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Editorial 2
Alan Bellamy

The dialogic unconscious: The missing link or a contradiction in terms? 3
Deborah Diamond & Martin Milton

Adult Community Psychology Services: Tiering and its seams 11
Roger Willoughby & Leanne Ashdown

Butterflies in possibility land: An example of the miracle question when counselling briefly 17
Russell Hurn

Therapist dilemmas: A discussion paper 30
Kate Bewsey & Abigael Odulate

Book Reviews 38

Newsletter Section

Letter from the Chair 40
Glimpses of the 2003 Conference 41
Division Committee 42
Is counselling good for you? 43
Correspondence 45
Conference Diary 47
Talking Point 49
Diane Hammersley
In this *Counselling Psychology Review* we have a mixed bag of papers in the first section, covering a theoretical conceptualisation of psychological disturbance and therapy, a way of structuring NHS psychology services, an account of the use of a particular brief intervention with a client, and a discussion paper about the dilemmas therapists may meet in their work. Coming after the discussion of Evidence-Based Practice in the last *CPR*, it reminds me of the wide spectrum of areas of interest that comes under the umbrella of Counselling Psychology. This ranges from the ‘soft-centred’ to the ‘hard-nosed’, and an unfortunate example relating to the latter came to my attention recently. An NHS Trust had advertised a B Grade (i.e. senior level) Clinical Psychology post. A number of Counselling Psychologists had contacted the Head of Department by telephone to discuss the post. So far fair enough. However, it rapidly became apparent to the Head of Department that many of these enquirers had nothing like the depth and breadth of experience and knowledge of NHS working that was required for such a post. When this was pointed out, some of them all but accused the Head of Department of being prejudiced against Counselling Psychologists. The Head of Department later commented that Counselling Psychologists were ‘shooting themselves in the foot’ by such behaviour, and that they were less likely to consider applications from Counselling Psychologists in future because of this. Now I know that many Counselling Psychologists have no intention of working in the NHS, and those of us who do worry sometimes about losing our identity. Nevertheless, it is vital for the standing of our profession that we all recognise that the NHS is a ‘hard-nosed’ environment, where we will be judged against often highly-skilled colleagues, and will have to compete for very limited public funds. As a new profession in that setting we are under particular scrutiny; if we wish to operate successfully in it, whether at junior or senior levels, we have to be perceived as competent and realistic professionals, not just in our work with individual clients, but in matters appertaining to Clinical Governance, Evidence-Based Practice, risk assessment and management, multidisciplinary working, service planning priorities, and all the myriad other requirements of such a complex, no frills, hard-nosed, environment. While I fully support what Stephen Munt writes in his Chair’s Letter later in this issue about the erosion of personal and professional autonomy and responsibility in the public services, nevertheless applying for NHS posts without being aware of the things that are seen as important in such environments does Counselling Psychology no favours.

At the back of this *CPR* you will find revised guidelines for contributors. We have tried to simplify these, and I hope more readers will be encouraged to contribute to *Counselling Psychology Review*.
'Between nature and nurture it looked quite grim. I'd been for some time, as I put it to myself, all right. But how could I be, genetically and psychologically, with parents like that? I came from a family of suicidal hysterics. I'd been suicidal and hysterical in my time, then taken stock and made a decision, or just grown out of it, but now I felt, as I walked back to the car, that for years I had been deluding myself into the notion that I had a choice. I felt myself to have been all along skating over the thinnest sliver of ice; believing that it was solid when it was only ever a brittle and probably diminishing floe… Thank you, Darwin; thank you, Freud.'


**Introduction**

For many years the author Jenny Diski suffered from depression, having several episodes of inpatient care and sampling many of the various types of therapy on offer, both privately and within the NHS. Her lament, centring around the notion of choice, echoes that of many clients who express distress or frustration at feeling hemmed into particular ways of being either by developmental process or biological determinants or sometimes by limited social opportunity. The above quote acts as a starting point for this paper because we do not intend to claim that the approach upon which the theoretical stance is based, and which supports the first author’s clinical work, is a conclusive end product of study or that it in any way reflects an ‘answer’ to the struggles faced in therapeutic encounters. Rather, it provides a fluid, adaptive framework for the investigation of the client’s distress, their needs and their preferred lifestyles and choices and it addresses individual and interpersonal dimensions of life. In that sense, the notion of the ‘dialogic unconscious’ provides a lens through which attempts to focus attention on the client’s lived experience at all of these levels can be made.

**The contextualised psyche**

The dialogic unconscious is a concept that attempts to bridge the psychoanalytic and discursive readings of human experience. Readers of this journal will be aware that psychodynamic practitioners, and in particular adherents of the traditional Freudian and Kleinian models, privilege investigations and speculations concerning the mind, accepting as ‘facts’ the universality of psychological processes and mechanisms, seeing these things as an ‘ontological reality’. For instance, every child at the ‘oedipal’ age of about three is presumed to negotiate a psychological, and sometimes a physical, state of sexual desire for the parent of the opposite sex. In therapy it is often speculated that developmental problems arising from such negotiations underlie and ‘cause’ adult psychological ‘dysfunction’ in such a way that problematic behaviours are repeated within the therapeutic relationship. Freud (1924) called this a ‘compulsion to repeat’.

Conversely, discursive psychology is theoretically influenced by aspects of philosophy, sociology and linguistics and it is underpinned by a social constructionist perspective. This perspective can be identified by four essential characteristics: it questions...
the taken-for-granted assumptions on which conventional knowledge is based; it views ways of understanding as being historically and culturally relative; it considers ‘truth’ to be constructed in social process and, it understands social actions as being conjoined with systems of knowledge (Burr, 2000). Normally, discursive psychology constrains investigations of constructs like the mind and the unconscious. Instead, it looks to the socially occasioned nature of speech acts to account for psychological phenomena. Language, therefore, takes centre stage as the medium through which people make sense and meaning of the world around them. The historical and social contexts in which people construct their self-identities and formulate their world perspectives are privileged as essential elements of self-identity within social constructionist, post-modern theory. Clients attending therapy are, therefore, seen not only as having a multiplicity of ever fluid and changing identities, but also as co-constructing these identities within the context and influence of the consulting room and the therapist (Gergen, 1990).

In their work on integration, Safran and Messer consider the contribution of social constructionist theory to clinical approaches and conclude that it acts as a bridge across theoretical divides. They suggest that post-modern approaches endorse a movement away from the ‘confrontation of adjoining therapeutic cultures’ towards a sense of surprise and eagerness to learn’ (1997, p.142). The movement between and across therapeutic approaches is therefore recognised and valued as a positive contribution to the therapeutic endeavour (Safran & Segal, 1990). Likewise, psychoanalytic practitioners Orange, Atwood and Stolorow (1997) and Stolorow and Atwood (1992) argue that clinical reference to contextualism, or the awareness of context to therapeutic process, aids understanding of intrapsychic movement as evolving within a constellation of social systems. According to Stolorow and Atwood, this concept ‘brings to focus both the individual’s world of inner experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence’ (1992, p.18). Because of the ideological link these writings make between psychoanalytic and social constructionist theory, we were led to explore the concept of the dialogic unconscious.

**The dialogic unconscious**

Developed by Billig in 1997, the dialogic unconscious represents an attempt at marrying the above-mentioned psychodynamic and discursive psychological schools. Like such theorists as Frank (2002) and Stolorow and Atwood (1992), Billig (1997, 1999, 2001) brings together these apparently conflictual approaches and he attempts to bridge their theoretical differences. This struggle to integrate approaches is one that is frequently encountered by counselling psychologists in their clinical work. While being concerned with maintaining a social constructionist stance Billig critiques both approaches – seeing a limitation of psychodynamic work in its lack of attention to the linguistic, or what he terms ‘dialogic’, construction of unconscious processes. Billig argues that there is also a gap in the discursive approach because it fails to account for what is left unsaid and he suggests that he has found an explanation of this in Freud’s theory of repression. According to Freud (1915, 1924), repression occurs when thoughts, ideas or impulses are not allowed into conscious awareness because they would be a source of anxiety or distress. Billig (1997, 1999, 2001) appropriates the concept of repression and, applying it to discursive acts, he contends that language has repressive as well as expressive possibilities. Initially, the performance of repression, he maintains, is learned throughout childhood mainly through parental attempts to teach children how to suppress rudeness and how to conform to the rites, rituals and customs of speech that maintain and replicate cultural prescriptions of politeness. Garfinkel (1967) called this ‘everyday morality’. The dialogic unconscious can, therefore, be seen as a means of understanding the significant role of repression in psychological development and human interaction whilst also maintaining the discursive psychology stance that psychic ‘realities’ are constructed in the everyday exchange of language. This is, of course, all well and good as an interesting academic development but for readers of this journal the real question is likely to be, what are the implications for practice?
The authors’ therapeutic experience and stance

The reasons why we attempt to combine these two seemingly inconsistent approaches are myriad – both professionally and of course in relation to our own personal histories and experiences. According to Larsen (1996), all psychological theories are a reflection of their creators’ life experience. Of course we do not claim to have hit upon the notion of the dialogic unconscious ourselves but, like all therapeutic practitioners, our interest in it, our interpretation of it and its application are a reflection of our own idiosyncratic readings of it. This understanding of discursive practice had strong resonance with our own nascent conceptualisation of dynamic social interaction. But, why should that be when the merging of the two ideologies appears to be so untenable? In fact, much literature argues that bridging these theoretical gaps is not possible (Baker, 1993; Milton, 2001) or that one theory threatens the foundations of the other (Dunn, 1995; Fonagy, 1999). However, it is their very incompatibility that explains the attraction to this model. Like salt and vinegar, the distinctive flavour of each theory combines to make more palatable what might otherwise seem appealing but unseasoned or incomplete.

From the perspective of the first author, [Debora Diamond], the experience of her own personal therapy was crucial to the development of her current therapeutic stance and she writes: For a number of years, several times a week, I took my place on the couch for psychoanalytic psychotherapy. This experience was foundational to my current view that the ‘undoing’ of repression is probably the single most crucial aspect of the therapeutic encounter. In therapy I had a voice that was not permissible in any other time or in any other space and it was this discursive freedom that was the amalgam binding my therapist and myself to each other. It would be misleading to suggest that I had the courage to fully embrace every opportunity for self-disclosure but as time passed so too did my reluctance to explore what might elsewhere be socially prohibited.

According to Milton (2001), when the client reaches the stage of being able to say whatever they like to the therapist they probably no longer need therapy. This supports the conviction that what cannot be said is particularly salient to the therapeutic endeavour. Many psychodynamic clinicians would concur, arguing that by examining the client’s unconscious communications, their defensive repressions can be exposed whereupon they can begin to be – in a more traditional view - ‘cured’ of their individual ‘psychopathology’. However, when the client’s self-identity is seen as multiple, fragmented and changeable as well as being historically and culturally dependent, then the ‘undoing’ of repression takes on diverse meaning and purpose. Our interest is particularly strong here as some practices within traditional psychoanalysis seem potentially as repressive as expressive, e.g. silence can be a punitive, inhibiting experience for some as well as an expressive opportunity for others. Good practice requires us to ensure that as much as it is possible, our influence should facilitate an experience where selfhood can be explored and experienced in new and alternate ways as discursive possibilities are broadened.

One of the dictums of Billig’s (1997) theory is that linguistic rules learned for the production of conversation with others will match those used in the production of inner dialogue. That is not to say that one will always adopt the same speaking positions both internally and externally. Indeed this point lies at the very heart of the theory of the dialogic unconscious in that it proposes that one of the most important skills of social discourse lies in the repression of external dialogue when taking part in mundane conversation. However, the rules, habits and customs employed in adopting any discursive position will be reproduced whether in conversation with oneself or others. For instance, a speaker might greet a friend with the familiar words, ‘Hello, lovely to see you’ when all along he had been hoping to avoid them for one reason or another and he might, therefore, say to himself, ‘Bugger’! What will not change are the customary habits of one’s own speaking practices. Therefore, when these habits of external speech are changed and new voices emerge in conversation with the therapist, it follows that changes, however gradual, will naturally occur in unspoken, self-talk, potentially providing the client with a more
positive experience of their inner and outer worlds. So, on a future occasion when such an awkward encounter occurs with a friend that has been avoided the speaker might say, ‘Hello, I haven’t seen you in a while because…’.

**Considering practice in light of the dialogic unconscious**

How might attention to the dialogic unconscious work in therapeutic practice? Like all practitioners, both psychoanalytic therapists and discursive psychologists attend as closely as possible to what, precisely, is said in conversation - the therapist using process notes and the discursive psychologist analysing transcriptions of dialogue. The process in both cases is similar, as the respective practitioners examine not merely the content of the spoken words but what the speaker is accomplishing by uttering them. In working with the dialogic unconscious it is also necessary to attend to issues of process and to explore the ways in which a client might attempt to shut down or close off areas or topics of conversation. By attending to this process, therapists can become aware of how a client will construct themselves as a moral being in their reproduction of the customs of speech which, for them, conform to the cultural prescriptions of everyday morality.

Moral positions are, therefore, accomplished between the client and therapist as each utilises their own familiar, discursive frameworks. It is the tension that arises between these two frameworks that facilitates and draws out the meaning and importance of specific discursive repressions for the client. In other words, the freedom offered within the therapeutic space can be used as a means of altering the client’s perception of what he is permitted to say and also how and when it might be said. In so doing, the client’s unconscious is reformulated as the nature of their repressions is altered. This will, of course, have an impact upon the client’s habits of mundane speech and the way in which others are engaged in conversation. For instance, in mundane social conversations a pause of more than a second normally poses a problem for speakers (Jefferson, 1989), however, in the therapeutic encounter longer silences are tolerated in order to indicate that the client has a greater share of speaking time (Sacks, 1989). The client’s response to silence in therapy may reveal something about their ability to adapt to contexts where the rules of discourse shift in unfamiliar or seemingly unusual ways. The therapist will also be alerted to the way in which the client has developed their unconscious processes.

