

---

# **Counselling Psychology Review**



**The Journal of The British Psychological Society  
Division of Counselling Psychology**

**Volume 18**

**Number 1**

**February 2003**

# Counselling Psychology Review

<i>Editor:</i>	Alan Bellamy	Pembrokeshire and Derwen NHS Trust
<i>Reference Library Editor and Consulting Editor:</i>	Waseem Alladin	Hull University, Centre for Couple, Marital & Sex Therapy and Hull & East Riding Health NHS Trust
<i>Book Reviews Editor:</i>	Kasia Szymanska	Centre for Stress Management
<i>Consulting Editors:</i>	Malcolm C. Cross Ruth Jordan Martin Milton Stephen Palmer Linda Papadopoulos John Rowan Mary Watts	City University Surrey University Surrey University Centre for Stress Management and City University London Guildhall University The Minster Centre City University
<i>Editorial Advisory Board:</i>	Alan Frankland Heather Sequeira Sheelagh Strawbridge	APSI Nottingham St. George's Medical School Independent Practitioner and Kairos Counselling and Training Services, Hessle, East Yorkshire

## Subscriptions

*Counselling Psychology Review* is published quarterly by the Division of Counselling Psychology, and is distributed free of charge to members. It is available to non-members (Individuals £12 per volume; Institutions £20 per volume) from:

Division of Counselling Psychology  
The British Psychological Society  
St Andrews House  
48 Princess Road East  
Leicester LE1 7DR.  
Tel: 0116 254 9568

## Advertising

Advertising space is subject to availability, and is accepted at the discretion of the Editor. The cost is:

	Division Members	Others
Full Page	£50	£100
Half Page	£30	£60

High-quality camera-ready artwork and the remittance must be sent together to the Editor:

Dr Alan Bellamy, Brynmair Clinic, Goring Road, Llanelli, Carmarthenshire, SA15 3HF. Tel: 01554 772768. Fax: 01554 770489.  
Cheques should be made payable to: Division of Counselling Psychology.

## Disclaimer

Views expressed in *Counselling Psychology Review* are those of individual contributors and not necessarily of the Division of Counselling Psychology or The British Psychological Society. Publication of conferences, events, courses, organisations and advertisements does not necessarily imply approval or endorsement by the Division of Counselling Psychology. Any subsequent promotional piece or advertisement must not indicate that an advertisement has previously appeared in *Counselling Psychology Review*.

Situations vacant cannot be accepted. It is the Society's policy that job vacancies are published in the *Appointments Memorandum*. For details, contact the Society's office.

## Copyright

Copyright for published material rests with the Division of Counselling Psychology and The British Psychological Society unless otherwise stated. With agreement, an author will be allowed to republish an article elsewhere as long as a note is included stating: first published in *Counselling Psychology Review*, vol no. and date. Counselling psychologists and teachers of psychology may use material contained in this publication in any way that may help their teaching of counselling psychology. Permission should be obtained from the Society for any other use.

The British Psychological Society

# **Counselling Psychology Review**

*Volume 18 • Number 1 • February 2003*

<b>Editorial</b>	<b>2</b>
Alan Bellamy	
<b>The Call of the Wild: Lessons from Natural History</b>	<b>3</b>
Martin Milton	
<b>Dead but not Forgotten: A Self-Reflexive Commentary on the Death of Resistance</b>	<b>12</b>
John Davy	
<b>Ideal and Actual Referral Choices for Mental Health Problems in Primary Care</b>	<b>20</b>
Tania Dolley, Bryan Adams & James Hampton	
<b>The Client Experience of Counselling and Psychotherapy</b>	<b>34</b>
Mark Elliott & David Williams	
<b>Book Reviews</b>	<b>40</b>
<b>Newsletter Section</b>	
<i>Letter from the Chair</i>	<b>42</b>
<i>Division News</i>	<b>43</b>
<i>Statement of Interest for Committees</i>	<b>45</b>
<i>The Draft Mental Health Bill: A Briefing for Counselling Psychologists</i>	<b>46</b>
Susan van Scoyoc	
<b>Correspondence</b>	<b>49</b>
<b>Conference Diary</b>	<b>50</b>
<i>Talking Point: Counselling psychology and diagnostic systems</i>	<b>53</b>
Louise Turner-Young	

# Editorial

*Alan Bellamy*

Welcome to the first *Counselling Psychology Review* of 2003.

As Counselling Psychologists we occupy a sometimes uncomfortable place. We expose ourselves to the therapeutic relationship, the here and now meeting of patient/client and therapist. We eschew the comforting idea of any one grand theory of counselling/therapy being universally adequate, and we ask our trainees to show understanding of more than one approach. We honour our place within psychology but can have difficulty in finding much in the established canon of psychological research to help us in our work with deeply troubled souls. We can struggle to maintain a place for a humanistic vision in workplaces dominated by biomedical or mechanistic views of what it is to be human. And yet, as Irving Yalom says; 'Life as a therapist is a life of service in which we daily transcend our personal wishes and turn our gaze toward the needs and growth of the other. There is extraordinary privilege here, and extraordinary satisfaction, too.'

We begin with Martin Milton's paper, 'The Call of the Wild: Lessons from Natural History'. Those of you who were able to be at last year's conference in Torquay may have heard Martin read an earlier version of this paper, and we are indebted to the *Journal of the*

*Society for Existential Analysis*, in which that original version was published. Last summer I was in the mountains and forests of British Columbia and whilst there I read Jon Krakauer's *Into The Wild*, an account of a young man's ultimately fatal psychological need for the wilderness. I was reminded of that experience by Martin's paper.

Then we have a paper by John Davy, who, writing from a systemic perspective, explores de Shazer's idea of 'the death of resistance' and describes how the meaning and significance of that concept has changed for him as he has developed as a therapist. The third paper, by Dolley, Adams and Hampton, is an attempt to shed some light on how General Practitioners make referral choices in the area of Mental Health. For those of us who are involved in NHS Mental Health services that are bulging at the seams, such research is welcome. Finally we have Mark Elliott and David Williams' paper, 'The Client Experience of Counselling and Psychotherapy', in which the authors review the literature on how clients perceive their therapist and the process of therapy.

The papers and book reviews are followed by our regular Newsletter section, with Divisional news and notices, correspondence, and Talking Point.

# The Call of the Wild: Lessons from Natural History\*

*Martin Milton, University of Surrey.*

IT WILL BE evident to counselling psychologists that evolutionary psychology seems to be commanding attention recently (see *The Psychologist*, 14 (8)). This literature argues that therapeutic psychology gains valuable insights by locating emotion, consciousness, meaning and the like in an evolutionary context (Bailey & Wood, 1998; DelMonte, 2001; Gilbert, 1998a; Silverstein, 1998). It is also argued that it may be helpful to recognise that some of our evolved talents and abilities have not had the chance to 'catch up' with cultural change (de Waal, 2001; Dixon, 1998; Gilbert, 1998b). This paper is related to this literature to the extent to which some people remain attuned to our proposed origins, i.e. living in the wild.

A central organising feature of counselling psychology is the importance of privileging experience over theory. In this regard, this paper explores the nature of Being as expressed through natural history writing. While located within the domain of 'Natural History', some of this literature is located within the realms of autobiography – for instance Joy and George Adamson (1960, 1968), Patterson (1995a), Jane Goodall (Goodall and Peterson, 2000) and Birute Galdikas (1995). Some can be found within natural science – Dian Fossey (1983) and again Jane Goodall (1971) come to mind. And, of course, people like Craig Packer (1994) and George Schaller (1993) write from within the field of conservation. And some, such as the powerful account by Mark Ross (2001), are located within travel writing as well. The accounts provide powerful descriptions of the authors' experiences in this domain.

When reviewing this literature, a number of themes are abundant in this literature and shed light on psychological factors that are relevant to the contexts in which counselling psychologists work in our day to day practice. Some of these themes will now be elaborated.

## **Physicality and embodiment**

There are significant differences between the post-modern, urban life of most counselling psychologists and that of those who live in the wild. We spend a lot of our time, thinking, speaking, writing, e-mailing, and in general being quite cerebral and technical. For those that live in the wild – it is very different – as we know from our own trips into the wild or the stories of disorientation and transformation that our clients share with us.

Living in this world requires a different attunement to the surroundings, developing heightened awareness to light, sound and wind. It seems that those that live in this way, at times, think more along the lines of the animals that they study. Adamson (1961, 1969, 1972, 1980) and Patterson (1995a, 1995b) describe the ways in which this attunement allows them to pinpoint the sounds and locations of their various big cats time and time again over vast distances. The researchers at Gombe National Park traverse the terrain in a manner similar to the chimpanzees (Scott & Uhlenbroek, 1996).

A related theme is of the physical discomfort that has to be endured in these contexts. The discomforts experienced are both internal and external to the body. Many write of the difficult experience of constant humidity (Attwater, 1999; Galdikas, 1995) Galdikas

---

\*This paper is based on one previously published in the *Journal of the Society for Existential Analysis* and presented at the Annual Conference of the Division of Counselling Psychology, 2002, Torquay.

provides many descriptions of her experience of living with virtually 100 per cent humidity day in and day out in the rainforests of Borneo. This is such a constant in her world that on entering a swamp the wetness scarcely increases (Galdikas, 1995).

Alternatively, when at the Karisoke Gorilla Research Station in the Virunga Mountains<sup>1</sup>, Ian Redmond is said to have worn shorts on the mountain despite the thick and vicious plant-life. He noted: *'when you wear shorts in the field, you are more aware of your surroundings. You can sense the difference between the saddle<sup>2</sup> area with its soft vegetation, the marsh plants of the meadows, and the bleakness of the alpine zone'* (Fossey, 1983, p.164).

As well as accommodating these experiences as part of a meaningful existence, Being in this domain also entails adjustment of the physical immune system – a response that is outside of one's reflective awareness and control. For one author, this meant particular embarrassment after being on safari, when his illness lead to losing control of his bowels during a stay in an up-market hotel. Packer's embarrassment is evident when he writes: *'...then I have an accident on my third trip to the loo. Oh, god – there's no place to wash, or even change pants'* (Packer, 1994, p.213). But, he is indeed out and about. For many of us (and our



clients), such physical discomfort would have meant that we would not have left the house that day. Despite these embarrassments and difficulties, Packer is matter of fact about the experience, recognising that he chooses to live this way and accepts the challenges that arise.

The authors don't just talk about minor illnesses. Some of these illnesses are serious. For example, many of the authors reflect on their experience of Malaria. Delia Owens contracted it in the Kalahari (Owens & Owens, 1984), Attwater (1999) describes the recurrent nature of malaria on herself and her husband in Brazzaville and Goodall (1990) contracted it soon after arriving in Tanzania. At times, for these authors, staying indoors is just NOT an option. Goodall continued to get out of bed to follow the chimpanzees as they roamed throughout their range. She writes: *'As soon as the fever left me I was impatient to start work again [...] After ten minutes or so my heart began to hammer wildly, I could feel the blood pounding in my head and I had to stop to catch my breath'* (Goodall, 1971, p.25).

Like Packer, Goodall illustrates this passion (or resignation) to participate in the natural world and a reluctance to withdraw even when her body may have needed it.

In terms of the care that is afforded the physical body, a different focus is again required, and the tone of these accounts is one, not of complaint but rather a recognition of valued aspects of existence. They are experiences not to be sought nor avoided but accepted as part of a meaningful way of Being. As George Schaller notes *'one tends to complain of discomfort but relish the memory of hardship'* (1993, p.120).

As well as discomfort there is obviously something of value in surviving physical difficulty.

## Death and dangers

Death and physical danger is not specific to the natural world – indeed this is often the issue that many of our clients will bring to the therapeutic setting. However, the awareness of death and physical danger seems somehow

<sup>1</sup> The site of Fossey's long-term study of the Mountain Gorillas. It is situated in a mountain range that sits across the borders of Uganda, Rwanda and Zaire.

<sup>2</sup> The area between two peaks in the mountain range.

closer than in other domains. It seems to be an intrinsic part of living in the wild. Some authors reflect on their experience of such dangerous conditions as, for example, freezing (Brandenberg, 1990; Schaller, 1993) or exceptionally hot temperatures (Douglas-Hamilton & Douglas-Hamilton, 1975), floods (Adamson, 1969; Owens & Owens, 1992), drought (Owens & Owens, 1984) or fire (Adamson, 1969, 1972; van Dyk, 1991). In addition these conditions may add to the possibility of disease (Galdikas, 1995; Goodall, 1971; Owens & Owens, 1992; Packer, 1994). Avoidance of this aspect of the natural world is not possible as diseases – dysentery, AIDS, cholera, tuberculosis – are common in the areas where much conservation work is done (Owens & Owens, 1992). Of course, the dangers are not all environmental, the accounts provided in these texts also acknowledge the dangers of other humans especially bandits (Gallman, 1999) and poachers (Fossey, 1983; Owens & Owens, 1992) and warring factions (Ross, 2001).

Attwater (1999) tells of saving and attempting to rehabilitate mountain gorillas in the midst of civil war, students at the Gombe Research Station were abducted and held hostage by Zairean terrorists (Goodall, 1990) and some of those whose words are quoted here (Dian Fossey and Joy Adamson) were killed in the wilds by humans. One of the most powerful phenomenological accounts of facing death in the wild is by Ross (2001) where he describes the abduction of tourists and guides and the murder of some in the mountains of Uganda.

These accounts also address the fact that the animals themselves can be dangerous and this requires facing up to and responding to. Streetley puts it that to live in the wild: *'I have to live with wildlife, not against it; I have to experience the beauty and the violence, I have to be part of the circle'* (Streetley, 2000, p.26).

Streetley illustrates this by reflecting on a primordial interaction between herself, her pet dog and the local wolves. She says *'at some moments my position will be lowlier than that of others. I have to take care, guard my territory and myself, just like the rest of the animals do – every minute, every second'* (Streetley, 2000, p.26).



After living in East Africa and becoming familiar with the powerful and dangerous African elephants, the Douglas-Hamilton's appear to come to a more confident relationship with the dangers. Indeed, Oria Douglas-Hamilton writes: *'I could stand up to a charging elephant and call his bluff with a wave of my arm, then walk away. It was not bravado, I just knew what I was doing. It was up to me to recognise danger and to get out of the way, or else I would fall to a really hostile elephant's tusks, in the same way that they would fall to a hunter's bullets'* (Douglas-Hamilton & Douglas-Hamilton, 1975, p.202).

### **Physical proximity and the nature of encounter**

For some, these accounts suggest that the possibility of a closer relationship with non-human animals is what drew them away from the cities and communities of their birth into this other world in the first place. This is certainly the case when one sees the lengths to which Louis Leakey's 'Trimates' went to secure their posts. Dian Fossey even agreed to (although didn't have to undergo) an appendectomy prior to being sent to the Mountains



of Rwanda (Montgomery, 1991). Although it may not be this intense, this yearning for contact with animals and the wild is described by others in the media, in the consulting room and of course in the travel industry.

The nature of the encounter with those they have studied and the form in which it is embodied varies a great deal. Payne's (1998) research – first studying whales and other cetaceans and later elephants in East Africa meant that her relationship with the animals had to be from land or from the safety of some container (boat, car or watch tower). Despite this, her writing conveys a sense of intimate engagement with these animals, following and observing herds of elephants for long periods of time, getting to know their characters, watching the births and developments of individuals. As well as allowing her to feel intimate with these animals the study was a dyadic interaction allowing Payne to be recognised and accepted by the elephants within their domain and activities without moving on.

Other authors describe a much more physical intimacy due to different environments and species. Some describe an increased physical engagement with the forests. Goodall, Galdikas and Fossey walked for miles at a time, being caught by trees or spiders webs (Goodall & Berman, 1999), stung by nettles (Fossey, 1983) and being sucked into swamps (Galdikas, 1995). Goodall recounts that this

immersion and her attempts to understand the lives of the chimpanzees meant that she came to act like them: *'I climbed up into some of the nests after the chimpanzees had left them'* (Goodall, 1971, p.29).

For a number of these authors, contact with the apes came to be physical. The Leakey 'trimates' took a particular stance to contact with the apes – choosing not to intrude or impose upon those they were studying but allowing the apes to approach or touch them and this seems to have been a source of great meaning for each of these researchers. Galdikas described Goodall's approach as *'a science of collaboration, not control'* (Galdikas, 1995, p.386). An approach that many counselling psychologists might also aspire to in our interactions with those that enter into therapy with us.

Goodall describes what happened when David Greybeard<sup>3</sup> reached out to her for the first time. *'...I found a palm nut, nice and ripe and red, and felt sure David would appreciate it. So I held it out in my outstretched palm. [...] suddenly. He turned towards me, reached out his hand to the nut, and, to my astonishment and delight, held my hand with his, keeping a firm warm pressure for about 10 seconds. [...] If it had not happened to me I think I would never have believed it possible'* (Goodall & Peterson, 2000, p.267)

Goodall describes David Greybeard's treatment of her as a fellow chimpanzee seeking comfort and reassurance as *'one of the most*

<sup>3</sup> David Greybeard was the name Jane Goodall gave to the alpha male of the Kasekela clan when she first arrived in the Gombe Reserve. This was due to his white, tufted beard.

*amazing things that has happened since I started working with the chimps'* (Goodall & Peterson, 2000, p.267). Touch was also a factor in Dian Fossey's relationship with the Mountain Gorillas and between Birute Galdikas and the Orang-utans of Borneo.

The contact between the animals and the authors is, therefore, based on more than scientific or intellectual interest but relationship and an embodied engagement. This is something that is present in many of the relationships that urban people describe with their cats, dogs and other pets and sometimes also an important aspect of the lives and work of police dog and horse handlers. It is something that counselling psychologists might usefully reflect on when hearing about human interactions with other species.

## Emotion

Regardless of the usual questions that get asked when we think of emotion, e.g. do animals experience emotion, the experience of these authors lead them to describe an emotional life experienced in relation to the animals and to the natural world and suggest both depth and a vast range of emotional experiences for themselves and for those they write about. Although many urban pet owners may also have something to say about this, as does Masson and McCarthy (1994), these authors seem to have reflected on this experience far more eloquently than most.

When writing about sadness, Iain Douglas-Hamilton writes *'the death of an elephant is one of the saddest sights in the world'* (Douglas-Hamilton & Douglas-Hamilton, 1975, p.234). This comment is applicable both to his own emotions but the Douglas-Hamilton's suggest that it is a feeling shared by the 'bereaved' elephants – that the concept of 'bereavement' is apt.

Fear is also a common emotion. Fear in the face of wild lions is described and the embodied nature of emotion is evident as Delia Owens illustrates when she writes: *'I was stirring my supper over the fire when seven lions came padding directly toward camp. My heart began doing flip-flops, and I very quickly put the pot of stew on top of the hyena table and hurried deep into the tree island'* (Owens & Owens, 1984, p.96).

Mark Owens writes of another of Delia's encounters with lions: *'Slowly she began to back away, trying to read the lions' expressions and postures. But suddenly she realised that, by retreating, she was inviting their pursuit, so she forced herself to stand still. [...] When they were close to 30 yards, her fear reached a primal level [...] and from deep inside her came a sound so primitive it could have come from a Neanderthal woman. 'HAARRAUGGH!'* (Owens & Owens, 1984, p.211)

As Cohn (1998) points out, as well as being experienced physiologically, the expression of an emotion includes the embodied manifestation. Counselling psychologists (particularly those of us working in medical contexts) might reflect on this when we try to understand the 'symptoms' of anxiety and other 'disorders' that are frequently presented to us as isolated phenomena rather than as related to the contexts in which the client exists (past, present, and future).

While some emotions are difficult to savour, other emotions are also described. Oria Douglas-Hamilton writes of joy in her encounters with elephants: *'I was drawn to them. Was it their size, their power, or their gentleness that attracted me? I could not tell. I just know that I loved being surrounded by elephants and that this experience brought me great joy'* (Douglas-Hamilton & Douglas-Hamilton, 1975, p.203).

Joy Adamson's reflections after having released Elsa into the wild are both informative and poignant. She writes: *'I realised acutely how much I had become dependant on her; how much I had for nearly three years lived the life of a lioness, shared her feelings, interests and reactions. We had lived so intimately together that being alone seemed unbearable. I felt desperately lonely with no Elsa walking at my side, rubbing her head against me and letting me feel her soft skin and warm body'* (Adamson, 1960, p.172).

Of course, this paper can only provide a snap shot of the emotional experiences reported in this literature. Many other feelings are also evident. Payne alludes to 'guilt' when reflecting on the taping of the snores of sleeping elephants, *'...it didn't feel like something I should do'* (Payne, 1998, p.152). She notes this again after, having physically explored a sedated lion and how this left her feeling that it

was wrong as he would awaken and know that he had been touched without his consent. Thus, the world of values also comes to play in the experience of the natural world.

Poaching is a major focus of this literature and highlights the emotional, ideological and political stances that these authors have. Attempts to thwart poaching were not always successful and after the murder and burial of Digit, one of the Gorillas that she knew, Fossey wrote: 'I was muddy, hungry, exhausted and more depressed than I had ever been at any point of the 11-year research' (Fossey, 1983, p.216).

Another response to this struggle is great sadness. After hearing of Fossey's murder. Galdikas says: 'I realised that I was not weeping just for Dian or the mountain gorillas, I was also weeping for chimpanzees, for Orang-utans, and for a world that is rapidly disappearing' (Galdikas, 1995, p.396).

