlying the genesis of, and recovery from, eating disorders.

The population used in this study meets the criteria for the 'at risk' group identified by Garner and Garfinkel. These women were largely white, middle-class individuals. Their BMI was on average very low, i.e. 21.3 compared to a normal range of 20 to 25.

Implications – where should research go from here?

This study was restricted by methodological issues concerning sample, statistics and availability of valid psychometric instruments. Despite this, some significant correlations between investigated elements were found. There is a need to develop a questionnaire that examines food, and/or sexuality, related to obsessionality. This study needs to be replicated with a larger clinical group. The relationship suggested is specific, and is related to only some cases of clinical eating disorders. Of particular interest is the relationships between eating disorders and obsessive worries about dirt. This is where the implication of sexual abuse in this model may lie. Eating disorders need to be considered along a continuum, which in turn will lead to increased attention to subclinical cases. In particular, counselling psychologists need to assess and where appropriate target directly obsessive behaviour in eating disordered clients.

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Glossary of terms

EDI tot =	total score on EDI2.
DFT =	drive for thinness subscale of EDI2.
BULIMIA =	bulimia subscale of EDI2.
BODDISS =	body dissatisfaction of EDI2.
SEQtot =	total score on SEQ2.
SEQfam =	score for unwanted sexual experiences within the family.
SEQchild =	score for unwanted sexual experiences in childhood.
SEQforce =	score for unwanted sexual experiences involving force.
PADmot =	score for urges and worries of losing control over motor behaviour.
PADdirt =	scores for worries of becoming contaminated.
PADimp =	score for impaired control over mental actives.
PADcheck =	score for checking behaviour.

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Resuscitating the author: A protocol for the reflexive and recursive analysis of discourse

Malcolm C. Cross & Mary H. Watts

Unhappy with letting the 'dead author' of post-modernism rest (Foucault, 1977), this paper identifies and experiments with a methodology designed to capitalize on the human capacity to generate and reflect upon meaning.

Within the context of postgraduate counselling psychology trainees talk of counselling; a combination of focus group methodologies, discourse and content analytic procedures were used to arrive at 'text'. The text and it's treatment subsequently became the focus of further talk. This procedure was applied recursively, giving rise to nomothetic data, which was primed for reflexive, ideographic evaluation at successive stages of the research process.

This paper is based on a presentation at The X11 International Congress on Personal Construct Psychology, 9–12 July 1997, at Seattle, Washington, USA.

Introduction

As a doctoral student, the first author lives with the expectation that he should seek to answer intelligible questions using credible methods. Once, before now, he suspects things were a little more certain in terms of the 'question–answer' dimension of a doctoral readership. The area of teaching speciality, research and professional practice of both authors is counselling psychology. We are interested in a range of issues, not the least of which is defining the domain of interest, that is, answering the question *what is psychological counselling?* The mode by which we choose to explore our question on this occasion is initiatory and reflects the collaborative stance which we seek to imbue in all our work, whether it be with *clients*, *trainees* or *research participants*.

Post-modern trends in thought have been attributed with the wide sweeping revision of a range of assumptions about the nature of truth (Kaval, 1994). Constructivists too are suspicious of singular and reified truths. These two positions however vary greatly in their treatment of the individual. The post-modern position is often summarized by Foucault's (1977) suggestion that discourse can circulate without any need for the author device. This position (re)places truth, knowledge and power outside the individual, arguing that they are far from the immutable qualities of human beings.

Constructivists and Kellian psychologists, like their post-structualist colleagues, see sense as something to be made. These groups vary however in their emphasis on

the site of production. Truth, knowledge and power for the Kellian does not exist apart from the individual, but rather is manufactured by individuals, usually but not exclusively, in relation with others. The philosophical underpinnings of the psychology of personal constructs rests on the assumption of human agency, particularly as it relates to the creation of knowledge. As Kelly (1996, p.15) states:

> 'Natural events themselves do not subordinate our constructions of them; we can look at them in any way we like. But, of course, if we wish to predict natural events accurately, we need to erect some kind of construction which will serve the purpose. But the events do not come around and tell us how to do the job – they just go about their business of being themselves. *The structure we erect is what rules us.*' (p.14) [emphasis added]

Kelly (1996) further elaborates this notion when he suggests that ultimately we set the measure of our own freedom and our own bondage by the level at which we choose to establish our convictions (Kelly, 1996). In describing the human process of construing and reconstruing in therapy Kelly (1996) provides a perspective which is particularly relevant to a discussion which seeks to explore the relationship between trends in post-structuralist thought and constructivism.

> 'Therapy is concerned with setting up regnant personal constructs to give new freedom and new control to the client who has been caught in a vicelike grip of obsolescent constructs.' (p.141)

Each person, suggests Kelly (1996), evolves a construct system with which to anticipate events. Each person is empowered therefore to interpret or make meaning and may subsequently revise these meanings.

A pertinent example of the interpretation of events

The distinctions between post-structuralist thought and constructivism may be further elaborated through the use of a topical example. Let us turn our attention briefly to new technologies of communication and in particular electronic text.

There is a growing trend in the theorizing of those writing about electronic writing to interpret new technologies as realizing or instantiating the theoretical assertions of poststructuralism, postmodernism, or deconstruction (Grusin, 1996). Indeed as Lanham (1993, p.130) suggests:

> 'it is hard not to think that, at the end of the day, electronic text will seem the natural fulfilment of much current literary theory, and resolve many of its' questions.'

Authors like Landow (1996) see electronic technologies converging with the claims of poststructural theory, hypertext in such circles often touted as the embodiment of the Derridean text (Grusin, 1996). For contemporary literary theorists the recent events of technology are evidence for the viability of notions of decentred text. Electronic writing is prima facie support for the contention that knowledge exists outside the subject, and by implication, of an agency residing *in* technology.

As Kellian psychologists we take a somewhat different perspective. Electronic writing, facilitated through the medium of the world wide web, and in particular news groups and bulletin boards, provide in our view, compelling evidence that knowledge threads grow with our capacity to respond to what is said in the knowledge context of all that has gone before and our anticipations of the future. We do not see the text talking to itself. Rather, we imagine others, as ourselves, making sense of the talk of another in the light of their own construct systems. As constructivists living in a post-modern era we say talk is important – but only as important as our capacity to apprehend and reflect upon it.

Constructivists see discourse as not necessarily, but typically co-created and have argued that this awareness has often been absent in attempts to formalize knowledge (Viney, 1987). Through talk, parties to social, therapeutic or research enterprises are able to validate or invalidate old meanings, revise and generate new ones. Constructivists acknowledge that talk also involves discourse through time, where participants reflect upon their talk. Research modalities (including some con-

structivist attempts to know) rarely capture or profit from the human capacity to create, reflect upon and revise meaning. Viney (1987, p.32) described such methods as falling within a category of 'mutual orientation' and suggested that they were the rarest model of data collection used within psychological research.

The desire to maximise co-participation and reflexivity in the research process, embrace postmodernist calls for local, relevant and perspectival knowledge, while refusing to accept the 'necessary' disempowerment of the 'subject' led to the development of a new method applied to the interest domain of psychological counselling.

The method

Two groups of postgraduate students in psychological counselling (group membership varied between 12 and 6 at various stages in the research process), at different levels of postgraduate study, were invited to participate in the present investigation. Participants were informed in great detail of the aims and protocol of the investigation, both in order to achieve their fully informed consent and to set the stage for what we aimed to be a uniquely transparent research endeavour. The data collection process is described in three stages.

Stage 1: Groups 1 and 2 met separately. On meeting, each group was reminded that all conversations were to be recorded. Data collection was initiated by broadly asking participants to describe what they understood psychological counselling to be. Discussions were moderated by the first author in line with standard focus group practice (Krueger, 1988; Stewart & Shamdasani, 1990; Morgan, 1993). Groups 1 and 2 spoke for a period of approximately 45 minutes. The group's talk was recorded and transcribed. Transcripts were later subjected to a thematic analysis and this initial classification led to the development of a conceptual framework for psychological counselling. Textual data was managed using the Q.S.R. NUD.IST (Version 3) application which enabled the construction of a hypothetical model comprised of category titles and definitions clustered into groups of conceptual similarity and tied together through a series of hierarchical linkages.

Stage 2: Individual copies of the transcript (from their respective focus group meeting), conceptual framework and abstract for the present paper, were posted to group members for consideration prior to their next meeting. Upon meeting, the group were asked to comment on: 1) the adequacy of the transcript for defining the phenomena of psychological counselling; 2) the validity of researcher interpretations; and 3) the utility of the method for describing and/or revising personal meaning and the creation of shared 'knowledge'. The groups response to recursive questioning became text which in turn was subjected to further analysis.

Stage 3: Feedback from Groups 1 and 2 arising out of the second focus group meeting was integrated into the evolving theoretical framework and is described in detail in the results section of this paper.

Results

The results of the recursive process are summarized in Figures 1, 2 and 3, which correspond with Stages 1, 2, and 3, of the data collection process described in the method section. Of particular interest are changes (additions, deletions or replacements) within the successive models which are highlighted by bold lines and enlarged text in Figures 2 and 3.

Figure 1 represents the text driven model of psychological counselling arrived at through thematic analysis of the transcripts provided by the focused meeting of groups 1 and 2. The tree graphic attempts to associate and operationalize definitional features present in the talk of trainees as they struggled to define psychological counselling. The structure contains 29 definitional nodes across four levels of association.