**The clinical case of Mr Fischer**

How the concept of the dialogic unconscious has impacted upon and informed our therapeutic practice might be best illustrated by reflections on the first author’s clinical practice. Mr Fischer* attended therapy with symptoms of anxiety. He was unable to endure being in public place like cafés, supermarkets or train stations. He was also finding sleep difficult and he would spend much of the night ruminating on thoughts about his boss whom he disliked or about his weight, which, although it was average, he considered to be too high. These difficulties were detailed and explained as unwanted but at the end of each description he would claim that they were ‘not a problem’. The story he told of his life was filled with sadness, loss and frightening drama. From his earliest memories his father had been physically violent and psychologically aggressive toward his mother. When he was aged 10, Mr Fischer was admitted to hospital with near-fatal heart failure and put on a life support system. The following eight years of his childhood were taken up with in-patient and out-patient care and medical interventions and then, 10 days after his consultant discharged him, his grandmother died. Yet, all of these events were ‘not a problem’. For Mr Fischer, his repressions were constructed around his sense of his body and his physical vulnerabilities. It was important, therefore, to explore the meaning of these repressions in therapy.

Of course, Mr Fischer was preventing us from pursuing these particular, difficult areas of conversation more fully by constructing them as unproblematic. If it wasn’t a problem then there was no need to talk about it. Persevering

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*Details have been altered to protect the client’s confidentiality and the name used is a pseudonym.*
with a subject or area that the client attempts to
dismiss in therapy can be problematic for
therapists and psychoanalytic practitioners,
therefore, often make links with childhood
events or occurrences. Rather than focusing on
troubled childhood relationships - as might
have been done in traditional psychodynamic
therapy – we explored what it would mean to
him if these childhood experiences had been
and continued to be a problem. How would
things be different? Mr Fischer talked about
listening to his father beating his mother, over-
hearing his consultant tell his mother he was
dying, and learning only hours beforehand that
his grandmother was about to die. These diffi-
culties had been managed in his family by
silence and denial of pain. He believed that it
was acceptable to say what had happened to him
as long as an investment of emotion, and hence
verbal elaboration, were not required. To open
these events up for discussion seemed too
painful and, therefore, too threatening to his
sense of self. Token acknowledgements could
be made but there was an unspoken code
amongst the family that prohibited any further
detailed dialogue.

The silence employed by Mr Fischer’s family
was in stark contrast to the information passed
onto him by health care professionals, including
the alarming, and fortunately erroneous,
proclamations made about his impending
death. It was, therefore, also important to
explore in therapy how Mr Fischer had engaged
with his medical consultants. What patterns of
conversations were used with these people that
might also be drawn upon in his talks with me?
Additionally, what was Mr Fischer expecting back and, crucially, how
might this be altered for us? The therapeutic
space was used as a vehicle to explore the
contradiction of dialogic morality between the
sometimes bluntness of ‘professionals’ and his
family’s conversational reticence.

Psychodynamic theory postulates that
anxiety is associated with feelings of guilt,
whereas cognitive behavioural (CBT) theory
suggests that anxiety is created in habits of
moods, thoughts and behaviours. To work
within the dialogic unconscious approach is to
consider elements of both of these models.
Conversational repressions, arising from the
unconscious suppression of thoughts are
perceived as leading to the development of
habits of thought and behaviour. The dialogic
unconscious is not an integration of these
theories but an over-arching approach to the
client’s difficulties. It provides an account and
an explanation based on internal and external
conversation for the phenomena of psycholog-
ical angst described within both. Additionally it
suggests that, as repressions are opened up,
unconscious changes occur that impact on
conversations and behaviours in both inner and
outer dialogue. Mr Fischer’s problems were
perceived within a dialogic framework wherein
he was constrained from self-expression and
elaboration of thoughts and ideas.

Gradually Mr Fischer began to talk more
about the pain of his experience and about his
vulnerability – both physical and psychological –
and eventually he was able to voice some of the
thoughts that he may have been harbouring for
the greater part of his life. He wondered if he
was to blame for his father’s violent outbursts
and for the pain that this had caused his family.
He wondered too if ‘everyone’ would have been
better off if he had died that day in hospital. Mr
Fischer also discussed the anger he felt towards
the ‘good’ people in his life who had tried so
irrepressibly to protect him from his own feel-
ings. These had previously been unspoken and
also largely unrecognised. Mr Fischer’s saying of
what, for him, had previously been unsayable
was a mutative experience. He enlarged his self-
perceptions and was able to speak about himself
in ways that were more reflexive about issues of
blame and responsibility. The opening up of
discursive possibilities unsettled Mr Fischer’s
previous assumptions about himself and
allowed him to ponder unfamiliar, alternative
identities. His view changed of what he was
permitted to discuss with others and this
seemed to create a new harmony in his
relationship with his wife and children. His
behaviour changed not merely because he
could express himself in new ways but because
the nature of his unconscious repressions was
explored and identified. This may sound like a
tidy summary and that Mr Fischer was ‘cured’ of
his problems but, of course, he must continue
to negotiate his family’s silences and the
pronouncements of professionals, together with
the discursive routines and habits of speech imposed by society at large. This presents a daily challenge to Mr Fischer’s unconscious processes.

It could be argued that we would have arrived at the same therapeutic space and outcome had another model been adopted. Of course like any client, Mr Fischer’s case might be formulated in any number of ways, utilising a variety of approaches. However, Mr Fischer was reluctant to problematise his early relationships and this did not comprise the sole therapeutic agenda. He already knew that relations with his father were poor and he came to acknowledge that, in trying to protect him from anxiety by avoiding certain topics, his other well-meaning family members had perhaps contributed to his anxiety instead. He valued his early relationships, particularly cherishing memories of his grandmother and he was concerned not to cast a shadow over them by blaming her for the way in which she chose to conduct her own death. Both the psychodynamic approach and the dialogic unconscious take a developmental perspective but departures in focus arise when constructions of meaning rather than presumptions of ‘compulsion to repeat’ are privileged in the therapeutic encounter. In the case of Mr Fischer, searching out new meanings rather than isolating past relationship failures allowed him to discover a novel sense of his own potential. The unique contribution that the concept of the dialogic unconscious made in the work with Mr Fischer was that the notion of repression could be explored within a framework that allowed his own interpretations of dynamic interaction to dominate the therapeutic exchange. Additionally, formulations were made on the basis of an understanding of both psychic phenomenon and culturally relevant linguistic practices.

Conclusion
This case study illustrates the usefulness of the notion of the dialogic unconscious in the therapeutic practice of Debora Diamond. It is an over-arching theory that does not blend therapeutic models, as in the case of cognitive analytic therapy or schema-focussed work, which can be complex in their conceptualisation and thus confusing to therapist and client alike. It is guided by the view that the unconscious reformulates according to conversational changes and adaptations to thought and behaviour. It raises the question in every therapy of what is not said and how what is not said can be identified. This means a rigorous self-examination of our own dialogic processes and a great attention to, what Billig refers to as, ‘the small words’.

Perhaps the greatest problem with working with the dialogic unconscious is that, like much work that comes under the heading of ‘innovative practice’ in evidence-based practice, it is still new and creative. Because it is neither widely understood nor employed in therapeutic practice, obtaining supervision that corresponds to its central tenets is difficult. Hence, work is evaluated through traditional supervision as well as through feedback from the client, our sense of attunement with the client and informal dialogues with social constructionist practitioners. Our utilisation of the dialogic unconscious is, therefore, a work in progress that could be enhanced by the input of other professionals.

To return to Jenny Diski, our aim in utilising the dialogic unconscious is that it should act as a therapeutic structure to support the client. Like a solid floe of ice, this approach may not be entirely without ruts or catches or cracks but nonetheless it should help to prevent the client from slipping helplessly into the black and treacherous waters of anxiety, depression or suffering, below. In therapy this means first achieving some understanding of what may be repressed and making this explicit. The meaning of the repression should then be explored, including the ways in which this has impacted upon behaviour. New linguistic possibilities should be raised and any changes in self-expression should be noted. Finally, the effect of these changes on behaviour and self or world perceptions should be assessed. For the therapist, this should also encourage fresh understandings of what it means to make the journey into the Antarctica of the client’s distress and to help them face the challenge and risk of gliding uncertainly across the therapeutic ice. From the approach of the dialogic unconscious we are able to draw upon our own experience of therapeutic discourse and it’s

Counselling Psychology Review, Vol. 18, No. 4, November 2003
corollary of psychological freedom and change, together with preserving our theoretical commitment to the endeavours of social constructionism. Far from being a contradiction in terms, the dialogic unconscious provides a complimentary link between our personal processes and professional doctrines.

References

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We are looking for a new Editor for Counseling Psychology Review, to replace the present postholder who will be leaving to become Division Chair in May 2004. We wish to identify a replacement well before that date so that they can shadow the present Editor through at least one issue.

The Editor is responsible for ensuring that CPR is prepared and delivered to the Preparation for Print Department of the BPS within the deadlines set for each edition. He or she receives submissions and arranges for them to be refereed, encourages and commissions contributions, liaises with contributors, referees, advertisers and the BPS, and develops the editorial policy and style of CPR in conjunction with the Editorial Board. The Editor is an ex officio member of the Divisional Committee and is expected to attend its meetings, and also to organise meetings of the Editorial Board.

Further details are available from the Editor, Alan Bellamy, and statements of interest should be sent to the Hon. Secretary, DCoP, at the BPS.
Stratification and hierarchical arrangements are ubiquitous aspects of societal organisation, sometimes welcome, sometimes less so. They may both facilitate a good life and psychological well-being and contribute to human unhappiness and everyday psychological problems. As counselling psychologists this is familiar to us, both from our everyday work with people in distress and closer to home in struggling for our own professional recognition and a niche within the market, especially the NHS. Tiering, as one form of stratification, has served to order services, supposedly distinguishing clients according to needs and marshalling human resources in turn, through skill-mix for example. Knowledge of such boundaries, together with an informed view on their validity or otherwise, is important in attempting to match specific clients to the most appropriate workers and in clarifying and developing professional roles.

Introduction

Within community psychological services primary and secondary care tiers have generally been differentiated by a variety of staff, organisational and client dimensions. Among the latter, chronicity and severity of psychopathology have been regarded as primary distinguishing characteristics, with clients experiencing more severe difficulties clustering in Secondary mental health services and those in Primary Care generally exhibiting lesser morbidity (Goldberg & Huxley, 1980, 1992; Cheston & Cone, 1999). Goldberg and Huxley (1992) situate GPs as the traditional gatekeepers between the two tiers, managing the bulk of psychological presentations within their own practices and identifying and facilitating the onward referral of those clients who require more specialist mental health services. These functions have been frequently highlighted for their variable quality (Goldberg & Huxley, 1980, 1992) and consequently as an area for professional or organisational development (Sartorius et al., 1990). Decentralising policies promulgated by the Department of Health have led to a refocused emphasis on Primary Care, with some specialist services being increasingly provided there, including dedicated mental health input. As part of this trend counselling and counselling psychology in Primary Care has proliferated, and its results favourably evaluated, at least when the services have been appropriately targeted and quality controlled (Rowan & Chandrakumar, 1996; Bellamy & Adams, 2000). Such developments have tended to blur the traditional distinctions between tiers, which, while increasing the possibilities for a more seamless community provision, problematised professional identity and role clarity and demand a more comprehensive approach to service planning. Cheston and Cone (1999) found that the differences between clients at the two levels were quantitative rather than qualitative, with for instance intensity and frequency of distress rather than diagnosis differentiating clients at one or other tier. The emphasis on research and development in the NHS (Milne, 1999), together with the advocacy of evidence-based practice, has resulted in efforts to systematically measure and evaluate psychological services for clinical effectiveness, using standardised outcome measures wherever possible (Barkham et al., 1998). The present paper sets out to delineate further the seams,
especially in terms of the commonalities and differences, between community psychological services for adults at the Primary and Secondary Care tiers and their respective recipients within one Trust area using common measures. This may then act as a comparator to others developing and benchmarking comprehensive community adult psychological services.

The service

The Trust area (East Kent) is semi-rural, covering approximately 750 square miles with a population of 592,603. The area is subdivided into five localities, divided between three Primary Care Trusts, and has some 106 GP practices.

The Adult Community Psychology Service (ACPS), catering to adults 16–65, is a multi-professional service, which at the time of study comprised of clinical psychologists (5wte), counselling psychologists (2wte), counsellors (2.2wte) and psychotherapists (2wte), who are based at centralised locality sites. Referrals are primarily from psychiatrists and other Secondary level services, with GP and Primary Care referrals accepted in all localities except one. The Service organises and manages the Primary Care Counselling Service (PCCS) which comprises 10 (3.3 wte) counsellors and psychotherapists, working in a total of 24 GP surgeries across the Trust, with clients aged 16 years and upwards, including a small number of older adults aged 66 and over. The PCCS operates within a seven session intervention frame, whilst the ACPS offers more medium term interventions, typically of between 10 and 40 sessions. All staff hold a pertinent professional registration, either BPS Chartership, or UKCP or BACP accreditation.

Method

The sample was made up of all client audit and evaluation forms returned by clinicians in both services (397 in the ACPS and 1079 in the PCCS) during the 12-month period of the study. Routine audit and evaluation forms were developed based on the model proposed by Berger (1996). Data collected included client demographics (sex, age, marital status, occupation, ethnicity, number of children) and clinical characteristics (such as primary presenting problems (as described by the clinician), previous contact with mental health services and whether clients referred were using psychotropic medication at the time of referral). In addition Service administration details were collected (response times) as well as treatment and outcome data (such as the number of sessions attended, cancellations, DNAs, discontinuation rates, and clinician ratings of improvement). The CORE outcome measure (Barkham et al., 1998) was used to further evaluate clinical effectiveness, this instrument being given to clients prior to assessment and again following the intervention stage. Barkham et al. (1998) developed this for use in routine clinical practice, with ‘widespread utilisation’ and the intention of creating an ‘anonymised UK national database’ (Barkham et al., 1998). The questionnaire comprises 34 items, tapping the domains of well-being, symptomatology, functioning and risk to self or others, which when combined yield a global measure of distress.

Data was analysed for statistical significance using non-parametric tests as it was found to be not normally distributed; chi-square analysis, and the Mann-Whitney U test for unrelated samples was used to look at means and CORE scores.

Results

Demographic data is presented in Table 1. Statistically significant differences were found between clients at the two tiers in terms of sex, age, marital status, occupation and the prevalence of parenthood.

Table 2 shows the data for the clients’ basic clinical characteristics and highlights significant differences between those at the Primary and Secondary Care tiers regarding previous contact with services, the use of psychotropic medication at the time of referral and the kind of primary presenting problem or diagnosis.