There is also the issue of one's own sense of groundedness in relation to animals. This can lead to decisions about which world one is really committed to. My own experience in this respect was quite powerful. On stopping beside a cheetah in the Masai Mara game reserve I unreflectively opened a window and experienced a strong desire to reach out and touch the beautiful big cat – at this point the experience was almost trancelike. As I became aware of the action and the desire, I found that I unreflectively snapped back my arm. Now of course, for those I was with this was full of humour. However, my concern at that point was not for my physical safety, but a sense that if I entered this world so fully, I would not be able to return to my own world – a fear of getting lost in a world in a world that I was not yet ready for. This experience may be something that counselling psychologists are called upon to engage with those who make the transition from the wilds into urban contexts – whether it be in the student counselling setting (where post-graduate zoology students may present) or other professional contexts.

## Relatedness

For those that leave the world of the city behind, living in the natural world (and the adaptations that one must make to engage in this fully) puts a great strain on intimate rela-

tionships between people (Attwater, 1999; Patterson, 1995a). Life is physically and emotionally demanding, potentially dangerous and at times requires all of the attention of the individual. This is evident in the tension that came between Mark and Delia Owens for a period (Owens & Owens, 1992). Delia Owens writes: 'He has not had time to visit my camp, and the only chance we have to see each other is when I come to Marula-Puku for supplies. There is still a strain between us and we operate more or less in our own realms, our personal lives on hold' (Owens & Owens, 1992, p.218).

Attwater writes poignantly about this when she notes: 'Mark and I were unable to talk about what had happened. Instead of uniting us, our sadness [about the death of several gorillas] alienated us from one another' (Attwater, 1999, p.153).

This is also evident in the separate lives that the Adamsons came to lead (Adamson, 1969, 1972, 1980; Cass, 1992). Goodall and van Lawick separated and divorced after a period of time (Goodall, 1990; Goodall & Berman, 1999) and after spending many years working on her research, Fossey came to be known as Nyiramachabelli. This translates into 'The old woman who lives alone in the mountains without a man' (Fossey, 1983; Montgomery, 1991, p.130). Forgetting what we in the West would see as sexist and heterosexist assumptions – this shows the recognition that Fossey's primary relationships were with the Gorillas, the mountains and the conservation crisis.

As well as separateness from other people, Fossey came to epitomise many of these authors and their separateness from Western cultures and how they were perceived as strange when judged by the standards of Western contemporaries. After Fossey's death Galdikas came to reflect on this and suggested that: 'Much of the problem, I believe, is that visitors to Karisoke did not understand how African Dian had become. [...] Culture is more than skin deep. At Karisoke, Dian was Western in appearance only' (Galdikas, 1995, p.394).

This is obviously of relevance to the practice of counselling psychology. Fossy's critics focussed on the meaning that her behaviour had for them rather than the meaning it might have for her in the contexts that she was living. While the specific form of her dedication may



not be common, it is not unusual for counselling psychologists to recognise the fact that we and our clients may often privilege the meaning of something even when some might claim, that objectively, 'it makes no sense'.

### View of the Self

Counselling psychologists recognise that our contexts, and the ways that we relate to them impacts upon our sense of self. One common experience in these accounts, is of oneself as less central to the universe – and it can be experienced in different, multi-layered ways with a potentiality of emotions. For some it is quite a pleasant experience. While Payne reports: *'I liked the knowledge that I was only a tiny and inconsequential person'* (Payne, 1998, p.161), the Owens write: *'The vast untracked savanna, broken only by occasional isolated trees made us feel frail, minuscule, vulnerable. It was beautiful, exciting – but also a little intimidating'* (Owens & Owens, 1984, p.11).

Galdikas reflects on a sense of boundaries that were completely blurred. She writes: *'I had been immersed in the world of orang-utans. Orang-utans are everywhere: [...] The distinction between humans and orang-utans had begun to blur in my mind. I could rattle off a list of the differences. But I had lost that gut feeling, which is an integral part of Western intellectual consciousness'* (Galdikas, 1995, p.311).

The impact on the self-concept is also described in painful and dangerous ways.

After the murder of Digit, Fossey states: *'There are times when one cannot accept facts for fear of shattering one's being'* (Fossey, 1983, p.206).

### Reflections

When counselling psychology looks to the experience of different populations it then has to consider a very challenging question, and that is – what does this mean? How can an awareness of these experiences help us in our professional roles? This is of course an important consideration, as according to Bor and Achilleoudes (1999), most counselling psychologists work in public sector settings or organisational contexts that are completely different to those outlined.

Despite this, these accounts remain important and useful. These accounts illustrate the ways in which we have moved away from the contexts for which we physiologically and mentally evolved. These accounts also highlight how the technologisation of existence has distanced us, not just from poverty, unnecessary illness and the like, but also from core, meaningful and rewarding aspects of our being.

It may also be useful to consider whether there are lessons to be learnt about our ability to face all sorts of difficulties when we are truly engaged in a meaningful relationship with the world *as it is* rather than *as we would have it*. When we face the world and its challenges we may be less prone to the depression and anxiety that seems fostered by so many of the trappings of our contemporary technological and social contexts. Recent accounts of the 'Big Brother contestants' suggest that boredom was a greater feature of living on the 'rich side' than on the more demanding 'poor side'.

If we were to be open to the descriptions of existence that the natural science literature makes available to us, we might be able to gain further clarity into a wider range of human experiences – as humans, as another species and as humans involved in cross-species relationships. In this way, Natural History and Conservationist writers may have particular contributions to add to the exploration of the nature of Being. We may be reminded of the strengths and potential that exists within all of us, but our urban living has long made us forget.

## References

- Adamson, G. (1968). *Bwana Game: The life story of George Adamson*. London: Collins Harvill.
- Adamson, J. (1960). *Born Free: A lioness of two worlds*. New York: Pantheon Books.
- Adamson, J. (1961). *Living Free*. London: Collins & Harvill Press.
- Adamson, J. (1969). *The Spotted Sphinx*. New York: Harcourt, Brace & World.
- Adamson, J. (1972). *Pippa's Challenge*. London: Collins & Harvill Press.
- Adamson, J. (1980). *Queen of Shaba: The story of an African leopard*. Johannesburg: Collins & Harvill.
- Attwater, H. (1999). *My gorilla journey: Living with the orphans of the rainforest*. London: Sidgwick & Jackson.
- Bailey, K.G. & Wood, H.E. (1998). Evolutionary kinship therapy: Basic principles and treatment implications. *British Journal of Medical Psychology*, 71, 509–523.
- Brandenberg, J. (1990). *White wolf: Living with an arctic legend*. Minnetonka, MN: Northwood Press, Inc.
- Bor, R. & Archilleoudes, H. (1999). Survey of the BPS Division of Counselling Psychology Members: 1999. *Counselling Psychology Review*, 14 (4): 35–44.
- Cass, C. (1992). *Joy Adamson: Behind the mask*. London: Orion.
- Cohn, H. (1998). *Existential thought and therapeutic practice: An introduction to existential psychotherapy*. London: Sage.
- DelMonte, M.M. (2001). Evolutionary psychology: Does mind matter or is it immaterial? *The Journal of Critical Psychology, Counselling and Psychotherapy*, 1 (4), 217–229.
- de Waal, F. (2001). *The ape and the sushi master*. London: Penguin.
- Dixon, A.K. (1998). Ethological strategies for defence in animals and humans: Their role in some psychiatric disorders. *British Journal of Medical Psychology*, 71, 417–445.
- Douglas-Hamilton, D. & Douglas-Hamilton, O. (1975). *Among the elephants*. London: Book Club Associates.
- Fossey, D. (1983). *Gorillas in the Mist*. Boston MA: Houghton-Mifflin.
- Galdikas, B. (1995). *Reflections of Eden: My life with the orang-utans of Borneo*. London: Indigo.
- Gallman, K. (1999). *Night of the lions*. London: Penguin Books.
- Gilbert, P. (1998a). Evolutionary psychopathology: Why isn't the mind better designed than it is? *British Journal of Medical Psychology*, 71, 353–373.
- Gilbert, P. (1998b). The evolved basis and adaptive functions of cognitive distortions. *British Journal of Medical Psychology*, 71, 447–463.
- Goodall, J. (1971). *In the shadow of man*. London: Phoenix.
- Goodall, J. (1990). *Through a window: 30 years with the chimpanzees of Gombe*. London: Phoenix.
- Goodall, J. & Berman, P. (1999). *Reason for hope: A spiritual journey*. London: Thorsons.
- Goodall, J. & Peterson, D. (2000). *Africa in my blood: An autobiography in letters*. Boston, MA: Houghton-Mifflin.
- Masson, J. & McCarthy, S. (1994). *When elephants weep: The emotional lives of animals*. London: Vintage Books.
- Masson, J. (1998). *Dogs never lie about love*. London: Vintage Books.
- Masson, J. (1999). *The Emperor's embrace: Fatherhood in evolution*. London: Vintage Books.
- Montgomery, S. (1991). *Walking with the Great Apes: Jane Goodall, Dian Fossey, Birute Galdikas*. Boston, MA: Houghton-Mifflin.
- Owens, M. & Owens, D. (1984). *Cry of the Kalahari*. London: Harper Collins.
- Owens, M. & Owens, D. (1992). *Survivor's song: Life and death in the African wilderness*. London: Harper Collins.
- Packer, C. (1994). *Into Africa*. Chicago IL: University of Chicago Press.
- Patterson, G. (1995a). *My soul against lions*. London: Hodder & Stoughton.
- Patterson, G. (1995b). *The last of the free*. London: Hodder & Stoughton.
- Payne, K. (1998). *Silent thunder: The hidden voice of elephants*. London: Phoenix.
- Ross, M. (2001). *Dangerous beauty: Life and death in Africa: True stories from a safari guide*. New York: Hyperion.
- Schaller, G. (1993). *The last panda*. Chicago IL: University of Chicago Press.
- Scott, J. & Uhlenbroek, C. (1996). *The chimpanzees of Gombe: Dawn to Dusk*. BBC Bristol.
- Silverstein, L.B. (1998). New directions for evolutionary psychology. *Feminism and Psychology*, 8 (3), 375–382.
- Streetley, J. (2000). Wolf at my door. *BBC Wildlife*, 18 (7), 24–26.
- The Psychologist* (2001). Journal of the British Psychological Society, 14 (8).
- van Dyk, A. (1991). *The cheetahs of De Wildt*. Cape Town: Struik Publishers.

## Correspondence

Dr Martin Milton

Department of Psychology,  
School of Human Sciences,  
University of Surrey,  
Guildford GU2 7XH.

E-mail: M.Milton@surrey.ac.uk.

*Photographs scattered throughout this article were taken by the author himself.*



## PROGRAMME OF COURSES HELD IN LONDON

### Modular Programmes

Diploma in Stress Management

Advanced Certificate in Cognitive-Behavioural Approaches to Psychotherapy and Counselling

*Focus on ... Diploma in Rational Emotive Behaviour  
Psychotherapy and Counselling*

*21-25 July and 15-20 September and 15-19 December*

The Centre's *Advanced Certificate in Cognitive-Behavioural Approaches to Psychotherapy and Counselling* is a modular programme that forms the foundation for the practitioner level Diploma. Successful completion of the entire 200 hour programme satisfies the UK REBT training requirement necessary for a qualified health or caring professional to become Accredited as a Rational Emotive Behaviour Therapist with the Association for Rational Emotive Behaviour Therapy and Registered with the UKCP. (For example, Chartered Psychologist, UKCP Registered Psychotherapist, Nurse registered with the UKCC, BACP Accredited Counsellor, Psychiatrist, General Practitioner, Occupational Therapist) Counsellors who are not BACP Accredited will need to have successfully completed a further 220 hours of training consisting of major courses (i.e. over 75 hours in length). The programmes are run by experienced practitioners. For further details, please request a brochure. Professor Stephen Palmer is Director of the Centre.

### Primary Certificate Courses (2 days)

Assertion & Communication  
Skills Training  
8-9 March 8-9 October  
Cognitive Behavioural Therapy  
& Training  
12-13 March 23-24 April  
28-29 May 28-29 June  
28-29 July  
Counselling Skills  
TBA

Critical Incident Stress Debriefing  
12-20 May 24-26 November  
Multimodal Therapy & Counselling  
10-11 March 13-14 October  
Problem Focused Counselling,  
Coaching & Training  
3-4 February 12-13 May  
Multimodal Emotive Behaviour Therapy  
12-13 February 1-2 May  
5-8 August

Organisational & Occupational  
Stress Management  
2-3 June  
Stress Management  
10-11 February 26-27 March  
28-29 April  
Training & ITSD (Levels 1 & 2)  
24-25 March (3) 9-10 June (1)  
17-18 November (1)  
Relaxation Skills Training  
5-8 February 21-22 May

\*These courses held in Edinburgh

Courses held in London unless stated otherwise. Trainers include: Professor Stephen Palmer, Michael Keenan, Gladziana McMahon, Kasia Szymanska, Liz Doggart and Irene Tubbs.

### Other courses

Correspondence Course in Stress Management  
Setting up in Private Practice (5 December)

Limited numbers only on each course. The Centre also offers stress audits, consultancy & research, counselling therapy supervision, in-house courses, seminars and workshops and counselling for organisations. Full details from:

PROF. STEPHEN PALMER, PhD, C Psychol • CENTRE FOR STRESS MANAGEMENT • 7-9 WEST COMBE HILL • LONDON SE25 7DN  
Course details tel: 020 8257 9494/24hrs answerphone fax: 020 8257 9494  
Course admin: 020 8257 9493 Course availability: 020 8257 8448 Website: <http://www.managingstress.com>  
Mail for Centre for Stress Management, 170 Box 24935, London SE25 7EA

RECOGNISED BY THE INSTITUTE OF HEALTH PROMOTION AND EDUCATION AS A CENTRE OF EXPERTISE  
COURSES RECOGNISED BY THE IHPA FOR CONTINUING PROFESSIONAL DEVELOPMENT

# Dead but not Forgotten? A self-reflexive commentary on the death of resistance

**John Davy,**

*Brookside Family Consultation Clinic.*

*This paper presents a self-reflexive review of 'the death of resistance', an idea introduced to systemic therapy literature by de Shazer (1984). The author suggests that self-reflexive practice as a therapist requires an examination of the interaction between evolving theoretical ideas debated in public professional/academic discourse and the therapist's own personal experience and development. The article illustrates how the meaning and use of the concept of the death of resistance has changed over time, not simply in relation to discussion within systemic literature (an 'exterior history', pace Davy (2001)), but also in relation to the author's own personal and professional development (an 'interior history').*

## Introduction

**I**N A RECENT constructionist paper on neutrality in systemic therapy published in *Counselling Psychology Review* (Davy, 2001) I showed how multiple histories can be told about the development of an important idea in systemic theory, with each version of history privileging certain meanings and values while concealing others. That paper suggested that as well as tracing the public or 'exterior' histories of a therapeutic concept, it is also important to explore the 'interior histories' of the relationship between the concept and any particular therapist or client. A therapist's understanding and use of an idea like neutrality is shaped by their own personal and professional history, in a complex epigenetic interaction (Bertrando, 2000) with the 'external histories' of the idea as presented in the literature.

This argument is consistent with a self-reflexive emphasis (e.g. Hoffman, 1992, Lax, 1992) on the person of the therapist as a major influence on therapeutic possibilities and practice, which counselling psychologists argue should be explored and developed in training and beyond. However, although Davy (2001) offered a reflexive study exploring connections between theory and its contexts for development and application, that paper did not demonstrate how a self-reflexive interior history can be developed; the author's own relationship to neutrality remained opaque. By contrast, in this present paper I sketch a self-reflexive example cross-mapping the development of an concept from systemic theory with my own changing relationship to the idea over time.

This paper examines an idea known as 'the death of resistance' (hereafter referred to as DOR), a term coined by Steve de Shazer (1984) in the early years of developing solution-focused brief therapy (SFBT). I attempt to outline my own relationship to the idea, which has changed over time. The meaning and use of any theoretical idea in systemic therapy is co-determined by the structure (Maturana 1988, p.36) and position of the reader/clinician encountering it, not simply the intentions of the original author/theoretician (cf. Culler, 1982).

## De Shazer's idea of the death of resistance in 1984

De Shazer suggested that *it is a tactical error for therapists to allow themselves to conceptualise aspects of the therapeutic process as resistance, or to think of clients as being 'resistant'*. He did not attempt to argue that there is no such phenomena as resistance in therapy, nor that clients vary in motivations and attitudes to change. Rather, he claimed that the idea of DOR is a pragmatic orientation guiding the therapist to talk in ways which will be useful to a client. That is, even if it were possible to 'know' categorically that a particular client is particularly predisposed to 'resist' change, he suggests that it is more useful for the therapist to behave 'as if' this were not so. The death that de Shazer recommends is that of the idea of resistance within the specific local context of the therapist's conceptual repertoire.

De Shazer argues that instead of thinking about clients as resistant, it is more helpful in clinical practice for the therapist to *treat instances of apparent conflict or stuckness within sessions as feedback to the therapist that the therapist needs to find a different way of co-operating with that particular client*. For example, this could mean reviewing the client's goals more closely, changing the pace of therapy, reconsidering the balance between future focus and talk about past exceptions, etc.

### A strategic/behavioural theory of change

De Shazer's professional development as a therapist began through training and practice alongside strategically oriented family therapists. His early paper on solution-development (de Shazer *et al.*, 1986) clearly mirrors the structure and style of a key MRI paper on problem resolution (Weakland *et al.*, 1974). From a strategic perspective, the clinical utility of DOR relates to its function as a means for *pattern intervention* (Cade & O'Hanlon 1993, ch.10). MRI theorists believed that problems arose from the continued application of a pattern of behaviour which may have been functional in a previous context, but which was mistakenly

still being applied in different circumstances (e.g. Watzlawick *et al.*, 1974). Therapeutic intervention to disrupt the 'doing' of the problem pattern would create space for more patterns with better current function. De Shazer's use of DOR can be seen as a means to disrupt recurrent patterns of 'problem talk', viewing talk and language here as highly salient forms of *behaviour* in therapy.

### A linguistic philosophy of change

De Shazer himself claims that SFBT and key concepts within it such as DOR were not organised by a theory of therapy or change as such (e.g. de Shazer, 1994), but rather stem from careful *description* of successful therapy.<sup>1</sup> In making this claim, however, de Shazer enacts a broader theoretical 'style' developed in Wittgenstein's post-Tractarian work (Wittgenstein, 1958; Sluga 1996), which emphasises the worth of close description and redescription to escape the mystifying effects of theorising. Increasingly, de Shazer has interpreted the disruption of problem talk in terms of problems and solutions belonging to different 'language games' in Wittgenstein's terms, with the therapist hosting a conversation promoting a language game of solutions. Talking about resistance or overcoming this would promote the opposite.

### A constructionist theory of change

This shift towards explanations of SFBT and DOR in terms of language games rather than pattern intervention, together with the recent fashion in the systemic world for postmodern ideas, has led many therapists to understand SFBT as a form of constructionist therapy (e.g. Carr, 2000). This recruits a different theory of change to account for the utility of DOR, emphasising the *content* of the particular narratives or solutions constructed within therapy. From this stance, change occurs as different social realities are constructed in language, with consequent changes in beliefs and relationships, a similar theory of change to that driving narrative (e.g. White & Epston,

<sup>1</sup> In my own reading of his work, de Shazer tends not to discuss the way in which the implicit theoretical prejudices of an observer shape the way in which therapies are seen as 'successful' or not in the first place. Deconstruction of the *talk in-between* therapist and client is encouraged in SFBT, but *self-reflexivity* on the part of the therapist is not.

1990) and collaborative language system therapies (e.g. Anderson, 1997). Hart (1995) goes so far as to argue that there are few substantial differences between SFBT and narrative therapy.

This constructionist focus on the content of therapy differs from a strategic emphasis on the process of playing solution-oriented language games rather than problem-oriented language games, irrespective of the specific content of ideas within these language games.

### **A Buddhist theory of change**

De Shazer has also been influenced by Buddhist theories concerning the nature of change and suffering. From a Buddhist perspective, change is inevitable and constant, part of existence within the ordinary illusion of reality; suffering arises from attachment, attempts to cling to the appearance of stability and place/possession. While other systemic therapies, particularly those labelled 'first-order' have tended to concentrate on how to produce change, SFBT claims to privilege changes already underway. In other words, focus on resistance is unnecessary since resistance cannot prevent change, although a preoccupation with resistance may divert the attention of therapist and client from navigating well within the eternal currents of change.

### **My early relationship to the death of resistance**

I first read about DOR when I was beginning to work as a therapist in the mid-1990s. Many strategic ideas like this appealed to me as a keen games player.

### **A means of self-preservation**

The concept of DOR can be used as an anchor or reference point to help the therapist avoid recruitment into a family's problem story, in a similar way to the Milan team's use of team members behind a one-way mirror (Selvini-Palazzoli *et al.*, 1978). As a novice therapist, I sometimes felt a sense of rising panic with clients, as though I might 'drown' in their pain. I think that DOR was useful to me at that time partly as a means of self-protection, rather than change. That is, it helped me maintain a degree of neutrality or distance from clients' problems to regulate the levels of distress I experienced.

In contrast to Haley's insistence (e.g. 1996) that strategic therapists must take responsibility for producing change in their clients, using power to overcome or utilise resistance, DOR (and SFBT more broadly) seemed to offer the therapist an 'easier ride' in a sense by 'side-stepping' disputes and the therapeutic use of power. I am not suggesting here that this was always helpful to clients, more that as an inexperienced therapist this may have been partly for my own benefit.