The tree structure originates from the counselling root into two distinct branches; what psychological counselling is, and what it is not. Psychological counselling was described as *not* 'Friendship', 'Guidance', 'Conversation' or 'Doing for' clients. Instead, psychological counselling

Figure 1

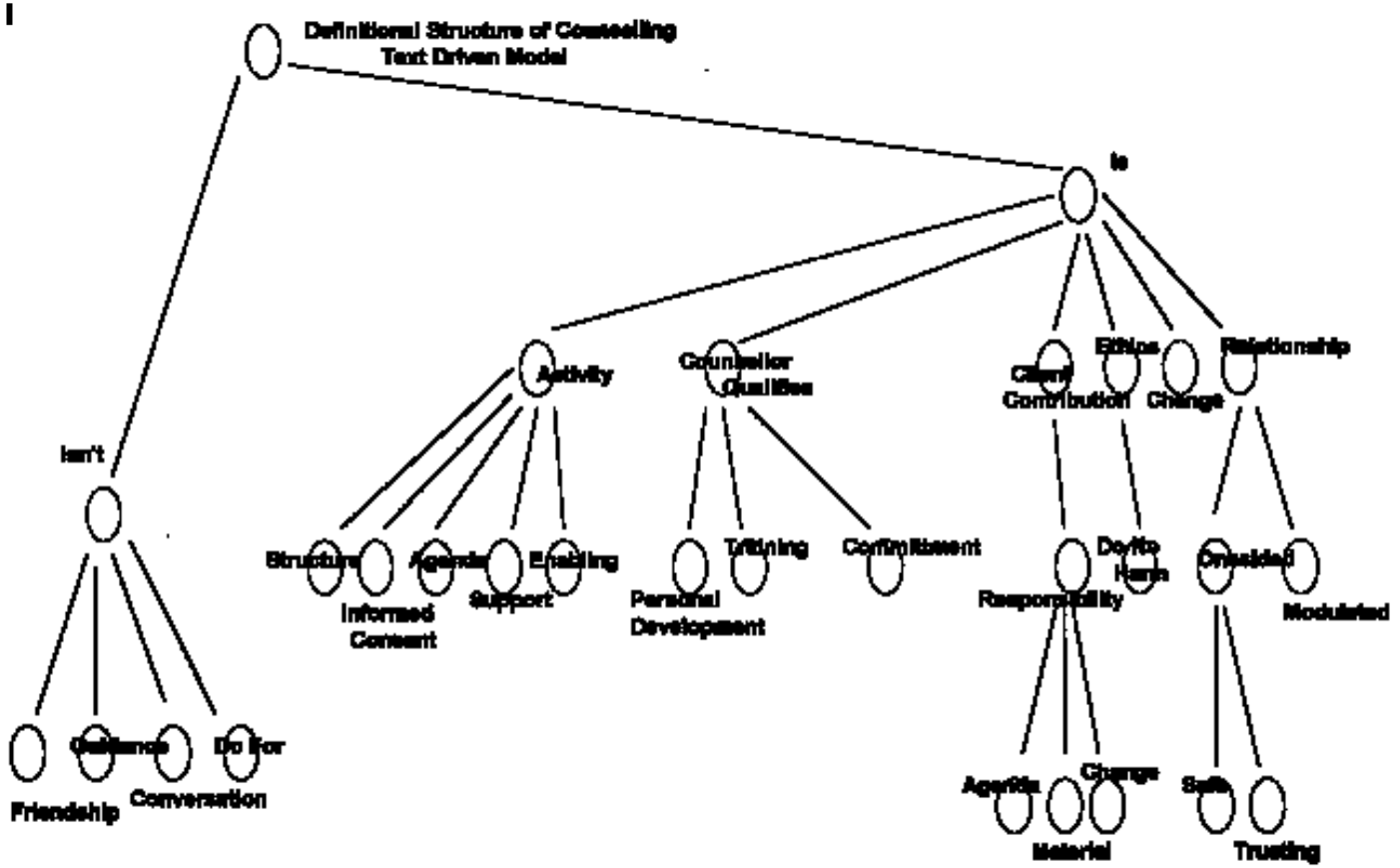
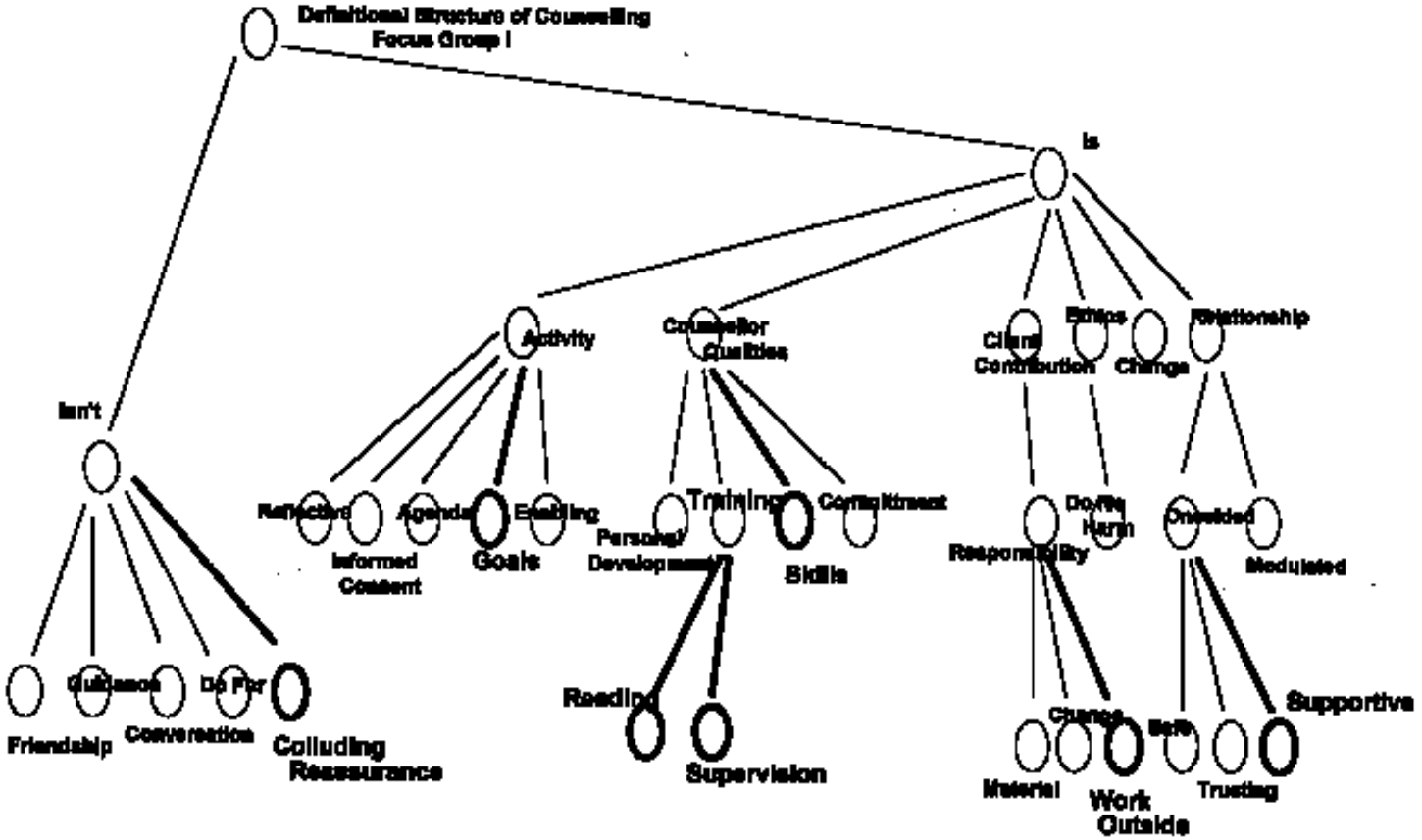

Definitional Structure of Counselling
Text Driven Model
Is
Isn't
Activity
Counsellor Qualities
Ethics
Relationship
Change
Informed Consent
Support
Personal Development
Responsibility
Modulated
Friendship
Conversation
Agenda
Change
Material
Trusting

Figure 2


Definitional Structure of Counselling
Focus Group I
Is
Isn't
Activity
Counsellor Qualities
Client Contribution
Change
Relationship
Informed Consent
Goals
Training
Skills
Personal Development
Friendship
Conversation
Colluding Reassurance
Reading
Supervision
Responsibility
Modulated
Supportive
Material
Work Outside
Trusting

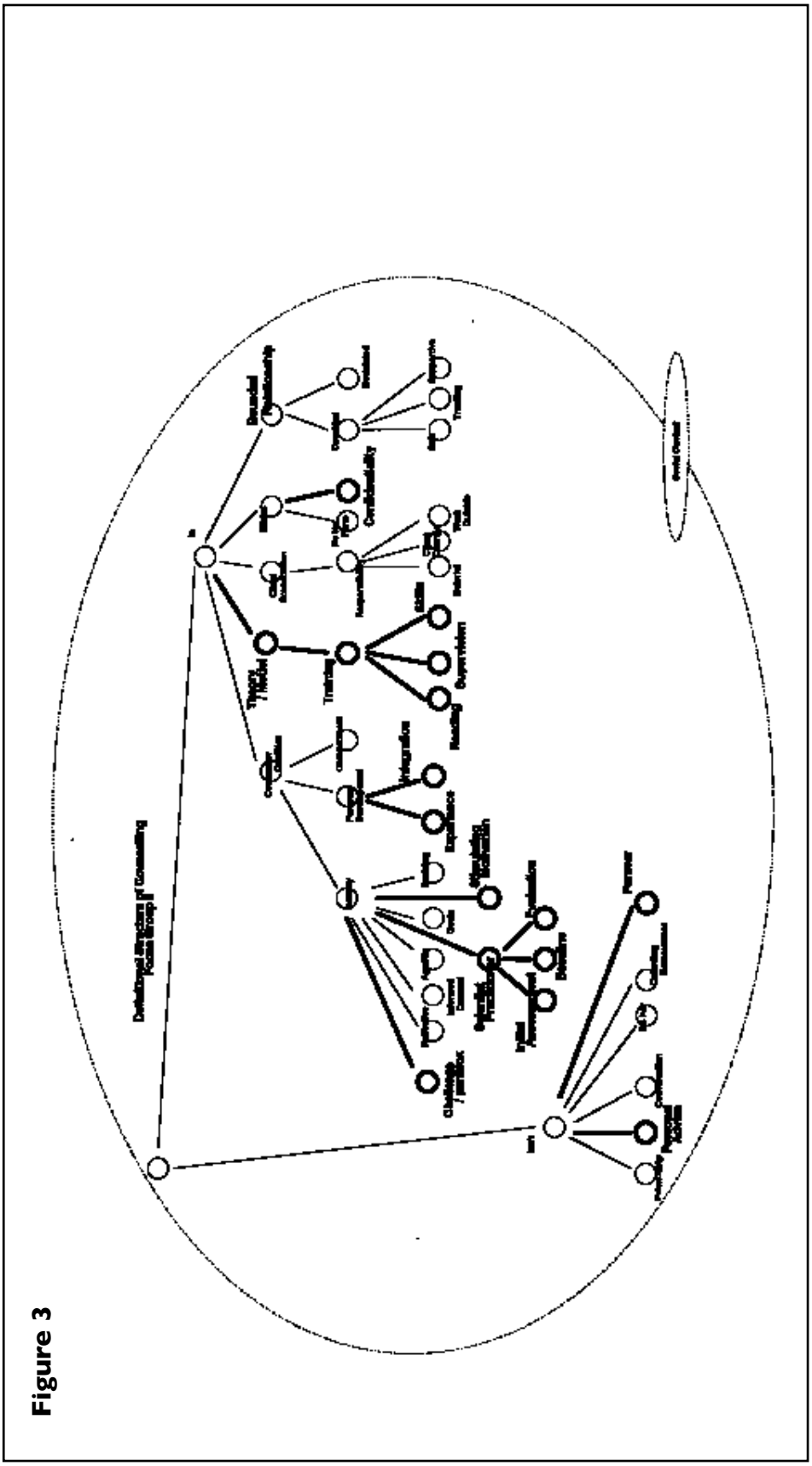


Figure 3

was described as a dynamic activity, where the counsellor and client were central. Both counsellor and client related branches extend downward to give rise to additional components of the counselling process, as too do 'Ethics', 'Change' and 'Relationship'; all first generation children of what psychological counselling is.