Table 3 summarises the treatment and outcome data. Statistically significant differences were found between the Primary and Secondary Care services in terms of average waiting times between referral and offer of a first appointment (waiting times were reported using the seven-day week), the average number of sessions attended, cancelled or DNAs. Clinician ratings of improve-
### Table 1: A comparison of primary and secondary care client socio-demographic data.

<table>
<thead>
<tr>
<th>Category</th>
<th>Primary Care N=1079</th>
<th>Secondary Care N=397</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>33.3</td>
<td>P = &lt;0.05</td>
</tr>
<tr>
<td>Female</td>
<td>73</td>
<td>66.7</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>&lt;19</td>
<td>5.8</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>20–29</td>
<td>23.3</td>
<td>27.9</td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td>28.2</td>
<td>35.4</td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td>21.4</td>
<td>16.7</td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td>14.7</td>
<td>12.3</td>
<td></td>
</tr>
<tr>
<td>60–65</td>
<td>2.6</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>&gt;66</td>
<td>4.0</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
<td></td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>Single</td>
<td>18.8</td>
<td>29.7</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>48.6</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Cohabiting</td>
<td>9.9</td>
<td>15.9</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>10.7</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>6.4</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>5.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Ethnicity:</td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>White</td>
<td>98.6</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>Non-white</td>
<td>1.4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Occupation:</td>
<td></td>
<td></td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>Full-time</td>
<td>35.3</td>
<td>22.1</td>
<td></td>
</tr>
<tr>
<td>Part-time</td>
<td>13.9</td>
<td>17.5</td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>21.1</td>
<td>13.0</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>9.7</td>
<td>22.1</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>7.3</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>Sick/Disabled</td>
<td>8.1</td>
<td>12.7</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>3.2</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1.1</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td>0.2</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Children:</td>
<td></td>
<td></td>
<td>P = &lt;0.02</td>
</tr>
<tr>
<td>Yes</td>
<td>74.3</td>
<td>66.4</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: A comparison of basic clinical characteristics between groups.

<table>
<thead>
<tr>
<th>Category</th>
<th>Primary Care</th>
<th>Secondary Care</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous service utilisation (%)</td>
<td>30.6</td>
<td>78.7</td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>Previous services used:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling Services</td>
<td>41.4</td>
<td>15.3</td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>Psychiatric out-patient</td>
<td>23.6</td>
<td>42.7</td>
<td></td>
</tr>
<tr>
<td>Psychiatric in-patient</td>
<td>5.9</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td>Psychology Services</td>
<td>13.2</td>
<td>15.1</td>
<td></td>
</tr>
<tr>
<td>Private Therapy</td>
<td>3.6</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>4.5</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>Voluntary/Self-help</td>
<td>0.5</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td>5.5</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Primary problem:</td>
<td></td>
<td></td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>Anxiety</td>
<td>39.1</td>
<td>28.3</td>
<td></td>
</tr>
<tr>
<td>Sexual Dysfunction</td>
<td>0.6</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>0</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>40.2</td>
<td>39.4</td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>0.5</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>0.9</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>–</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>18.8</td>
<td>14.1</td>
<td></td>
</tr>
<tr>
<td>Psychotropic Medication (%)</td>
<td>37.2</td>
<td>55.8</td>
<td>P = &lt;0.001</td>
</tr>
</tbody>
</table>
Table 3: A between groups comparison of mean treatment and outcome data.

<table>
<thead>
<tr>
<th>Category</th>
<th>Primary Care</th>
<th>Secondary Care</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting time:</td>
<td>50.8 days (SD 49.83)</td>
<td>86.85 days (SD 102.76)</td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>Sessions attended:</td>
<td>3.83 (SD 2.62)</td>
<td>7.64 (SD 6.84)</td>
<td>P = &lt;0.02</td>
</tr>
<tr>
<td>DNAs</td>
<td>0.44 (SD 0.68)</td>
<td>0.89 (SD 1.39)</td>
<td>P = &lt;0.02</td>
</tr>
<tr>
<td>Cancellations (%)</td>
<td>0.35 (SD 0.68)</td>
<td>1.03 (SD 1.30)</td>
<td>P = &lt;0.001</td>
</tr>
<tr>
<td>Discontinuation (%)</td>
<td>56.8</td>
<td>54.0</td>
<td>NS</td>
</tr>
<tr>
<td>Clinical rated improvement (%):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much Improvement</td>
<td>26.7</td>
<td>29.2</td>
<td></td>
</tr>
<tr>
<td>Moderate Improvement</td>
<td>29.3</td>
<td>23.1</td>
<td></td>
</tr>
<tr>
<td>Slight Improvement</td>
<td>20.5</td>
<td>14.0</td>
<td></td>
</tr>
<tr>
<td>No change</td>
<td>22.7</td>
<td>32.3</td>
<td></td>
</tr>
<tr>
<td>Slight Deterioration</td>
<td>0.9</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Moderate Deterioration</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Much Deterioration</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Table 4: A comparison of men’s and women’s pre- and post-therapy CORE scores by tier.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pre-therapy</th>
<th>Post-therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary care</td>
<td>Secondary care</td>
</tr>
<tr>
<td></td>
<td>N=137</td>
<td>N=93</td>
</tr>
<tr>
<td>Men: well-being</td>
<td>2.22 (SD 1.00)</td>
<td>2.29 (SD 0.98)</td>
</tr>
<tr>
<td>Men: problem</td>
<td>2.23 (SD 0.95)</td>
<td>2.40 (SD 0.91)</td>
</tr>
<tr>
<td>Men: functioning</td>
<td>1.71 (SD 0.87)</td>
<td>1.92 (SD 0.86)</td>
</tr>
<tr>
<td>Men: risk</td>
<td>0.62 (SD 0.83)</td>
<td>0.77 (SD 0.84)</td>
</tr>
<tr>
<td>Men: total scores</td>
<td>1.76 (SD 0.78)</td>
<td>1.93 (SD 0.79)</td>
</tr>
<tr>
<td>Men: total scores (minus risk)</td>
<td>2.01 (SD 0.84)</td>
<td>2.19 (SD 0.84)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pre-therapy</th>
<th>Post-therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary care</td>
<td>Secondary care</td>
</tr>
<tr>
<td></td>
<td>N=368</td>
<td>N=162</td>
</tr>
<tr>
<td>Women: well-being</td>
<td>2.46 (SD 0.89)</td>
<td>2.61 (SD 0.85)</td>
</tr>
<tr>
<td>Women: problem</td>
<td>2.33 (SD 0.80)</td>
<td>2.56 (SD 0.78)</td>
</tr>
<tr>
<td>Women: functioning</td>
<td>1.78 (SD 0.76)</td>
<td>2.05 (SD 0.79)</td>
</tr>
<tr>
<td>Women: risk</td>
<td>0.41 (SD 0.56)</td>
<td>0.67 (SD 0.72)</td>
</tr>
<tr>
<td>Women: total scores</td>
<td>1.82 (SD 0.65)</td>
<td>2.04 (SD 0.67)</td>
</tr>
<tr>
<td>Women: total scores (minus risk)</td>
<td>2.11 (SD 0.72)</td>
<td>2.35 (SD 0.71)</td>
</tr>
</tbody>
</table>
ment were not significantly different between the two services. Nor were significant differences found for discontinuation rates between services.

Table 4 shows mean CORE scores for males and females at the Primary and Secondary Care tiers, pre- and post-therapy. No significant differences were found between men’s scores in Primary and Secondary Care on all domains at pre and post therapy. By contrast, women’s scores revealed a strongly significant difference between those at the Primary and Secondary Care tiers at the pre-therapy stage in all domains except well-being: Mann-Whitney Test, p=<0.005. By the post-therapy stage women’s CORE scores at both tiers had evened out, inter-group differences at that point being statistically non-significant.

Discussion
The present study indicates that both the client populations and the clinical services at Primary and Secondary Care tiers are distinctive, being distinguishable on a wide range of variables chiefly associated with complexity and chronicity of client psychopathology. Thus clients at the Secondary Care tier, although tending to be younger (Fylkesnes, Johnsen & Forde, 1992), have had substantially more past contact with mental health services, particularly as psychiatric outpatients or in-patients. More intractable problems, such as psychosis, sexual dysfunction, personality disorders and eating disorders, clearly contributed to this trend and mark some categorical differences. Corresponding levels of self-reported distress, as reflected in the CORE scores, tallied with this picture, with higher symptom levels being reported at the Secondary Care tier (Goldberg & Huxley, 1980, 1992), a finding supportive of the tier seams as described by Cheston & Cone (1999). The waiting time for Secondary tier psychology was significantly longer as was the subsequent intervention. Cancellations and non-attendance were also markedly higher, indicative perhaps of a more volatile psychopathology among clients at the Secondary Care tier, although service factors (such as accessibility) may also have contributed.

At the Primary Care tier anxiety and mood disorders formed the bulk of presenting difficulties. Referrals at this tier were far from being the pejoratively labelled ‘worried well’, initial CORE scores falling within ‘caseness’ on all CORE domains, confirming the findings of Rowan and Chandrakumar (1996) among others about the significant needs of clients in Primary Care. PCCS clients previous service utilisation, where it existed, tended to be within a similar counselling context, mirroring that of clients within secondary services, findings in line with both Hannay (1986) and Dew et al. (1991) who highlighted past patterns of service utilisation as being predictive of similar future use.

The client outcomes across tiers were broadly similar, with both clinician ratings and clients self-ratings (as portrayed in their CORE outcome scores) revealing no statistically significant differences, and both having fallen below ‘caseness’. Whilst clearly a welcome finding and in line with comparable other NHS psychology studies (Ambrose, Botton & Ormrod, 1998; Turvey, Humphreys, Smith & Smeddle, 1998), the present CORE discharge scores would need to be compared to the CORE national discharge data when this becomes available.

Within the present study, gender trends proved to be one area of emergent interest during the analysis of the results. While women formed the majority in both tiers, a factor that supports previous findings (Briscoe, 1987; Fylkesnes et al., 1992; Scambler & Scambler, 1984), there were proportionately more males within Secondary services. Women’s CORE scores in both tiers at intake and at discharge were in general higher on all domains with the exception of the risk scale than men’s. While CORE scores overall were higher at the secondary care tier, as previously noted, the differences between the tiers only reached statistical significance in relation to women’s scores. The degree of risk may partly account for men’s facilitated access to secondary tier services, however other issues, such as gender-related help-seeking behaviour or referrer attitudes and perceptions, would need to be considered.

Obviously there are caveats that go with the present study in terms of possible selectivity and the generalisability of both the Service and the client population data. Outcome data primarily for Secondary tier longer-term clients was limited given continuing treatments, a factor that would be expected to impact significantly
on the average length of treatments reported. Nevertheless, the study should aid other adult community psychology services in developing client and tier appropriate provision and quality benchmarking within that process, with psychological practitioners contributions informed by awareness of clients actual needs and not merely supposition.

References

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Mrs Leanne Ashdown
Trainee Counselling Psychologist,
City University and East Kent Community NHS Trust.
This report features the use of a solution-focused intervention (miracle question, see de Shazer, 1988), to try to define workable goals within, time limited, one to one therapy with a depressed single mother. The work was conducted as part of a multidisciplinary team approach to advise and manage the referral, which in this case had originally been for the woman’s eleven year-old daughter.

Introduction

While working within a brief time frame with this client the miracle question technique was used to try and help the client focus on specific goals that could help her ability to cope with her daughter’s behaviour and increase the quality of their relationship. de Shazer (1988) suggests that asking about goals using this type of question elicits a concrete description based on specific behaviour. This produces a set goal, which in turn provides the client with the opportunity for knowing when it has been attained, and consequently when therapy can end. Working briefly is not a core theoretical approach to therapy but can be more adequately perceived as a meta-theory that can be applied to any clinical intervention. Gill (1999) suggests that the task of counselling is then to focus on what has already been achieved by the client and identify their areas of competence. This shifts their perspective from victim to survivor, deconstructing previous ideas about themselves so that they can escape the ‘passen- gerhood’ in life and generate new models of thinking and behaving based upon what has already been accomplished (White, 1991). The therapist elicits the expertise of the client so they can re-connect with what works for them. The therapeutic conversation is an invitation to be reflective on their life, focusing on competence and resourcefulness. As such ‘the client is the expert the counsellor a retained consultant’ (Strong, 2000, p.39).

Brief therapy attempts to introduce a new premise (idea that constrains behaviour in a system), with this accomplished the behaviours connected with the old premise fall apart (Penn 1985). Watzlawick, Weakland and Fisch (1974) describe this as reframing, noting that it must fit with the patient and as such is based on something that they are already doing that works (albeit unrecognised). In this way the facts do not change but the perception of them does. O’Hanlon and Weiner-Davis (1998) argue that therapy has moved beyond the exploration of problem cause and maintenance and is now concerned with how they can be solved. Problems arise when ordinary events get mishandled, the problem then is maintained by unsuccessful attempts to solve them, it is therefore an attempted solution that has gone wrong. A solution is doing or seeing something differently which leads to an increase in satisfaction (de Shazer, 1988). Solutions can be generated by the individual from their reservoir of learned wisdom, this may have been forgotten but is still available.

This focus on resources is done within a time-limited framework. There is no magic number of sessions but the aim is to make therapy as brief as possible, within the limits of what is deemed possible by the client and thera-
pist. In short brief means ‘no more than necessary’ (Hoyt, 1995, p.78). The contracting and communication of time restraints increases the awareness and focuses attention on work that has to be done, change that has to be made today. Bellak (1980) argues that temporal goal settings increases motivation, forces the therapists to conceptualise clearly and avoids dependence and passivity, it is more cost effective, can be more readily available, treats more people and frees time for those who need longer-term therapy.

**Referral and setting**

The original referral was made to a Child and Adolescent Mental Health Service (CAMHS), by the family GP. The referral was on behalf of Lisa’s daughter Kylie, whom was described as having behavioural problems.* I was approached to meet them with their existing case-worker to assess whether I could do some complimentary individual work with Lisa. She has herself been referred to the adult mental health service and is waiting for an appointment. It was felt some brief work with the mother at this stage may help alleviate the problems being experienced at home and reduce any risk or emotional upset to Kylie while she is being seen at CAMHS.