For example, my use of DOR in those days sometimes meant that if my attempts to engage a client were not working well (perhaps because I was frightened or overwhelmed by them) I could justify to myself clients' decisions to leave therapy relatively easily by seeing this as valid client choice rather than a failure on my part. Looking back on this, I realise that this amounted to ignoring resistance altogether, rather than choosing to reframe resistance as feedback that I should try to work differently with a client. In this sense, I think I misread de Shazer's DOR from the beginning, but I suspect that DOR and SFBT more generally are often attractive to therapists precisely because of this possibility for side-stepping emotional engagement and meaningful differences between the client and therapist (cf. Miller & de Shazer, 2000; Piercy *et al.*, 2000).

### **A means of protecting clients**

Also, I think I may initially have been attracted to DOR as a means to help protect clients from me. I come from a family background where arguments were frequent, sharp and often quite brutal emotionally. As a young adult I was often conscious of having a very quick temper, and a tendency to bully others in arguments. In some senses I think my interest in therapy has related to a broad personal project of attempting to find a different way of being. The DOR has sometimes served me as a way to avoid getting drawn into bullying arguments with clients. However, this early use of DOR as avoidance may have hindered my progress in learning how to have 'good arguments', or in reinterpreting difference as something that can not only be tolerated but openly discussed as an asset or vehicle for therapeutic change.

## Using the DOR to construct a meta-position in family/school work

While working as an educational psychologist in the early 1990s I found DOR a refreshing way of thinking more flexibly about families that school staff were trying to tell me were obstructive or downright malevolent. In this sense, the concept of the death of resistance helped me to maintain a meta-position from the problem of the referring person/[school] (Selvini-Palazzoli *et al.*, 1980), enabling me to stay respectfully curious about families' beliefs and ideas. This is a more therapeutic use of DOR to remain meta- than simple self-preservation as described above. In hindsight, however, I was less willing or able to apply the idea to my relationships with school staff, with some loss of neutrality arising from my asymmetrical application of DOR. I think this was partly because as an LEA educational psychologist, there was some role strain between my responsibilities as an agent of a statutory authority, as a consultant to schools and as a child advocate.

Arguably, one limitation of DOR is its relevance to contexts with multiple stakeholders who may actually have opposing goals. Systemic and constructionist ideas focusing on the understanding and negotiation of conflict and difference within organisations and teams may be more parsimonious than DOR in these situations (e.g. Bor & Miller, 1991; Campbell, 2000).

### The death of resistance as an aid to engagement

I indicated earlier that DOR could be misapplied simply to excuse a therapist from poor engagement skills. However, as my practice has developed I have also found it a helpful companion in trying to engage families who seem particularly hostile or worried about the involvement of professionals. In a recent case, I have been able to form a relationship over time with the family of a very long-term school 'refuser' who have rejected (and complained about) several previous therapists who tried to offer solutions/approaches to the family prematurely. DOR has helped me co-operate

with the parents' unusual and challenging demands regarding particular times, places and agendas for meetings, without feeling either angry or frustrated. Instead, I am attempting to let them teach me how to co-operate with them.

This case also highlights a potential weakness of radical acceptance of the DOR, namely that the therapist can only co-operate with the requests that they can hear, and not all members of the family have equal opportunities to speak. This family have been extremely reluctant to allow professionals to meet their teenage daughter at all. Through my more gradual engagement, accepting the parents' presence at all times, I have had more chance to develop contact with their daughter than other workers before me, but I still find myself wondering how well I understand her wishes, fears and goals so far.<sup>2</sup> There is a continuing dilemma for me of working with the family's particular demands, versus an ethical duty to focus on the needs of the child herself. Is it possible that I must resist her parents' demands at some point in order to hear her own?

### The death of resistance and sharing knowledge or expertise

I initially understood DOR to mean that I should not talk about ideas that seemed opposed to my clients' own solutions, as though I was not allowed to hold a separate view. Gradually, I have come to think about implementing the DOR as more to do with the *way* in which ideas are shared. I now understand DOR as an antidote to attempts to impose ideas on clients as though the therapist's ideas were hierarchically more true, rather than as an injunction against difference.

This way of thinking has been useful to me recently in work with a teenager with obsessive-compulsive disorder. As a very intelligent young man, he shows great ingenuity in devising very elaborate avoidance procedures. However, I am aware from the nomothetic evidence-base that good symptom change is more usually associated with changing the interpretation of, and increasing contact with,

<sup>2</sup> And, of course, reviewed the possible child protection issues here with my supervisor.

feared triggers (Carr, 1999). A collaborative interpretation (Anderson, 2001) of the DOR allows me to support and be interested in his ideas, but also share with him *for discussion, and possible experiment if he wishes*, what I know about success rates of different approaches with other people who have experienced similar problems.

## **The death of resistance as an integrative device**

Although de Shazer argues that his work represents a radical departure from other therapies, personally I have found the DOR useful as a bridge for the importation and integration of other ideas into therapy. For example, the idea that apparent 'resistance' in therapy should not be seen as a problem, but rather treated as a source of information or feedback for the therapist resonates closely with the elaboration of the psychoanalytic concept of countertransference by Bion, Melanie Klein and subsequent object-relations theorists. Freud originally thought of countertransference as a form of contamination in therapy that should be minimised or avoided. However, Kleinian reworkings of the concept of projective identification meant that the therapist's own experience within the session could be regarded as a potentially valuable source of communication about the client and the therapeutic relationship (Heimann, 1960). Analysts of the Independent School such as Casement (1985) and communicative psychoanalysts (e.g. Langs, 1994) extended the idea to include the concept of the client offering the therapist ongoing live 'supervision'. DOR can be read as an injunction to attend to the client's supervision carefully.

This discussion illustrates a potential hazard for me of using the concept of the death of resistance in this way. By allowing it to serve as a bridge between systemic thought and other schools of therapy, there is a risk that I may lose sight of some of the distinctive nature of systemic thinking and practice, and so offer clients a rather muddled experience. In terms of my own stage within a professional life-cycle, I am at a point in my career when I have knowledge and interests from outside systemic therapy that I would like to draw on, yet I am

also at an early stage of learning and consolidating a distinctly systemic mode of practice. A rush towards integration might constitute an attempt to run before I can walk.

## **Risks of theoretical integration**

There is a parallel yet opposite risk, that a determination to abandon the concept of resistance may deprive systemic psychotherapists of many rich insights and methods derived from other modes of therapy, particularly psychoanalysis, but also for instance newer schema-focused work within the cognitive therapies (e.g. Butler, 2000), or cognitive-analytic therapy (Ryle, 1990). The specific risk is that in attempting to reconceptualise 'resistance' as a process of feedback to the therapist, resistance could progressively be seen as something to be avoided or to be ignored 'tactically' (to avoid 'problem talk'), rather than welcomed as an informational resource or a meaningful relational aspect. If a systemic therapist becomes very skilled in working so as to avoid the provocation of resistance, or skilled in carrying on down alternative avenues when resistance seems to be creeping in, there is a risk that feedback from clients through apparent 'resistance' will be restricted as this means of expression is forbidden or ignored.

Following the ideas of Cecchin *et al.* (1992) on irreverence, one way forward is to become dead to the *truth* of resistance, rather than dead to the concept altogether. This suggests a metaphor of theoretical interplay rather than integration.

## **Revisiting my relationship to the concept**

### **A humanistic philosophy of therapeutic change in systemic practice**

I have come to think that that the power of DOR relates to a broader theory of change, namely the construct that clients have an innate tendency towards growth and change, with problems arising from impediments to this 'self-actualising' tendency. I am suggesting a connection to theories of change and development within the humanistic psychologies, for example as developed by Maslow (1968) and Rogers (1951). The acknowledgement of such theoretical ancestry has not been popular

within systemic therapy, although there are signs of change (Anderson, 2001; Bott, 2001).

On my own part, thinking about DOR in a humanistic framework represents an attempt to reclaim some of my pre-systemic training as a person-centred counsellor, facilitated by the notion of therapeutic theories as 'prejudices' to be treated irreverently (Cecchin *et al.*, 1992, 1994), and Bertrando's thoughts (2000) on the epigenetic development of systemic therapists. Perhaps also my enchantment with the novelty of much systemic theory has worn off a little, leaving me more able to make connections between my actual clinical practice and a greater range of previous ideas and experiences.

### **The death of resistance: approach, method or technique?**

Burnham's (1992) distinction between approach, method and technique offers a way of conceptualising my changing relationship to the idea of the death of resistance. I think that initially I related to DOR at the level of technique. Over time, I have come to think of DOR more as an overall orientation for listening and responding within therapy as a whole (method). Recently, I have begun to wonder about the reinterpretation of therapeutic practice as an ethical concern (cf. Aponte, 1985), with DOR relating to an attitude or ethic of collaboration (approach), or in Anderson's terms a philosophy of practice rather than a theory of therapy (2001, p3.47).

### **On meeting the face of the other in therapy**

Many writers on therapy, both within the systemic field and without (e.g. Inger & Inger, 1994; Flaskas & Perlesz, 1996; Clarkson, 1995; Lomas, 1999), argue that the therapeutic relationship is a major force for change and healing, with agreement that the therapist should endeavour to be present in the session, to be congruent and to be a 'real person'. It seems to me that 'resistance' (or at least difference, conflict and disagreement) is part of an ordinary but important range of human experience, perhaps at times developmentally very necessary.

The philosopher Levinas argued that there is a moral imperative for each of us to allow ourselves to be affected by other human beings, to 'meet the face of the Other'.<sup>3</sup> For this to be possible in therapy, the clinician must be capable of tolerating distress arising from meaningful contact with the client, and must be capable of managing their own pain, anger and bewilderment felt in sessions in ways which are constructive rather than damaging for the client. As I develop personally as well as professionally, I am finding this more possible.

I think it may actually be unethical for a therapist to persistently deny clients the opportunity to offer 'resistance' to the therapist which is acknowledged or noticed in *some* way (whether this be to reframe, explore, battle against, or despair). An excessive devotion to the avoidance of resistance, or indeed to an overly cognitive and optimistic rendering of resistance simply as 'useful feedback', risks a dehumanisation of the therapeutic encounter.

### **Concluding note**

This paper has reviewed some aspects of my own development as a therapist in relation to a specific theoretic idea, that of the 'death of resistance' as proposed by de Shazer (1984). As with any public discussion of a personal journey, some readers may view this paper as self-indulgent or lacking in broader relevance for the field. I recognise too that many therapists hold very different ideas about resistance and will have little patience for de Shazer's concept in the first place if they see resistance as a characteristic of the client (and counter-resistance as a property of the therapist). However, my primary purpose in this paper is not to recruit others into a solution-focused perspective on resistance. Rather, I have aimed to illustrate how the development of a theoretical idea in psychotherapy can usefully be understood not just in relation to its elaboration within the literature and the professional community (an exterior history), but also as a changing relationship between the concept and the person of the therapist (an interior history). For a therapist to 'know' an idea is not an act of possession, but rather is a description of an evolving relationship between the knower and

---

<sup>3</sup> Gordon (1999) provides a helpful discussion of Levinas in relation to psychotherapy.

the known, which is epigenetically co-constructed as the idea evolves in the wider field and as the therapist's personal ecology of ideas changes (Bateson, 1972). I offer this paper as an invitation towards theoretical self-reflexivity in professional development for therapists. This position is not specific to resistance, and can be extended to any therapeutic construct deemed particularly important by each therapist, whether this be transference, schemas, empathy, boundaries, and so on. Conceptual development as a therapist is not just the progressive accumulation and integration of new ideas constructed by others, but also requires the ongoing reappraisal of the therapist's position in relation to ideas as their own person and practices evolve.

## References

- Anderson, H. (1997). *Conversation, language and possibilities: A post-modern approach*. New York: BasicBooks.
- Anderson, H. (2001). Post-modern collaborative and person-centred therapies: What would Carl Rogers say? *Journal of Family Therapy*, 23 (4), 339–360.
- Aponte, H.J. (1985). The negotiation of values in therapy. *Family Process*, 24, 323–338.
- Bateson, G. (1972). *Steps to an ecology of mind*. New York: Jason Aronson.
- Bertrando, P. (2000). Text and context: Narrative, post-modernism and cybernetics. *Journal of Family Therapy*, 22 (1), 83–103.
- Bor, R. & Miller, R. (1991). *Internal consultation in health care settings*. London: Karnac.
- Bott, D. (2001). Client-centred therapy and family therapy: A review and a commentary. *Journal of Family Therapy*, 23 (4), 361–377.
- Burnham, J. (1992). Approach-Method-Technique: Making distinctions and creating connections. *Human Systems*, 3, 3–26.
- Butler, G. (2000). Formulating meanings: Integration from the perspective of a cognitive therapist. *BPS Psychotherapy Section Newsletter*, 27, 25–46.
- Cade, B. & O'Hanlon, W.H. (1993). *A brief guide to brief therapy*. New York: Norton.
- Campbell, D. (2000). *The socially-constructed organisation*. London: Karnac.
- Carr, A. (1999). *Handbook of child and adolescent clinical psychology*. London: Routledge.
- Carr, A. (2000). *Family therapy: Concepts, processes and practice*. Chichester: Wiley.
- Casement, P. (1985). *On learning from the patient*. London: Routledge.
- Cecchin, G. (1987). Hypothesising, circularity and neutrality revisited: An invitation to curiosity. *Family Process*, 26, 157–163.
- Cecchin, G., Lane, G. & Ray, W. (1992). *Irreverence: A strategy for therapist survival*. London: Karnac.
- Cecchin, G., Lane, G. & Ray, W. (1994). *The Cybernetics of prejudices in the practice of psychotherapy*. London: Karnac.
- Clarkson, P. (1995). *The therapeutic relationship*. London: Whurr.
- Culler, J. (1982). *On deconstruction*. Ithaca, New York: Cornell University Press.
- Davy, J. (2001). Tracing neutrality in the systemic therapies: Histories of an idea. *Counselling Psychology Review*, 16 (4), 4–13.
- de Shazer, S. (1984). The death of resistance. *Family Process*, 23 (1), 79–93.
- de Shazer, S. (1994). *Words were originally magic*. New York: Norton.
- de Shazer, S., Berg, I.K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W. & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process*, 25, 207–222.
- Flaskas, C. & Perlesz, A. (1996). *The therapeutic relationship in systemic therapy*. London: Karnac.
- Gordon, P. (1999). *Face to face: Therapy as ethics*. London: Constable.
- Hart, B. (1995). Re-authoring the stories we work by: Situating the narrative approach in the presence of the family of therapists. *Australian & New Zealand Journal of Family Therapy*, 16 (4), 181–198.
- Heimann, P. (1960). Counter-transference. *British Journal of Medical Psychology*, 33, 9–15.
- Hoffman, L. (1992). A reflexive stance for family therapy. In S. McNamee & K.J. Gergen (Eds.), *Therapy as social construction*. Sage: London.
- Inger, I. & Inger J. (1994). *Creating an ethical position in family therapy*. London: Karnac.
- Langs, R. (1994). *Doing supervision and being supervised*. New York: Aronson.
- Lax, W.D. (1992). Post-modern thinking in a clinical practice. In S. McNamee & K.J. Gergen (Eds.), *Therapy as social construction*. London: Sage.
- Lomas, P. (1999). *Doing good? Psychotherapy out of its depth*. Oxford: Oxford University Press.
- Maslow, A.H. (1968). *Toward a psychology of being*. Princeton, New Jersey: Van Nostrand.
- Maturana, H.R. (1988). Reality: The search for objectivity or the quest for a compelling argument. *The Irish Journal of Psychology*, 9 (1), 25–82.
- Miller, G. & de Shazer, S. (2000). Emotions in solution-focused therapy: A re-examination. *Family Process*, 39 (1), 5–23.
- Piercy, F.P., Lipchik, E. & Kiser, D. (2000). Commentary: Miller and de Shazer's article on 'Emotions in solution-focused therapy.' *Family Process*, 39 (1), 25–28.
- Rogers, C.R. (1951). *Client-centred therapy*. Boston: Houghton Mifflin.
- Ryle, A. (1990). *Cognitive-analytic therapy: Active participation in change*. Chichester: Wiley.

- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G. (1978). *Paradox and counter-paradox*. New York: Jason Aronson.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1980). The problem of the referring person. *Journal of Marital and Family Therapy*, 6, 3-9.
- Sluga, H. (1996). Ludwig Wittgenstein: Life and work. Introduction to H. Sluga & D.G. Stern (Eds.), *The Cambridge companion to Wittgenstein*. Cambridge: Cambridge University Press.
- Watzlawick, P., Weakland, J.H. & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. London: Norton.
- Weakland, J.H., Fisch, R., Watzlawick, P. & Bodin, A. (1974). Brief therapy: Focused problem resolution. *Family Process*, 13, 141-168.
- White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Wittgenstein, L. (1958). *Philosophical investigations* (3rd ed.). (Trans. G.E.M. Anscombe). New York: Macmillan.

## Correspondence

Dr John Davy

Brookside Child and Family Consultation  
Clinic,

18d Trumpington Road,  
Cambridge CB2 2AH.

Tel: 01223 746001

E-mail: john.davy@dial.pipex.com

*John Davy is Principal Counselling Psychologist with the Child and Adolescent Mental Health Service of Cambridge and Peterborough Mental Health Partnership NHS Trust. He is also a chartered educational and health psychologist, and has completed advanced clinical training as a family and systemic psychotherapist with the Institute of Family Therapy in London.*



British Association  
Counselling and Psychotherapy

### Conference Announcement:

\*

### 9th Annual Counselling & Psychotherapy Research Conference

Theme: 'Research and Diversity' – 16 & 17 May 2003

\*

with Leicester University as co-host

\*

For all details visit our website: [www.bacp.co.uk](http://www.bacp.co.uk) or call  
Angela Couchman or Beverley Brennan on 0870 443 5252  
or e-mail [angela.couchman@bacp.co.uk](mailto:angela.couchman@bacp.co.uk)

1 Regent Place, Warwickshire, Rugby CV21 2PJ. Tel: 0870 443 5252. Fax 0870 443 5160.  
Company limited by guarantee 2175320. Registered in England and Wales. Registered Charity 298361.

# Ideal and Actual Referral Choices for Mental Health Problems in Primary Care

**Tania Dolley, Powys Healthcare NHS Trust, Bryan Adams, City University & Dr James Hampton, City University.**

*With the increasing role of primary care in managing mental health problems there are now a number of different professionals who may deliver this service. GPs in one county were surveyed to find out which professionals they currently refer patients to with particular psychological problems, and which they would perceive to be the ideal referral choice if available. Results identified GPs' perceptions of ideal professionals to treat each problem, their degree of consensus on this and discrepancies between ideal and actual referral choices.*

*Overall, at least half the GPs could refer to their perceived ideal practitioner. There was greater discrepancy between actual and ideal referral choices for several problems, where 30 per cent to 50 per cent of patients were not currently being referred to the ideal choice. This may indicate short-falls in service provision, for various practitioners, and raises questions about the effectiveness of treatment available to these patients. GPs often see patients themselves instead, or refer elsewhere, especially to CPNs who are readily available.*

*Consensus was high for some problems, and for others was spread between four or five different practitioners. Questions arise about appropriateness of some referral choices and practitioner qualifications. The need for clearer information and referral guidelines is highlighted, and perhaps a reassessment of priorities in service provision.*

*The case for referral guidelines has been made by 'Treatment Choice in Psychological Therapies and Counselling – evidence-based clinical practice guideline', Department of Health, February 2001. ([www.doh.gov.uk/mentalhealth/treatmentguideline](http://www.doh.gov.uk/mentalhealth/treatmentguideline)).*

*This study reinforces this need for clear referral guidelines.*

## Introduction

A NUMBER OF DIFFERENT professionals now service the growing number of mental health problems seen by general practitioners (GPs) (Corney, 1996). This growth has coincidentally coincided with the expansion of Counselling Psychology training courses. These practitioners may employ different psychological approaches and have different levels of qualification. Yet there has been relatively little research into GPs' referrals to this range of professionals offering psychological treatments. What determines GPs' referrals to different mental health professionals and what treatment would they consider to be appropriate for which problems? Service provision and referral patterns often appear somewhat idiosyncratic. On what criteria are these referral choices based? To what extent are GPs aware of the differences between the various therapies and what, if any, distinction do they see between counsellors, psychothera-

pists, counselling psychologists, clinical psychologists and other practitioners? Do GPs take into account the practitioner's approach, training or areas of expertise when making a referral? To what extent might confusion or lack of information be a barrier to appropriate referrals?

This study investigated referral practices in one Primary Care Agency to find out to which professionals GPs refer patients with psychological problems, and to discover any discrepancies between these actual referrals and their preferred referral choice if the service were available. GP consensus on ideal referral was investigated and perceptions of the role of counselling psychologists was considered. This will inevitably highlight gaps in service provision which counselling psychologists might help to fill.

## **Mental health services in the NHS**

Psychological therapies are becoming the treatment of choice for a wide range of psychological and psychiatric presentations (Kosviner, 1994). The White Paper 'Health of the Nation' (Department of Health, 1992) highlighted mental health as a key issue, encouraging primary care to take a lead in developing effective services for people with psychosocial and mental health problems. However, there appears to be some 'ignorance and confusion' (Clarkson, 1994) between different service provision, and a need for clearer referral guidelines.