Figure 2 was arrived at subsequent to the revision of the text driven model (represented in Figure 1) following the second focus group meeting where participants reflected on the adequacy of the primary researcher's interpretation of their talk. For the purposes of charting the evolution of the model, additions, alterations and replacements (the shifting of nodes and branches within the model) are highlighted by enlarging areas where change occurred. It may be noted that 'Colluding Reassurance' was added to the branch – psychological counselling 'Isn't'. 'Goals' was added to 'Activities', while 'Training' gave rise to the children 'Reading' and 'Supervision'. Other additions included the expectation that clients will 'Work outside' or between sessions and that the counselling relationship had distinctly 'Supportive' qualities.

The revision of Figure 2, subsequent to focus group meeting two, has seen an increase in nodes from 29 to 33 across four levels of association.

Figure 3 represents the revision of the definitional model of psychological counselling, constructed from the feedback of participants following their reflection on the framework presented in Figure 2. A number of changes are observable in the representation including a revision of the term 'Guidance' to 'Personal Advice', a suggestion made to avoid confusion with psycho-education. Two new children of 'Activity' were proposed, these being: 1) 'Scientist Practitioner', which enabled the subsequent addition of 'Assessment', establishing a 'Baseline' and 'Evaluation' of practice; and 2) 'Stimulating Motivation.' A major change saw the introduction of 'Theory/Model' which participants felt was a highly significant feature of their understanding of psychological counselling. With the articulation of this branch several defining features of psychological counselling were re-placed under it as children. These were features primarily associated with training and involved 'Reading', 'Supervision' and 'Skills'. 'Confidentiality' was added as a child of 'Ethics', while the title for 'Relationship' was revised to 'Bounded Relationship' implying that it is a unique relationship existing within special limits.

The revisions leading to the development of the most current model of psychological counselling see a structure falling across four levels of association and comprising 44 definitional nodes. This entire structure now may be observed to be enclosed within a frame designed to represent the social context of professional practice.

Conclusion

This project has provided a snapshot of what is potentially an infinitely evolutionary process of knowing and re-knowing in the context of professional enculturation. Probably the single most striking finding has been the relatively late inclusion of elements seen by participants as essential or superordinate within their understanding of psychological counselling. The importance of 'Theory' and an acknowledgement of the 'Social Context' in which psychological counselling takes place provide examples of where elements fundamental to an understanding of psychological counselling were elicited relatively late in the process of model development. Only after the opportunity to reflect upon the adequacy of the framework articulated thus far were they able to identify what was missing for them in an adequate definition of the phenomena of interest.

This paper, whilst championing the constructivist perspective of mutual orientation, argues that postmodernism (particularly the decentring notion of death-of-the-author) has resulted in disempowerment of the person and a potential loss of valuable contributions to localised, applied and perspectival knowledge. Research adopting a mutual orientating stance does acknowledge the evolutionary quality of personal and shared knowledge

and is thus poised to profit from the human capacity to generate, reflect upon and revise meaning.

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Counselling in China: Telephone 'hotlines'

Stephen Palmer, Wang Xingjaun & Xiao-Ming Jia

Stephen Palmer interviews Ms Wang Xingjaun and Professor Xiao-Ming Jia of the Women's Hotline counselling service in Beijing, China.

During October 1997 I (SP) was invited out to Beijing, China, to run a series of workshops and lectures on stress management/counselling, managing pressure and the multimodal theory of stress. Before leaving London I had read an article in a national newspaper which referred to the development of telephone counselling services in China. With my on-going interest in telephone counselling (see Palmer and Milner, 1997) I decided to make contact with Beijing's own telephone 'Hotline' as soon as I arrived in Beijing. I was hoping to interview key staff running the service. By a round about route I finally made contact with Ms Wang Xingjuan and Professor Xiao-Ming Jia from the Women's Hotline.

The Women's Hotline was started by the Women's Research Institute (WRI) which was founded by Ms Wang on her retirement. Previously, she had a career in journalism working for the *Xinhua Daily*, *Chinese Youth Daily*, and the *Beijing Press*. After 'retirement' she has spent her second 'career' devoting herself to the cause of women's liberation in the Chinese People's Republic. Professor Xiao-Ming is also Director of the Mental Health Guidance Centre, Beijing Institute of Technology.

Initially, some commentators predicted that the Women's Hotline would not be warmly received as telephones were unpopular in the country and the Chinese, in particular the women, would not wish to talk to strangers on the telephone (see Maple Women's Psychological Counselling Centre, 1996). However, they were proved wrong and the Hotline has gone from strength to strength. In fact, between September 1992 to April 1995, the Women's Hotline received nearly 15,000 calls. However, the service does have a number of limitations (see Table 1).

As my Mandarin is nonexistent this interview took a few hours. I have edited out sections where we spent time clarifying meanings of specific words or phrases (Palmer, 1997: 473-479):

Stephen Palmer (SP): Today, I would like to focus on a number of issues. I want to learn more about the Women's Hotline service you set up, the type of problems that your counsellors deal with, the therapeutic approach used by your counsellors, the training and supervision you offer the counsellors and finally how the West may be able to help.

When did you set up the Hotline?

Wang Xingjuan (WX): We set up the Women's Hotline on the 1st of September 1992 – this was the first Women's Hotline in our country. In 1993 we opened a second Women's Hotline and Women's Expert Hotline. We are open every day, Monday to Friday, for 11 hours for Chinese women.

SP: Why did you set up the Hotline?

WX: For the women of this country because when this country was opened to

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Table 1 Limitations of the Service

The Hotline service recognizes that it has five key limitations (adapted The Maple Women's Psychological Counselling Centre, 1996:6):

1. Time limitation: The Women's Hotline has two lines in operation, yet many telephone callers complain that it is difficult to get through. As the Women's Hotline serves women nationwide and there are so many advice-seekers, they are unable to service their needs.

2. The Hotline can only offer a general service of 'psycho-counselling' to those who have general psychological problems, but it can do nothing for advice seekers who have a psychological disorder.

3. The Hotline is unable to undertake follow-up activities or give continuous guidance. As the principle of secrecy is advocated, the counsellor does not ask the name and address of the caller, therefore no further contact can be made after the caller hangs up.

4. Limitations of area: As telephones have not reached every part of China's rural areas, there are few calls from 'peasant women'. The Hotline mainly provides a service to urban women, and 80 per cent of calls come from large and medium sized cities.

5. Limitations of the abilities to help: They are unable to give assistance to women wishing to be transferred to another post or helping those made redundant to become employed.

the outside world many Chinese women had to face new problems and challenges. Some lost their jobs, and the divorce rate is rising every year which means some losing their family and their marriage. They experienced many psychological problems and mental stress. We hoped to help these women. Our counsellors' slogan is: 'Pour forth your troubles. We'll try our best to help you. The commitment of our Women's Hotline is to give our love, care and show our warm and sincere feelings to women of all circles'.

SP: Are the calls mainly from Beijing?

WX: Currently, the ratio between calls from Beijing and the provinces is 54:46 per cent respectively for the Women's Hotline. The ratio of the Women's Experts Hotline is 50:50 percent. This indicates that the hotline service is now being used by women all over the country. This is an encouraging development. Also, it probably reflects the rising rate of telephone installation all over China.

SP: Now that is has been running for some years what sort of problems are your callers bringing to you now?

WX: For many callers the main problem is marriage and family. The second problem is about love and the third their mental health and childcare problems. The fourth area of problems is sex and the fifth area is legal problems.

SP: In your analysis of issues raised by callers which is printed in your booklet there are three areas – domestic violence, interpersonal relationships, and family upbringing – that you did not analyse early on (see Table 2). Why was that?

WX: Because in China we believe that men and women are equal, so we do not think that women will be beaten by their husbands. In China they do not recognize that domestic violence could be a problem.

SP: When did you start to recognize it as a problem on the Hotline?

WX: On the Hotline some callers began to discuss this problem. They said they were beaten by their husbands. We realized this was a new problem in our country so we decided to research this subject. Subsequently, over the last year we have analysed it and published our findings.

SP: Do men use the service?

WX: Yes. Generally men discuss issues about marriage, adjustment of relations

Table 2 Analysis by issues raised (September 1992 to December 1996)

Issue	Sept. 1992 to Aug. 1993		Sept. 1993 to Dec. 1994		Jan. 1995 to Dec. 1995		Jan. 1996 to Dec. 1996	
	Number	%	Number	%	Number	%	Number	%
Marriage	834	23.1	2161	20.6	1337	18.8	1411	20.2
Love	850	23.6	2509	23.9	1182	16.6	1191	17.1
Sex	328	9.1	1280	12.2	1286	18.1	1291	18.5
Domestic violence					64	0.9	54	0.8
Sexual harassment	45	1.2	106	1.0	104	1.5	70	1.0
Women and child health	606	16.7	1854	17.7	1446	20.4	1417	20.3
Work-related problems	236	6.5	611	5.8	104	1.5	105	1.5
Legal	143	4.0	460	4.4	553	7.8	525	7.5
Interpersonal relations					251	3.5	208	3.0
Psychological problems	149	4.1	372	3.5	352	5.0	279	4.0
Family upbringing					109	1.5	114	1.6

with their family members, and the harmonization of sexual life between husband and wife.

SP: What problems do you have running the Hotline as a manager and supervisor of the service?

Xiao-Ming Jia (XJ): I think first of all the callers have many different problems. We talk about how these problems are common and we ask them what they want to do in the future. There are many ways to solve their problems and we talk to them about choosing the best way. We want them to choose the most helpful option so we don't tell them precisely which is the best. However, the caller wants us to solve their problem, but because they only see one way to solve it, they want us to give them another way.