**Assessment**

Lisa is a 30-year-old, divorcee who has been bringing up her two girls alone for the past nine years. At our first meeting she appeared somewhat nervous, tearful and in some distress over her current situation. The family system had been shaken by the hospitalisation of the maternal grandmother who had recently become very supportive of Lisa and her eldest daughter Kylie. Lisa appeared thin and emotionally frail, she often resorted to laughter rather than letting tears come out. She is dyslexic and is currently studying English at a local college.

Lisa’s problems can be described as depressive feelings stemming from her beliefs (or thoughts) of worthlessness. These thoughts she believes are the product of physical and emotional abuse by her father. She blames him for making her the ‘weakest one of the lot’, referring to her siblings. Lisa remembered specifically one incident from her childhood that made her feel this way. When she was six, she had been admitted to hospital and had very few visits from her parents. On the day of her discharge no one came to get her and the hospital put her in a taxi, in her pyjamas, and sent her home. Nothing was ever said about this event. Lisa has developed a coping strategy of containing her emotions, she is afraid to lose her temper because she feels that if she did she, like her father, would be unable to control it and someone would get hurt.

Lisa acknowledges some apprehension of counselling having undergone some treatment before which resulted in the revelations of sexual abuse by her brother-in-law. This was handled badly by the counsellor and caused family disruption culminating in Lisa taking an overdose. This has added to her inability to express her feelings, as she believes discussion makes her vulnerable and open to abuse.

**Problem formulation**

At the time of referral, Lisa was finding it very difficult to deal with her daughter’s behaviour describing her as disruptive and aggressive at home. The problem had been increasing over the past couple of years. Lisa felt this was due to jealousy because she had to spend so much time attending to Kylie’s sister who has severe eczema. Kylie was just old enough to remember her parent’s divorce and has linked the event to the arrival of her sister Lacey. As such Lisa feels that Kylie is playing for her attention in case Lacey takes her Mum away from her. Lisa’s feelings of worthlessness add to the problem as she responds very defensively to any comments made by Kylie and tends to end up shouting at her eldest daughter, when she would rather be cuddling her. Lisa also felt that Kylie may be developing an eating disorder, something she herself had had when younger, and that Kylie has some difficulties forming relationships at school. This may indicate her concern that Kylie is experiencing life in the same way she did and

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*The names of the clients have been changed to ensure confidentiality. All identifying material has been removed and the client gave informed consent for the use of material.
she is afraid that Kylie will turn out like her, depressed, unhappy and lonely.

**Aims of session and contract history**

We initially contracted for six sessions with the aim of trying to find some workable solutions to the distress she was experiencing. The second session had just been an outpouring of emotion. I felt this was necessary to acknowledge the client’s experiences and ideas about her life. With this established we could then work on discovering and increasing the possibility for change. The message being I understand where you are and that’s OK but you can change (O’Hanlon & Beadle, 1996).

Levey (1995) suggests that when working briefly the aim is to make the most of each session and to move towards an obtainable goal. The aim of this featured session was to clarify the problem with the use of the miracle question. This is an exercise, which describes a detailed picture of a future time when the problem does not exist. It helps build a belief that the problem can be solved and this expectation can lead to the fulfilment of it (de Shazer, 1988). The magic wand questions help us to clarify and focus on goals, create strong images of preferred actions and find the powerful interest and images that pull the client along (O’Hanlon & Beadle, 1996).

**Lead into transcript**

At the beginning of this session (No. 3), I noted Lisa looked more relaxed and she commented that others had said the same thing, but she was unsure why. I had at the previous session negotiated some homework for Lisa to give Kylie a cuddle at eight o’clock. This is the time she usually finishes attending to her youngest daughter’s eczema. The homework had not been completed, instead they had been rowing. This resulted in a shouting match about Kylie’s trip to see her father. This had been arranged after a previous fight when Lisa had demanded that her ex-husband take Kylie away for a week to give her a break. This is a pattern to Lisa’s behaviour, she distances herself physically and emotionally when the arguments become unbearable. Later in the evening Lisa had tried to give her daughter a cuddle but had been rebuffed and consequently did not try again. Despite the emotions, which were behind the trip, Lisa did report that she missed Kylie and the chats they have when they are together on their own.

With brief intervention in mind I asked what we could achieve at this session that would mean it had been worth coming. Lisa was unsure. I therefore decided to start globally and work down. I asked what overall she would like to get from our meetings. She replied that she would like to get a better understanding of her relationships and how to improve them. She indicated her children as the most important and then Kylie as the most important of all. When she was asked how she would know improvements had been made, she said that they would be shouting less and they would be having more fun together, like laughing about things and going to the park. With this is mind I asked Lisa the miracle question.

**Transcript**

(C = counsellor / L = client)

C If I was to transform my pen now into a magic wand, give it a little wave, and of course make everything better.

L Mmm.

Lisa seemed a little bemused at the idea and was unsure what to say, she was playing with her hands and I was wondering if she would be able to give the question the thought and detail it requires to be therapeutically effective.

C So that tomorrow morning when you woke up everything was just how you want it to be.

L Life’s not like that is it? (Despondent sigh, then this is turned into a laugh.) Lisa had often done this, when she feels emotional she replaces her mounting feelings with a laugh to avoid crying.

C Life’s not like that is it? (Despondent sigh, then this is turned into a laugh.)

L Lisa had often done this, when she feels emotional she replaces her mounting feelings with a laugh to avoid crying.

C No life’s not like that.

I may here have caught the negative ‘language virus’ (see O’Hanlon & Beadle, 1996) and Lisa is imposing her beliefs that she cannot change, onto me. A more positive statement from me at this point may have served to infect her with positivism. However, her use of the laugh to diffuse the feeling of despondency that she had, seemed to force me into agreeing with her. My
agreement was an attempt to express some empathy in case her comments may have been an expression that I was not understanding her and thus moving too fast. I had to acknowledge this communication (O’Hanlon & Beadle, 1996).

C But what I want you to do is just imagine for a moment that it is.

L Right.

C I want you to just imagine you have woken up and everything is different, everything is how you want it to be.

L Right.

C Describe it to me. What would it be like?

L I’d be more relaxed.

C How’d you know you’d be more relaxed?

L Umm, because I wouldn’t be angry.

This is a negative, something that is not there. I wanted her to tell me the positive things about this miracle and be able to identify the things she would be doing, the things that would be different.

C How do you know you are not angry?

L Umm. Don’t know, just would I suppose. Umm.

There is some confusion here and her thoughts have been upset this could mean she is about to make a change in her thinking or I may be not expressing myself in a way she finds easy to understand. I attempted to use a multiple-choice question in an attempt to seed new ideas (O’Hanlon & Beadle, 1996).

C Would it be something you felt or something, how you looked or something you did?

L How I felt? I think, I wouldn’t. I feel it inside all the time I’m angry.

There is uncertainty in her voice, Lisa is coming out of the exercise here and grounding herself in her current feelings. I felt I had to go with her for a moment to help her feel understood before moving her forward.

C So what’s the feeling you get?

L Umm. I don’t know really. Umm. Like I wanna scream … inside my head.

C Scream inside your head?

L Yeah.

C Do you get any physical sensations?

L No just that.

I get the feeling that this has been explored enough and is not really helping with the exercise. The responses seem to be based on internal states without reference to behaviour. This detail is needed if I am to compare the differences between the hypothetical solution and the practicalities of her current situation (de Shazer, 1988).

C (Pause three seconds) So you woke up and realised that a miracle’s happened and everything is wonderful because you instantly don’t want to scream.

L Mmm.

C Is that right?

L Yeah.

C How else would you know things were different?

L Umm (pause five seconds) because I’d just be happy I’d be smiling I suppose.

C So you’d be smiling. Where would you be?

L (underneath what I said) I’d be jolly.

C Where would you be?

L Where would I be?

C Mmm.

L In what way?

At this point I am detecting some possible resistance and I am not sure of whether to stop the questions or to delve further and help her understand the exercise. Strong (2000) suggests that in therapy the counsellor attempts to have a different conversation with the client than the one they are used to with all other social interaction. I decide to pursue the intervention and create a unique conversation that she has not had before. I did, however, feel the need to reinforce the idea of the exercise at this point.

C Would you be in the house you are in now or would you be living somewhere else? This is a miracle anything can happen.

L (Nervous laugh) I’d be in the house I am now.

C Be in your house. OK! Would it look the same?

L Umm. Yeah I think so.

Lisa seems uninterested or even confused I am beginning to think this exercise is not going to be as effective as I had hoped. A more thorough introduction may have been necessary.

C The walls and everything all the same decoration?

L Apart from (pause) apart from the bathroom and my bedroom, yeah.

Now she seemed interested and had a smile on her face, I felt she was finally letting her mind work.

C How would they be different?
L Because my bedroom is just plain I’d have it, umm, I’d have it more girly I suppose. More bright.

C (Over her last words) You’ll have to describe that for me.

L (Laugh) This seemed to be a nervous laugh unsure really of what I was doing and what she should say.
I felt I could probably help out here with ideas but realised that for me the position of not knowing is more ethical, it stops me leading the patient in a direction I want. To do this would only serve to destroy the exercise and retard therapy (Anderson, 2001).

L More, I don’t know. It’s just beige there’s just nothing in there. It’s just a bed.
Again a return to the present as she struggles with the idea of a brighter future. It is not surprising that this happens she is after all focused on the problem, which drove her to seek therapy. The maintenance of a problem is down to the setting or context and the expectation that it will continue. The aim of the miracle question is to break this idea by experiencing a future without the problem. The expectation that things can get better underlies the success of therapy (de Shazer, 1988).

L I’d have it more romantic I suppose, more girly, more pink.

C (over last words) What things would be different? More pink?

L Umm.
C Pink walls?
L No, pink bedding I suppose, white walls.
C What about ornaments or a new bed?
L Yeah I’d have uh (laugh) a new bed.
C Anything else in there?
L Just a picture above the bed.
C What would that be?
L Umm, it would be a scenery or something, the seaside or something.
C The seaside. Anywhere that you have been in particular?
L Umm, Corfu probably.
C What about the bathroom?
L It’d be tiled from top to bottom in yellow and white and it would be full of butterflies.
C Butterflies?
L Yeah.
C What, pictures or?
This break in the sentence is an indication for her to complete it to help construct the imagine and not to be led by me.

L Umm, just any butterflies, pictures or whatever, yeah, hanging butterflies anything.
I was wondering where suddenly all this information was coming from. Anderson (2001) suggests ideas do not spring from a vacuum but grow in a contextual history of moulding personalities and desires. They either have some significance to her or have been created through our communication in some way.

C OK. You like butterflies?

L Do I? Not really into butterflies but yeah, butterflies.
C Does, does that mean something, butterflies?
L Umm, no, it’s just the colours I think.
I made a mental note of this need for colour in her life but I was also thinking that butterflies seem to be very free spirited, relaxed, calm floating on the breeze. I felt this symbol probably indicated many of the things that Lisa wanted to see in her life.

C It symbolises sort of brightness and happiness?

L Yeah and it’s the first place you go in the morning, it’s the first place I go in the morning.
I was beginning also to wonder in there was some sexual attraction in form of transference from my client. We had discussed bedrooms and how she would make it romantic and then she said the bathroom was the first place I would go in the morning. Lisa had spoken at length at other sessions about her relationships with men and her beliefs that the only way for them to stay interested in her was to sleep with them. At the previous session she had also expressed that she no longer wanted to dig up the past, I felt if I dwelled on this any further it may alienate my client and reduce the effectiveness of the exercise. This moment of therapy may also have related to my own countertransference or unease dealing with these possible feelings from my client relating to my inexperience of such transference issues.

C OK. So you have a posh new bedroom with your picture of Corfu, you have this lovely bathroom yellow and white with all these butterflies and all these colours. How would, how would Kylie be acting?

L Umm.
C What would she be doing?
Singing? 

Laughing.

Where would she be?

Getting dressed in the morning in her bedroom, or between there and the bath.

How would Kylie know that you were, that everything was fine when she saw you?

This is finally getting back to the focus of the miracle question the behaviour of the client and the noticeable differences.

Umm, because she would say morning and she would give me a cuddle or I'd give her a cuddle.

(Pause five seconds) Anything else, any other signs or things that she would recognise or you would recognise?

Umm, tone of voice would be different.

How would that be different?

Umm, because it would be lighter and it would be jolly (pause 10 seconds).

I was waiting for her to expand this further but she was not forthcoming, so I decided to repeat the line of questioning from her other daughter's perspective and see if that enabled her to progress further with the miracle.

What about Lacey?

Well, Lacey is just Lacey anyway so.

What would she be doing?

She is always jolly, umm.

So she would be pretty much the same?

Yeah, yeah. She’s not really a stressed person as such.

She seems again to be coming out of the exercise and I feel I need to concentrate her mind again. A more solution-focussed question would try to identify the differences rather than similarities I felt I needed to focus more.

Kylie is singing between the bedroom and the bathroom so what would Lacey be doing?

Lacey would be shouting at her probably to shut up (laugh).

This is again a slip into her current problem situation, again fuelled by a little laugh indicating the familiarity of it. I wanted to get her back on track since moments before she seemed to have really begun to really think out her miracle and I felt this was leading us towards an identifiable goal.

Perfect, it’s a miracle remember. Is that just how you want them so is, is that how you want them?

No. Lacey would be the same then obviously.

This is too simple an answer and I feel she again needs more encouragement to think at a deeper more imaginative level.

So would she be doing the same sort of things as Kylie or something different?

She would, no, Lacey would be dancing.

Dancing?

Mmm.

And how would Lacey know, by looking at you and seeing you that things were different?

Umm, I don’t know. Just by the way I am I suppose or by the way I talk to her or the way I’m smiling at her.

Again smiles and tone of voice.

I felt it necessary to punctuate these points as they had been mentioned before and were a significant step to a positive change in her relationships.

What about, what would you be wearing?

What would I be wearing?

Mmm?

Jogging bottoms and a top probably, relaxed.

Relaxed.

Yeah, comfortable.

And what would the kids be wearing?

Umm (pause). Lacey would probably be the same but with a girlie top on. Umm, Kylie would be in jeans and a jumper.

Everything, everyone looking sort of very casual?

Yeah, yeah.

Is that different to the way things are now?

Umm (laugh). Yeah.

How are things now in comparison?

Umm because Kylie wears a load of clothes and she can’t make up her mind and she’ll change four times in the morning and.

This could easily revert Lisa to discussing the problem now. I interrupted her to keep her focused on the future.