## **The prevalence of mental health problems**

Mental health problems are extremely common. It is estimated that at any given moment, 30 per cent of the UK population are suffering from symptoms of anxiety or depression (Huppert, Roth & Gore, 1987). Many GP trainees comment that their hospital-based psychiatric training does not prepare them appropriately for the psychological problems they encounter in general practice (Markus *et al.*, 1989).

## **Range and provision of mental health services**

The number of mental health care professionals connected with a general practice has increased

substantially since 1991 (Corney, 1996). Increases in the demand for counselling (Sherrard, 1993) and the range of psychological services has resulted in the growth of a vast assortment of professionals providing psychological help (Tyndall, 1993). Current government provision includes: psychotherapists (Temperley, 1978; Gask & McGrath, 1989), clinical psychologists (Milne & Souter, 1988; Salmon, 1984) and psychiatrists, who increasingly work in community mental health teams (Strathdee & Williams, 1984; Burns, 1990). Many community psychiatric nurses (CPNs) (Briscoe & Wilkinson, 1989; Robson, France & Bland, 1984; Espie & White, 1986), social workers (Corney, 1985) and counsellors (e.g. Waydenfeld & Waydenfeld, 1980; Rowland & Irving, 1984; McLeod, 1988; Pereira Grey, 1988; Martin & Mitchel, 1983; Sibbald *et al.*, 1993) also work in primary care settings.

These practitioners use a range of different approaches. Kosviner (1994) summarises the major psychological therapies available within the NHS that are substantiated by sound psychological theories and/or empirical research, including psychoanalytic, cognitive and behavioural, systemic, humanistic or existential psychotherapies and counselling approaches. Practitioners do not often, of course, fit into any one category and over the last two decades there has been a trend internationally towards 'integrative' approaches (Dryden, 1984).

In spite of this range – or perhaps because of it – there has been concern about the quality and accessibility of this broad spectrum of psychological services now available in the NHS. Kosviner (1994) suggests that psychotherapy services are often unevenly distributed and poorly integrated with other psychiatric and psychological services. This fragmented provision is neither conducive to good patient care nor comprehensible to most referrers (Kosviner, 1994). Confusion may perpetuate existing difficulties in providing the best cost-effective help for people with emotional or psychological difficulties (Clarkson, 1994). It is precisely this confusion that the new government guidelines (Department of Health, 2001) address.

## Definitions and confusions

When it comes to distinguishing between therapies/therapists opinions differ on what, if any, the differences are. Clarkson (1994) suggests that identifying the factors differentiating counselling, psychotherapy, psychology, psychiatry and allied fields might help provide guidelines for referral agencies, professionals and the public to align needs and resources more accurately.

For example, a GP's perception of counselling may range from 'sympathetic chat' to skilled professional service. Although some GPs consider counselling to be specifically non-directive in nature (Pringle & Laverty, 1993), Curtis-Jenkins (1993b) points out that many other forms of counselling or psychotherapy are being used viz. brief therapy models, behaviour therapy and gestalt, as counsellors match patients needs to therapy and not vice versa. Farrell (1993) distinguishes between counselling and counselling skills - for example the difference between a nurse, community psychiatric nurse (CPN) or social worker with counselling skills, and a trained or experienced counsellor. He points to the complex distinction between 'counselling' and 'psychotherapy', which he considers as umbrella terms for sets of activities. Some writers consider there to be little essential difference and use the terms interchangeably (e.g. Dryden & Feltham, 1992).

Three main approaches to considering the relationship between counselling, psychotherapy, psychology and psychiatry have been identified (Carroll, 1991). There are those who 'lump' them all together and refuse to acknowledge any differences; those who refuse to acknowledge any similarities; and finally those who consider 'overlap' between the groups, with areas of both similarity and difference. Some inter-professional tensions, and anxieties about professional roles may consequently arise.

## GP referrals to mental health services and related issues

Access to services inevitably depends on GPs' assessment skills and referral decisions, which may be influenced by a variety of factors, including resources and availability of services.

Corney (1990) demonstrates the important role GPs play in the treatment of psychosocial problems, although early studies by Goldberg and Blackwell (1970) revealed that GPs missed much psychosocial disturbance and psychopathology, and not all are skilled at either detecting or managing these problems (Goldberg *et al.*, 1982). GPs show a wide variation in referral patterns, possibly due to their unique referral thresholds (Cummins *et al.*, 1981).

## Qualifications

Psychological professionals vary in the range of therapy offered, and breadth and level of training. So what is an appropriate referral? This issue is particularly pertinent to counselling services in primary care, since for nearly ten years, a third of GPs in England and Wales have been employing counsellors (Kendrick *et al.*, 1993).

Sibbald *et al.*'s (1993) survey of counsellors found a high proportion lacked adequate qualifications, and many were referred problems outside their knowledge. GPs were often unaware what qualifications were held. They concluded that while many counsellors may be skilled in a range of approaches, any one counsellor is unlikely to be qualified to deal with such a broad range of illness, a concern echoed by Fallowfield (1993). Strouthos, Ronder and Hemmings (1995) also express concern on both the variable training and supervision that counsellors have received, and lack of clear guidelines on referral. Watts and Bor (1995) point out that the range of qualifications among the professionals who may provide counselling in primary care includes clinical psychologists, counselling psychologists, UCKP registered psychotherapists, community psychiatric nurses, social workers and nurses who may have counselling or psychotherapy qualifications and some GPs with training in counselling or psychotherapy. Areas of competence will inevitably differ.

## Assessment

All this raises the question, how is need matched to therapy, and by whom? How are patients assessed? Are counsellors expected to be trained in a variety of models? Do GPs take into account training or type of qualification

when referring? To what extent are GPs even aware of the different types of training a counsellor or therapist may have received?

The important task of assessment and the need to determine which therapy(s) is appropriate, in what setting, and for what duration has been addressed in the BPS/Royal College of Psychiatry Statement (1993), emphasising that the present situation is clearly not in the best interests of service users. It stresses that the range of therapies offered should be broad, balanced and co-ordinated. It emphasises the need for specialist assessment, treatment and training. This sounds like a highly ideal situation, but may be a system to aspire to!

### Choice of referrals

Sibbald *et al.* (1993) suggest GPs need to be more discriminating and need better research into which types of patient problems are best treated by which types of psychological intervention. Corney (1992, p.331) suggests that due to the wide range of therapies ranging from behavioural approaches to psychoanalysis 'We urgently need to know which therapies benefit which patients most and which ones are more acceptable to patients.'

Fallowfield (1993) cites the lack of any clear model as one of the difficulties with evaluating counselling, a theme echoed by King *et al.* (1994) who suggest that the multifarious nature of counselling is partly responsible for the confusion about efficacy. Although a number of studies have highlighted the value of counselling (e.g. Corney, 1992; King *et al.*, 1994, Boot *et al.*, 1994), and a meta-analysis found that treatment by mental health professionals was about 10 per cent more effective than treatment by GPs (Balestrieri *et al.*, 1988), Webber *et al.* (1994) suggest that both the kinds of problems being referred and how they are met need further evaluation. For example, some treatments such as exposure therapy for phobias are offered by several professional groups. Who will provide the treatment often depends more on availability than clinical policy.

There have been few attempts to look at which problems are referred to which professionals. Webber *et al.* (1994) considered reasons for patients being referred to a practice counsellor. Sibbald *et al.* (1993) investigated which

problems are referred to onsite counsellors, who may be a CPN, 'practice counsellor' or clinical psychologist. They found that affective and psychotic disorders were often referred to CPNs, suggesting that GPs see them as skilled in managing psychiatric illness; psychosexual difficulties, eating disorders, phobias and obsessive-compulsive disorders tended to be referred to clinical psychologists; and bereaved patients were often referred to practice counsellors. O'Neill-Byrne and Browning (1996) described the first study to compare referrals to, and activities of, psychiatrists, psychologists and CPNs working within primary care. They found that where GPs have access to mental health professionals of different disciplines, they refer different patients groups to each professional. Younger, more socially stable patients went to the psychologist and older patients to the CPN. Psychiatrists and CPNs were referred a higher proportion of patients perceived to have a risk of suicide, CPNs saw all patients referred for 'social support', and all psychotic patients. Patients referred to psychologists were more likely to be under 35 and in full-time employment.

There is little research into GPs' awareness of the various therapies available and the effect of this on referral patterns, or whether a lack of information may result in inappropriate referrals. The literature often refers to 'counselling' or 'psychotherapy' in generic terms, with little differentiation between either what kind of counselling or therapy is being talked about, what training/qualification is involved, or what other psychological therapies might be available or appropriate. The present confusion needs to be clarified and guidelines for assessment and referral are required.

All this paints a picture of a wide variety of psychological services and types of practitioner available, with various different models of therapy being practised and of fairly sporadic, ad hoc service provision with a great range of referral patterns. Small wonder then, that confusion reigns and that some GPs feel 'It's a minefield out there!' (Markham, 1994)

This study was mounted to gain a clearer picture of how GPs are using mental health services and how this would be changed if they

had the freedom to refer to whomsoever they chose. It also aimed to identify the familiarity of GPs with the emerging profession of counselling psychology.

## Method

A quantitative survey was carried out using a self-administered questionnaire and sent to 298 GPs in practices of varying size between one to nine GPs, in one of the Home Counties. There was an approximately equal distribution of male and female GPs.

A list of problems covering the range of psychological referrals that commonly occur in general practice was compiled. These were serious suicide attempt; depression, not suicidal; depression, possibly suicidal; simple phobia; unresolved bereavement; agoraphobia with panic attacks; post-traumatic stress disorder (PTSD); eating disorder; general anxiety disorder (GAD); chronic relationship difficulties; stress related headaches; possible psychosis; and alcohol/drug related problem. This list included a spectrum of problems from 'serious suicide attempt' or 'possible psychosis' where a greater consensus between GPs on referral choice would be expected, to those where there might conceivably be less referral agreement.

The five-page questionnaire consisted of two sections. Along with instructions and example chart, Section A included two identical charts listing the 13 patient diagnoses of psychological problems along the side and a list of 13 mental health professionals along the top. To reflect the wide range of professionals to whom a patient might be referred, the following choices were included: psychiatrist, clinical psychologist, counselling psychologist, counsellor, psychotherapist, family therapist, community psychiatric nurse, practice nurse, psychiatric social worker, nurse behaviour therapist, 'see patient myself rather than refer', 'whichever is available', and 'other (please specify)'.

The first chart related to their actual choice of practitioner, i.e. who they would refer this patient to if consulted today, and the second chart related to their ideal choice, i.e. who they would ideally refer the patient to if this practitioner were available. GPs were asked to

indicate their first, second, and third choice of practitioner to whom they would refer a patient diagnosed with each psychological problem given.

In Section B, the first question asked GPs for the reasons for any differences in their actual and ideal choice of referral, giving four options of 'financial constraints', 'time constraints', 'unavailability of psychological services' and 'other (please specify)'. The remaining questions considered practice size, years of practice as a GP and amount of post-graduate mental health training, current availability of mental health professionals referred to, and professionals needed but not available.

Although categorising patients according to a simple diagnosis of psychological problem might be generalised and limiting, in order to keep the questionnaire simple and quick to complete it was decided to give GPs the diagnosis rather than in effect testing their diagnostic skills with a vignette, especially as referral thresholds vary widely.

## Data analysis

Cross tabulation analyses were conducted to compare the actual and ideal referral choices for individual GPs. In addition a hierarchical classes (HICLAS) analysis was used to simplify the actual and preferred referral choices.

Differences between GPs in *actual* referrals might indicate disparities in resource availability in the area. In the *ideal* scenario, differences could also indicate varying perceptions among GPs as to which practitioners are the most appropriate for treating specific psychological problems. This could perhaps reflect GPs' knowledge (and possible confusion) of the differences between professionals and awareness of what is the most appropriate referral. Differences for the same GP between their actual and ideal choice could reflect service provision and indicate that GPs do have an idea of what they would consider to be the most appropriate referral, but are unable to do so.

## Results

Sixty-eight completed questionnaires were returned – 23 per cent of those sent out. Over

half came from practices of between five and seven GPs. For simplicity, results are presented in two formats. First we have used a HICLAS diagram to give an overall pattern of Actual and Ideal referrals. Secondly we have presented some of the data in tabular form, to illustrate in more detail points of interest.

## Hierarchical Class Analysis (HICLAS)

HICLAS is a general data reduction method developed by De Boeck and Rosenberg (1988) that takes as input a matrix of binary data. Data can be prepared for analysis using most spreadsheets. An introductory account can be found in De Boeck *et al.* (1993). As applied to our data HICLAS aims to provide a summary diagram that shows in a direct way which of the problems were referred to which type of practitioner. It achieves this by allocating both problems and practitioners to a hierarchy of classes, with those problems or practitioners at the most general level having the widest range of referral. In Figure 1 a HICLAS solution is shown for the average judgement for actual referrals. A problem was considered linked to a practitioner if five or more of the sample made that connection.

Problem categories are shown in the top half of the diagram, and practitioner categories in the lower half and the two are separated by the dotted line. For problems, the most general level of category [phobias] is at the top, while for practitioners the most general level (represented by the classes [See self, CPN and clinical psychologist]) is at the bottom. The two domains (problems and practitioners) are connected through a set of *bundles* at the lowest level, shown by the zig-zag lines connecting base level problems to base level practitioners. Thus, for example, the problem class [serious suicide risk, psychosis and alcohol/drug problems] was directly connected to the practitioner class [psychiatrist], showing that this group of problems was referred to that group of practitioners.

In general, to find which problems are referred to which practitioners and vice versa one simply looks to see if they can be connected by a vertical path through the network. Thus, since there are no further connections below the

level of psychiatrist, no other practitioners would be referred the set of three problems just described. On the other hand, counsellors would be referred the problem class of [bereavement and GAD], and these problems could also be referred to the practitioner class [see self] and [CPN], as there are links to these below [counsellor]. The symbol  $\emptyset$  in a class indicates an empty set. The reader may wish to check their understanding of the diagram by confirming that the [clinical psychologist] class would be referred the problems in the classes of [agoraphobia/panic], [panic] and [eating disorder, PTSD].

The HICLAS diagram is useful in that: (a) it clusters together problems referred to the same set of practitioners and clusters together practitioners referred the same set of problems; and (b) it shows the class inclusion hierarchy of both problems and practitioners from the most specific, at the centre of the diagram, to the most general, at the top and bottom. In order to achieve this level of clarity it is necessary to introduce a degree of simplification. The amount of data distortion is indicated by the number of discrepancies (in the case of Figure 1, there were seven). A discrepancy occurs when a cell in the problem-by-practitioner matrix has had to be changed in order to generate the structure shown. The number of discrepancies is reduced as the number of base bundles (known as the rank) is increased, but as there is usually a corresponding increase in the complexity of the diagram, a compromise is needed between accuracy and readability. Cells that have had data changed are shown on the diagram with individual goodness-of-fit measures beside them. (See for example that PTSD had a goodness-of-fit measure of .67 next to it indicating that not all psychiatrists and clinical psychologists were the actual referral choices). In addition an overall goodness-of-fit is generated for the whole data file. In Figure 1 this figure is .767 indicating that just short of eighty per cent of the data is represented by the diagram. The final point to note in Figure 1 is that four types of practitioner (counselling psychologist, psychotherapist, family therapist and other) do not appear in the diagram, as there were no problems referred to them at a level that reached our inclusion criteria.

Figure 1: GPs' stated actual referrals based on problem data.  
 Rank = 5; Discrepancies = 7; Goodness of fit = .767

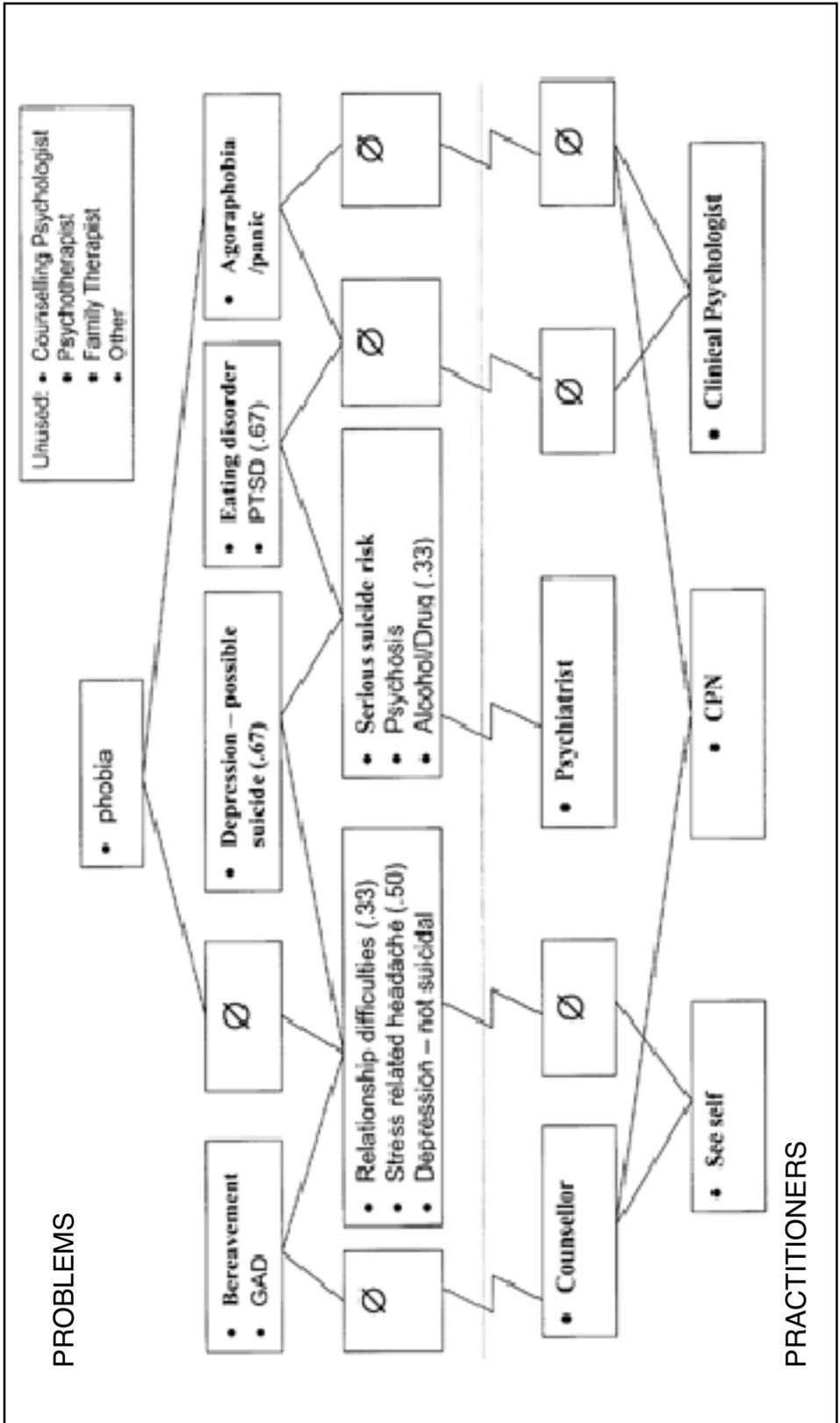


Figure 2 shows the HICLAS diagram for the ideal referral data.

It is immediately apparent that there was greater differentiation of both problems (10 distinct classes against six) and practitioners (six against five, and no class of practitioners with no referrals). Again for clarity, only practitioners chosen by five or more GPs in each case were considered. This accounted for over 90 per cent of the sample. The role of the counsellor in actual referrals was differentiated into two classes [counsellor and counselling psychologist] and [psychotherapist and family therapist]. The latter would ideally handle referrals only in relationship difficulties, whereas the former would also be referred problems of bereavement, stress related headaches and PTSD. The clinical psychologist continued to be referred the same problems as before, but in addition in an ideal world may be referred problems of GAD and stress related headaches. The role of psychiatrist was mostly unchanged. The category of 'other' practitioner was introduced to handle problems of alcohol and drug abuse, suggesting that the other practitioner that the GPs had in mind would be a specialist in addictive behaviour. Most interestingly the GPs saw themselves and the CPN as ideally fulfilling the same role as each other, and covering a much-reduced range of problems – GAD and mild or moderate forms of depression only. This is evidence that GPs would wish to make greater use of referrals for mental and behavioural problems, freeing up themselves and their CPNs for other forms of medical practice.

To illustrate where consensus on ideal referral was high and where it varied among GPs we have included the following examples.

For patients making a serious suicide attempt and with possible psychosis, virtually all GPs would refer to a psychiatrist. Over nine in 10 GPs would also refer patients with depression to a psychiatrist, CPN or see patients themselves. For convenience these can be considered *high consensus* choices.

Eating disorders, simple phobia and agoraphobia with panic attacks were areas of *moderate consensus* with over 60 per cent of GPs referring to either a psychiatrist or clinical psychologist. Thus 40 per cent of referral

choices for patients with these problems were spread fairly evenly between six and eight other practitioners in some cases. These included counsellor, CPN, nurse behaviour therapist, see patients themselves and other – in this instance, the Community Mental Health Team or occupational therapist.

Stress-related headaches, PTSD and unresolved bereavement, GAD and chronic relationship difficulties were all areas of *low consensus* and would be referred to any one of five or more practitioners. Actual referrals were more likely to be informed by available resources than confusion, since GPs' ideal choices were often different from the actual choices with these disorders.