SP: So essentially you've got conflict here because the caller wants you to give them an answer whereas the telephone counsellor does not want to provide them with a direct answer to their problem.

XJ: Yes.

SP: So the volunteer counsellors have problems too!

XJ: Yes [laughter]. The volunteer wants to help the callers but sometimes the counsellor doesn't know how to help the caller. The counsellor then feels unhappy and sometimes anxious. Another problem is that sometimes the caller's problem is similar to the counsellor's own problem. This is a very big problem. So the counsellor wants help and so does the caller!

SP: So do you discuss this kind of problem in supervision?

XJ: Yes.

SP: How many of these volunteers do you have?

WX: We have trained about 150 volunteers and at the moment we have about 70 volunteers working on the Hotline.

SP: With how many supervisors?

WX: Seven.

SP: I think I'll return to the issue of supervision a little later once I've understood the approach your counsellors use. What training do you give to the volunteers?

XJ: Sometimes we have a lecture. An expert counsellor helps to train the other counsellors on how to deal with the many problems. The experts come from foreign countries such as Britain, Australia, Hong Kong and Malaysia. We also have workshops to talk about the main topics such as divorce and marriage. In addition, we have seminars once a month to discuss difficult cases.

SP: So they don't necessarily have intensive training but regular lectures and seminars.

WX: Yes.

SP: What theoretical approach do you teach the volunteers?

WX: Our volunteers need the skill to answer questions. For example, our volunteers will answer any question about maternal health, legal matters, marriage, some about HIV; they ask a whole range of questions so our volunteers must know everything.

SP: So it's a very practical approach providing information on a range of topics?

WX: Yes.

SP: If someone rings up who is feeling suicidal how do your volunteers help them?

WX: This is a very difficult problem. But the number of callers like this is not very big.

SP: I would like to clarify this issue. If a caller telephones in with a marriage problem or a work-related problem, they don't say my big problem is depression or anxiety. They would say that they have a practical problem?

WX: Yes.

SP: It might be an idea if we take a specific example. Let's say a woman has rung in and told the counsellor that her husband abuses her or beats her and asks what she should do – how would you help?

XJ: First we ask the caller what they are feeling. We give the caller a long time to talk about their problem. We think this is very important. Usually the caller hasn't spoken to anyone else about this problem.

SP: They don't share it with anybody not even their family?

XJ: No. They are very ashamed about their problem. They don't like other people to know about their problem. So they have many pressures and they keep them inside. They don't have a chance to speak about their feelings so we give them a chance to do this. If a woman rings in and says that her husband beats her we ask her what has happened. Sometimes they explain they have fought with their husband and they can't resolve the problem and they want to know what to do. So we tell them that if they want to do something have they thought about the consequences – what would be the result? For example, if a woman leaves her husband she may lose her home and may face a very difficult future. We would ask the caller lots of questions about her social support and resources. On the other hand, inner resources are also important. As the caller discusses her problem we hope she will gain inner strength too.

SP: It sounds as if you are taking a problem focused or solving approach to counselling once you have explored how they feel.

XJ: Yes. That's it.

SP: Is the counselling on-going?

XJ: Yes. Sometimes the caller rings back when she knows the counsellor will be staffing the hotline and continues the conversation.

SP: Are there any long-term training courses for counsellors in Beijing at, for example, Certificate, Diploma or Masters levels at Beijing University?

WX: Some. At Beijing University on psychology but only a few.

SP: Are they taught counselling and therapy on the psychology courses?

XJ: Yes.

SP: Do they get any counselling skills practice on the courses?

XJ: Very little. Lots of theory but they don't learn how to do it.

SP: I think I now have a better understanding of the Hotlines' approach and the training available in Beijing.

I would like to return to our earlier conversation about supervision. Your literature suggests that the supervision focuses on monthly seminars and lectures. What else do you discuss in supervision?

WX: In some cases we discuss how to answer the questions asked by the callers. Also we look at particular case studies in more depth.

SP: Is it one-to-one supervision or is it in a group?

XJ: A group of about 30 to 40 counsellors with one supervisor.

SP: I would imagine that there are lots of questions and problems to deal with in the supervision session. How much time is devoted to the session?

XJ: Three to four hours.

SP: Is this sufficient time?

XJ: Not always.

SP: Apart from the supervision process, how do you monitor the standard and quality of work of the volunteers?

WX: The supervisor listens in to the call and writes down her answer and response. It wouldn't be good if the volunteer was

heard to speak to the supervisor while on line to the caller.

SP: I would agree.

XJ: Two counsellors may also work together – one answers and the other writes down the case notes. Sometimes in supervision we role play too. This helps us to learn from each other's experience.

SP: What sort of resources do you have to run the Hotline?

WX: We have to rent the house, we have to employ managers; we need to have computers to analyse all our calls. Our big problem is getting money.

SP: Do you receive any government funding?

WX: No. We have to rely on foundations both in this country and abroad. For example, the Ford Foundation has helped us. We hope to do many things but of course without money we cannot.

SP: What other things would you like to do?

WX: We would like to help the battered women in the countryside. They need to learn how to protect themselves legally. We need to train the police and government officers to protect and help battered women.

SP: This would need a fair amount of funding. In what way can the West help you?

WX: I hope the West will be able to help train our volunteers and supervisors to improve the quality of counselling. Secondly, an exchange of experience because in our country right now we have over a billion people so I would like to ensure that every province in China has a Women's Hotline. We have 31 provinces and there are local women's hotlines in Shaanxi, Shenyang and Shanghai. In 1996 we trained counsellors from nine cities and provinces and achieved great success. With our existing number of hotlines, callers sometimes ring for two weeks and can't get through so we need more lines. More funds would mean more lines. Although the caller pays for the call we have to rent the house and telephones.

SP: There have been many changes in China during the 1990s. How have they affected the demands upon your organization?

WX: Before the reforms and opening up to the outside world all women had jobs but now many people have lost their jobs and they are old. Women face many new problems now, as their economic position changes. We hope the Hotline will help women become more confident.

SP: I would like to thank both of you for taking part in this interview and for being so patient with my poor Mandarin.

Additional facts

China has a population of around 1.237 billion of which women make up 592 million or 49.1 per cent of the total.

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Counselling in health care settings: Some theoretical and practical considerations

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Illness is at one level a private and individual matter. At another level, it has implications for family and social relationships. In spite of many significant advances in the diagnosis and treatment of medical conditions, a degree of ill health invariably affects most people in their lifetime. Some may have to endure life-long and chronic ill health. Not only does illness evoke fears and anxieties – be they about pain, suffering, loss of functioning or death – but it also directly affects relationships. Partners may become carers; children may be called on to provide care and support; while hospitalization may lead to periods of separation from the family and dependence on professional carers.

Counselling can help people to cope with and adjust to new and unwelcome circumstances. It can also help other family members to adapt to the changes brought about by illness, whether it is an acute episode, or a chronic, life-long (inherited) or life-threatening condition. The notion of 'needing counselling', however, can inadvertently create a problem, undermining an individual's ability to cope and adapt, because of the associations between mental health and illness. Some unique and specific issues arise in health care settings which must be recognized by counsellors when working with people who are ill and their families. Some examples of questions we have been asked by counsellors help to open up some of these issues for further scrutiny:

- Should counsellors give information to patients about medical conditions and treatment?
- Does the counsellor need to have detailed knowledge of a medical condition to counsel someone about it?
- How do confidentiality rules apply in health care settings?
- If we cannot cure patients of their medical condition, what is the role and task of the counsellor?
- How should we approach a patient who has just been given bad news by a doctor?
- What do we do when the doctor asks us to see a patient who refuses to take his or her medication?
- How do you work with family members?

- How can I work in a setting where privacy and time boundaries may be lacking'?
- How do I work with a person who has been referred for counselling but does not want it?
- What is the counsellor's role in dealing with loss and bereavement'?
- Where does a counsellor fit into a multidisciplinary health care team?

These and many similar issues are addressed in our new book *Counselling in Health Care Settings* (Bor *et al.*, 1998) which describes a theoretical framework and related skills to effectively counsel patients and families affected by illness in a range of health care settings. While counselling and communications skills have always been central to the provision of medical care, it is clear that they have assumed a new level of importance. Counsellors and psychotherapists, whose specialist understanding of communication and relationship problems is well recognized, are now increasingly sought to work in health care settings with medically ill patients and their families.

The benefits of modern medicine mean that many more patients now live longer with a chronic illness; this in turn may have an impact not only on the relationship between the patient and his family, but also between the patient and health care providers. All health care providers are expected to be effective communicators, able to counsel their patients about their problems, investigations, treatment and to prevent illness. Furthermore, in an era in which medico-legal issues are becoming prominent in health care, with litigation a more common outcome, counselling and psychotherapeutic skills could be central in reducing the risk of adverse outcomes and, if possible, avoiding litigation. We use an integrative counselling model, drawing on ideas from complementary theoretical frameworks. We endeavour to be flexible and responsive to the patient's and other health care provider's ideas or beliefs. Counselling and psychotherapy can imply weekly, or more frequent sessions with a trained counsellor over many years. While this may be necessary or helpful for some patients, there is also a place for information, or advice-giving in counselling in health care settings, as well as briefer periods of contact with the counsellor. Indeed, effective counselling can sometimes be conducted in a single session, or through consultations with other professionals caring for the patient which may obviate the need for a face-to-face contact between the patient and the counsellor.

A basic tenet of the systemic approach is that all behaviour is part of an interactive process, whether at home, at work, or in a counselling session. Reciprocity in relationships implies that if something happens to one member of the family, it will affect the rest of the family who, in turn, will affect the behaviour of that individual. This means that behaviour cannot be studied in isolation, without taking into account the situation in which it occurs. The counsellor may influence the patient whose reactions, in turn, have an effect on the counsellor. Counselling is not a process of 'doing something to someone'. It is best described as an interactive process. Although there are many definitions of counselling and psychotherapy, it is necessary to clarify our definition:

> Counselling is an interaction in a therapeutic setting, focusing primarily on a conversation about relationships, beliefs and behaviour (including feelings), through which the patient's perceived problem is elucidated and framed or reframed in a fitting or useful way, and in which new solutions are generated, and the problem takes on a new meaning.

An overemphasis on counselling in health care settings may inadvertently cause some patients to believe they have a psychological problem. The approach described in this paper and our book starts out with the premise that problems first need to be identified and defined by patients or health care providers. An assumption on the part of the counsellor that all medically ill patients require or will benefit from counselling is unfounded. This view can be detrimental to the patient,

the position of the counsellor in the system, and to how others view the practice of counselling. Many psychological problems in health care settings are adequately assessed and managed, and in some cases prevented, in the course of comprehensive medical care.