So she would have just made up her mind that I’m just wearing jeans and that jumper?

Yeah, Yeah and that would be it but she doesn’t.

Lisa was trying to get back to her present situation.
here. It is a familiar pattern that she feels comfortable with, however I felt at this point that Lisa was actively engaged enough for us to pursue the miracle further and I thought an exploration of a perfect day would be appropriate. It would also give me some insight into her current life. On reflection I wonder whether I was being led by the technique rather than being more aware of the process.

C So take me through this new wonderful perfect day what, what would happen?
L (Laugh) I don’t know. Does it have to be a school day or?
C It’s up to you.
I am trying to empower my client to help her find an undiscovered country of potential, so she can choose the direction of her life. de Shazer (1988) states that the only difficulty is that clients do not know how to solve their problems.
L Umm, I don’t know, probably go round a friend’s house.
C Who would that be?
L Umm, I don’t know because I haven’t got any (laugh).
This laugh is completely misplaced and is a defence to hide the emotions she has which surround her possible feelings of worthlessness and vulnerability without having friends around her.
C So you would have a friend?
This was a deliberate attempt to focus on the future positive and establish that she will have peer support.
L Yeah, I’d have a friend and we would go round there, yeah.
Lisa has accepted this and seems willing to continue.
C What would this friend be like?
L Umm, someone that’s jolly, someone that makes me laugh, someone that’s loud, umm and chatty.
From my earlier conversations with Lisa I got the feeling that these characteristics were parts of herself that hadn’t been seen for many years and that she misses the associated feelings of freedom and happiness.
C What would her name be?
L Umm, I haven’t got a name.
This seems to again tie in with the missing bits of herself. She can’t name then because of her core belief that she is worthless (as such not worth identifying).
C Mmm.
This little encouragement seems to make her dig deep and she again plays the game.
L Shanice.
C Shanice (pause 10 secs).
I was surprised for a moment that she had been able to come up with a name and one so unusual. I began to think that this new imaginary friend may be based on her friends in the past, as Gill (1999) states the therapeutic conversation is fuelled by the constellation of relationships the client has experienced previously.
C What would you do?
L We’d go round there and her kids would play with my kids and we’d be chatting or just mucking about. We’d have a cuppa and a chat and we’d probably go into town.
C Mmm.
L Umm, we’d go down to the, dunno, to the park we got the water in the town and we’d take the, the kids would take their swimming costumes and just lark about all day and take our music down.
She is really thinking now and I want her to go deeper and really experience the possibility of this future.
C So is it a nice day?
L Yeah.
C What sort of weather?
L Umm, hot but not too hot, not sticky.
C (Over last words) What time of year?
This takes us away from the basic format of the miracle question which focuses on the next day when all the presenting problems have disappeared. We are now talking more generally about preferred futures.
L Umm, August.
C The girls take their swimming costumes are you taking yours?
L Yep.
C Everyone’s got swimming costumes.
L Yep.
These affirmations were much more positive. She had previously only commented ‘yeah’ but the change here is noticeable. She seems part of this exercise now and knows what she wants and seems to be enjoying the experience.
L We’ve got a football as well.
C Yeah?
L Mmm.
C So who gets in the pool first?
L (Laugh) Me. Mmm.
C Do you have to encourage the others in or?
L No, no they all jump in.
C They all jump in?
L Yeah.
C Do you walk in slowly or do, do you just dive in?
This was an attempt to discover how she would like me to take the course of our sessions. Motivation is a dynamic process determined by personality and context. I wanted to know if she wanted to do things slowly or was prepared to take some big jumps forward. In a sense I am discovering the extent to which Lisa is a Customer (de Shazer, 1988).
L Umm. No, you can’t dive in there because the water’s not that deep, it’s like knee high.
C Its a perfect day remember so it can be deepened if you want it to be.
L All right then (laugh). No, it’s knee high.
L Lisa has communicated that she doesn’t want to jump right in it could be a sensible reaction of a mother protecting her children and/or possibly an unconscious message that she wants to proceed in therapy with some caution. My thoughts at the time were focusing on the latter as I was aware of her previous experience of therapy and the way disclosures were mishandled (in a sense she had been thrown in at the deep end).
C Knee high?
L And we just, yeah, and we are all in there holding hands jumping about in the water splashing.
C All holding hands?
L Yeah.
C Who are you holding hands with?
L Kylie, Lacey, the other kids, my friend.
C Who’s, but who are you directly holding?
L Kylie and Lacey.
C So one on either side?
L Yeah.
C Who’s on which side?
L Kylie’s on my left, Lacey on my right.
C Are you right- or left-handed?
I felt I needed to know because there maybe a reason why the girls were on which side, possible the favourite being on the favourite hand. This is my act of strategising, what Tomm (1987) defines as the therapists cognitive activity in evaluating the effects of their interaction, how to proceed to maximise the therapeutic utility. The therapist, therefore, flows with the stream of spontaneous activity.
L Right-handed.
This means that her second daughter would be in the favourite position. This may indicate part of the problem that she feels it is easier to be with or favours Lacey over Kylie. This may be a result of the time spent caring for her youngest daughter’s medical needs. Previous sessions have indicated that Lisa tends to attribute the majority of arguments at home to Kylie’s behaviour. I contemplated whether or not to reflect this but decided it really did not have a place within the positive connotations of the miracle question and I would retain the information until a more appropriate time for reflection, when it could be supported by facts rather than conjecture.
C (Pause 10 seconds) So, the girls are on both your side jumping up and down splashing?
L (Over my words) Mmm, yeah.
C And what happens next?
L And then we, umm, go and get an ice cream or something because the ice cream man comes and then we’ll, the kids will play in the park while me and my friend sit and listen to music or sunbathe.
C So the kids are able to have fun on their own?
L Yeah.
C And you don’t have to worry about them?
I missed the opportunity to investigate how she would be feeling at this point. The exercise seems to be creating a picture of relaxation and yet we haven’t actually identified this feeling. I was in fact feeling rather relaxed at this time and should possibly have reflected this back. Casement (1985) describes this as communication by impact, silence or absence listening to what the patient makes you feel.
C (Pause 5 secs). Play catch as well with the ball.
L Play catch as well with the ball (pause five secs).
C What games, just with the ball?
L Yeah, football, piggy in the middle.
C Who’d be the captains of the teams?
L Kylie (laugh).
C And then?
L My friend’s daughter.
C Who would win?
L Us (laugh).
C So us is, are you on Kylie’s team?
L Yeah (laugh).
Do you win everything?
This is an attempt to see how grounded she can be, is she excepting of reality and prepared to incorporate this into her miracle.

No, No.

What games would you win?
I don’t know it depends what we played really. Umm, we’d win a couple and they’d win a couple so that it’s fair.

You’ve had a swim, had an ice cream had a relaxing chat, the girls have been playing sort of family games?

Mmm.

What happens then?
Then we walk back into town and the kids would get McDonalds, me and my friend could have something to eat and then I suppose we would go our separate ways home.

And what would happen at home?
Umm. The kids would probably sit there and listen to their music; they’d had a nice day, they’d be singing, Lacey would be dancing, making up their own music. Umm, and that’s it I suppose (laugh).

What would you be doing while they did that?
Sitting there listening, watching.

You’d just watch them?
I’d join in probably give them a few, umm, words to their songs and, yeah, I’d just be laughing at them.

How would that day end?
Umm (pause five seconds), umm, giving them a kiss and a cuddle, umm, and perhaps reading them a book or taking it in turns to read bits out of a book. At bedtimes or just before perhaps, umm, perhaps in the bedroom cuz its nice to read and it’s nice to hear, hear Kylie read as well.

Yeah.

She likes reading. Do that then cuddle them and then (pauses)
Lisa has paused and I am unsure if she is just stuck for ideas or whether she is actually enjoying this moment of family bliss, that she has just put into words. I try to encourage her a little further.

What do you do then?
After? Go to bed (laugh).

You go to bed too?
Knackered (laugh).

It’s been a busy day.
Yeah.

Would you be on your own?
This was an attempt to see if there needs to be a significant other in her life for her to be happy.

I’d be on my own. Yeah, probably.
Without the need for a partner this means that her miracle is a lot easier to build straight away.

OK. If you had to choose a few words to sum up that day what words would you choose?
Umm. Brilliant, exciting, relaxed, chilled out. That’s it really.

Summary
As we approached the end of the miracle day I decided to conclude with words that described the day so that these may serve to punctuate a view of the future. Hopefully providing a positive perspective to her land of possibility. With these words still fresh in her mind I then asked what tiny sign she might notice that was an indication that this was achievable and that this miracle was happening. She said that a sign would be not arguing with her daughter for the first hour when she returns from her father’s. We discussed in some detail the circumstances surrounding Kylie’s home coming in an attempt to plan possible behaviours that could ensure that the first hour was positive. This enabled us to spend sometime discussing what behaviours she would like to see and how they might be obtained. de Shazer (1988) suggests that a conscious and deliberate plan towards solutions are made between therapist and client based on the resources of the client. ‘Clients are constructing their lives and it is the therapists task to help them; get on with life in a way that they will find satisfactory’ (p.77).

The use of the miracle question with this client did prove to be a lengthy exercise, which may in part have been a result of my inexperience using the technique. Solution-focused therapy integrates the miracle question as part of a first session in combination with an exploration of the client’s ability to relate the experience of the miracle to a scale so that it can be seen as the final step or goal for therapy. These aspects were missing from the session and may therefore have reduced the understanding of the client’s competencies and the necessary steps she could take to get closer to her miracle.
Although she enjoyed the miracle question at the end, there was a good deal of confusion at the beginning. When completed I enquired as to my client’s thoughts on the session and whether it had been useful. This was to ensure that the feeling of competence stayed with her. Therapists can make sure they don’t collude with the notion they have expert access to the truth by constantly asking for clarification of issues and how therapy is helping. The person’s experience of therapy is essential (White, 1991). Lisa remarked that following the exercise she found that she was able to think positively as well as negatively about her situation. This may reflect what Tomm (1987b) describes as a charmed loop, this is a reflexive moment but one where meanings stay the same. This may mean that although there has been no reframing of the situation the thought process may have begun to erode previous views and open the possibility for future change.

At the following session Lisa reported that she had a new friend and that they were spending a lot of time together and their children all got on. They were currently planning days out together.

**Discussion**

The use of the miracle question was to identify a workable goal and possible solution. de Shazer (1988) argues that the exercise enables the client and therapist to see a clear picture of what a solution would look like even when the problem is poorly described. The better the imagined future is described, the more confident the therapist can be in defining the client as a customer rather than a complainant (de Shazer, 1988). For Lisa, a solution would involve a more relaxed and fun relationship with her girls and a new friend with whom she could share the experience. On reflection though I am aware that a large percentage of the exercise was spent describing material aspects of the future rather than focussing on the client’s behaviour and recognition of differences in herself and others.

Subsequently, I have found that if the question is not set up initially to identify that the miracle is the absence of the problem that brought the client to therapy they tend to resort to describing material changes (usually linked to a lottery win). The effectiveness of the technique may have been reduced because of my inability to define the scenario correctly and possibly the nature of the questioning I used. More helpful questions, when exploring the miracle, may have been ‘How will you do that?’ ‘In what way would that help?’ ‘What needs to happen so that …?’ These could then have tied in with identifying steps on a scale towards the miracle.

The emphasis of Solution-focussed Brief Therapy is to find exceptions to patterns of behaviour, these exceptions are part of deconstructing the frame of thinking that governs the client’s life. The aim is to find an undecidable, an element that does not fit within the frame of thinking and calls into questions the appropriateness of that frame, to help establish a new view of the self as a survivor and build a solution from material outside of the pattern of the complaint (de Shazer, 1988). Although Lisa did actively imagine a problem free future she found it difficult at times to escape the ties of her problem in the present. The exercise although enabling her to think positively did also cause a small amount of distress. She said it was easy to imagine a future because she had experienced times like that before. This made her sad because she was not experiencing them now. Lisa seems, therefore, to have based her current feelings on identifying negative exceptions to a former state of being. These negatives need to be reframed as a base level from which positive exceptions can be identified as she moves towards her construction of a brighter, more relaxed relationship with her daughters.

I did find this technique somewhat clumsy at first, the wording is difficult and some clients need continual reminders of the concept of the exercise. However, in my experience the question has been effective in freeing the client from feeling stuck and providing hope and the mental experience of a more positive outcome than the one her problem thinking dictates. The developments of Solution-focussed therapy highlighted in de Shazer (1988) include a shift in focus from the techniques, to the solution related things that clients and therapists do in the session (de Shazer, 1988). In a sense from content to process which can then enable the client to do more of what works. This develop-
ment seems to be more directly in keeping with
the core role of counselling psychology and the
importance of the therapeutic relationship.
This may suggest an effective fit between the
discipline and brief solution-focussed tech-
niques.

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The aim of this paper is to act as a springboard to generate discussion between therapists about ethical dilemmas raised through their clinical work. It is hoped that this paper will provide a starting point for an interactive forum to encourage the discussion of ongoing practice issues and dilemmas. Two case examples are presented, one by each therapist, which grapple with therapeutic/ethical/legal issues within the settings of: (1) a Domestic Violence Project, and (2) a Community Mental Health Team.

Therapists’ dilemmas have been highlighted by Lindsay and Clarkson (1999) and Dryden (1985). In our case examples the focus is upon ethical dilemmas. These include: giving information within the counselling role, supporting and containing a client if wider systems fail, role conflict within the therapeutic relationship, professional and ethical ‘mismatching’ within a team and managing personal feelings within the therapeutic relationship. For ease of reading the case examples are presented separately although there is a significant amount of overlap between them.

Introduction

As psychologists our focus is primarily upon the intra-psychic world of our client. However, it is also important to recognise the impact of larger systems upon the therapeutic relationship. The biopsychosocial model (Engel 1977; McDaniel, Hepworth & Doherty, 1992) highlights contextual meaning and considers the importance of significant people and/or systems surrounding the client. McGoldrick (1998) also takes a systemic view and suggests that not only clients’ lives but also counselling psychology can be constrained by larger forms of inequality. Tensions, therefore, exist between the demands of individual client work and that of the larger system.

The case examples below explore therapeutic dilemmas related to domestic violence, abuse and rape. As therapists we often find ourselves having access to a world which is mainly secret. This can raise certain questions as to: (1) how society perceives these issues, and (2) the personal feelings of the therapist when working with abuse. Further discussion related to domestic violence is outlined in case example one.