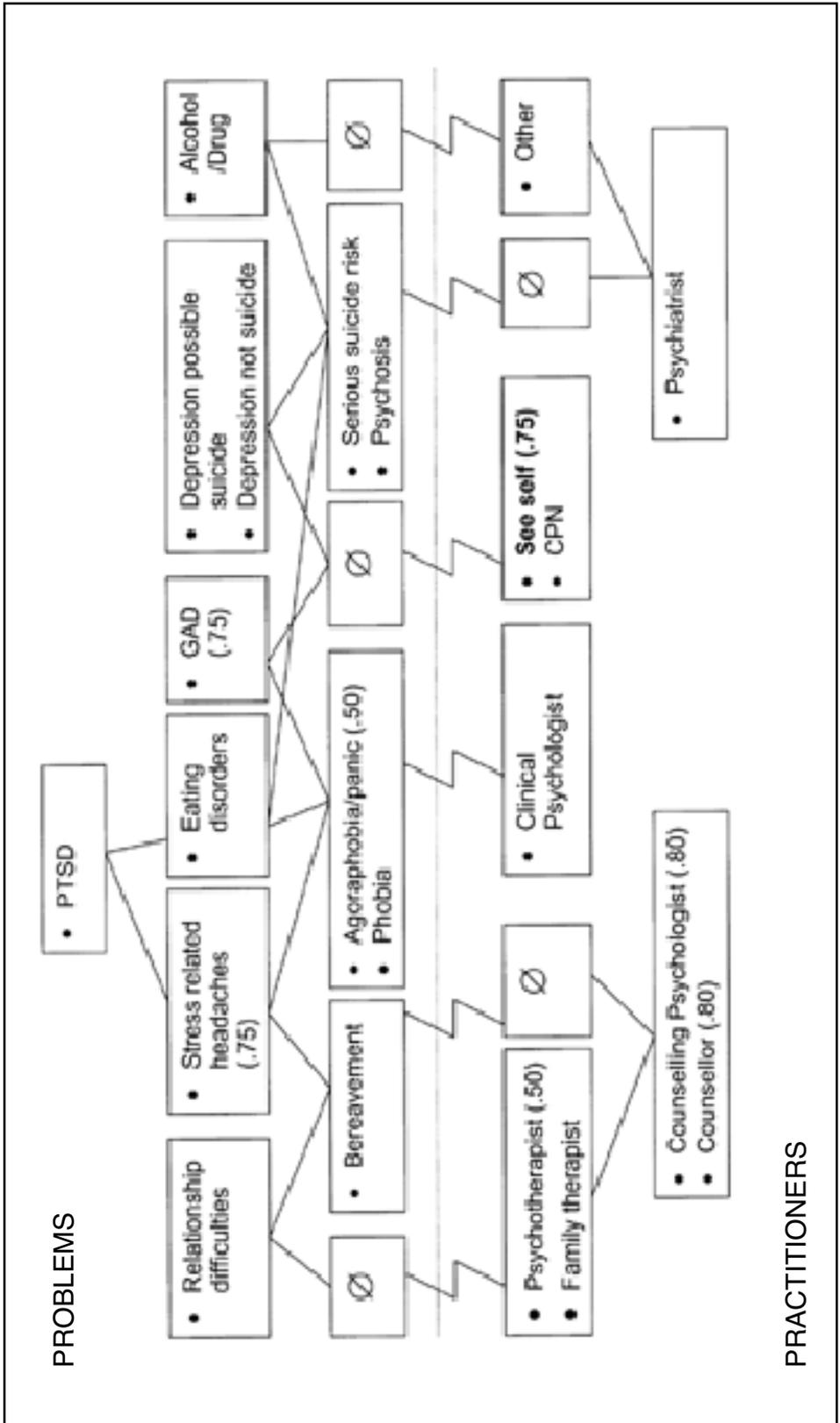
Comparing Figures 1 and 2 shows that with over half the problems GPs could refer to the practitioner of their choice. For several problems, between a third and a half of GPs, ideal referral choices were unavailable. Since these represent serious perceived shortfalls in primary mental health care services we have included Table 1 below to identify these areas.

**Table 1: Overall per cent GPs unable to refer patients with a particular psychological problem to preferred practitioner.**

Problem	GPs unable to refer (%)
Chronic relationship difficulties	47
Unresolved bereavement	44
Agoraphobia w. panic attacks	42
Stress related headaches	40
General anxiety	38
Simple phobia	35
PTSD	30

Chronic relationship difficulties and unresolved bereavement was an area where counsellor/counselling psychology numbers were perceived to be insufficient. In particular one in seven GPs differentiated between counsellors and counselling psychologists, preferring the latter to receive unresolved bereavement referrals. For agoraphobia with panic attacks, simple phobias, general anxiety and stress related headaches and PTSD, ideal

Figure 2: GPs' perception of ideal referral choice based on problem data.  
*Rank = 6; Discrepancies = 4; Goodness of fit = .882*



referral choices were varied and represented at times idiosyncratic choices which are examined in the discussion.

## Discussion

### Perceived ideal referrals

Nearly all GPs would refer to a psychiatrist patients making a serious suicide attempt or with possible psychosis, and patients with depression who were also possibly suicidal. This supports previous findings that psychiatrists and CPNs were referred a higher proportion of patients perceived to have a risk of suicide (O'Neill-Byrne & Browning, 1996). For depression without suicide risk, the majority of GPs would both actually and ideally see patients themselves although several would refer to a psychiatrist or CPN instead. For patients with a simple phobia, the professional of choice would be a clinical psychologist, but in fact more GPs were referring instead to a CPN or seeing these patients themselves. Similarly for agoraphobia with panic attacks, the largest proportion of GPs would refer to a clinical psychologist, but several were actually referring to a CPN. For these two problems, results support findings by Sibbald *et al.* (1993) that clinical psychologists tend to be referred problems such as psychosexual difficulties, eating disorders, phobias and obsessive-compulsive disorders which are believed amenable to the behavioural therapies practised by these professionals. However, substantially more GPs in the present study perceive a psychiatrist as the ideal professional to refer patients with eating disorders, in both actual and ideal scenarios.

For patients with unresolved bereavement and chronic relationship difficulties, the professional chosen by the largest proportion of GPs both actually and ideally was a counsellor. This again supports Sibbald *et al.*'s (1993) findings that bereaved patients are generally referred to practice counsellors, which they suggest indicates that GPs see this as a problem that responds to the non-directive forms of counselling associated with these professionals. For unresolved bereavement, the majority choice of counsellor was followed by a counselling

psychologist in the ideal scenario but actually several GPs were seeing these patients themselves or referring to a CPN. Several GPs also considered a family therapist, counselling psychologist, and psychotherapist the ideal referral for chronic relationship difficulties. Specialist agencies or professionals, followed by a psychiatrist, were the actual and ideal referral choice for patients with alcohol and drug related problems. Many GPs were seeing patients with stress related headaches themselves, but would ideally use both clinical and counselling psychologists. For general anxiety, the ideal for most GPs would be to use either a clinical psychologist or CPN rather than either see themselves or refer to a counsellor which most were doing at present. Finally, patients suffering from PTSD were currently referred to a clinical psychologist, perceived to be the ideal professional by a similar number of GPs – followed by a psychiatrist and counsellor. Ideally others would also choose a counselling psychologist and psychotherapist, but fewer would ideally refer to a psychiatrist than currently do.

Results give a general indication of GPs' perception of the ideal mental health professional for specific problems and how this compares to current practices. They also indicate where service provision is perceived to match need, and where shortfalls arise. Obviously there were occasions where both actual and ideal choices were too few to be included in the analysis. However reference to Figures 1 and 2 shows how nearly 80 and 90 per cent respectively of GPs' choices were incorporated. A number of questions and issues arise from the results.

### Perceived lack of service provision for specific practitioners

Although for many problems GPs appeared satisfied with the resources available and are referring patients to the professional they consider the ideal choice, there are discrepancies, possibly indicating a lack of service provision. Psychiatrists were perceived by 15 per cent of GPs as unavailable for patients with depression and possibly suicidal, though 95 per cent said that a psychiatrist was easily

available. The obvious reason for this would be long waiting lists. However, GPs may be rationing scarce resources and tending to refer only where suicide was a distinct possibility.

Less surprising, however, were cases where perceived need to refer to a clinical psychologist was not being met. For patients with a simple phobia and a similar proportion for agoraphobia with panic attacks, one in five GPs had no clinical psychologist available. In half as many cases GPs were unable to refer to a clinical psychologist for an eating disorder. Although all GPs said a clinical psychologist was available, two-thirds experienced long waits. This is the most likely reason for these patients' needs not being met by GPs' perceived ideal professional.

For counsellors the picture was mixed. Cases where a significant proportion of GPs perceived counsellors as the appropriate professional but were not actually able to refer to one included chronic relationship difficulties, general anxiety and unresolved bereavement. There was also a significant lack of counselling psychologists as the ideal professional for patients with unresolved bereavement, PTSD and chronic relationship difficulties. Half the GPs had no access to a counselling psychologist. Half of these said they would use one if available.

For psychotherapists and family therapists a low number of GPs perceived a need that was not being met, which possibly reflects less familiarity with these practitioners and types of appropriate referrals. Limited availability may also create less demand; where three-quarters of GPs had access to a family therapist, two thirds said there was a long wait. Of those with no access to a family therapist, seven in ten said they would use one if available. Availability was even less for psychotherapists, eight in ten GPs with access to one experienced a long wait. Perhaps this reduced availability/familiarity was reflected in only four in ten saying they would use one if available.

### **Alternative choices**

Where GPs are unable to refer to the professional they would ideally choose, they see patients themselves or refer to another practitioner, in particular a CPN. Figure 1 shows the

problems GPs presently deal with themselves. For agoraphobia with panic attacks in particular 20 per cent of GPs refer to a CPN instead of the preferred professional, generally a clinical psychologist. Similarly GPs refer patients with simple phobia, unresolved bereavement and general anxiety to a CPN instead of the preferred professional. CPNs appear to be one of the most readily available mental health professional with all GPs having access to one and nine in ten considering their services fairly quick or immediate. This perhaps raises questions about the scope of clinical activities expected of CPNs, about which concern has been raised, e.g. Tyrer (1990); Robertson and Scott (1985); Wooff and Goldberg (1989).

Significant shortages exist for stress related headaches, simple phobia, agoraphobia with panic attacks, general anxiety, PTSD and unresolved bereavement referrals, with less than half the GPs able to refer to their ideal choice. For chronic relationship difficulties, only one third of GPs were currently referring patients to their ideal professional. These are all common mental health problems, which raises the question of whether this significant proportion of patients are perhaps receiving less than optimal treatment. Where actual and ideal referral choices are the same it could be inferred that these GPs are satisfied with the services available. How appropriate are these choices in the light of outcome research?

### **GP consensus on ideal professional**

Serious suicide attempt or possible psychosis, eating disorders, simple phobia and agoraphobia with panic attacks were being appropriately referred to either a psychiatrist or clinical psychologist by about six in ten of GPs. This fits with research showing for example that a cognitive-behavioural approach (as often practised by clinical psychologists, but certainly not exclusively) is most successful in treating these disorders (Hawton *et al.*, 1989). For the remaining 40 per cent, perceived ideal referrals were spread between six and eight practitioners. Are all the professionals chosen by GPs in this case assumed to be practising this type of approach? Or, are these patients too possibly receiving less than optimal treatment?

To what extent are GPs aware of the types of therapy practised by the various professionals to whom they may refer and what do they consider to be appropriate for whom?

For PTSD in particular, there was no clear consensus on referral, a third of GPs preferring a clinical psychologist. This raises similar questions. How appropriate are these referrals? Is there perhaps no evidence-based reason for choosing one practitioner over another? Are all likely to provide equally effective treatment? To what extent are GP referrals based on knowledge of types of treatment used by a practitioner (regardless of title) and are these supported by outcome research? Where, for example, a third of GPs would rather see patients with GAD themselves, does this reflect their own clinical skills? To what extent are GPs aware of research demonstrating the effectiveness of cognitive-behavioural therapy for GAD? Might they perhaps be prescribing tranquillisers instead? Would this be the most effective treatment? A lack of consensus would to some degree be expected and corresponds to the known wide variation in referral patterns (e.g. Cummins *et al.*, 1981). Yet it could also indicate confusion or lack of knowledge about which practitioners or treatments are likely to be most effective. Alternatively, a variety of professionals could achieve an equally successful outcome for many problems.

The NHS Executive paper 'Primary Care: The Future' (NHSE 1996) acknowledged that the wide variation in clinical practice for mental health problems needs to be addressed, and the frequently idiosyncratic service provision rationalised (Rowland & Irving, 1984; Clarkson, 1994). It highlights the need for evidence-based, locally developed guidelines for treating common mental disorders and locally agreed referral criteria, to improve diagnostic skills and increase knowledge of effective treatments. Training and education of health professionals to reflect the incidence of mental health problems in primary care populations is also suggested. Despite the common occurrence of mild to moderate mental health problems, the likelihood is that many of these will either not be recognised or may be inadequately treated and recovery delayed with consequent social and economic costs.

## **Perceived role of counsellors and counselling psychologists**

GPs frequently perceived counsellors to be appropriate for patients with unresolved bereavement and chronic relationship. Surprisingly many saw them as appropriate for GAD, stress related headaches and PTSD.

In this sample, three-quarters of GPs had a counsellor available, though a quarter said this involved a long wait. Although this study does not differentiate whether or not these counsellors are within the primary care setting, this figure is much higher than Sibbald *et al.*'s (1993) finding that only a third of all general practices have a dedicated counsellor. Sibbald *et al.* also included CPNs and clinical psychologists as counsellors, whereas in the present study 'counsellor' was a discrete practitioner. This sample of GPs thus seem to be relatively well resourced.

Counselling psychologists were perceived by fewer GPs as the ideal professional for patients with, for example, unresolved bereavement, PTSD, chronic relationship difficulties, agoraphobia with panic attacks and stress related headaches. Could this reflect less familiarity and GPs favouring 'tried and trusted' professionals they know better? Perhaps limited availability creates less demand? Is there any particular training needed to equip counselling psychologists to meet GPs' needs? To what extent could they help make up the shortfalls in clinical psychologists? How could they best promote their services?

## **Professional roles**

Is there a need to clarify the roles and remits of the different professional groups as well as types of therapy? 'Confusion of roles and poor communication can lead to service gaps and poor patient care' states 'Primary Care – the Future' (NHSE, 1996); this also must include mental health services. Clarkson (1994) offers useful differentiation between the various mental health professionals in counselling, psychotherapy, psychology, psychiatry and allied fields which could help establish separate professional identities for these practitioners, and provide helpful guidelines, distinguishing between differing kinds of service provision to best match needs with available resources. It could also help alleviate

inter-professional tensions and anxieties about professional roles and conceptual differences between psychological therapies, (Kosviner, 1994) which could hinder the provision of effective and integrated mental health services. Otherwise there is a danger of an increasingly muddled field where no-one is really certain who does what, how, and for whom.

Addressing these issues would seem to be an important part of providing an effective, coordinated and comprehensive mental health service for the 21st century.

## References

- Balestreiri, M., Williams, P. & Wilkinson, G. (1988). Specialist mental health treatment in general practice: A meta-analysis. *Psychological Medicine*, 18, 711–717.
- Boot, D., Gillies, P., Fenelon, J., Reubin, R., Wilkins, M. & Gray, P. (1994). Evaluation of the short-term impact of counseling in general practice. *Patient Education & Counselling* 24, 78–89.
- Briscoe, M. & Wilkinson, G. (1989). General practitioner's use of community psychiatric nursing services: a preliminary survey. *Journal of the Royal College of General Practitioners*, 39, 412–414.
- British Psychological Society/Royal College of Psychiatrists (1993). *Joint Statement: Psychological Therapies for Adults in the National Health Service* (Draft).
- Burns, B. (1990). Mental health in the community. *Hospital Psychiatry*, 5, 157–169.
- Carroll, M. (1991). Counsellor training or counsellor education? A response. *Counselling*, 2 (3), 104–114.
- Clarkson, P. (1994). The nature and range of psychotherapy. In P. Clarkson & M. Pokorny (Eds.), *The handbook of psychotherapy*. London: Routledge
- Corney, R.H. (1985). Marital problems and treatment outcome in depressed women. *British Journal of Psychiatry*, 151, 652–659.
- Corney, R.H. (1990). Counselling in general practice: Does it work? Discussion paper. *Journal of the Royal Society of Medicine*, 93, 253–257.
- Corney, R.H. (1992). The effectiveness of counselling in general practice. *International Review of Psychiatry*, 4, 331–338.
- Corney, R.H. (1996). Links between mental health care professionals and general practices in England and Wales: The impact of GP fundholding. *British Journal of General Practice*, 46, 221–224.
- Cummins, R.O., Jarman, B. & White, P.M. (1981). Do general practitioners have different 'referral thresholds'? *British Medical Journal*, 282, 1037–1040.
- Curtis-Jenkins, G. (1993b). Counselling in general practice – letter to Editor. *British Medical Journal*, 306, 391.
- De Boeck, P. & Rosenberg, S. (1988). Hierarchical classes: Model and data analysis. *Psychometrika*, 53, 361–381.
- De Boeck, P., Rosenberg, S., & van Mechelen, I. (1993). The Hierarchical Classes Approach: A Review. In I. Van Mechelen, J.A. Hampton, R.S. Michalski & P. Theuns (Eds.), *Categories and concepts: Theoretical views and inductive data analysis*. London: Academic Press.
- Department of Health (1992). *Health of the Nation: A strategy for health in England*. London: HMSO (Cm. 1986)
- Department of Health (2001). *Treatment choice in psychological therapies and counselling – evidence-based clinical practice guidelines*. London. [www.doh.gov.uk/mentalhealth/treatmentguideline](http://www.doh.gov.uk/mentalhealth/treatmentguideline)
- Dryden, W. & Feltham, C. (1992). *Brief counselling*. Open University Press.
- Dryden, W. (Ed.) (1984). *Individual therapy in Britain*. London: Harper & Row.
- Espie, C.A. & White, J. (1986). The effectiveness of psychological intervention in primary care: A comparative analysis of outcome ratings. *Journal of the Royal College of General Practitioners*, 36, 310–312.
- Fallowfield, L.J. (1993). Evaluation of counselling in the National Health Service. *Journal of the Royal Society of Medicine*, 86, 429–430.
- Farrell, W. (1993). Differing approaches to training and practice in counselling. *Journal of the Royal Society of Medicine*, 86, 424–425.
- Gask, L. & McGrath, G. (1989). Psychotherapy and General Practice. *British Journal of Psychiatry*, 154, 445–453.
- Goldberg, D.P. & Blackwell, B. (1970). Psychiatric illness in general practice. A detailed study using a new method of case identification. *British Medical Journal*, 2, 439–443.
- Goldberg, D., Steele, J.J., Johnson, A. & Smith, C. (1982). Ability of primary care physicians to make accurate ratings of psychiatric symptoms. *Archives of General Psychiatry*, 39, 829–833.
- Hawton, K., Salkovskis, P., Kirk, J. & Clark, D.M. (1989). *Cognitive behaviour therapy for psychiatric problems*. Oxford: Oxford University Press
- Huppert, F.A., Roth, M. & Gore, M. (1987). *Health and lifestyle survey. Preliminary report*. London: Health Promotion Research Trust.
- King, M., Broster, G., Lloyd, M. & Horder, J. (1994). Controlled trials in the evaluation of counselling in general practice. *British Journal of General Practice*, 44, 229–232.
- Kendrick, T., Sibbald, B., Hall, J.A., Brenneman, D. & Freeling, P. (1993). Distribution of mental health professionals working on site in English and Welsh general practices. *British Medical Journal*, 307, 544–546.