Counsellors may increasingly have opportunities to become involved in patient care due to increasing workloads and constraints arising from pressures of time: increasing costs of diagnostic tests, investigations and treatment regimes, and evidence of benefit to some patients and their caretakers from counselling in some settings and for certain problems. There may also be a pressure to treat the patient's problems in the shortest possible time. The conventional 50-minute counselling session may not always be appropriate, although the number of sessions may also be fewer than with a conventional open-ending contract. Systemic counselling can sometimes extend over a longer period, with sessions being held at greater intervals. A clearly mapped-out plan of action with the patient may itself be a major psychotherapeutic intervention for a patient who is dying, uncertain, anxious and bewildered.

Considerations for counsellors working with medically ill patients

We have identified 10 main considerations for the counsellor which reflect the unique and specific features of therapeutic work with medically ill patients. These are derived from different theories of counselling and psychotherapy (including psychodynamic, systemic, person-centred, cognitive-behavioural and personal construct, among others), and our own clinical experience. They are as follows:

1. Biopsychosocial approach: the application of a biopsychosocial approach (integrating biological, psychological and social features) to counselling has been extensively illustrated by McDaniel, Hepworth and Doherty (1992). There is a need for the counsellor to work collaboratively and without undue emphasis on either biological or psychological processes (to the detriment of the other). Social, medical and psychological events and processes are viewed as being interconnected and all require the ongoing attention of the counsellor. There is sometimes a tendency to over-emphasize psychological and social processes, whereas biomedical events may be equally relevant and themselves give rise to psychological problems.

2. Context: it is important to understand the context in which problems are identified or treated. The setting or context may be an in- or out-patient clinic, a GP surgery, a ward or private practice setting. Each will influence or constrain the amount of time available for the patient, the degree of privacy in counselling sessions and sometimes too the psychotherapeutic approach used. The context determines how problems are viewed, what can be done about them, who should be involved in treatment and care. Systemic counsellors have been closely associated with the development and application of contextual therapies and conceptual ideas pertaining to counselling and context, advanced by Selvini-Palazzoli and her co-workers (1980).

3. Beliefs: beliefs about health and illness are central to an understanding of how people are affected by illness, how they may respond to their care and treatment, and how they are likely to cope. The cognitive behavioural and personal construct approaches emphasize the relevance of cognition and beliefs in the onset, maintenance and treatment of psychological problems. Wright, Watson and Bell (1996) distinguish between constraining and facilitative beliefs in relation to health and illness. Constraining beliefs maintain problems and impede in the search for new options or alternatives. Facilitative beliefs expand possibilities for solutions. Beliefs are directly linked to behaviour. If a patient does not believe that a particular prescribed medication is likely to help his or her condition, for example, it is less likely that he will comply with the treatment regime.

4. Attachment: the connection between attachment anxieties later in life and secure

or insecure attachments to parents in infancy and childhood (Bowlby, 1979) helps us to understand how people relate to one another. The advent of illness can intensify, challenge or alter these patterns of attachment. Not only does illness have the potential to threaten existing attachments (especially where there is the possibility of death), but illness can also give rise to new attachments, such as in the patient-health care provider relationship. John Byng-Hall (1995) has provided a solid foundation for understanding attachment in human relationships, especially in the context of changing family relationships.

5. Typology of illness: an understanding of the main characteristics of an illness is important in order to determine how a person may be affected. Rolland (1994) distinguished between four dimensions: onset, course, outcome and degree of incapacitation. It is not necessary to have an extensive understanding of a particular illness in order to offer counselling to an affected person, but it is important to appreciate the time phase (especially if it is a chronic illness) and practical consequences of the condition. This also helps to determine the possible ramifications for the patient's relationships.

6. Development and lifecycle: developmental and lifecycle issues determine how an individual, couple or family are affected by illness. For an individual, this will depend on whether it is a newly born infant, child, adolescent, adult, and so on. Couples and families also progress through a series of developmental phases and each may imply or lead to changes in relationships between people. A newly wed couple, reconstituted family, or couple facing the 'empty nest' may each be affected differently in response to illness in the family. Carter and McGoldrick (1989) and Edwards and Davis (1998) have written extensively about the psychological impact of health problems at different stages of individual, couple and family development.

7. Curiosity and questions: counselling proceeds in many different ways. Reflection and interpretation are probably most commonly associated with the process of counselling. However, the clinical interview, using carefully thought out questions, provides an important source of information for the therapist (Tomm, 1987). Questions are a main catalyst for patient change and healing. Different types of questions can be used to link comments on behaviour, beliefs, feelings and ideas about the future. The purpose of such questions is to heighten the counsellor's sense of curiosity (Ceechin, 1987), and to avoid becoming judgmental or to have a fixed view of the patient and problem rather than a desire to uncover a single 'truth'. Circular, reflexive and hypothetical or future-oriented questions provide the patient and his or her family with the opportunity to view themselves in the context of relationships, and to recognize different perspectives of the problem.

8. Language, narratives and meanings: narrative therapy, which draws on the language and stories of the patient, helps to reveal meanings about problems and how problems come to be viewed as such. It can be used when working with the full range of somatic symptoms (Anderson & Goolishian, 1988). The narrative approach avoids stigmatizing or blaming the patient and also uses language to help resolve or alleviate problems associated with health-related issues (Griffith & Griffith, 1994). Different groups of professionals are taught to think about psychological problems in different and seemingly incompatible ways. Ailments of the mind and body are often conceptualized differently by counsellors, psychotherapists, family therapists, as they are by doctors, nurses and other health care providers. One result has been that some counsellors are not referring patients suffering from a 'real' medical or psychological problem. Similarly, some counsellors may not think to explore 'medical' meanings associated with psychological problems. The problem becomes more complex when treating patients whose symptoms appear to lie at the intersection of two. This includes those suffering from somataform disorders, such as non-electrical seizures, persistent headaches or conversion paralysis.

9. Cognition and behaviour: the direct (and circular) relationship between cognition

Table I Levels of counselling

1. Information-giving: the provision of factual information and advice about medical conditions, laboratory tests, treatments, drug trials, disease prevention, and health promotion among others.

2. Implications counselling: a discussion with the patient and/or others which addresses the implications of the information for the individual or family, and his or her personal circumstances.

3. Supportive counselling: in which the emotional consequences of the information and its implications can be identified and addressed in a supportive and caring environment.

4. Psychotherapeutic counselling: focuses on healing, psychological adjustment, coping and problem resolution.

(thought) and behaviour (action) is central to an understanding of how problems are maintained and can be resolved. Many psychological problems or symptoms associated with health-related problems can be effectively treated with cognitive-behavioural therapy (Beck, 1976). Cognitive-behaviour therapy is especially useful whcn treating patients suffering from anxiety, depression, insomnia and other problems typically seen in mental health care settings, as well as for pain management and chronic fatigue syndrome. Identifying early experiences, dysfunctional assumptions, critical incidents, negative automatic thoughts, and other factors which may maintain the problem are first steps towards its resolution. Thinking errors or cognitive distortions are often implicated in mood-related problems stemming from ill-health, hospitalization or a fear of undergoing medical procedures. For patients referred for counselling because of a fear of physical pain or separation from the family, behavioural methods (such as desensitization) can be used to ameliorate some symptoms.

10. Time and timing: illness brings into sharp focus issues about time and longevity. The prospect of a shortened lifespan, or one in which quality of life is drastically curtailed, are often sources of psychological distress. Long-term counselling approaches may be neither desirable nor feasible in a context in which there is high demand for psychological care or where patients cannot regularly attend counselling sessions over a prolonged period because of their illness. Counsellors who work in health care settings may be required to be flexible and to improvise, thereby remaining responsive to the patient's needs. Decisions have to be made about which problems can be treated and the duration of counselling.

One consequence may be the need to focus more on issues of timing in counselling. Some patients may not require a lengthy lead-in to counselling and may be willing and able to work at a deep level from the outset. Others, by virtue of their views about counselling, their problem, how they view themselves as coping and the natural employment of defences, may never benefit from the range of psychotherapeutic interventions that could otherwise have been employed. The challenge in these settings is for the counsellor to either work more quickly and intensively, or more slowly and cautiously. It is important to keep in mind how the patient and others view progress and outcome in counselling, as this will influence whether the patient continues in treatment and whether the therapist continues to receive referrals from the medical team. Some constraints may also relate to the physical setting, such as a lack of privacy or nowhere to sit comfortably with the patient receiving treatment (such as through a drip), which may affect when sessions can be arranged and for how long they last.

Levels of counselling

It is useful to distinguish between different levels of counselling in order to illustrate the range of activities carried out by counsellors and also to help identify what 'mode' the counsellor may be engaged in at any time. Each one suggests a different relationship with the patient. For example, contrary to both some lay and informed beliefs about counselling, sometimes it is necessary for the counsellor to give information about treatment and care. This is usually in highly specialized fields where dedicated counsellors are part of a multidisciplinary team. The best known specialities which have a tradition of

employing counsellors are oncology, HIV/AIDS, infertility, multiple sclerosis, haemophilia, spinal injury and paediatrics. The different levels of counselling should be viewed on a continuum rather than as discrete and unrelated activities.

The title of 'counsellor' or 'psychotherapist' is largely interchangeable. Professional training, preferences of other colleagues, and tasks may influence which professional title or 'hat' is chosen. It is reasonable to argue that in health care settings all counselling work involves psychotherapy, and vice versa. However, those trained to only undertake information-giving and implications counselling should not treat patients using psychotherapeutic approaches and techniques without further training and supervision. Untrained and unsupervised counsellors may be ineffective or even damaging to the patient.

Stages of counselling in health care settings

Most counsellors are comfortable exploring issues and concerns with patients without too much reliance on a structure or agenda. There is wide variation in how sessions are conducted and managed, usually in response to the needs and concerns of the patient, where the patient is seen, the context in which the counsellor works, and the counsellor's professional training. In health care settings where patients are physically ill, counsellors must be able to respond to and cope with a high level of unpredictability and emotional intensity. Ideally, a range of issues need to be covered with patients in a first session, in a reasonably logical manner, progressing from one issue to the next.