The vignettes illustrate how the legal and health systems impact upon the therapeutic work, increasing feelings of client helplessness and powerlessness. They demonstrate that clients with a history of childhood abuse display a vulnerability to further abuse and may experience larger systems as abusive (Dale, 1999; Jehu, 1988; Russell, 1993; Sanderson, 1990; Schwartz, Galperin & Masters, 1995). The extent of the power dynamic within the therapeutic relationship is raised as well as a consideration of the ethical issues involved irrespective of the therapist’s model of practice.

Ethical issues underpin our dilemmas and will be explored in detail in Case example 2. Ethical frameworks have been developed in order to guide our work as counselling psychologists, e.g. BACP and BPS codes of ethics, incorporating a wider view of each practitioners work. Such protocols represent the consensus of a large number of individuals within the profession and hence represent shared ideas, rules and guidelines. However, ethics are also part of a system and the question has been asked as to how ethical these codes and guidelines are as well as their cultural relevance (Pattison, 1999; Raven, 2000). In order to overcome these difficulties and ambiguities Kitchener (1984, 2000) has proposed that we use the idea of ethical
principles. These are: **Beneficence** – the principle of benefiting others, of accepting responsibility to do good. **Non-maleficence** – doing no harm, requires psychologists not to perpetuate physical or emotional harm or to engage in behaviour that could result in harm to another. **Autonomy** – is our belief in a client’s right to choose. **Justice** – requires psychologists to act fairly and justly, balancing the rights of the clients with those of others. **Fidelity** – includes keeping promises and being trustworthy and loyal.

**Case example 1 – The Domestic Violence Project**

It is believed that at least one in four women experience domestic violence during their lifetime (British Medical Association, 1998) carrying with it a range of devastating physical and psychological effects (Andrews, 1991, 2000). Despite this, there appears to be a high dismissal of ‘relationship’ cases in court (Buzawa & Buzawa 1996; Hoyle, 1998). On the domestic violence project much discussion has been generated in relation to the invisibility of this issue as well as accompanying stigmatisation, taboo and often shame. Domestic violence, by its very nature often takes place behind closed doors and is, therefore, hidden from public view. It is also an issue which is historically rooted in religion and law where a husband had the right to ’physically chastise’ an errant wife, provided the stick was no bigger than his thumb (Blackstone’s codification of the common law, 1768). In the case below, questions are raised in relation to societal response in condoning violence and the reinforcement of client learned helplessness. Therapeutic dilemmas hinge around our attempts as therapists to empower clients in the face of abuse, injustice and the wider system.

A 44-year-old woman from a lower socio-economic background was referred to the Domestic Violence Project as a result of being raped and assaulted by the man she was having a relationship with. Prior to this she had experienced a recurrent pattern of domestic violence, and had a history of sexual abuse. Her presenting problems included depression, low self-esteem and a lack of assertiveness. Shortly after referral this client decided to go forward with legal proceedings – which seemed to give her a great deal of confidence. However, despite having made substantive progress the client relapsed as a result of her perpetrator being acquitted and did not attend any further therapy sessions.

**Dilemma 1 – Giving information within the counselling role**

In Case example one a dilemma exists in relation to empowering the client in her decision to take legal action (autonomy) and realising that she was not fully aware of the full range of consequences. The dilemma raised is how far to inform such a client of the possible pitfalls of taking her perpetrator to court – based on cumulative experience of working on the domestic violence project. Whilst it is suggested that the giving or clarifying of information by the counselling psychologist can lead to a better outcome for the client (beneficence), questions are raised in relation to the following:

i. *Feeling uncomfortable about giving information in a person-centred frame* (the model adhered to on the domestic violence project). In order to maintain congruence the counselling psychologist needs to share her knowledge in order to help the client reach an informed decision as well as to help prepare the client for possible unfavourable outcomes. This highlights the limitations of this therapeutic approach when working with domestic violence.

ii. *Possible confusion between information and advice giving*. In order to clarify the difference between these two concepts it may be helpful to distinguish between information giving (imparting knowledge or facts) and advice giving (an opinion or recommendation about a future action). Bor *et al.* (1998, p.88) emphasises the importance of information giving within the counselling psychologists’ role, suggesting that it can help ‘to achieve a better outcome for patients and facilitate the process for the person giving information’.

iii. *A lack of clarity around how much specialist knowledge is necessary for the task* and an awareness of not working outside the boundaries and limi-
tations of therapist competence: If and when information is given, it needs to be accompanied by close liaison with a supervisor (preferably specialised in the field of domestic violence), relevant support/advisory agencies, specialist training and extensive reading. As legal implications may result from the imparting of incorrect information, counselling psychologists should always mention the limitations of their competence, be tentative in their answers and direct clients to appropriate specialist services.

iv. Maintaining role boundaries. Apprehension may be experienced about entering into a dual role relationship with a client and the principle of non-maleficence must be borne in mind at all times. As mentioned above, the counselling psychologist needs to be extremely careful not to appear as an expert as she could be extremely influential upon a client’s decision (Woolfe & Dryden, 1996). Whilst this dilemma addresses the need to maintain clear boundaries in relation to role, it should also be remembered that giving/discussing or clarifying information within the counselling role is only one component of the communication between psychologist and client.

Dilemma 2 – Supporting and containing a client if a system fails
Therapy does not occur in a vacuum and as shown above may be impacted upon by all types of prejudice and/or injustice from surrounding systems. In the vignette the perpetrator of domestic violence was acquitted leaving the client to feel that the judicial system had colluded with her abuser. In a case such as this a dilemma exists as to how a therapist can empower a client to gain control over a system she perceives as failing her. Kitchener (1984, 2000) highlights justice as an ethical principle which requires therapists to act fairly and justly balancing the rights of clients with those of others. However, the issue of justice and client rights are questionable when considering the impact of such legal decisions upon a client’s mental health. In the above case the court decision reinforced the idea that sexual and physical abuse was acceptable; maintaining the client’s victim position. Feelings of hopelessness in the therapist can be evoked due to the fact that therapeutic relationships can seem to do little in redressing the balance of power between the individual and such wider systems.

Dilemma 3 – Managing personal feelings within the therapeutic relationship
It is believed that the therapist’s feelings are a critical part of the therapeutic process (Johns, 1996). Transference/countertransference issues are central to psychoanalytic thinking and may be usefully applied to working with domestic violence and abuse. However, an understanding of such concepts need to be carefully balanced with the real injustice of a client’s situation in order to provide a correct therapeutic response. This in itself raises a dilemma.

Working with domestic violence
Feelings of injustice – may be experienced by female therapists working with an issue such as domestic violence as much of the work hinges around treating clients whose problems in part reflect the societal role of women. This poses a dilemma for the therapist who is working towards changing a client’s perspective and reactions so that they can more easily accept and function in the world as it exists. However, implicit in such work is the fact that therapists through their treatment may be inadvertently reinforcing the status quo. A dilemma, therefore, exists between the therapist’s desire to bring about social change on one hand whilst possibly finding herself acting as an agent of social control on the other.

Feelings of vulnerability – may be experienced when working with the issue of violence. Secondary traumatisation has been highlighted by Hudnall Stamm (1997) and Figley and Davison (1997) and is believed to affect therapists who work with victims shortly after a traumatic event. Therapists, therefore, need to be aware of the ‘ripple’ effects of trauma when working with victims of domestic violence and good supervision and training is important to combat these effects.
Case example 2 – The Community Mental Health Team

Van Hoose and Kottler (1985) discuss how ethical principles influence the therapist’s role and responsibilities. The therapist must also bear in mind that there are ethical biases that are implicit in the therapeutic models we use and we must also be aware of the ethics and policies of the environments in which we work (Bond, 2000). Van Hoose and Kottler also advocate that therapists develop a personal style of ethics as ‘to blindly follow ethical codes without questioning their personal relevance is to continually live up to others’ expectations for how one ought to act’. They remind us that the therapist tends to behave according to his belief as to what is right or wrong for a particular client. As a guide, Van Hoose and Kottler list 12 questions for examining the moral rules one lives by. These questions have evolved from their experiences and their research into ethical theory. Two of the questions ‘To what extent would you obey professional codes of ethics, society’s laws, or institutional policies if they are incompatible with your own?’ and ‘How tolerant are you of colleagues’ unethical practices? Under what circumstances would you turn someone in?’ were of particular interest when considering the following case example.

A 39-year-old mother of three, had a history of childhood sexual abuse and had married a man similar in character and behaviour to her abusive father. This client had a long history of psychiatric interventions due to her chronic depression, anxiety and self-harming behaviour. After her discharge from hospital, she was referred to the Community Mental Health Team. However, before attending her first therapy session she revealed to a team member that she had been sexually assaulted by one of the hospital staff.

Dilemma 1 – Managing the role conflict within the therapeutic relationship

The Counselling Psychologist’s main role is to provide therapy that is beneficial to the client (Altmaier, Johnson & Paulson, 1998). Within a therapeutic relationship, clients can demand many things of the therapist. Sometimes they do not know what to expect – Russell (1993) writes that the client may wish to use the therapist as many things. In Case example two the client expected the psychologist to fulfil roles of advocate, solicitor, policeman, friend and supporter.

In addition, the multidisciplinary team and hospital managers have different perspectives as their expectations of the therapist incorporate ‘Key-working’ and ‘Care Co-ordination’ roles. Hence client, team and managers have different expectations of the counselling psychologist, creating conflict between therapeutic philosophies, the professional care system and the client’s needs. This resulted in dilemmas for the counselling psychologist, as she was also the client’s Key-worker and Care Co-ordinator according to the Mental Health Trust’s system of CPA (Care Programme Approach). Managing such dual relationships is never easy. Pope and Vetter (1992) state dual relationships as being the second most reported ethical dilemma.

Dilemma 2 – Professional and ethical mismatching within a team

It can be difficult working in a multidisciplinary environment (Robinson Kurpius & Vaughan Fielder, 1998). However through case discussion, joint meetings and supervision a cohesive package of care can be achieved. In case example two, different members of the same team delivered their service in contradictory ways, creating a split between the team and distress to the client. It also became clear that a colleague’s approach and ethical principles colluded with the client’s ‘dysfunctional behaviour’ adding complications and eroding any progress made in the therapeutic work. Bor, Miller, Latz and Salt (1998) and Bond (1993, 2000) do offer solutions, however, and counselling psychologists have to be aware of such external factors and address them with all concerned.

As therapy proceeded, the client decided to make a complaint to the hospital managers. However, the investigating managers insisted on communicating to the client via the therapist and did not appear to consider the principle of autonomy as important (Kitchener, 1984). It became clear that the complaints procedure and the way it was conducted was
actually contributing to the client’s distress and deterioration of her mental health. It was not adhering to the principles of autonomy, beneficence or non-maleficence and the client was experiencing this larger system as abusive (Dale, 1999; Sanderson, 1990). The client was left feeling unsafe, believing the whole system to be biased, untrustworthy and in collusion with her perpetrator. This culminated in her suicidal feelings increasing and her re-admittance to hospital.

This paradoxical situation questions the six functions of ethical codes cited by Russell (1993) – in particular function four regarding self-regulation and integrity. Russell (1993) states this function is contentious as a self-regulating organisation risks being accused of being self-serving. In this case, the therapist was part of a system that ‘injured’ a client yet was supposed to be providing a service that ‘healed’.

**Dilemma 3 – Managing personal feelings within the therapeutic relationship**

*Working with sexual abuse*

*Protection versus empowerment* – because of the ‘fragility’ and apparent ‘neediness’ of the client there was a feeling of wanting to protect her from further pain or hurt (Watkins, 1983).

*Rescuing versus autonomy and self-efficacy* – the therapist wanting to rescue the client from the awfulness of her situation whilst knowing that she did not have the right to do so is a difficult feeling to manage. It contravenes the whole notion of enabling the client to become efficacious (Russell, 1993; Lakin, 1988).

*Advice versus guidance* – both clients often wanted straight advice and it was necessary to distinguish for them the difference between giving of advice and guidance to think about all options in order to take responsibility for their own decisions (Van Deurzen, 1999).

Acknowledging ethical principles allows some guidance and support when considering personal reactions. The principle of autonomy was particularly important. Rescuing the client contravenes the notion of autonomy and links to issues of ‘maternalism’ – the therapist assuming she had knowledge of what was best for the client. Although believing a course of action was in the client’s best interests may seem to be within the principle of beneficence, it may also have contravened autonomy (Kitchener, 1984). Advice goes directly against most counselling codes and Van Deurzen (1999) points out that our aim is to allow the client space to make their own decisions, relying on the principle of autonomy again.

Hetherington (2000) emphasises it is important for subsequent therapists to convey non-acceptance of abusive behaviour by clinicians in order to help stop the cycle of abuse. This is difficult to gauge with clients possessing such low self-esteem and ambivalence towards the perpetrator. This ambivalence is quite commonplace in such situations and is an important issue to be aware of (Dale, 1999; Jehu, 1988; Russell, 1993; Sanderson, 1990). Hence making the separation of personal feelings a vital element of therapy (Lakin, 1988; Wosket, 1999).

**Conclusion**

Both case examples demonstrate:

1. how the wider system impacts upon client feelings of helplessness and powerlessness;
2. the difficulties of addressing issues related to domestic violence, abuse and rape;
3. the need to be aware of personal feelings in therapeutic relationships;
4. the importance of an ethical framework.

In both cases ethical dilemmas were raised as a result of perceived injustice in the larger system. In the first case, the client felt ‘betrayed’ by the agency that she had turned to for ‘justice’. In the second case the client was ‘hurt’ by the system that should have been a source of her ‘healing’. What can we learn from this?

Engel (1977) and McDaniel et al. (1992) suggest that it may be helpful to understand the influence of belief systems upon the therapeutic work. We therefore need to consider the impact of wider systems upon our relationship with the client and recognise that these can form complex interactions during a client’s time in therapy. McGoldrick (1988) points out that it is not only clients lives but also counselling psychology that can be constrained by larger forms of sexual, class based, cultural, racial and other types of inequality. Our learning there-
fore needs to incorporate this knowledge whilst remembering that we are also a part of the system. By developing such an understanding we can raise awareness and move towards greater collaboration between agencies.