- Kosviner, A. (1994). Psychotherapies within the NHS. In P. Clarkson & M. Pokorny (Eds.), *The handbook of psychotherapy*. London: Routledge
- McLeod, J. (1988). *The work of counsellors in general practice. Occasional Paper 37*. London: The Royal College of General Practitioners.
- Markus, A., Murray Parkes, C., Thomson, P. & Johnston, M. (1989). *Psychological problems in general practice*. Oxford: Oxford Medical Publications.
- Markham, S. (1994). *Counselling in primary care in an inner London health district: The general practitioner's response*. Unpublished MSc Dissertation, City University.
- Martin, E. & Mitchel, H. (1983). A counsellor in general practice: A one-year survey. *Journal of the Royal College of General Practitioners*, 33, 366–367.
- Milne, D. & Souter, K. (1988). A re-evaluation of the clinical psychologist in general practice. *Journal of Royal College of General Practitioners*, 38, 457–460.
- NHS Executive (1996). *Primary care: The future*. London: Department of Health
- O'Neill-Byrne, K. & Browning, S.M. (1996). Which patients do GPs refer to which professional? *Psychiatric Bulletin*, 20, 584–587.
- Pereira Grey, D. (1988). Counsellors in general practice. *Journal of the Royal College of General Practitioners*, 38, 50–51.
- Pringle, M. & Laverty, J. (1993). A counsellor in every practice? *British Medical Journal*, 306, 2–3.
- Robson, M., France, R. & Bland, M. (1984). Clinical psychologist in primary care: Controlled clinical and economic evaluation. *British Medical Journal*, 288, 1085–1088.
- Robertson, H. & Scott, D.J. (1985). Community psychiatric nursing: A survey of patients and problems. *Journal of the Royal College of General Practitioners*, 35, 130–132.
- Rowland, N. & Irving, J. (1984). Towards a rationalisation of counselling in general practice. *Journal of the Royal College of General Practitioners*, 34, 685–687.
- Salmon, P. (1984). The psychologist's contribution to primary care: A reappraisal. *Journal of the Royal College of General Practitioners*, 34, 190–193.
- Sherrard, C. (1993). The rise in demand for counselling. *Counselling Psychology Quarterly*, 6 (1), 53–57.
- Sibbald, B., Addington-Hall, J., Brenneman, D. & Freeling, P. (1993). Counsellors in English and Welsh general practices: Their nature and distribution. *British Medical Journal*, 306, 29–33.
- Strathdee, G., Williams, P. (1984). A survey of psychiatrists in primary care – the silent growth of a new service. *Journal of Royal College of General Practitioners*, 34, 615–618.
- Strouthos, M., Ronder, J. & Hemmings, A. (1995). Would you like to see a counsellor or a psychiatrist? *Psychiatric Bulletin*, 19, 427–429.
- Temperley, J. (1978). Psychotherapy in the setting of general practice. *British Journal of Medical Psychology*, 51, 139–145.
- Tyndall, N. (1993). *Counselling in the voluntary sector*. Milton Keynes: Open University Press
- Tyrer, P. (1990). The role of the community psychiatric nurse. *British Journal of Hospital Medicine*, 41, 439–442.
- Watts, M. & Bor, R. (1995). Standards for training and practice in primary care. *Counselling Psychology Review*, 10 (3), 32–37.
- Waydenfield, D. & Waydenfield, S. (1980). Counselling in general practice. *Journal of the Royal College of General Practitioners*, 30, 671–677.
- Webber, V., Davies, P. & Pietroni, P. (1994). Counselling in an inner city general practice: Analysis of its use and uptake. *British Journal of General Practice*, 44, 175–178.
- Wooff, K. & Goldberg, D.P. (1989). Further observations on the practice of community care in Salford. Differences between community psychiatric nurses and mental health social workers. *British Journal of Psychiatry*, 154, 30–37.

## Correspondence

**Tania Dolley**

Powys Healthcare NHS Trust,  
Psychology Department, Bronllys Hospital,  
Bronllys, Powys LD3 0LU.  
E-mail: tania.dolley@powys-tr.wales.nhs.uk

# The Client Experience of Counselling and Psychotherapy

Mark Elliott & David Williams,  
Department of Psychology,  
University of Hull

*What little research there is from the client perspective shows clients to attribute change more to the personal qualities of the therapist than the particular way of working.*

**T**HE MASS OF literature on counselling and psychotherapy invariably presents issues from the practitioner viewpoint. Such work 'tells us little of what it feels like to be on the receiving end' (France, 1988). In fact, it is 'somewhat amazing, given the large amount of studies dealing with therapy and therapists, there exists very few studies that focus exclusively on the clients experience of therapy' (Spinelli, 1994, p.77). Yet the raison d'être for therapy is the client.

Reasons for the paucity of research from the clients' viewpoint are not difficult to identify. There are obvious difficulties relating to access to material, matters of confidentiality, and the acknowledged unreliability of self-reports (Berger, 1963; Gurman, 1973). These problems are exacerbated by the fact that psychoanalytically oriented practitioners may have difficulty taking the clients account at face value. At the other end of the continuum Behaviourists too cast doubt on verbal reports, placing more reliance on overt responses. Institutional pressure to follow the assumptions and practice of the natural sciences also serves to restrict the kind of data considered acceptable. Overall research epitomises the culture of the medical model where 'the expert knows best', denying access to the very material – the clients' thoughts and feelings – which are, or surely should be, the focus of the whole enterprise.

What research has been carried out has tended to reflect both the theoretical perspective of the researcher and the prevailing favoured research methodology. Thus Rogers and his colleagues (Axeline, 1950; Rogers, 1951; Lipkin, 1954) adopted a client-centred approach involving participants writing accounts of their experiences. Questionnaires have been universally popular (cf. Feifel & Eells, 1963; Strupp *et al.*, 1964, 1969), as have interviews (cf. Mayer & Timms, 1970; Beck & Jones, 1973; Sainsbury, 1975; Brannen & Collard, 1982; Markova *et al.*, 1984). These methods have been augmented by the use of rating scales, checklists and card-sorts (e.g. Hunt, 1985), together with case notes and agency files (e.g. Howe, 1989). More recently IPR (Interpersonal Process Recall) has been added to the methodology (e.g. Elliott, 1986; Rennie, 1990, 1992, 1994). There has also been a move to using more quantitative data (e.g. Orlinsky & Howard, 1986), which paradoxically has sometimes aimed at a more holistic view of the client experience. Research has covered a range of client types, therapeutic approaches and counselling contexts; it has focused on the whole experience, individual sessions, or moments in sessions. But all this work amounts, in total, to very little compared to the vast literature on the theory and practice of counselling and psychotherapy. In attempting to summarise this research it is instructive to distinguish between clients perceptions prior to, during and at the end of therapy.

## Pre-counselling feelings

Events in the pre-counselling phase can clearly have an impact on the eventual experience and effectiveness of subsequent work. Mayer and Timms (1970) found that the majority of clients in their study had not confided in those close to them prior to counselling (see also Cantley, 1987) – preferring to talk to a stranger – in part because of the perceived confidentiality that therapy offers (Phillimore, 1981). It is apparent that society preaches self-reliance, resulting in clients believing that they should be able to sort out their own problems (Brannen & Collard, 1982). Consequently self-searching for solutions with concomitant increase in anxiety may go on for a long time before professional help is sought (Strupp *et al.*, 1969; Elliott, 2000). Reticence in seeking help can result in clients feeling embarrassed, weak, ashamed and inadequate (Fitts, 1965). Timms and Blampied (1985), for example, found that two-thirds of their sample revealed feelings of shame in seeking marital counselling. Certainly seeking help seems to involve ‘loss of face’, which is coupled with an unwillingness to disclose to those who may not be trustworthy (Mayer & Timms, 1970).

## Initial experience of counselling

Research suggests the clients first experience of therapy focuses on evaluating the practitioner’s professional and practical efficacy (Maluccio, 1979). Clients are initially judging whether this person is going to be of any help to them (Howe & Hinings, 1989). At this stage they may be particularly sensitive to the environment. Sainsbury (1975) found that some working class men felt uncomfortable when the (usually female) social worker visited their home, whereas France (1988) found that the more natural the surroundings, particularly if this was the clients own home, then the easier it was to develop a therapeutic relationship. Minor matters, like whether the client is offered a cup of coffee (Howe, 1993) are seen to be important. Such gestures may signal acceptance and understanding.

By far the most significant finding in the literature is the initial clash in perspectives between client and counsellor (Mayer & Timms, 1970). What the client expects – maybe

‘problem solving’ – can differ from what the practitioner offers – perhaps ‘personal development’ (Williams, 1994). Dissatisfied clients include those who had been hoping for expert diagnosis, advice, recommendations and action to deal with their problem. McLeod (1990, p.7) argues that it is ‘*not so much that the client has a well defined set of expectations’ but comes from a position of asking ‘is this someone who can help’*. Clients say that ‘*I really didn’t know what to expect...no experience to go on’* (Brannen & Collard, 1982, p.172). It is hardly surprising then that there is a contrast in the literature between reports of initial experiences by the client and by the counsellor, with counsellors perhaps not realising how extremely nervous their client may be (Allen, 1990). Maluccio (1979) showed that when counsellor and client are each asked to describe their initial contact the counsellor is more likely to recall the client problem, whereas the client is more likely to recall their feelings and the impression made by the counsellor. Indeed the intensity of the client’s feelings at this stage may be withheld from the counsellor as the client continues to evaluate the situation (Hunt, 1985). Gaunt (1985) provides evidence that lack of affinity between client and counsellor at this stage can create feelings of confusion and rejection, which may ultimately lead to the client abandoning counselling.

Yet not all clients are naïve about counselling and some may shop around. Initial experiences will then be contrasted to previous professional and non-professional help, until they find someone who meets their personal needs (France, 1988). Maluccio (1979, p.131), for example, found clients who referred to their counsellor as ‘*like a mother*’ and ‘*like a good friend*’; Timms and Blampied (1985) employ the phrase ‘*formal friend*’ to capture the views of those clients they interviewed.

It would appear that the key factor in the development of an effective relationship is the counsellor’s non-judgemental acknowledgement of the clients’ feelings. A participant in the study by Mayer and Timms (1970, p.84) said ‘*I sort of felt, well, somebody understands, and they’re interested, and they want to help, and they don’t think it is silly*’. Kline *et al.* (1974) confirm in their study of former psychotherapy clients

that accurate insight and the perceived interest of the therapist are the most important ingredients for effective practice. Accordingly, a major source of client dissatisfaction is the failure of the therapist to understand what the client is feeling (Lietaer & Neirinck, 1987). Consumers tell us that it is vital that they believe that the professional helper understands what they are going through.

## **The experience of counselling**

For many clients counselling represents a time of self-reflection. Using IPR interviews Rennie (1984, 1985, 1987) showed clients to be aware of clear themes in what they disclosed, and to have a clear sense of direction. Clients used their narrative to deal with feelings of residual tension, to re-enter difficult areas of feeling and to encourage a wider network of thoughts and images. McLeod (1990) notes that while the counsellor hears the story the client experience something more complex. Counselling can be for the client an emotional roller coaster. Clients at this time typically experience high levels of anxiety (Orlinsky & Howard, 1986), of 'feeling dismantled' (Hunt, 1985), of a 'trip through Hell' (Fitts, 1965). But not all is negative. Clients may also experience a feeling of relief (Mayer & Timms, 1970). The opportunity to talk heads the list of what clients find most helpful (Feifel & Eells, 1963), as long as it is to someone who listens (Howe, 1993). The counselling process is of exploration, discovery and change, in which clients may grow in confidence (Orlinsky & Howard, 1986), and experience feelings of pride (Fitts, 1965).

It is now generally accepted that the relationship between client and counsellor is the potent factor in ensuring effective therapy (Clarkson, 1996). And it is becoming evident from studies of the client view that the attitude and personal characteristics of the therapist are crucial to the development of such a relationship. Maluccio (1979) reports that the greater client-counsellor congruence, in terms of age, gender and social status, the greater client satisfaction. Therapists may not want to acknowledge that contextual variables can exert such important effects, yet Llewelyn and Hume (1979) confirm that clients attribute success more to such non-specific factors than

to any techniques that are employed. In the same vein Kaschkak (1978) found that clients attributed change to such intangibles as 'just having someone to talk to' or a 'non-judgemental attitude'; in contrast counsellors were more likely to attribute change to specific techniques, supportiveness and the use of confrontation.

While therapists are paying attention to their clients, clients are paying attention to their therapists! Rennie (1994) describes the ways in which clients defer to their counsellors, keeping quiet when the counsellor has misunderstood or said something not helpful, and notes that consumers in his study were reluctant 'to disclose their disenchantment with the therapist' (Rennie, 1994, p.15). The client can therefore withdraw somewhat and withhold vital information. Lists of what clients find helpful include hope, talking to an understanding and interested person, encouragement and awareness (Murphy *et al.*, 1984). The favoured counsellor characteristics are warmth, and being calm and objective (Oldfield, 1983), with warmth probably the most potent (Dinnage, 1989). Clients want to speak to a real person not a 'technical junky' (Howe, 1993, p.24). Success thus depends on how the therapist is viewed. Clients seek evidence of truthfulness and honesty (Strupp *et al.*, 1969). Where honesty and openness are lacking clients become suspicious (Merrington & Cordon, 1981). Clients look for support but what seems valued most is 'insight' (Oldfield, 1983) – 'the transformation of what seemed to be mysterious and mystifying symptoms into phenomena with explainable antecedents' (Strupp *et al.*, 1969, p.121). Insight and understanding are rated higher by clients than behavioural change or symptom reduction (Dinnage, 1989).

Factors that clients find unhelpful include lack of advice (Oldfield, 1983); lack of counsellor participation (Howe, 1993); the use of silence (France, 1988); a lack of warmth and understanding (Oldfield, 1983); non-acceptance and a negative attitude; talking superficially; challenging too much (or not enough); counsellors pursuing their own agenda, or making comments that are inappropriate (Lietaer & Neirinck, 1987). Finally, it is evident that practitioners should not under-

estimate the power of their profession, the strength of feelings they engender, or the dependency that their clients have upon them (Dinnage, 1989).

## Endings

There is surprisingly little research on endings in therapy, and consequently little from the client perspective. The therapeutic relationship is probably the only close relationship a person enters into with the clear aim that it should end. It is not surprising then that endings can be more difficult than beginnings. Clients may find ending a traumatic experience in itself – like losing a lifelong friend (Maluccio, 1979). Hunt (1985) distinguished between clients motivated by the ‘pull of hope’, and those by the ‘push of discomfort’. Some endings are thus precipitated by loss of hope, while those, whose discomfort led them to seek help, tended to end up feeling better, and to have taken part in planned endings. Hunt found that a number of clients were surprised at the end point, feeling that there was unfinished business, and a minority were angry, and felt let-down by their counsellor. It would appear that the more effective therapy has been for the client the more important the ending (Maluccio, 1979), not least because to stop something which is deemed useless is to lose nothing. Considering how important an ending is to the perceived success of any therapeutic process, it is surprising that ‘endings’ have not received more research attention.

## Conclusions

Practitioners may be surprised at some of the views clients express. For clients seem to have little regard to theory or technique, but do recognise the importance of the person who is the therapist, and the relationship they have with them. In this clients endorse the view that it is the relationship rather than a particular way-of-working which carries therapeutic gain. Clients value talking to someone who is warm and listens in a non-judgemental manner. It is interesting to observe that despite differences in research methods and theoretical positions, that the client viewpoint has remained amazingly consistent from the 1950s to the present day. More reason to listen to them!

## References

- Allen, L. (1990). A client's experience of failure. In D. Mearns & W. Dryden (Eds.), *Experiences of counselling in action*. London: Sage.
- Axline, V. (1950). Play Therapy Experiences as Described by Child Participants. *Journal of Consulting Psychology*, 14, 53–63.
- Beck, D.F. & Jones, M.A. (1973). *Progress on family problems: A nationwide study of clients' and counsellors' views on family agency services*. Family Services Association of America.
- Berger, P.L. (1963). *Invitation to sociology: A humanistic perspective*. Doubleday & Co.
- Brannen, J. & Collard, J. (1982). *Marriage in trouble: The process of seeking help*. London: Tavistock.
- Cantley, C. (1987). *Coventry Mental Health Crisis Intervention Team: The views of clients and their families*. Birmingham: Social Administration Dept., University of Birmingham.
- Clarkson, P. (1996). The Eclectic and Integrative Paradigm: Between the Scylla of Confluence and the Charybdis of Confusion. In R. Woolfe & W. Dryden (Eds.), *Handbook of counselling psychology*. London: Sage.
- Dinnage, R. (1989). *One to one: Experiences of psychotherapy*. London: Penguin.
- Elliott, M.S. (2000). *The Client, Counsellor and Organisation: Components of an External Workplace Counselling Service. An Evaluation*. Unpublished doctoral thesis. University of Hull.
- Elliott, R. (1986). Interpersonal Process Recall (IPR) as a psychotherapy process research method. In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*. New York: Guilford Press.
- Feifel, H. & Eells, J. (1963). Patients and Therapists Assess the Same Psychotherapy. *Journal of Consulting Psychology*, 27 (4), 310–318.
- Fitts, W.H. (1965). *The experience of psychotherapy: What it is like for client and therapist*. Princeton, NJ: Van Nostrand Reinhold.
- France, A. (1988). *Consuming psychotherapy*. London: Free Association Books.
- Gaunt, S. (1985). *The first interview in marriage guidance*. Rugby: National Marriage Guidance Council.
- Gurman, A.S. (1973). The effects and effectiveness of marital therapy: A review of outcome research. *Family Process*, 12 (2).
- Howe, D. (1989). *The consumers' view of family therapy*. Aldershot: Gower.
- Howe, D. (1993). *On being a client. Understanding the process of counselling and psychotherapy*. London: Sage.
- Howe, D. & Hinings, D. (1989). *Adoptees and their families: The Post-Adoption Centre, First Three Years. Research Report No.2*. Norwich: University of East Anglia.
- Hunt, P. (1985). *Clients' responses to marriage counselling*. Rugby: The National Marriage Guidance Council.

- Kaschkak, E. (1978). Therapist and client: Two views of the process and outcome of psychotherapy. *Professional Psychologist*, 9 (May), 271–277.
- Kline, F., Adrian, A. & Spevak, M. (1974). Patients evaluate therapists. *Archives of General Psychiatry*, 31 (1), 113–116.
- Lietaer, G. & Neirinck, M. (1987). Non-helping and hindering processes in experiential psychotherapy: A content analysis of post-session comments. In W. Huber (Ed.), *Progress in psychotherapy research*. Louvain-la-Neuve: Presses Universitaires de Louvain.
- Lipkin, S. (1954). Clients' Feelings and Attitudes in Relation to the Outcome of Client-Centered Therapy. *Psychological Monographs: General and Applied*, 68 (1), Whole Number 372.
- Llewelyn, S.P. & Hume, W.I. (1979). The Patient's view of therapy. *British Journal of Medical Psychology*, 12, 137–146.
- Maluccio, A. (1979). *Learning from clients: Interpersonal helping as viewed by clients and social workers*. New York: The Free Press.
- Markova, I., Forbes, C. & Inwood, M. (1984). The Consumers' Views of Genetic Counselling of Haemophilia. *American Journal of Medical Genetics*, 17, 741–752.
- Mayer, J. & Timms, N. (1970). *The client speaks: Working-class impressions of casework*. London: Routledge and Kegan Paul.
- McLeod, J. (1990). The client's experience of counselling and psychotherapy: A review of the research literature. In D. Mearns & W. Dryden (Eds.), *Experiences of counselling in action*. London: Sage.
- Merrington, D. & Corden, J. (1981). Families' impressions of family therapy. *Journal of Family Therapy*, 3, 243–261.
- Murphy, P., Cramer, D. & Lillie, F. (1984). The Relationship between Curative Factors Perceived by Patients in Psychotherapy and Treatment Outcome: An Exploratory Study. *British Journal of Medical Psychology*, 57, 187–192.
- Oldfield, S. (1983). *The counselling relationship: A study of the client's experience*. London: Routledge and Kegan Paul.
- Orlinsky, D.E. & Howard, K.I. (1986). Process and outcome in psychotherapy. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change* (3rd ed.). New York: Wiley.
- Phillimore, P. (1981). *Families speaking: A study of 51 families' views of social work*. London: Family Service Unit.
- Rennie, D.L. (1984). *Clients' Tape-Assisted Recall of Psychotherapy: A Qualitative Analysis*. Paper presented at the Canadian Psychological Association, Ottawa, 31 May.
- Rennie, D.L. (1985). *Client deference in the psychotherapy relationship*. Paper presented at the 16th Annual Meeting of the Society for Psychotherapy Research, Evanston, Illinois, 19 June.
- Rennie, D.L. (1987). *A Model of the Client's Experience of Psychotherapy*. Paper presented at the Sixth Annual International Human Science Conference, Ottawa, 31 May.
- Rennie, D.L. (1990). Towards a representation of the client's experience of the psychotherapy hour. In G. Lietaer, J. Rombauts & R. Van Balen (Eds.), *Client-centered and experimental therapy in the nineties*. Leuven: University of Leuven Press.
- Rennie, D.L. (1992). Qualitative analysis of the client's experience of psychotherapy: the unfolding of reflexivity. In S.G. Toukmonian & D.L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches*. London: Sage.
- Rennie, D.L. (1994). Clients' deference in psychotherapy. *Journal of Counselling Psychology*, 41, 427–437.
- Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.
- Sainsbury, E. (1975). *Social work with families: Perceptions of social casework among clients of a family service unit*. London: Routledge and Kegan Paul.
- Spinelli, E. (1994). *Demystifying therapy*. London: Constable.
- Strupp, H., Fox, R. & Lessler, K. (1969). *Patients view their psychotherapy*. Baltimore: John Hopkins Press.
- Strupp, H., Wallach, M. & Wogan, M. (1964). Psychotherapy Experience In Retrospect: Questionnaire Survey of Former Patients and their Therapists. *Psychological Monographs: General and Applied*, 78 (11), 588.
- Timms, N. & Blampied, A. (1985). *Intervention in marriage: The experience of counsellors and their clients*. University of Sheffield: Joint Unit for Social Services Research.
- Williams D.I. (1994). Who (and what) is counselling for? *Counselling News*, 13, 3–4.

## Correspondence

M.S.Elliott & D.I.Williams

Department of Psychology,  
University of Hull,  
Hull HU6 7RX.



in association with Centre for Stress Management

**CERTIFICATE IN COACHING**  
**7-12 April; 28 July - 2 August**

**AIM**

This six-day Programme provides delegates with an underlying philosophy of Coaching together with a range of practical skills required to be able to undertake Coaching with individuals.