Having a check-list in a first counselling session can help keep a focus by having a limited agenda. This is especially helpful in work settings where patients (a) are likely to have high levels of emotional intensity, (b) are unfamiliar with counselling and therapeutic processes, (c) have a diminished capacity to participate in counselling because of the effects of illness, treatment or constraints of the setting, (d) are likely to have multiple or complex issues that may need to be discussed and (e) may have only a single, one-off session or may be unable or unwilling to be followed-up.

The special circumstances and features of counselling in health care settings may mean that an initial consultation is possibly the only direct patient contact in some cases. Consequently, the counsellor needs to be adept in making an assessment and intervening all in the same session. Unlike in some other settings, patients may not benefit from follow-up because they may not want or need further sessions. They may opt to be treated elsewhere and receive psychological support in another setting or they may recover and be discharged, or they may become more unwell and even die.

Practical hints for improving collaboration in health care settings

The 'rules' for collaborative and effective practice in health care settings vary from one context to another. Opportunities to reflect on practice in a wide range of health care settings through collaborative work, case discussions, peer supervision, consultation and research have highlighted some ways to enhance practice without straying beyond the boundaries of professional competence. Some ideas that have helped to achieve this are listed below:

- *Make no assumptions* about what constitutes a problem, for whom it is a problem, how people should cope with illness or disability, or how they should relate to one another. Also, do not assume that they understand their illness, its implications. treatment, and so on.
- *Practice collaboratively* as part of a team; dispel the myth that counsellors always have their own agenda and 'get on their high horse' in order to assert their views and opinion.
- *Be humble* but communicate directly. Learn from others and be tentative if you are unsure. Do not overstate the importance of counselling – patients rarely live or die by what happens in counselling, and medical and nursing

concerns should take precedence. Refer patients to other colleagues where appropriate; but do not be reticent to offer directives if indicated.

- *Learn about health care issues* by attending case meetings, lectures, sitting in with doctors when they consult with patients, learning the language of the health care staff, acquiring and developing an interest in anthropology and sociology so as to learn more about the health care setting.
- *Be curious;* adopt a stance of receptive openness and ask questions. Avoid making assumptions and becoming prescriptive.
- *Be flexible* about where you see patients, when you see them, your working hours, about approaches used in counselling for which there may be special demand in a health care setting (cognitive-behavioural and family therapy); work at the patient's pace and determine whether the problem is best solved by open-ended, exploratory counselling or by problem-focused counselling.
- *Be time conscious;* aim to achieve the most within the time constraints. Learn how to do counselling briefly. When feeding back to other colleagues, either verbally or in a letter, be succinct and to the point; avoid wordy and lengthy reports, and unfocused discussions about patients.
- *Be proactive* by not waiting for problems to occur or for patients to start discussing their main concerns and fears. Waiting for patients to talk about their problems and fears may be too late to help in any practical way or the patient may believe that you too are colluding with his/her denial of the problem.
- *Where appropriate give information;* counselling should be more a dialogue than a monologue. Do not be afraid to give information or to suggest who the patient can talk to if he/she requires more specialist information (although doctors and nurses must be consulted).
- *Practice defensively;* patients are increasingly conscious of their rights and what they can expect from health care professionals and in the course of their treatment. In some cases this can lead to litigation or a complaint to hospital/clinic managers or to your professional body. The likelihood of this being done is reduced if (a) you refrain from making unrealistic claims, (b) you defer to doctors or nurses when in doubt about how to deal with a problem, (c) you keep factual notes of what happens in sessions but limit your opinions to what has been deduced from observations of behaviour, i.e. have evidence, and, (d) by being curious and only offering ideas and opinions tentatively. Be accountable to your profession, colleagues and managers of the institution or setting in which you practice, by giving feedback about your work and related problems without necessarily breaching patient confidentiality.
- *Be practical;* as counsellors we are sometimes long winded and overly cerebral in response to patient problems. Learn to make rapid decisions, to take small risks and think imaginatively, yet practically, about possible solutions.
- *Respect patients' defences*, which may serve to protect them. Talk about what you observe with the patient but it is not always necessary to confront or directly challenge their defences. Counter any suggestion of blame for illness from either the patient or family members.
- *Sustain realistic hope;* therapeutic neutrality sometimes interferes with our ability to offer supportive and comforting words to the patient and others. By focusing on practical issues it may be possible to give a message of some realistic hope without denying the gravity of the situation. Similarly, it is important not to shy away from discussing issues about death, dying, disfigurement, loss and pain, when it is obvious that these need to be openly addressed. Help the patient to see a future and to participate in decision-making for his/her future.
- *Suggest participation in rituals*, or create rituals which help people to focus on a

particular issue or event (a birth or a death). Rituals give meaning to events, help to amplify feelings in a focused way and a supportive context, and are a part of everyday life. Counsellors can help their patients create personally meaningful rituals to help them cope better with their circumstances, and some even participate in these with their patients and family.

- *Help patients to gain a sense of mastery over their situation*, by involving them in decisions. Work towards increasing their choices or options. Avoid fostering too much dependence as this may be counter-productive.
- *Evaluate your practice;* it is good practice to audit and evaluate your work. This can also help in the maintenance and development of your counselling service. Decisions about health care delivery are increasingly made on evidence-based practice. Evaluation and audit of counselling practice should be initiated by counsellors, otherwise there is a danger that others will take charge of the evaluation process.
- *Dress according to the context.* Unlike doctors and nurses, counsellors do not have a uniform nor any props (stethoscopes or white coats) which may identify them. Even so, most hospitals and clinics are rather conservative establishments and the expectation is to be dressed in conservative and formal attire. Expectations may be different for counsellors working in community and outreach settings.
- *Teach others;* the accusation that some counsellors do not help other health care professionals to understand more about psychological process and counselling is not without foundation. Offer to give seminars, invite colleagues to case discussions, collaborate in research and offer to see patients jointly with another professional colleague. Foster a climate of openness about your work as this may help others to understand better what you do with patients and may lead to them being more supportive of your service.

Conclusion

No counselling approach described in published literature teaches one 'what to say when'. Instead, counsellors and trainees in counselling can be introduced to new (either more or less expansive) ways of examining psychological problems and can incorporate an ever-widening range of concepts and skills in their practice map. Different theoretical approaches contribute complementary ideas to the practice of counselling in health care settings. The emphasis in counselling should be on developing an integrative approach, which brings together different ideas and skills in a unifying conceptual framework, rather than eclecticism which may seem confusing or muddled in practice. The approach described in this paper and our book is mainly derived from systems theory with an emphasis on solution-focused counselling. Experience has taught us to be receptive to ideas developed outside of our main theoretical framework and to integrate these into our practice.

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Questions and answers

Therapist Dilemmas
Windy Dryden
Sage 1997, ISBN 0 7619 5354 9, £12.99, pp198

Producing a book from a series of interviews has some advantages, but also some down sides. The major advantage is probably that the interviewee may be more willing to agree to provide the interview: it's less time consuming than writing a chapter. The disadvantages would include potential biases that might emerge from the questions put by the interiewer and/or the conciseness or verbosity of the interviewee.

The result of verbosity is that we get a polemic view; that of over conciseness in that we have a limited explanation of the idea, concept or model.

Dryden, probably because of the interview approach, has been able to persuade a considerable array of talent to provide chapters for the book. Sixteen therapists, including Dryden, provide their views on the therapist's dilemmas. Dryden identifies six major dilemmas from the interviews. They are the: compromise that is the contrast between the ideal and the pragmatic boundary, which would include how much of the self to reveal; allegiance to a particular school of therapeutic thought; role, for example, the possible conflict between education and healer responsibility; the possible tension between client autonomy and the therapist's responsibility for their welfare; and impasse dilemmas: to what extent should therapists make themselves vulnerable to facilitate a client overcoming a block?

Dryden says, in his chapter "The book is not intended for those therapists who are seeking 'cookbook' answers to different clinical issues. It is rather designed for those who are prepared to be personally confronted by the issues raised in the interviews." He adds that the discussion questions at the end of each interview are provided there to help this process. Perhaps that is a clue as to how the book should best be used. It could be that as a teaching text, in a therapy training institute, it would be useful as a source of material for group discussion. Certainly, reading the book alone without the benefit of a discussion tended to be a struggle. The interview style does not make easy reading. There were times when it would have been easier to have listened to a tape of the interview, instead of having to read page after page of questions and answers. Again, there were times when questions were raised in me for which, without the benefit of a discussion group, it was hard to find answers. Additionally, the differences in interviewee response style could tend to be irritating.

However, sometimes the interview provided an excellent insight into the nature of the interviewee and that's exciting. Albert Ellis's ego shines out. There is a man who does not appear to have dilemmas. He has REBT and he evangelises its benefit over all other therapeutic methods. The contrast between Ellis and Brian Thorne is equally intense. Thorne wants to have a positive impact on institutions such that they become "the kind of place where people are more likely to develop as persons". Make the world a better place. It sounds a wonderful, if challenging, dilemma.

The questions at the end of the chapters, where you have a group to discuss them, are good prompts - where you are left in isolated suspension they may be overly challenging. An example would be the questions asked at the end of Marion Goldreid's interview "To what degree do you maintain a 'within session' focus as opposed to a 'between session' focus in your therapeutic practice?" "What determines your choice of focus in this respect?"

Because of my split interests, therapy and occupational, it is not surprising that I should have been interested in Paul Brown's interview, he being a clinical and occupational psychologist. The dilemma is that of scientist-practitioner. The evidence is that change, in Brown's case of marital-sex therapy, will not occur (scientist) while the therapist is optimistic and wants/needs (?) it to happen. No answers, but some very interesting questions and, from Dryden, observations.

The book provides some very quotable sentences. Paul Wachtel, a psychoanalytically-trained therapist, who has tried to integrate psychotherapy and personality theory, says "I mean we all depend on mummy and daddy, somewhere in some deep recess of the mind" and "To work with people who have a history of thwarting themselves and to think that we can reverse this trend. Inevitably, at least part of the work involves getting caught up in that pattern. There is a kind of quicksand involved here and therapy is the art of extracting oneself from quicksand, that's not the easiest thing to do."

The final chapter, Tim Bond's concluding chapter, is not as intensive and seems to sum up my feelings about therapists' dilemmas. He says, and 1 would agree: "Dilemmas

chase us away from a tendency to see ourselves as omnipotent and omniscient. They provide "the challenge of learning from the dilemma about what its existence tells us about our own involvement in the provision of therapy, and about the nature of therapy itself". This statement alone should make therapists read the book, even if, as I, they don't like the interview style.