Bor et al. (1998) and Gallop (1998) point out that solutions are found by reflecting on the dynamics of a situation; recognising and understanding the relevant influence of contextual and organisational issues in counselling; more effective team collaboration; supervision and consultation and sometimes personal therapy for the therapist.

It has been shown that many clients test the limits of individual psychological theory. It has also been shown that domestic violence, abuse and rape are difficult issues to work with. Rather than being examined through a singular lens these issues may be better understood through a binocular vision of multiple understanding. A biopsychosocial model indicates that there can be at least three systems interacting with abuse. These include the family, the healthcare system and the legal system. As therapists we often find ourselves being given a magnifying glass through which to examine these systems in order to help the client make sense of the injustices they are experiencing. This can raise questions in relation to the ethical behaviour of those around us.

Ethics and ethical behaviour are complex and involve issues that impact on the individual and society as a whole. These issues can develop into complex dilemmas for the therapist – trying to match personal ethics with the ethics of the larger system. In our cases, the larger systems appeared to collude/reinforce the idea that sexual and physical abuse is acceptable. This is itself raises further complications.

Referring to the particular professional codes and guidelines can be helpful, but as mentioned even these codes are limited and so each individual needs to feel confident and competent to develop there own internal guide. However, it seems clear there is a need for further training on ethics to enable practitioners to develop their own particular ethical practice with a systemic overview – suiting them and the welfare of their clients, whilst upholding and furthering the reputation of the profession.

To conclude, discussion of these issues can increase the effectiveness of therapeutic interventions and help develop a greater awareness of these considerations. Talking openly about these issues may also increase the cohesiveness of teams, reduce stress and ultimately deliver a better service to the client and all concerned. It is, therefore, hoped that the raising of such dilemmas in this paper will provide a foundation for further discussion and so increase the effectiveness of therapeutic interventions in a range of settings.

**References**


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Skills in Person Centred Counselling
Janet Tolan
ISBN: 0-7619-6118-6

Skills in Person-Centred Counselling and Psychotherapy is one of a series of books edited by Francesca Inskipp. Written by Janet Tolan, it has inserts from Alan Brice and Rose Cameron. This series, in which there are three books so far, looks in depth at skills specific to the different theoretical approaches to counselling and psychotherapy.

The strength of this book lies in its structured simplicity and use of everyday language. The operational definitions contained therein render the publication a ‘must have’ for the trainee therapist. For the experienced therapist this book is thought-provoking, rich in imagery and metaphor and represents true testament to the knowledge and expertise of the authors.

Tolan describes theory as the ‘map which guides us through our insecurities when the going gets tough’. Her topography of the concepts inherent in Rogerian principles is effortlessly comprehensible. For the trainee, she creates a comfort zone in that she addresses the issues of fundamental uncertainty experienced by all embryonic therapists around doubts about authenticity in the therapeutic relationship and the worries around deficits in the various core conditions. Tolan normalises this process and in her study of the limitations of the two-circle model of congruence and the need for self-acceptance in the therapist she preaches caution in the absolute pursuit of authenticity as this in itself can ‘easily become a condition of worth’. Her graphic approach to unconditional positive regard and its practical application to a specific case study is refreshing in its departure from traditional verbosity.

The case study presented by Alan Brice is a prime example of sub-personality at work and the reader is drawn into reflection on rather colourful and divergent configurations of self both from client and therapist perspectives. The book is further enhanced by Rose Cameron’s explorations of psychological contact in which her reflective vignettes and practical exercises subtly prompt the reader towards self-exploration and understanding within the parameters of the psychological relationship with others.

Skills in Person Centred Counselling and Psychotherapy is not just an academic guide; it is a valuable tool-kit for the therapist regardless of the level of expertise. It provides, at times, an almost visual insight to the therapeutic process by drawing on the emotional and reflective resources of the reader though the use of the simplest of language. The process is grounded in reality in that there is no idealisation – the story of therapy is told as it is. The insecurities that face us all as therapists at times are confronted in the cleverest of formats and from the book the reader inherits an acute awareness of his or her own humanity in the therapeutic process.

Sheila Hawkins
This third edition of *Grief Counselling and Grief Therapy* is published 10 years after the second edition. I read it with great interest having based much of my work with bereaved clients on Worden’s ‘Four Tasks of Mourning’ taken from the second edition.

It is a comprehensive study of the problems arising after bereavement and is written in a down-to-earth and jargon-free manner. Primarily aimed at the mental health practitioner, it is a useful text for psychologists, psychotherapists, counsellors, social workers and nurses.

Worden starts with a study of the part that attachment plays in grief and examines the normal grief reactions as feelings, physical sensations, cognitions and behaviours. He also explores the distinction between grief and depression.

He explores the mourning process in terms of his four tasks of mourning. These are: to accept the reality of the loss; to work through the pain of grief; to adjust to an environment in which the deceased is missing; and to emotionally relocate the deceased and move on with life. In using the concept of tasks, Worden argues this is more consonant with Freud’s concept of ‘grief work’ implying that the mourner needs to take action and can do something about the way that s/he feels.

He expands this to introduce the mediators of mourning as a way of understanding individual responses within grief.

Chapter 3 explores working with uncomplicated grief, who does it, how to do it and with whom. Worden identifies 10 principles for working with normal grief and lists useful techniques to use. He includes an examination of group work as an effective and efficient way of offering emotional support.

Chapter 4 covers what he refers to as complicated mourning, looking at why people fail to grieve and how grief goes wrong. He offers clues to diagnosing complicated mourning. Chapter 5 then examines ways to resolve complicated mourning using grief therapy and includes a study of dreams and how to work with them.

The remaining chapters address issues relating to: different types of losses including stillbirth, abortion and death by AIDs; a study of family systems including the findings of the Harvard Child Bereavement Study (Silverman, 2000; Worden, 1996); and the counsellor’s own grief and training for grief counselling which includes 18 grief sketches for use in training.

This third edition incorporates new thinking into his previously-developed models of care. As the second edition redefined the fourth task, so the third further refines the basic model of mourning as well as taking into account new thinking in the field.

Worden’s updated volume remains a major text on grief theory and therapy and continues to have much to offer the practitioner working in grief and loss.

**Alison Gorman**

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*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.*
LETTER FROM THE CHAIR
Most counselling psychologists these days probably do at least part of their work for one of the public services, usually health or education. With the rise of management culture and its emphasis on accountability, the autonomy of professionals such as psychologists has been steadily eroded in recent years as management, with government as the top layer, has accrued more and more power and control to itself. There seems to be an assumption that employees cannot be trusted to perform their tasks without constant monitoring and that their only motivators are the carrot and stick of financial reward on the one hand and fear of unemployment on the other. The old implicit deal where people who were motivated primarily by a wish to do something useful for their communities did so for relatively meagre salaries but also a degree of security, autonomy and respect, seems to have been forgotten. In fact, from the point of view of modern market economics it appears ludicrous and antiquated.

My actual experience of the old deal was that whilst a few people may have taken an easy ride, the majority were extremely committed to what they were doing, often working far beyond the formal requirements of the job and giving fantastic value for public money. Of course, I can’t ‘prove’ this because neither the effort they put in nor its outcomes were ‘scientifically’ measured and recorded.

Every time we fill in another form detailing how we spend each hour of our working day, write a report for no good reason other than to account for ourselves to somebody whose job it is to monitor us, perform another perfunctory and largely spurious audit or meekly submit to yet one more inspection, we give something precious away. A university colleague was upset to be told that he was doing fewer teaching hours and producing less research output than the average. In fact both his teaching and his writing have a rare passion, depth and generosity of spirit that others find inspirational. One of the most subtle and creative people I know in the field of psychological therapy became so exhausted and discouraged by his interminable negotiations with a government regulating body, in the course of which he and his organisation had to produce a document of a million words, that he was contemplating giving up on a lifetime’s work. Passion, commitment, depth, inspiration, subtlety, creativity and generosity of spirit tend to go unmeasured by the crude instruments that are usually employed and may, therefore, not even be noticed, let alone valued, by those with decision-making power.

Of course, it isn’t only in the public services that this situation prevails and in a sense they were the last redoubt. But whatever the context, to be reduced to a ‘human resource’ is intrinsically dispiriting and I have the strong impression that this is becoming an increasing source of psychological distress both for those who consult us and perhaps also for ourselves.

Stephen Munt
Chair, Division of Counselling Psychology
GLIMPSES OF THE 2003 CONFERENCE

I checked into my newly re-furbished room at the Moat House Stratford-upon-Avon on Wednesday, before meeting Isabelle (the conference co-ordinator). We then made delegate-packs to put onto the registration desk. At 7.30 p.m. tired and hungry, we went for a pizza.

Thursday: I used the hotel’s swimming pool and jacuzzi at 6.30 a.m. before going for a peaceful walk by the river Avon. By 9.00 a.m. the conference co-ordinator, her deputy (Ann) and I, ensured that the reception desk was ready to welcome pre-conference workshop delegates. I was then introduced to an invited speaker, David Rennie. His workshop on client-centred qualitative research was intriguing. He generously expressed his perspective on how he developed Inter-Personal Process Recall. Discussion continued in the bar area, where delegates agreed to meet to go out for a meal. While eating a delicious curry, another invited speaker, Peter Heinl, explained how he used objects as an outward expression of what he sensed may be happening under the surface of his clients. At 11.00 p.m. we returned to the hotel.

On Friday, activity in the bath of the room next to mine woke me at 5.30 a.m. Conference packs for people arriving today were displayed for 9.30 a.m. I blew up a few balloons in the society’s colours to decorate the reception with. One of the highlights today was Jennifer Elton-Wilson’s prize giving for her outstanding contribution to counselling psychology. Afterwards, I attended three meetings which dealt with our Division’s matters. Then I listened to Kathryn Mannix. Her presentation was on CBT within palliative care. She ‘entertained’ delegates by inviting audience participation to show the link between thought and emotion in a novel way. During the afternoon, I checked the activities in the Press Office. The Daily Telegraph had an article on childless women which was based on Macallan and Rae’s: ‘Beyond childlessness: how women reshape their identity’. Later, I attended ‘Somatisation: having a disease, feeling sick or being ill?’ by Pat Russell. She emphasised that people talked about their problems in three ways: Firstly, they were just unwell, so they had no diagnosable illness. Secondly, they had a diagnosable illness, which they approached as a challenge in order to get rid of it. Thirdly, they suffered from a medically-diagnosed illness that they owned as their disease. Unfortunately, I did not have the opportunity to attend one of the groups which reflected on the day’s activities, due to another conference meeting. While some delegates enjoyed their evening meal and danced at the disco, others saw the RSC performing ‘The Taming of the Shrew’. Back in my room, I lay in bed and told myself that I would get up early to use the gym.

It is Saturday. I overslept, missed the gym and was late for Peter Heinl’s talk ‘Venturing into the terra incognita – The intuitive exploration of early trauma’. The main thrust of his presentation was that we have a way of knowing which is intuitive and we should not be afraid of using that. He used a koala bear in his example of the process he went through when he felt something unspoken being communicated by his client. The sight of the small toy made me smile. Later I attended Dr. Balamatsou’s ‘Culture and voice in Counselling Psychology’. She explained that there are three types of voices which clients have during therapy: firstly, the coper-voice during the beginning part of therapy; secondly, the vulnerable-voice during the middle part of therapy; and thirdly, the psychologised-voice during the third part of therapy. I particularly liked the graph she showed, illustrating how great the shift was between each of the ‘voices’. This was followed by Rose Riley who presented ‘Revisiting positive Psychology, focusing on aesthetic sensibility and sensuality’. She facilitates clients to focus on what is positively pleasurable, in order to nurture themselves, decrease negative thinking and move in a desired direction. Some delegates then attended the RSC’s performance of ‘Brand’. Back at the hotel Martin Milton presented ‘Doing violence to being: concerns for the therapeutic enterprise’.

John Rowan’s ‘Five distances in Counselling Psychology’ workshop on Sunday was herbal gelignite: He facilitated involvement at a relatively deep level. His presentation clashed with Petruska Clarkson’s, and I would have liked to have gone to hers, too. Feedback on it was positive. Today’s key speech was Professor Rennie’s ‘Counselling Psychology and Philosophy’. It struck a harmonious chord with me, because our philosophy as counselling psychologists is crucial
to our professional identity. I had the honour of sharing lunch with him before attending to the feedback sheets and attendance certificates, with the help of other committee members. I left at tea-time, wishing I had attended the early yoga sessions with Ingrid and taken advantage of the massage offered to delegates. Undoubtedly, I enjoyed the conference and I am pleased to go home. It will be another year before I see some of the old and new friends I met.

Many said what a ‘lovely surprise’ it was to have the alternative cultural programme. I will endeavour to have a ‘lovely surprise’ at future conferences. Put the proposed date for next year’s conference in your diaries; it falls on the same weekend as this year’s in the beautiful city of York. Do think about presenting there. Submit any paper, poster or workshop presentation proposals to Gella Richards (Counselling Psychology 2004 Conference Co-ordinator), via the Leicester office. If you would like to help with our conferences and join the DCoP Sub-Committee for Conference, or if you are interested in being the Conference 2005 Co-ordinator, please express your interest to the BPS DCoP Honorary Secretary, c/o the BPS.

Betty Rudd

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Conferences are a great idea: thought-provoking talks, exchanges of information, meeting old and new friends and colleagues, an opportunity to get away from your usual routine, and to bring new ideas and concepts into your work. But from the perspective of a body therapist, as a rule they can be pretty unhealthy things. All cooped up in a room, artificial lighting playing havoc with your eyes, sitting in one position for a long time causing low back pain and stiff necks and the only people getting fresh air are the smokers puffing away happily outdoors.

In my profession, I treat many counsellors, psychotherapists, psychologists and other people whose job it is to sit and listen for long stretches at a time, resulting in not just mental but physiological exhaustion.

With this in mind, and to see if I could be at hand to offer advice and treatment to the delegates, I made myself available at the recent DCoP conference in May 2003. I provided 15 minute remedial massage treatments for a nominal charge, part proceeds to go to the Macmillan Cancer Trust. The DCoP Committee provided full approval. I brought my trusted chair with me so that delegates were seated and remained fully clothed during the treatment. Isabelle, the conference organiser and I had no idea how I would be received, given that massage has, to my knowledge, never been available for BPS delegates or speakers. Would it be seen as a bit trendy or inappropriate? Would I remain alone and ignored in the corner, eyed suspiciously by muttering groups of counselling psychologists wondering what on earth was that strange woman doing smiling at them and beckoning them over?