**KEY OBJECTIVES**

During the six-day Programme delegates will:

- Be able to define coaching
- Understand the difference between coaching and counselling
- Become knowledgeable about types of clients and their problems
- Understand the concept of the life audit and how to structure initial meetings
- Develop and have an opportunity to practise a range of relevant skills
- Become proficient in using a coaching assessment form
- Explore four learning styles and relate these to the learning cycle
- Explore and resolve difficulties impeding goal attainment
- Understand the importance of keeping a time log to improve time keeping
- Troubleshoot obstacles to action plan implementation

**COURSE CO-DIRECTORS**

Gladeana McMahon, author of *Confidence Works - Learn how to be your own life coach*

Michael Neenan, co-author of *Life Coaching - A Cognitive-Behavioural Approach*

Professor Stephen Palmer, co-author of *Dealing with People Problems at Work*

**PRIMARY CERTIFICATE IN COACHING FOR CONFIDENCE: 17-18 March**

**PRIMARY CERTIFICATE IN PERFORMANCE COACHING: 19-20 February, 14-15 May**

**CERTIFICATE IN PSYCHOLOGICAL COACHING: 8-12 September**

**OTHER COURSES**

Certificate in Stress Management and Performance Coaching (modular)

Primary Certificate in Coaching for Resilience

Certificated Correspondence Course in Life Coaching: A Cognitive-Behavioural Approach

**DIPLOMA COURSES (modular programmes)**

Diploma in Coaching

Diploma in Psychological Coaching

*COURSES HELD IN LONDON*

Prof. Stephen Palmer, PhD, C Psychol, Centre for Coaching, 156 Westcombe Hill, London SE3 7DH

Course Details and Application form: Tel 0208 297 5656 leaving name and address on 24 hr answer phone

Course admin: Tel 020 8318 5653; Fax 020 8297 5656 Website: [www.centreforcoaching.com](http://www.centreforcoaching.com)  
Email: [admin@centreforcoaching.com](mailto:admin@centreforcoaching.com)

Course recognized by Association for Coaching (see their website at [www.associationforcoaching.com](http://www.associationforcoaching.com))



## **Psychological Approaches to Dermatology**

Linda Papadopoulos & Robert Bor

London: BPS Books, 1999. ISBN: 1-85433-292-9. 176pp. £14.95.

The publishers and the authors, together with the advice of a dermatologist, Professor John Hawk, have tried to make what might at first sight appear to be a backwater subject, a forefront issue for the counsellor, clinical or counselling psychologist. From the outset the authors emphasise the importance of the subject and show its unfairly neglected status within the medical field. They use epidemiological perspectives to show that quite a number of patients are beset with skin conditions at any one juncture and, also, that such cases are not merely confined to a sort of chronic club; skin troubles can come to all.

The book explains how the various conditions can affect people. The authors do this in a cleverly progressive way throughout the book, moving through the process by which a patient may learn of their condition and what they can expect to happen to them. With skin conditions what can happen can be bad news. Particularly informative are the descriptions of the various conditions that can afflict us. Even better is the modelling which the authors use to explain the effects on people of the different types of ailment. The relationship between mind and the skin is interestingly sketched. Incidentally, for the reader who is unaware of skin complaints, this text offers a mini handbook on the subject. There are many tables and text boxes with various ways of reflecting the diseases such as 'common myths about...' These devices help to make it interesting to read the necessary detail to understand the nature of eczema, psoriasis, vitiligo, atopic dermatitis, acne, port wine stains and melanoma – some of the more common conditions. However, in equal measure there are skin conditions caused by the activity of the person – usually this takes the form of scratching and the authors describe the mental and delusional states which give rise to this phenomenon.

Skin troubles cause problems with the most fundamental aspects of being human. The first half of the book is a progressive awareness-raising read about this area. For example, the issue of bullying is raised in the children's section, making the reader more alert to the implications of skin complaints.

The second half of the book turns its attention to counselling and it starts mildly with an introduction to counselling skills. This is very compact and would be excellent value for those in the medical professions although the counselling psychologist might feel that this was a chapter to be missed. There is then a progression to 'Advanced Counselling Skills for Dermatology'. Largely speaking, this chapter focuses upon cognitive-behavioural approaches to coping and follows a pathway that every counselling psychologist would recognise. Chapters following this specialise a little more precisely – for example, 'Counselling for Psychosomatic Problems' receives a chapter of its own. Considerations of children and families receive separate treatment. It is uncertain to whom the contents of these pages are addressed. I found useful guidelines as a counselling reader but one might wonder how a medical specialist in a nursing or a consulting role for those with dermatological conditions would receive the guidelines. Perhaps the lists of 'shoulds' might not always meet with the requisite patience. Nevertheless, the issue of interdisciplinary teams and the place of the counsellor amongst the personnel in this field receives an informative and useful discussion. The appendices include scales for rating such matters as quality of life, impact scales for family activity and a listing of organisations who offer help, support and advice.

This is a book which raises awareness and informs. The counselling psychologist who reads it will certainly have a wider appreciation of the issues which are raised for the patient with a skin condition. The practitioner will also have a variety of modelling tools with which to make their own formulations whilst at the same receiving adequate protocol advice for procedures in response to the expected reactions that patients may have. The mechanism of skin reac-

tions and the connections to the whole person may not stick so easily in the mind of the counselling psychologist and the book can also serve as reference material for all those necessary but hard to remember facts about skin disease. This book would sit well in the library of a Medical Practice. Psychologists, doctors and nurses could all learn from it. That is a challenge few texts are able to meet as well as this one.

Dennis Bury

---

## Handbook of Individual Therapy

Windy Dryden (Ed.)

Sage, 2002. 496pp. Paperback. £21.99.

Interest in the various forms of psychological therapies has never been greater than at the present time. Talks, debates, and conference/research presentations all focus around the many different forms of therapy. Most of these talks, debates, and presentations will have been forgotten, however, the *Handbook of Individual Therapy* (fourth edition) has managed to capture the essence of all major therapeutic approaches within its covers.

The book, written by leading professionals in the field, successfully draws the reader to delve through the 16 chapters – each chapter providing an in-depth look at the various therapeutic approaches without becoming overbearing.

The first chapter of the book captures the readers' attention by providing an overview of the cultural context of British psychotherapy. The subsequent chapters successfully introduce various therapeutic approaches by focusing on: historical overviews (e.g. general historical context, and the

development in Britain); theoretical assumptions underpinning the approaches (e.g. case conceptualisation, and acquisition of psychological disturbance); practice and application of therapy (e.g. goals and strategies); and a case example. Following the same structure, interesting comparisons can be drawn across the therapeutic approaches, together with the application of therapy-specific terminology.

Chapter 15 brings together the different therapeutic approaches by discussing specific research findings and at the same time highlighting the long-standing gap between practice and research. The final chapter discusses the training and supervision of individual therapists, by drawing attention to important issues that may arise in each form of therapy. The book further provides the reader with information on how to find a therapist, together with useful addresses, as well as recommended reading suggestions for each therapeutic approach.

The format of the book makes it easy to digest, each chapter being written by leading experts in their particular form of therapy, such as, Alessandra Lemma; Ann Casement; Brain Thorne and Stirling Moorey.

Overall, the *Handbook of Individual Therapy* makes for a very satisfying and compelling account of the various forms of therapy. In fact, the primary strength of this book may come from its combined attributes. It is a well-written, comprehensive core textbook that can be recommended not only to counselling psychology and psychotherapy trainees, to guide them through their training, but also to practising professionals to act as a reference textbook to draw upon when needed.

Stefania Grbic

---

*All book reviews and correspondence regarding book reviews should be sent to Kasia Szymanska, Book Reviews Editor, CPR, Centre for Stress Management, 156 Westcombe Hill, London, SE3 7DH.*

# Newsletter Section

## LETTER FROM THE CHAIR

### **Are (some of) the Divisions past their sell-by date?**

Counselling psychologists have spent some considerable time grappling with such questions as 'who are we?', 'what do we do?' and 'how do we differ from other Divisions?'

This was an important stage in negotiating and establishing our professional identity, particularly in the formative years of the Division of Counselling Psychology. This has been followed by a period of consolidation, manifested in such documents as the 'Chartered Counselling Psychologists' Training and Areas of Competence' and the information about Counselling Psychology posted on the Website under the heading 'About Counselling Psychology'. In line with this development of Counselling Psychology into a more mature discipline and profession, the Division is now carrying out a major revision of the Syllabus for Training, in consultation with the Board of Examiners for the independent training route and with the Training Committee (which is involved in accrediting courses in Counselling Psychology).

Should we now, perhaps, be starting to look outside the immediate horizons of our Division? If we consider the Divisions of Clinical, Health and Counselling Psychology, it is clear that each has its own specific knowledge base, and its own individual area of professional expertise. Theoretical orientations and philosophies may also differ, but may perhaps overlap. Yet many counselling, clinical and possibly health psychologists can find themselves working with similar populations with similar symptoms, and addressing similar sorts of problems, difficulties or issues with their clients, often in similar contexts. Perhaps the time has come to look at commonalities, with the view to sharing, rather than preserving, our own specific identities.

In my first Chair's letter, I wrote about how Counselling Psychology had played an important part in influencing professional applied psychology. I believe we have now established ourselves in this field and that the next task should be using our position to engage in open debate with our colleagues from other Divisions and to explore a way forward, in order to provide the best possible service to our clients. Clearly this will have implications for training, funding of training, employment and the provision of services. Is it not time for a re-think, not just about counselling psychology, but about the future of professional applied psychology as a whole?

Answers on a post-card please – or alternatively you can e-mail me your views on [jilldwilkinson@freenet.co.uk](mailto:jilldwilkinson@freenet.co.uk)

*Jill D. Wilkinson, Chair, Division of Counselling Psychology.*

## DIVISION NEWS

### News from the Division Committee

The Division Committee met on 25 November 2002. This is where the 'business' of the Division takes place which includes a considerable amount of liaison work with various committees/boards both internal to the Society, such as The Standing Committee for Psychologists in Health and Social Care and external, such as the Royal College of Psychiatry Psychotherapy Liaison Group.

The Agenda this time included:

- **The re-writing of the Division Rules** to allow for the setting up of Special Interest Groups and the formation of Branches;
- **Funding** – Pam James the current Past Chair reported on meetings she had attended with relevant government ministers and the union AMICUS. Hopefully we are moving closer to negotiating funding for counselling psychology training;
- **Report from the Syllabus Working Group**, members of which have been invited to the next Division Committee meeting on 25 January 2003.

Finally, in May, there will be a number of vacancies on the Division Committee (see below). The Committee is a great way to contribute to, and influence, counselling psychology; to meet and share ideas with colleagues and it can also provide extremely valuable source of Continuing Professional Development.

### Annual General Meeting of the Division

This will take place during the Annual Conference in May in Stratford-upon-Avon. Nominations are requested for Chair-Elect, Treasurer and Secretary, and for ordinary committee members. Full details and nomination forms are available from the BPS.

### New contact details for the Registrar

The Registrar of the Division of Counselling Psychology, Alan Frankland, can now be contacted by telephone on 0115 969 3027, by fax on 0115 969 3028, and by e-mail at [Dcop.Registrar@btopenworld.com](mailto:Dcop.Registrar@btopenworld.com)

### Co-options to the Division Committee

Representatives from the groups of Counselling Psychologists in Scotland and Wales have now been co-opted onto the Division Committee. They are Peter Ronald (Scotland) and Amanda Hall (Wales).

### New Website

The Wales Network of Counselling Psychologists (WNCOP) now has a website. This can be accessed via <http://www.bps.org.uk/sub-syst/dcop/networks.cfm>

### Proposal for a Trainee Column in CPR

Firstly, let me introduce myself to those who don't yet know me. My name is **Sally Greenfield** and I am the Independent Route Trainee Representative on the Division's Committee.

Both myself and Qulsoom Inayat, the Course Route Representative, have been approached by the editor of *CPR* offering trainees a new regular column. This is a wonderful opportunity for counselling psychologists in-training to have their voices heard, and to promote inquiry and discussion in a new forum. I know there are many issues debated amongst trainees informally and the DCoP internet group is one place where this can happen. However, this is your opportunity to be in print and I would encourage you all, whatever your stage in training, whether course or independent, to send your written contributions to myself or Qulsoom via the DCoP Committee and the BPS address or you can e-mail me at [sgreenfield@orange.net](mailto:sgreenfield@orange.net)

Please do use this opportunity and I look forward to receiving your column contributions in the near future.

## Prize for Trainee Counselling Psychologists

The Division of Counselling Psychology invites submissions for this annual award.

1. Contributors should be enrolled on either an accredited course in Counselling Psychology or on the BPS Diploma in Counselling Psychology (the 'Independent Route'). Those who have completed their training through these routes within the last six months may also apply.
2. Work submitted should have been undertaken either as part of the formal training or as part of related professional development during training. It should not exceed 5000 words.
3. Invited submissions might include: examples of professional practice such as client studies or process reports; reflections about a particular client group; literature reviews; academic essays or research reports.
4. Contributors should provide a brief statement to confirm their status as an enrolled trainee. This should be from either a Course Tutor or Co-ordinator of Training.
5. Where appropriate, the winning paper(s) will be published in *CPR*.

Closing date: **30 September 2003**. All applications should be made to the Hon. Sec., DCoP, at the BPS. The award winner will be announced at the AGM at the Conference in May 2004.

## 2003 European Year of Disabled People

The Standing Committee for the Promotion of Equal Opportunities (SCPEO) will be arranging a number of events and initiatives during the forthcoming European Year of Disabled People, 2003.

We shall be exploring all aspects of psychology, disability and equality:

- Preparing for new and pending legislation regarding disability and its impact on professional practice, research and education in psychology;
- Exploring aspects of working as a psychologist with a disability;
- Access to careers in psychology for people with a disability;
- Psychological provision for disabled people;
- Exploration of theoretical concepts on the psychology of disability;
- Current research conducted by psychologists into aspects of disability.

I would be very pleased to hear from you if you have an interest in any of these areas – or any other aspects not mentioned above – and would like to contribute to a possible special issue of *The Psychologist* and/or participate in a symposium at the Annual Conference. Please do get in touch if you would like to discuss this further, either directly or via Felicity Hector in the Society's Leicester Offices, telephone; 0116 252 9507, or e-mail felhec@bps.org.uk.

**Pat Frankish**, *Chair Standing Committee for the Promotion of Equal Opportunities*.

## National Assessors Guidance Document

*Recruitment and Selection to Senior and Consultant Psychologist Posts in Health and Social Care*

The long-awaited National Assessors guidance document is now available. The document consists of three sections:

1. Guidance to Psychology Managers
2. Guidance on the use of National Assessors
3. Appendices (Department of Health Circulars, extracts from Advance Letters, sample job descriptions, etc.)

Hard copies are to be circulated to all National Assessors, Clinical Psychology Doctorate Training Courses, Psychology Service Managers, and Trust HR Directors. If you would like a hard copy, please contact the Society's Subsystems Services (e-mail: [subsystems@bps.org.uk](mailto:subsystems@bps.org.uk), tel: 0116 254 9568). Alternatively, the document is available to download from the BPS website at <http://www.bps.org.uk/documents/Rep16.pdf>.

**BRITISH PSYCHOLOGICAL SOCIETY  
DIVISION OF COUNSELLING PSYCHOLOGY  
STATEMENT OF INTEREST IN VACANCIES ON COMMITTEES  
AND WORKING PARTIES**

From time to time, committees and working parties are looking for people to nominate for election or to co-opt to membership. Some posts are representative of a particular group, some posts require particular expertise or interests. In order to promote openness, the widest possible participation and equality of opportunity, the Divisional Committee invites expressions of interest from any Accredited, General, Affiliate or trainee members. (Trainees are needed from both course and independent routes). Individuals may also nominate themselves directly for election to the Divisional Committee or for posts such as the Editor of *Counselling Psychology Review*, when there are vacancies.

**WHAT ARE THE DIVISION OF COUNSELLING PSYCHOLOGY (DCoP) COMMITTEES AND WORKING GROUPS?**

- Division Committee (DC)
- Training Committee (TC)
- Board of Examiners (BoE)
- Sub-committee for Conference (5CC)
- Sub-committee for Practice and Research (SCPR)
- Public Relations (PR)
- Continuing Professional Development (C PD)

**HOW TO APPLY**

Please complete the section below and send to: The Honorary Secretary of the Division of Counselling Psychology, The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, together with a letter indicating your desire to serve, specifying in what area, whom you could represent and any special expertise or experience you have to offer. A willingness to learn, together with energy and enthusiasm, are particularly welcomed. CVs are not required.

Name .....

Address .....

.....

Tel. No: Home..... Work..... Fax.....

E-mail: .....

If you would like to discuss your application first please contact one of the committee members listed in *Counselling Psychology Review*.

---

# DRAFT MENTAL HEALTH BILL: BRIEFING FOR COUNSELLING PSYCHOLOGISTS

Susan Van Scoyoc

## Introduction

The Government published the draft Mental Health Bill on 25 June 2002. It is a long Bill covering a number of complex issues. This paper sets out some of the key points, and lets you know how to get involved in campaigning.

The Society has commented on the Mental Health Bill directly to the Government and also through our membership of the Mental Health Alliance. The Alliance is a coalition of over 50 organisations working together to respond to the Government's proposals. The Alliance's immediate reaction to the draft Bill was serious concern about the proposals for the reasons set out below.

It is important to remember that this is only a draft and can be influenced and changed. To become law the Bill will have to be passed by parliament. This would then have to be followed by the training of all the professionals involved in the new system. Only then could the new compulsory powers be used. It is unlikely to be in force before 2004 (probably later).

## General concerns about the proposals

The proposed Act could lead to an increase in the number of people subject to compulsory treatment. The Government has said that the aim of the new Act should be to reduce the numbers of people subject to compulsory powers. However, under the new proposals, compulsory treatment will be carried out and allowed in the community. This means it will no longer be necessary to find a hospital place. Thus the natural limit to how many people may be compulsorily detained at any one time will no longer exist. Without very strict criteria defining who can be subject to compulsory powers this could lead to an increase in the numbers who can be compulsorily treated. The Alliance is extremely disappointed to see that the criteria for compulsion have not been tightened. The proposed criteria are:

- That the person is suffering from a mental disorder.
- That the mental disorder warrants the provision of medical treatment from an approved clinician.
- That the treatment is necessary for the health or safety of the patient or the protection of others
- That the treatment cannot be provided without using the Act, (unless the person is at substantial risk of causing serious harm to another person).
- That appropriate medical treatment is available.

The definition of mental disorder is also wider than under the 1983 Act. It contains none of the exclusions (e.g. immoral conduct, sexual deviancy, dependence on alcohol and drugs) covered in the current Act.

## Requirement to provide treatment

Under the current Act, to detain a person for compulsory treatment, *there must be treatment available which will alleviate their condition*. The draft Bill removes this requirement. Whilst there is a requirement that treatment is available, there is no requirement for the treatment to be of therapeutic benefit to the patient. The definition of 'treatment' is very broad and includes 'care' and 'training in work, social and independent living skills'. This could mean people being forced to receive 'treatment' which will not be of therapeutic benefit to them. Under the proposed Bill treatment can be provided in order to protect from danger to others, *even where it will not benefit the patient*.

**The Alliance believes that the Mental Health Act should be about providing treatment for people's mental health problems. Public safety should not be dealt with in a health Bill. Public**

safety is a criminal justice matter. The Society suggests an Incapacity Act plus a Criminal Justice Act rather than attempting to cover 'incapacity' and 'dangerousness' in one Bill.

## Treatment in prison

The draft Bill includes powers to compulsorily treat people in prison. The current Act requires people to be transferred to hospital before they can be treated against their wishes.

## Positive aspects to the Bill

Whilst Mind and the Alliance have major concerns about the draft Bill there are some positive measures including:

- Compulsion beyond 28 days has to be authorised by a new Mental Health Tribunal. Patients with long term incapacity (sometimes known as 'Bournewood gap patients') will have new safeguards.
- People can choose their own nominated persons as representatives unless the person they choose is (a) disqualified by regulations, (b) incapable through illness, (c) 'unfit to perform duties'.
- There will be a duty on Ministers to provide sufficient advocates to meet 'all reasonable requirements'.

## Concerns for Counselling Psychologists

Main points made by the Society:

- The draft Bill attempts to protect vulnerable people and to protect society from people whose mental disorder renders them dangerous. But a Mental Health Act cannot protect members of society from all dangerous individuals – and it should not try to do so.
- The draft Bill reflects a disproportionate emphasis on requirements of risk management rather than protection of vulnerable people.
- The criteria for compulsory care in the draft Bill are far too wide and could lead to a large increase in the use of compulsory powers.
- The criteria for compulsion under the draft Bill should be tightened considerably and in keeping with a 'capacity' stance. The criteria should include the provision that 'the mental disorder is of a nature or severity so as to impair the individuals' judgement to the extent that the individual is incapable of making valid decisions about health care.' Such a criteria should be operationally defined in a Code of Practice in a similar manner to the Scottish Incapacity Act.
- The current exclusions (e.g. immoral conduct, sexual deviancy, dependence on alcohol and drugs) to the broad definition of mental disorder under the 1983 Act should be reinstated. The criteria that should govern the application of compulsory powers should closely echo the wording of the Scottish Incapacity Act.
- A compulsory care plan should only be sanctioned for prisoners and persons before the courts if they meet the same criteria as 'ordinary' persons.
- That psychosurgery and ECT should be proscribed.
- That polypharmacy (prescribing more than one example of any class of medication), hyperprescription (prescribing above BNF recommended levels) and forcible feeding can only be sanctioned if specifically approved by a Mental Health Tribunal.
- That Chartered Psychologists with demonstrable competence can take Clinical Supervisor responsibilities and that the Government support the principle and financial requirements for the necessary training.