Christopher Ridgeway

So little time

Time-Limited Therapy in a General Practice Setting: How to Help Within Six Sessions
Glyn Hudson-Allez
Sage 1997, Pb £13.99, pp221

This book, by a Chartered Psychologist and UKRC registered independent counsellor, is written principally for student counsellors, newly qualified counsellors, and counsellors whose main experience is in open-ended therapy. The stated aim is to help readers develop time-limited therapy skills for working with patients in primary care settings.

The book is divided into two parts. Part I concerns organizational and contextual issues for counsellors in primary care, with a discussion in Chapter 3 of some theoretical and political aspects of working therapeutically when only a small number of sessions can be offered. Part II is about three times longer, comprising 10 chapters which each focus on a particular client group or presenting problem (e.g. Chapter 5: Counselling for Anxiety and Depression; Chapter 12: Counselling People with Medical Problems).

Part I offers some sound basic advice on administrative aspects of counselling in GP settings which would be helpful to relatively inexperienced counsellors. However, there is relatively limited emphasis on the dynamics of working as part of a multidisciplinary team, which many therapists new in primary care find one of the most challenging or frustrating aspects of the work. The author does stress the importance of developing effective working relationships with GPs and associated secondary services, and gives some helpful guidance on confidentiality within a medical team, but without offering detailed discussion concerning the management of difficulties and uncertainties in these professional relationships over time. Some clinical vignettes in Part I to illustrate such problems and ways to address these would have helped. The book focuses mainly on counsellors employed directly by practices, rather than counsellors offering a service to primary care from an NHS Trust base such as the local psychology service.

Chapter 3 on the theory, politics and methods of time-limited therapy was disappointingly brief (18 pages) given the book's title, but the author goes on to develop some of the points raised through discussion of clinical material in a 'TLT procedures' section at the end of each chapter in Part II. These offer some useful pointers to inexperienced therapists trained in relatively 'non-directive' models that might help them pluck up courage to experiment with more active interviewing procedures, but might be read by more experienced therapists as sound integrative practice rather than specifically 'time-limited' points.

Part II uses many clinical vignettes to illustrate the problems discussed, although it would have been helpful to include more specific examples of therapist-client dialogue showing the actual interventions related to these. The book would certainly help student counsellors appreciate the varitey of psychosocial problems in primary care. However, in trying to cover this wide range on a 'problem-by-problem' approach, the book sometimes lacked depth.

Some of my reservations about this book related simply to the book's ambitious attempt to cover such a lot of ground in a single volume, and in particular, the relative brevity of Part I. However, I also had concerns about the ways in which people and problems seemed to be categorized and labelled at certain points. For example, Chapter 11 groups a bewildering selection of topics including Asperger's syndrome, Adoption, Step-parenting, and The Demented Parent under the title 'Counselling Individuals within Dysfunctional Families', without a convincing rationale. In Chapter 5 (stress), the author explains the 'type b' personality as "these people are so laid back they are (metaphorically) almost comatose ... they have a very Greek, philosophical approach to life: relax, no problem, don't worry?' (p.80). I would not recommend this book as a whole to colleagues.

John Davy

Book reviewers needed

If you are interested in reviewing books for CPR, please send in a CV and a sample of your work, including a list of areas you have specialist knowledge in, to:

The Editor, *Counselling Psychology Review*
Centre for Stress Management
156 Westcombe Hill
London SE3 7DH

Conferences

Format is:
date: **event**
venue
contact

May 98

6–8 May 98 Health & Safety at Work: Third European Film & Media Festival (Organized by European Commission with Health & Safety Executive)
Edinburgh
HSE Tel: 0151 951 3185 Fax: 0151 951 4913

12-13 May 98: RoSPA – Royal Society for the Prevention of Accidents: Health & Safety Congress 'Reducing Risk: Adding Value!'
NEC Birmingham

15-16 May 98: Association for Counselling at Work (Division of British Association for Counselling) Annual Conference & AGM with several keynote speakers & workshops
Eynsham Hall, Oxford
ACW Administrator Tel: 01788 335617 Fax: 01788 335618

June 98

4-6 June 98: The British Psychological Society Division of Occupational Psychology 3rd Test User Conference
Brighton
John Walker, BPS Conference Office Tel: 0116 252 9555 e-mail: conferences@bps.org.uk

24-25 June 98: Computers in Personnel Conference & Exhibition
Barbican Centre, London
Conference: contact IPD Training Tel: 0181 263 3434
Exhibition: contact Peter Mirrington Exhibitions Tel: 01284 850011

26-28 June 98: American Association for the Study of Headache 40th Annual Meeting
San Francisco CA, USA
AASH Tel: +1 609 845 1720

July 98

9 July 98: IPD Annual Employment Law Conference
QEII Conference Centre, London
IPD Training Tel: 0181 263 3434

21–26 Jul 98: World Congress of Behavioural and Cognitive Therapies
Acapulco, Mexico
WCBCT 98, Program Committee, Apartado postal 22–221, 14001 Tlapan, Mexico D.F., Mexico City, Mexico. Fax: +52 5 665 5228. email: johannes@servidor.unam.mx

August 98

4-7 August 98: World Congress for Counselling (UNESCO)
Theme: Counselling as a Profession : Status, Organisation and Human Rights.
Paris
Contact Dr Derek Hope, Brunel University, Uxbridge, Middlesex UB8 3PH
Tel: 01895 274000 ext. 2300
Fax: 01895 232806

9-14 August 98: 24th International Congress of Psychology
San Francisco, USA
Congress Secretariat, APA Office of International Affairs, 750 First Street, NE, Washington DC 20002-4242. USA. Fax: +1 202 336 5956. email: icap@apa.org

22-27 August 98: 9th World Congress on Pain
Vienna, Austria
International Association for the Study of Pain
Tel (USA): +1 206 547 6409

24-28 August 98: 13th International Congress of Group Psychotherapy
London
CASIL Tel: 0171 499 0900 Fax: 0171 629 3233 email: 10053.2405@compuserve.com

September 98

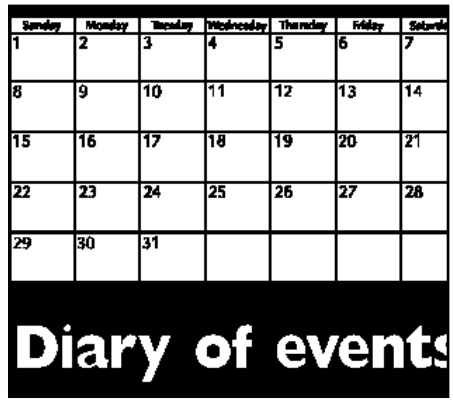
4-6 Sept 98: ISMA 98: International Stress Management Association (UK Branch) XI National Conference: 'Children & Stress'
Venue to be announced
Janet Williams: Tel: 0181 332 1842

2-5 Sept 98: V International Congress 'Constructivism in Psychotherapy'
Sienna, Italy
Prof. Mario A Reda, Dept. Clinical Psychology, Univ. of Sienna, Sclavo Hospital, Porta Tufi, 1-53100 Sienna, Italy Tel: +39 577 298927 Fax: +39 577 298925

8-12 Sept 98: European Association for Behaviour and Cognitive Therapies - 28th Annual Congress 'Effective Therapies for the 21st Century'
Cork, Ireland
EABCT Congress 98, Dept of Applied Psychology, University College, Cork, Ireland Tel: +353 21 902198 Fax: +353 21 270439

13-16 Sept 98: British Institute of Learning Disabilities Annual Conference
Eastbourne
Karen Clarke, bild, The Crescent, Wolverhampton Rd, Kidderminster, Worcs. DY10 3PP

17-19 Sept 98: British Association for Counselling Annual Conference
Southampton
BAC Office: 01788 550899



October 98

28-30 Oct 98: IPD National Conference & Exhibition
Harrogate
IPD Training. Tel: 0181 263 3434

November 98

Nov 98: Tenth International Montreux Congress on Stress
Grand Hotel Excelsior, Montreux, Switzerland
American Institute of Stress, 124 Park Ave, Yonkers, NY 10703
Tel: +1 914 963 1200 Fax: +1 914 965 6267 email: stress124@earthlink.net]

1999

Sept 99 ISMA VII – Seventh International Conference of the International Stress Management Association
Houston, Texas
Philip Morgan – email: epcint@interserv.com or Janet Williams, ISMA UK Chair: Tel: 0181 332 1842. Fax: 0181 332 2482

Courses

Recommended for Continuing Professional Development by the Division of Counselling Psychology

[Please note: 'CPD Recommended' status refers to short courses (lectures, presentations or courses) which have demonstrated a minimum requirement (see guidelines for assessors from The Society office). You should also note that further courses offered by the same – or other organizers/presenters may qualify for recommendation although not listed here.]

Format is:
course name
venue
dates
organizer/presenter
contact

Primary Certificate in Stress Management
Centre for Stress Management, London
next courses – 7/8 May, 1/2 Jun, 6/7 Jul
Stephen Palmer
Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH
Tel: 0181 293 4114
Fax: 0181 293 1441

Primary Certificate in Multimodal Therapy & Counselling
Centre for Stress Management, London
next course – 16/17 July
Stephen Palmer
Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH
Tel: 0181 293 4114
Fax: 0181 293 1441

One–day Counselling Skills Workshop (person–centred)
3 Northumberland House, 237 Ballards Lane, Finchley, London N3 1LB
next course – 30 Oct.
Dr. Sandra Delroy
Tel: 0181 346 4010 or 0956 297054, or at venue address

Primary Certificate in Cognitive Behavioural Therapy
Centre for Stress Management, London
next course – 3/4 Jun
Stephen Palmer
Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH
Tel: 0181 293 4114
Fax: 0181 293 1441

Primary Certificate in REBT
Centre for Stress Management, London
next course – 8/9/10 May
Stephen Palmer/Michael Neenan
Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH
Tel: 0181 293 4114 / Fax: 0181 293 1441

Three–day Counselling Skills Workshop (Person–centred)
3 Northumberland House, 237 Ballards Lane, Finchley, London N3 1LB
next course – 29–31 July.
Dr. Sandra Delroy
Tel: 0181 346 4010 or 0956 297054, or at venue address

Two–day Counselling Skills Workshop (Person–centred)
3 Northumberland House, 237 Ballards Lane, Finchley, London N3 1LB
next course – 2–3 July.
Dr. Sandra Delroy
Tel: 0181 346 4010 or 0956 297054, or at venue address

Two–day Assertiveness Training Workshop
3 Northumberland House, 237 Ballards Lane, Finchley, London N3 1LB
next course – 25–26 Jun, 26/27 Nov
Dr. Sandra Delroy
Tel: 0181 346 4010 or 0956 297054, or at venue address

Five–day Counselling Skills Course
3 Northumberland House, 237 Ballards Lane, Finchley, London N3 1LB
Next courses: 13, 15, 18, 19, 20 May and 5, 6, 9, 10, 11 Nov.
Dr. Sandra Delroy
Tel: 0181 346 4010 or 0956 297054, or at venue address.

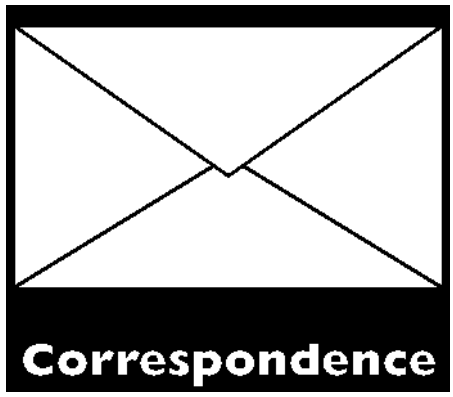
Please send details of appropriate conferences to me:
by post at – People in Progress Ltd, 5 Rochester Mansions, Hove, East Sussex BN3 2HA
by fax on – 01273 778847
by e-mail to – wellbeing@pip.co.uk

If you wish to apply for CPD Recommended status for your courses, **please request an application form from the Society's office.**

If you have had your courses approved for CPD recommended status, please make direct contact with me, as well as with the Division itself, in order to ensure your inclusion in the events diary.

I look forward to hearing from you.

Jennifer Smith



Position paper on Employment Issues for Counselling Psychologists

The SCPA (Standing Committee for Professional Affairs) has set up a working party to gather information from counselling psychologists with the intention of writing a position paper on Employment Issues for Counselling Psychologists. This is in response to feedback from individual members who have expressed concern about parity of pay and opportunity within the profession and have felt isolated in dealing with it. As an example, a Chartered Counselling Psychologist is told that there is no such thing as a Grade B counselling psychologist in the NHS and there never will be.

We would be interested in hearing members' personal experiences of parity of salary and position with practitioners of other psychology specialities within their work settings. Examples of good practice, where counselling psychologists have been successfully integrated into their employment structure, as just as welcome as those from individuals who have had difficulties. We would like to hear from anyone, not just those who are working in the NHS.

Please send all contributions in written form to:

SCPA Working Party
10 Parkmead
London SW15 5BS
Fax: 0181 789 0090

Ruth Jordan
Linda Papadopolous
Margaret Tholstrup

Network

I am a Chartered Counselling Psychologist and in May 1997 took up a new appointment as Co-ordinator of Counselling Psychology Services for Grampian Healthcare NHS Trust, based at the Royal Cornhill Hospital, Aberdeen. This Service is managed within the Department of Clinical Psychology, itself a part of the Adult Mental Health Clinical Services Management Group.

Currently, apart from myself, Grampian Healthcare employs two counselling psychologists in training, one part-time and one full-time. In order to expand and develop our counselling psychology input, I would now like to create a network, liaising with individual counselling psychologists who work in NHS departments in other parts of the UK.

I would therefore be very pleased to hear from interested members of the Division, with a view to sharing experience and discussing imaginative ways forward.

I may be contacted at the following address:

Philippa Comber BA, Dipl-Psych, CPsychol
The Department of Clinical Psychology
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Philippa Comber
Chartered Counselling Psychologist

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I C O P E

Independent Counselling Psychology
& Psychotherapy Education

ICOPE comprises a team of experienced practitioners and teachers of counselling and psychotherapy who are committed to increasing the opportunities available for mature students to engage in high quality and flexible education. Many are involved in the supervision and teaching of trainees on the accredited Counselling Psychology programme at City University.

SHORT COURSES FOR 1998/99 INCLUDE:

The Theory & Practice of Systemic Therapy with Individuals, Couples, Families and Wider Systems
6 & 7 July 1998 – Course Leader: Damian McCann

Cognitive & Behavioural Approaches in Counselling & Psychotherapy
8 & 9 July 1998 – Course Leader: Bryan Adams
(Repeated 22 & 23 March 1999)

Integrating Theory & Practice in Counselling Psychology*
13-17 July 1998 – Course Leader: Mary Watts

Theory Research & Practice in Counselling Psychology*
7-11 September 1998 – Course Leader: Malcolm Cross

Research Approaches in Counselling Psychology & Psychotherapy
14-18 September 1998 – Course Leader: Don Rawson

Carrying out Research in Counselling & Psychotherapy (focus on research projects)
14-18 December 1998 – Course Leader: Don Rawson

Personal Construct Approaches in Counselling & Psychotherapy*
4-8 January 1999 – Course Leader: Malcolm Cross

**indicates course based on MSc Counselling Psychology module and offered in association with City University*

Courses held at City University, London

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(for those who choose to take the independent route to chartering as a counselling psychologist)

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(individual & group)

***Research Supervision**

Full details from: Dr Mary Watts, Director, ICOPE, 12 Onslow Gardens, South Croydon, Surrey CR2 9AB. Tel/fax 0181 239 6947

CENTRE FOR STRESS MANAGEMENT

1998 PROGRAMME OF COURSES

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(12 to 30 hours)

PRIMARY CERTIFICATE IN STRESS MANAGEMENT (2 days) *
Trainer: Stephen Palmer.
Date: 7/8 May; 1/2 Jun; 6/7 Jul; 10/11 Sept; 6/7 Oct

PRIMARY CERTIFICATE IN PROBLEM FOCUSED PSYCHOTHERAPY &TRAINING (2 days)
Trainer: Kasia Szymanska. Date: 18/19 May; 21/22 Sept

PRIMARY CERTIFICATE IN SUPERVISION (2 days) *
Trainer: Gladeana McMahon. Date: 21/22 July; 29/30 Oct

PRIMARY CERTIFICATE IN RATIONAL EMOTIVE BEHAVIOUR THERAPY*
Trainers: Michael Neenan & Stephen Palmer.
Date: 8/9/10 May; 11/12/13 Sept

PRIMARY CERTIFICATE IN CRITICAL INCIDENT STRESS DEBRIEFING (2 days)
Trainer: Elizabeth Doggart. Date: 30/31 July

PRIMARY CERTIFICATE IN COGNITIVE BEHAVIOURAL THERAPY & TRAINING (2 days) *
Trainer: Michael Neenan.
Date: 3/4 Jun; 23/24 July; 2/3 Sept

PRIMARY CERTIFICATE IN ASSERTION AND COMMUNICATION SKILLS TRAINING (2 days)
Trainer: Gladeana McMahon.
Date: 14/15 July; 19/20 Nov

PRIMARY CERTIFICATE IN MULTIMODAL THERAPY & COUNSELLING (2 days) *
Trainer: Stephen Palmer
Date: 16/17 Jul; 4/5 Nov

PRIMARY CERTIFICATE IN TRAUMA & PTSD (LEVEL1) (2 days)
Trainer: Gladeana McMahon.
Date: 5/6 May; 24/25 Sept

PRIMARY CERTIFICATE IN TRAUMA & PTSD (LEVEL 3) (2 days)
Trainer: Gladeana McMahon.
Date: 28/29 July

*** These courses are Recommended for Continuing Professional Development of Psychologists by The British Psychological Society.**

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(30 to 150 hours)

Certificate/Diploma in Stress Management
Advanced Certificate/Diploma in Multimodal Stress Counselling
Advanced Certificate/Diploma in Multimodal Psychotherapy and Counselling
Advanced Certificate*/Diploma in Cognitive–Behavioural Approaches to Psychotherapy and Counselling
Advanced Certificate in Rational Emotive Behaviour Therapy and Stress Counselling
Diploma in Stress Counselling and Psychotherapy.
Advanced Certificate in Problem Focused Psychotherapy and Counselling
Certificate in Crisis and Trauma Counselling and Critical Incident Stress Debriefing
Certificate in Counselling and Stress Management

Courses are run in association with the Centre for Rational Emotive Behaviour Therapy and the Centre for Multimodal Therapy.

Limited numbers only on each course. The Centre also offers counselling, therapy, supervision: in–house courses, seminars and workshops: staff counselling for organizations: employee–assisted programmes: consultancy and research; books, tapes, videos, daily logs, manuals, multimodal life history inventories, biodots and biofeedback equipment.

Full details from:
DR STEPHEN PALMER, CENTRE FOR STRESS MANAGEMENT
156 WESTCOMBE HILL, LONDON SE3 7DH.
Course details: Tel 0181 293 4114 (24 hrs answerphone)
Course admin: Tel 0181 853 1122
Fax 0181 293 1441

The Centre's courses have been recognized by the Health Practitioners' Association and the Institute for Management Specialists

Division of Clinical Psychology
South Thames Branch

HEALTH AT WORK, CREATING AND SUSTAINING THE HEALTHY WORK ENVIRONMENT
4 June 1998

DCP South Thames Branch – Conference at Salomons Centre, Tunbridge Wells, Kent

Speakers:
Dr Valerie Sutherland – Optimising Health and Well-being in the Work Place
Dr Lyn Quine – A Survey of Stress and Bullying in an NHS Trust

Cost (including lunch):
South Thames DCP Members £20
Others £55

Apply to:
Jane Street, Branch Treasurer, Pathfinder Mental Health Services, Springfield Hospital, 61 Glenburnie Road, Tooting, London SW17 7DJ. Tel: 0181 682 6249

Notes for Contributors to
Counselling Psychology Review

Submissions
The Editorial Board of *Counselling Psychology Review* invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Academic submissions
Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author's name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to *Counselling Psychology Review*. As academic articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non–Sexist Language contained in the booklet *Code of Conduct, Ethical Principles and Guidelines*. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Full bibliographic references should be contained in the list of references at the end of each article. They should be listed alphabetically by author, be complete, accurate and in the format used in previous issues of *Counselling Psychology Review*.

Low–quality artwork will not be used. Graphs, diagrams etc. should be supplied in camera–ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables. diagrams etc. taken from other sources.

Proofs of academic articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs.

Contributors, wherever possible, should supply copy on either an Apple–or PC–compatible 3.5" disk. Please use ASCII format where possible, and if another format has been used. Contributors should enclose four hard copies with any disk sent.

Other submissions
Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor. However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

For publication in	*Copy must be received by*
February	5 November
May	5 February
August	5 May
November	5 August

All submissions should be sent to: *Counselling Psychology Review*, The Editor, Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH.

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