There are many other points being made but these give a flavour of the British Psychological Society response.

## How to be involved

The British Psychological Society and the Mental Health Alliance have been organising a range of activities. MIND are active in this field so watch their website <http://www.mind.org.uk>. To be kept informed watch for more details on the Society's website or e-mail Dr. Alan Bellamy, the DCoP representative on the BPS Working Party, at [alan@7thomas.freemove.co.uk](mailto:alan@7thomas.freemove.co.uk)

You can find the full text of the Bill and the consultation on the Department of Health website <http://www.doh.gov.uk/mentalhealth/draftbill2002/index.htm>

### *Postscript*

Since the above was written, members of the Society's Working Party have met with officials at the Department of Health and with Professor Louis Appleby, the National Director for Mental Health, to discuss the recommendations made by the working party for changes to the draft Bill. These recommendations had been formally submitted to the Department of Health on 16 September 2002.

The impression gained from these meetings was that some changes would be made to the Bill, and that the Government and the Department held a positive view of the involvement of the Society in these policy consultations.

---

## CORRESPONDENCE

Dear Editor,

My impression is that trainees on the Course Route have difficulty in understanding the diversity in the courses offered by different institutions. The likelihood that such diversity represents the unique ethos of these institutions is acknowledged. However, there needs to be some attempt to rationale these institutional differences in a manner that is transparent both for trainees and for those institutions that offer placements to trainees. Such an exercise would enable both parties to clarify the degree and type of competence required at each stage of the Programme.

As the representative for trainees on the Course Route, I would be interested in the opinions and experiences of trainees at different institutions. Suggestions for improvement are also welcome.

*Qulsoom Inayat, Representative for trainees on the Course Route, 6 Arlington Road, Woodford Green, Essex IG8 9DE. E-mail: Q.J.Inayat@gre.ac.uk*

---

Dear Editor,

I am a Counselling Psychologist (In Training) preparing my dissertation for Part 2 of my training on the Independent Route. I am exploring the use of Mindfulness-based Cognitive Therapy with older adults (65-years-old plus) who have a history of recurrent depression. I am interested in hearing from Counselling Psychologists who have experience of using mindfulness and/or meditation in their clinical practice.

I hope to identify sources of information/literature relevant to Counselling Psychology and the use of meditation in clinical practice and to perhaps strike up a dialogue with practitioners who have some knowledge or experience in this area.

Might it be possible to publish this letter in an issue of the *Counselling Psychology Review*, along with my home and e-mail address (lisa@ndaz.fsnet.co.uk).

*Lisa Graham, 3 Willow Tree Gardens, Thomton-Cleveleys, Lancashire FY5 5JT.*

---

Dear Editor,

I am a researcher carrying out some research on counselling. The aim is to better understand how, why and when counselling is successful. I am particularly interested in exploring those issues and areas that are of concern for counsellors as they carry out their counselling practice. The research is feminist in perspective and will explore issues of gender, power and sexuality as they arise in the context of counselling. If you know someone who would be willing to share recordings of teaching, supervision or actual counselling sessions (either by telephone or face-to-face) please get in touch with **Rebecca Shaw, Department of Sociology, University of York, YO10 5DD.** Tel: 01904 412730. E-mail: rls5@york.ac.uk

---

**CONFERENCE DIARY**

Format of events listed is:

**date: event**

*venue*

**contact**

**FEBRUARY 2003****18–22: Biofeedback Foundation of Europe: 7th Annual Meeting, Scientific Programme and Workshops**

*Hospital Gervasutta, Udine, Italy.*

Mark Schwartz, Project Manager

Tel: (1) 514 489 8251 Fax: (1) 514 489 8255

E-mail: [projectmgr@bfe.org](mailto:projectmgr@bfe.org)

Web: [www.bfe.org](http://www.bfe.org)

**MARCH 2003****13–15: The British Psychological Society Annual Conference**

*Bournemouth International Centre, Bournemouth.*

The British Psychological Society Conference

Office, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.

Tel: 0116 252 9555 Fax: 0116 255 7123

E-mail: [conferences@bps.org.uk](mailto:conferences@bps.org.uk)

Web: [www.bps.org.uk](http://www.bps.org.uk)

**20–23: Work, stress and health:****New challenges in a changing workplace**

The Fifth Interdisciplinary Conference on Occupational Stress & Health, convened by APA, NIOSH and the School of Business of Queen's University

*Sheraton Hotel, Toronto, Ontario, Canada.*

Wesley Baker, Conference Co-ordinator, American Psychological Association, Women's Programmes Office, 750 First Street, NE, Washington, DC 20002-4242, USA.

Tel: 202-336-6033 Fax: 202-336-6117

E-mail: [wbaker@apa.org](mailto:wbaker@apa.org)

Web: [www.apa.org/pi/work/niosh5call.html](http://www.apa.org/pi/work/niosh5call.html)

**MAY 2003****16–17: British Association for Counselling and Psychotherapy Annual Research Conference**

*Leicestershire.*

Angela Couchman, Research & Development Officer, British Association for Counselling and Psychotherapy, 1 Regent Place, Rugby, Warwickshire CV2 1 2PJ.

Tel (general): 0870 443 5252

Direct (Angela Couchman): 0870 443 4537

Fax: 0870 443 5161

E-mail: [angela.couchman@bacp.co.uk](mailto:angela.couchman@bacp.co.uk)

Web: [www.bacp.co.uk](http://www.bacp.co.uk)

**16–18: The British Psychological Society Division of Counselling Psychology Annual Conference 2003**

*The Moat House Hotel, Stratford-on-Avon.*

The British Psychological Society Conference Office, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.

Tel: 0116 252 9555 Fax: 0116 255 7123

E-mail: [conferences@bps.org.uk](mailto:conferences@bps.org.uk)

Web: [www.counsellingpsychology.org.uk/conferences.htm](http://www.counsellingpsychology.org.uk/conferences.htm)

**22–23: Second International Conference of the Institute of Health Promotion and Education**

*St. Catherine's Hospice Training Centre, Crawley, Sussex.*

Helen Draper, University Dental Hospital, Higher Cambridge Street, Manchester M15 6FH.

Tel: 0161 275 6610

E-mail: (Professor Anthony Blinkhorn, Hon Sec): [honsec@ihpe.org.uk](mailto:honsec@ihpe.org.uk)

Web: [www.ihpe.org.uk](http://www.ihpe.org.uk)

**22–25: VIII European Conference on Traumatic Stress**

*Berlin, Germany.*

VIII ECOTS Berlin 2003, CPO Hanser Service GmbH, P.O Box 33 03 16, D-14173 Berlin, Germany.

E-mail: [berlin@cpo-hanser.de](mailto:berlin@cpo-hanser.de)

Web: [www.trauma-conference-berlin/de](http://www.trauma-conference-berlin/de)

JULY 2003

**6–11: 8th European Congress of Psychology**

*Vienna, Austria.*

Berufsverband Österreichischer  
Psychologinnen und Psychologen  
Möllwaldplatz 4/4/37, A-1040 Vienna,  
Austria.

E-mail: [info@psycongress.at](mailto:info@psycongress.at)

Web: [www.psycongress.at](http://www.psycongress.at)

**12–16: 6th European Regional Congress of  
the International Association for Cross-  
Cultural Psychology (IACCP)**

*Budapest, Hungary.*

Dr Márta Fülöp, MTA Pszichológiai  
Kutatóintézet, Budapest, Victor Hugo utca  
18–22, Hungary-1132.

E-mail: [fmarta@mtapi.hu](mailto:fmarta@mtapi.hu)

[berkics@mtapi.hu](mailto:berkics@mtapi.hu)

Web: [www.psychology.hu/iaccp](http://www.psychology.hu/iaccp)

Our policy for including events for this diary is that the events should be broadly relevant to our readership and also bring together a range of speakers from different organisations or backgrounds (as opposed to single-speaker workshops, which we do not have the scope to promote).

Please send details of all appropriate conferences to me:

By post: People in Progress Ltd,  
5 Rochester Mansions, Hove,  
East Sussex BN3 2HA.

By fax: 01273 726180.

By e-mail: [wellbeing@pip.co.uk](mailto:wellbeing@pip.co.uk)

I look forward to hearing from you.

**Jennifer Liston-Smith**

## 2003 ANNUAL CONFERENCE STRATFORD-UPON-AVON – 16th to 18th MAY

\*

Invited Speakers:

**DR PETER HEINL**

'SEEING' THE UNCONSCIOUS TRAUMA DR. KATHRYN MANNIX

**DR KATHRYN MANNIX**

THE USE OF COGNITIVE THERAPY IN THE AREA OF PALLIATIVE CARE

**DR MARTIN MILTON**

DOING VIOLENCE TO BEING: CONCERNS FOR COUNSELLING PSYCHOLOGY

**PROFESSOR DAVID RENNIE**

RESEARCH SUPPORTING AND PRACTICE OF EXPERIENTIAL  
PERSON-CENTRED COUNSELLING

\*

For further details about the conference (including programme), invited speakers, etc.,  
see DCoP webpage.

\*

Registration application for workshops and conference is available on the DCoP webpage.

\*

If you have any queries, contact Isabelle Roney, 2003 Conference Organiser  
at [ironey@btopenworld.com](mailto:ironey@btopenworld.com) or the Society's Conference Office.

## PRE-CONFERENCE WORKSHOPS 15th MAY

\*

**DR PETER HEINL**

'SEEING' THE UNCONSCIOUS TRAUMA, EXPLORATION OF EARLY EXPERIENCES THROUGH  
INTUITION AND THE USE OF OBJECTS.

**DR KATH MANNIX**

THE USE OF COGNITIVE THERAPY IN PALLIATIVE CARE  
(SOME THEORY, ROLE PLAY AND REFLECTION)

**PROFESSOR DAVID RENNIE**

RESEARCH SUPPORTING AND PRACTICE OF EXPERIENTIAL  
PERSON-CENTRED COUNSELLING

\*

Certificate of attendance will be provided

\*

Further details about workshops, facilitators are on the DCoP webpage.

\*

Registration application for workshops and conference is available on the DCoP webpage.

\*

If you have any queries, contact Isabelle Roney, 2003 Conference Organiser  
at [ironey@btopenworld.com](mailto:ironey@btopenworld.com) or the Society's Conference Office.

## TALKING POINT

A series of short pieces by invited Counselling Psychologists on subjects of topical interest and debate. Responses to the views expressed in *Talking Point* are welcomed: write to the Editor marking your letter 'for correspondence'.

## COUNSELLING PSYCHOLOGY and DIAGNOSTIC SYSTEMS: DO THEY HAVE A PLACE IN OUR PHILOSOPHY?

Louise Turner-Young

There are a number of issues around the use of Diagnostic Systems and I am only addressing one or two of them here. DSM-IV began I believe with good intentions and it may seem to be useful and appropriate for severe and enduring conditions, however it has over the years grown unnecessarily. The expansion of DSM-IV has led to labelling and categorising quite normal human responses to events as pathological, and implicit in this is that there is some 'weakness' in the individual.

DSM-IV buys into the medical model of the construction of illness; we are surely aware in this third millennium that psychological and emotional distress and in many cases (some would argue all) physical disease/disorder are the product of an interacting system in which the physical-biological component is the least influential and often the *product* of psycho-social stressors.

The PAB working group paper in 1999 'Dangerous People with Severe Personality Disorder', recognises that 'Current risk assessment tools are not sufficiently accurate or sensitive to be used...without the risk of a high rate of people being wrongly diagnosed as personality disordered and dangerous.' (PAB, 1999).

Interpreting an individual's actions and attitudes from a medical model can diminish acceptance of personal responsibility for harmful behaviour which therefore encourages/permits paternalistic 'control' methods of 'treatment'.

The working group suggests that it may be better to view personality disorder from a Disability model. This allows the condition to be seen as originating in arrested or delayed emotional development or a response to a traumatic life event that creates a disorganised personality.

I will stay with Personality Disorder as the peg for my musings here:

There are three defining features of personality disorder:

1. An enduring pattern of personality organisation that deviates significantly from the norms of a culture.

What about sick societies, for example, Nazi Germany or Russian dissidents in the 20th century. Today we have Afghanistan and the Taliban. Are those who fought for freedom personality disordered?

2. Which leads to dysfunction in behaviour, emotional self-regulation and interpersonal relating.

The effects on Afghanistan: women, many of them doctors, lawyers or teachers - imprisoned and refused any education or mental stimulation ending up in 'mental hospitals' rocking and incoherent with grief and shock.

This was the result of them having developed within the cultural norm of freedom and then having a fundamentalist regime take over.

The Taliban were/are the personality disordered from my cultural norm of what is acceptable behaviour.

And what of the effects of multi-cultural societies on individuals acceptance of 'norms' - arranged marriages - in the film 'East is East', the son flees such a marriage - is he then personality disordered and if so was he 'mentally ill' or 'unbalanced'. And when we are rejecting and re-integrating concepts and value systems are we not in a state of mental imbalance, which is normal to the evolution of individuality.

3. The pattern is stable over time, beginning in adolescence or early adulthood, inflexible, resistant to change and pervades many aspects of life.

Is such a stable pattern a disorder? Could it be more usefully perceived as a coping mechanism which when it becomes maladaptive and inappropriate to the situation is in need of challenging/changing/controlling?

The issue of labelling cannot be ignored-it is central to any exploration of the use of diagnostic systems. I do not believe we can rely on the sensitive and appropriate interpretation of certain test results. I have had personal experience of reading a report based on such a test in which the psychologist moved from 'this indicates the presence of...' to 'X is' and 'X has' and 'X will' by the time s/he got to the second page. The psychologist had no dealings with X before or after the test administration.

Whether you feel comfortable using DSM-IV and other diagnostic systems that label an individual's distress may largely depend on your acceptance or not of the following foundational beliefs underpinning psychotherapeutic endeavours as identified by Mahrer (2000).

1. There are mental illnesses, diseases and disorders
2. Appropriate insight and understanding are prerequisites to successful psychotherapy
3. Prediction and explanation of empirical facts are important criteria for determining the worth of theories of psychotherapy

I am drawing here from Ernesto Spinelli's keynote speech at last year's conference: These Foundational Beliefs remain at the level of the implicit and the unspecified and are concealed in *accepted phrases*, e.g. borderline disorder, conditioned response; they are also concealed in *Common practices*, e.g. diagnostic assessment and via inadvertent validation when research is done *from* the Foundational Belief not *on* it. The example Spinelli uses is that of schizophrenia: research is carried out on the types, causes, epidemiology and treatment of schizophrenia thus 'effectively bypassing and reaffirming the root Foundational Belief in that which has been labelled schizophrenia'.

He goes on 'Foundational Beliefs can be exceedingly well-defended and immunised against critical analysis' because 'they are assumed to be accepted definitional truths by the majority of psychotherapeutic researchers' and that Foundational Beliefs 'serve to maintain the attitude that to attack one's own Foundational Beliefs is unfashionable and unwelcomed'.

Mahrer puts forward a number of ways of opening these Foundational Beliefs to critical analysis, one of which is to deliberately eliminate a certain Foundational Belief. Our Division could (should?) be taking a lead in this by working from a non-labelling perspective and resisting the incursion of diagnostic assessment systems. By buying in to these Foundational Beliefs we deprive ourselves as a profession of the opportunity to advance theory and practice in a novel way and to be open to innovative therapeutic practice.

The issue rests on how we 'do' science – under the old paradigm of Natural Sciences or as Spinelli puts forward the Human Science approach. This is surely the best-fit paradigm for Counselling Psychology; we do not stand outside the client as observers; we use the Therapeutic Relationship as a way of Being With not Doing To and so enter into what Gillett (1995) calls 'empathic and imaginative identification' with the client.

Again Spinelli points us to the work of Daniel Stern *et al.* (1998) who note that '*there is a growing consensus that something more than interpretation brings about change in therapy. This is a psychological act – the specific and unexpected 'moments' in therapy when the therapist-client relationship alters as a result of an authentic person to person connection. This in turn alters the client's perception of self.*'

We cannot do this if we are entering the therapeutic relationship with a previously fixed agenda, i.e. interpreting client way-of-being within a predetermined framework of a diagnostic 'box'.

It is always easier to stay with a bad habit than to change and practise a new way of being; similarly it is easier to bow to peer pressure than to stand alone or with a minority and challenge the validity of the 'old guard'.

And yet look at how the whole profession of applied psychologists has changed its attitude to the importance of supervision; surely a direct consequence of Counselling Psychology's influence.

## References.

- BPS Professional Affairs Board (1999). *Dangerous People with Severe Personality Disorder*.
- Gillett, G. (1995). The philosophical foundations of qualitative psychology. *The Psychologist* 8(3), 111–114.
- Spinelli, E. *Keynote Speech*. DCOP Conference Glasgow, 2001.
- Stern *et al.* (1998). Non-interpretative mechanisms in psychoanalytic therapy: the ‘something more’ than interpretation. *International Journal of Psycho-Analysis* 79, 903–921.
- Mahrer, A.R. (2000). Philosophy of science and the foundations of psychotherapy. *American Psychologist*, 55(10), 117–1125.

## Correspondence

Louise Turner-Young, Psychology Department, Dykebar Hospital, Paisley, Scotland.

---

FORTHCOMING FROM SAGE PUBLICATIONS

# Handbook of Counselling Psychology

Second Edition

Edited by Ray Woolfe *Private Practice, Manchester, Windy Dryden  
Goldsmiths College, University of London* and Sheelagh Strawbridge  
*Independent Practice, Hull*

The Second Edition is a developmental step forward for counselling psychology, where the discipline's stance on what constitutes science, inquiry and the nature of evidence based practice is clearly outlined. The versatility of the text is illustrated by theoretical perspectives on practice; the framework of the life span appreciates the developmental view where distress is seen as a part of human experience as opposed to pathology. These features contribute to a counselling psychology text that is essential reading material. *Professor Pam James, Liverpool John Moores University*

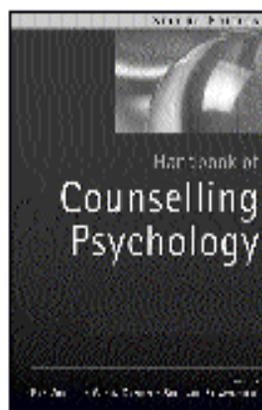
The Handbook of Counselling Psychology, Second Edition is the definitive guide to the context, theory and practice of contemporary counselling psychology. Designed primarily as a textbook for use in training, the Handbook is highly recommended by lecturers and trainees, while for practitioners it provides an excellent source of professional reference.

Bringing together the knowledge and experience of leading practitioners, the Handbook provides a uniquely comprehensive account of the major topics within counselling psychology, including:

• theoretical approaches • methodology • contexts of practice • psychological interventions • social, professional and ethical issues.

Fully revised and updated, the Second Edition includes six new chapters covering the transpersonal approach, gender issues, sexual identity, race and ethnicity, time limited practice and the body. This new edition is also supported by illustrative case material and examples throughout, which show how issues arise and are addressed in practice.

The Handbook of Counselling Psychology, Second Edition is an invaluable resource for all trainees, students, lecturers and practitioners working in counselling psychology, counselling, psychotherapy and other helping professions.



**Contributors:**

Chris Barker	Jim Dawney	Charles Legg	Diana Shmudder
Michael Barkham	Windy Dryden	John McLeod	Ernesto Spinelli
Simon Biggs	Zack Bekkeriadiou	Martin Milton	Sheelagh Strawbridge
Robert Bar	Alan Frankland	Vanja Orban	Eddy Street
Michael Burton	Maria Gilbert	Stephen Palmer	Léonie Sugarman
Cassie Cooper	Fiona Gaudie	David Purves	Angela M Taylor
Roslyn Corney	Diane Hammersley	Peter J Ross	Carol Tindall
Adrian Coyle	Henry Hollanders	John Rowan	Bill Wahl
	Carolyn Kagan	Michael J Scott	David A Winter
	Jennifer M Kidd	Carol Shillito Clarke	Ray Woolfe

March 2003 • 712 pages

Cloth (0 7619 7206 4) • Paper (0 7619 7207 2)

**SAGE Publications**  
6 Bonhill Street, London EC2A 4PU

Order Post-free online at [www.sagepub.co.uk](http://www.sagepub.co.uk)

# 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.

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 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.

Bibliographic references in the text should quote the author's name and the date of publication thus: Davidson (1999). All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in *The British Psychological Society Style Guide*, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK.

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.

## **Submissions should include abstracts**

The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed 'Abstract'. The British Psychological Society's *Style Guide* provides the following information on writing abstracts:

The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author's name, the abstract will be used for indexing and information retrieval by such services as *Psychological Abstracts*. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

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

**Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.**

## **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:

<i>For publication in</i>	<i>Copy must be received by</i>
February	5 November
May	5 February
August	5 May
November	5 August

**All submissions should be sent to:** Dr Alan Bellamy, Editor, *Counselling Psychology Review*, Brynmair Clinic, Goring Road, Llanelli, Carmarthenshire, SA15 3HF.

Book reviews should be sent to : Kasia Szymanska, Book Reviews Editor, Centre for Stress Management, 156 Westcombe Hill, London SE3 7DH.



ISSN 0269-6975

© **The British Psychological Society 2003**

St Andrews House, 48 Princess Road East, Leicester LE1 7DR

Printed and published in England by The British Psychological Society