It didn’t start too well. Due to a mix up with the hotel administration, my original brochures, set to be included in the pack and informing delegates who I was, what I was doing there, and where I was located, never arrived. So I hastily compiled what was, in effect, a bit of a shifty-looking replacement. But all ended well, and over two days, 33 brave souls came forward for treatment. One hundred pounds was raised for Macmillan who sent, via myself, the Committee a letter of thanks.

After chatting to so many of you at the Conference, you may be interested to know that the most common discomforts reported when counselling are tension in the shoulders, low back pain, headaches and overall tiredness. Here are a few simple little suggestions that may help you to remain healthy and focused during your sessions.

1. **Your chair.** You may have provided a nice, comfortable attractive-looking chair for your clients to sit on, but is your chair really suitable for you? After all, you have to sit on it for many hours a day. Does it support your back properly?

2. **How you sit.** Take care how you sit when counselling. Whether cross-legged or sitting on a sofa with your legs tucked under you may be ‘therapeutically friendly’ but after six hours it can cause lower back discomfort, causing you to tilt to one side which in turn can aggravate the neck and shoulders.

3. **Breaks.** Take time out between clients. It is essential to get out of your counselling room, even for two minutes, do some light stretching and shoulder rotations.

4. **Lighting.** Is the lighting really suitable? You may deliberately keep it low in order that your clients feel at ease and to create a softer environment, but is it, after a number of hours, causing too much of a strain on your eyes?

5. **Get some air.** In some cases it’s not possible, but if you have access to a window, take a few seconds before your next client arrives. You’ll feel a little more rejuvenated and alert.

Above all, take care of yourself; you are, after all, only human.

*Lalla Fox*, Remedial Massage Therapist
E-mail: info@lallafox.co.uk Mobile: 0779 608 4192
TRAINING WORKSHOPS
The Division of Counselling Psychology Divisional Committee is currently looking for ways of introducing self-funding workshops across the UK to further training opportunities.

The Committee would appreciate suggestions of both topics of interest and geographical locations from Counselling-Psychologists-in-Training and also from psychologists who would be prepared to lead workshops on this basis.

In the first instance please contact: Sally Greenfield, c/o Subsystems, The British Psychological Society, St Andrew’s House, 48 Princess Road East, Leicester LE1 7DR.

Or by e-mail on: DCopworkshops@fsmail.net

DIVISION WEBSITE
The DCoP website will shortly be expanded to include details of committee membership and who does what, as well as the agendas for meetings. You can access the website via the main BPS site.

CALL FOR PAPERS
10th ANNUAL BACP COUNSELLING & PSYCHOTHERAPY RESEARCH CONFERENCE
‘The World of Counselling Research’
21 & 22 May 2004 – London
IN ASSOCIATION WITH NINE INTERNATIONAL COUNSELLING AND PSYCHOTHERAPY ORGANISATIONS
For all details visit: http://www.bacp.co.uk/research/general_2004.html

Contact: Angela Couchman on 0870 443 5237
or e-mail angela.couchman@bacp.co.uk

British Association for Counselling and Psychotherapy
BACP House, 35–37 Albert Street, Rugby CV21 2SG.
Tel: 0870 443 5252 Fax 0870 443 5161 Website: www.bacp.co.uk

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Dear Editor,
This letter comes to you from the Royal College of Psychiatry Psychotherapy Faculty and British Psychological Society Liaison Group for Psychotherapy. We are a recently-constituted group attempting to make common cause in the provision of psychological therapies. In the first place we are trying to reduce professional rivalries and address boundary issues in order to facilitate joint working and to take account of the frequency with which patients require the services provided by two or more disciplines. In the second place we wish to highlight how all interventions have a psychological element that needs attending to in order to promote successful working.

To make progress with these concerns we need to study the specific ways in which organisational issues either facilitate or hinder clinical work. We are also concerned to study issues concerning the training and CPD of those engaged in psychological therapies.

We need your help in this undertaking and so would be very grateful for written examples which illustrate successful and/or unsuccessful working of psychological therapies. Of course anonymity of person and place will be preserved. We are seeking examples of day-to-day difficulties or successes which arise from either philosophy, structure or training issues. We would welcome vividly-written sketches of one or two pages in length.

We would be particularly keen to learn how you and your organisation began a particular plan or re-organisation, the steps pursued, the outcome and any lessons learned. For example, how does your local organisation enable both patients and staff to have access to a psychotherapeutically informed person in helping with the management of a patient or a related issue of facilitating treatment?

Our intention is to draw out common factors that lead to helpful clinical and team working and those that hinder successful working. We anticipate that it would be helpful to all involved in the provision of Mental Health Services if we can identify the fault lines which divide success from non-success. We intend to publish the results of this work in readily accessible journals such as the Psychiatric Bulletin and Clinical Psychologist, so that all may benefit.

Dr. A. Garelick (Royal College of Psychiatry) & Dr. R. Goldstein (British Psychological Society), co-chairs of Liaison Group for Psychotherapy.

Please address your replies to the Liaison Group’s Secretary, Dr. Goldstein, at 7 Oxford Road, Malvern WR4 2JD. E-mail: rgoldst@rg.u-net.com

Dear Editor,
This is an invitation for all counselling psychologists (including counselling psychologists in training) interested in researching and or working with the psychoses to contact Lorraine Rhule (E-mail: lorraine.rhule@slam.nhs.uk; Tel. 020 7737 4585) who is part of a team in London developing a counselling psychology and psychosis network.

Ms Lorraine Rhule

Dear Editor,
Psychodynamic-oriented Therapists’ subjective experience of providing therapy:

I am a student at the University of Surrey, where I am conducting a study on what Psychodynamic-oriented Therapists experience when they provide therapy to their patients. This study is being supervised by Martin Milton of the University of Surrey. Although this is not the first study of the kind, it is novel in that I am neither a counselling psychologist nor psychotherapist so I can adopt a position of non-partisan interest to what is expressed. The study aims to capture the essence of any ideas or feelings experienced by the Psychodynamic-oriented therapist at work.

I hope to interview therapists working from a Psychodynamic stance in the Guildford area, who could shed light on what it is they experience when they provide therapy to their patients.

Those who volunteer will be interviewed at a mutually suitable venue. Each interview is likely to last about 40 minutes, and will be fairly relaxed and informal. Names and addresses of volunteers are kept confidential.

The study will be of benefit to qualified therapists, anyone thinking about what therapeutic stance they would like to adopt in the therapy they would provide, and also to clients in Psychotherapy. Hopefully volunteers will also enjoy the interview.

If you would like to participate, please contact me for further details on how to sign up. I can be reached on: 0787 627 6993; e-mail: nuorox@yahoo.co.nz

Mark Lambiris

BPS ANNUAL CONFERENCE 2004

The next BPS Annual Conference will be held at Imperial College, London, from 15–17 April 2004. Invited speakers have been asked to present material relating to the themes of the event which are: Positive Psychology – Prof. Barbara Fredrickson, University of Michigan and Dr Felicia Huppert, University of Cambridge; Creativity and Innovation – Prof. Margaret Boden, University of Sussex and Prof. Steve Smith, Texas A & M University; Perception – Prof. Nikos Logothetis, Max Planck Institute for Biological Cybernetics and Prof. Tom Troscianko, University of Bristol.

For further information regarding the Conference please contact the Conference Office on 0116 252 9555 or visit the Society’s website at www.bps.org.uk.
CONFERENCE DIARY

Format of events listed is:
date: event
venue
contact

NOVEMBER 2003

Royal National Hotel, Russell Square, London.
Mary Meadows, Office and Logistics Manager, European Occupational Health and Safety Magazine (EurOhs), Angel Business Communications Ltd, 34 Warwick Road, Kenilworth CV8 1HE.
Tel: + 44 (0) 1926 512424
Fax: + 44 (0) 1926 512948
E-mail: mary@angelbc.co.uk
Web: www.eurohse2003.com

5: Workplace Stress Conference
Rose Bowl, Hampshire Cricket Ground, Southampton.
Andrea Millicent, Health for All, Eastleigh Borough Council, Civic Offices, Leigh Road, Eastleigh, SO50 9YN.
Tel: 023 8068 8095
E-mail workplace.health@eastleigh.gov.uk
Web: www.ewha.hants.org.uk

10: 2nd Annual Preparing for Parenthood Conference/Exhibition – New Directions in Parent Education
Chesford Grange Hotel, Warwickshire
Health Links.
Tel: 0121 248 3399.

13–15: International Coach Federation
8th Annual International Conference: ‘A Model of Excellence’
Denver, Colorado, United States.
International Coach Federation, 1444 I Street, NW, Suite 700, Washington, DC 20005-6542, USA.
Fax: +1 202.216.9646 or +1.888.329.2423
E-mail: DenverConference@coachfederation.org
Web: www.coachfederation.org/conference/international/index.htm

27: BACP Regional Conference: ‘Is work killing the workers?’
London.
British Association for Counselling and Psychotherapy, BACP House, 35-37 Albert Street, Rugby, Warwickshire CV21 2SG.
Tel: 0870 443 5241
E-mail: events@bacp.co.uk
Web: www.bacp.co.uk

FEBRUARY 2004

20 & 21: Integrated Care Conference 2004
Birmingham Botanical Gardens.
Organised by the International Journal of Integrated Care, in co-operation with the Health Services Management Centre of the University of Birmingham and the WHO European Office for Integrated Health Care Services Barcelona.
Contact IJIC’s managing editor, Ms Astrid van Wesenbeeck.
E-mail: ijic@igitur.uu.nl
Web: http://www.ijic.org/portal/
24–28: Biofeedback Foundation of Europe – 8th Annual Meeting
Zurich, Switzerland.
Danielle Matto P.O. Box 75416 1070 AK Amsterdam, The Netherlands.
Tel: +31 (0) 33 48 90 754
Fax: +31 (0) 33 48 00 520
E-mail: dm-matto@hetnet.nl
Web: www.bfe.org

MAY 2004

London.
Angela Couchman,
Research Development Officer,
British Association for Counselling and Psychotherapy, BACP House,
35-37 Albert Street, Rugby,
Warwickshire, CV21 2SG.
Tel: 0870 443 5237
Fax: 0870 443 5161
E-mail: angela.couchman@bacp.co.uk
Web: www.bacp.co.uk

SEPTEMBER 2004

15–17: The Promotion of Mental Health and Prevention of Mental and Behavioural Disorders: The Third World Conference – From Research to Effective Practice
Auckland, Aotearoa, New Zealand.
Organised by The World Federation for Mental Health, The Clifford Beers Foundation and the Mental Health Foundation of New Zealand in collaboration with The Carter Center, Mental Health Foundation of New Zealand, PO Box 10051, Dominion Road, Auckland, New Zealand.
Tel: 0064 (0) 9 300 7010
Fax: 0064 (0) 9 300 7020
E-mail: conference@mentalhealth.org.nz
Web: www.mentalhealth.org.nz

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

I look forward to hearing from you.

Jennifer Liston-Smith
SHORT CUTS AND CONSEQUENCES
Diane Hammersley

It is quite an opportunity to be invited to write about a topic of one’s own choice, but then less welcome to have to make a choice and decide how objective or personal you want the article to be. I decided to write about some matters that give me concern, about which I feel annoyed, and hope that you the reader will respond with your views so that we may discover whether counselling psychologists have a particular perspective on these issues, or whether we have a range of different perspectives.

From time to time there appears on the television news an item about a missing person, often but not always a child, with a request for help in finding them, giving details about the location, the person’s home and sometimes a photograph of the missing person on some happy occasion. If it is a partner who is missing, the report may suggest that the person has become confused or forgotten their identity with a request from the police for help in finding them.

Then comes the press conference, when relatives are shepherded onto the stage with a police authority backdrop, to make an appeal for the child to return home following assurances that they will not be in any trouble or a plea to the abductors to return the child now they can see how distressed their parents are that they are missing. I find these appeals gut-wrenchingly painful as others may do when I suspect that there is little chance that the missing person will be found alive. If a body is found and murder is suspected, the pleas change to requests to help the police catch the criminals. Usually, the relatives are accompanied by a police liaison officer who it appears is supporting the family, but are they minders or counsellors and how are they trained?

What are the consequences for relatives in appearing in this way at press conferences? Clearly the police may gain useful information and be seen to be working to find the missing person, but what effect does it have on the relatives? At the time, I suspect they want to do all they can to help and feel that this is the least they can do, but what about later? If their efforts appear to have failed, do they feel guilty? Do they feel stupid about having made a public appeal when later it emerges that it was too late and all hope was lost? Does taking part in a press conference expose people to unwanted publicity or further traumatise them?

Whose responsibility is it to deal with the consequences of the process that relatives have been exposed to? Were they really aware of the potential impact that being the focus of publicity might have? Who is taking ethical responsibility here and are the police competent to do so? Is it arrogant or naïve of me to believe that people may be harmed by this practice and to want it stopped or could the police teach us something about interviewing and engaging the public’s cooperation? Am I being harsh to suggest that the police act in their own interests, are not competent to assess the impact this may have on vulnerable people and do not consider consulting professional psychologists?

My second concern is about recent reports in newspapers about Ritalin, the drug prescribed for children ‘to increase their level of concentration and decrease their impulsive behaviour’ (The Observer, 17 August, 2003). An earlier report (The Observer, 4 May, 2003) claims that Ritalin transforms the lives of many ‘hyper’ children but is now being sold to girls who want to suppress their appetites and remain thin. What shocked me was the statement that ADHD/ADD, attention deficit (hyperactivity) disorder now accounts for more than half of all referrals to child and adolescent psychiatry services, and that last year there were over 250,000 prescriptions for Ritalin.
Ritalin is supposed to be part of a package which includes behaviour therapy, but in practice it is quite common for families to just get a prescription. It is little wonder that if it makes a difference, they are grateful for it. However this begs the question of what this ‘disorder’ is about. I know there are counselling psychologists who are much more involved in this field than I am, and I shall be pleased if they respond to this article with their well-informed opinions. However, I find it difficult to understand why psychiatrists cannot see that the answer is staring them in the face within the name they have given this condition, lack of the correct attention.

If in psychiatric settings, people are criticised for ‘attention seeking’ is it not obvious that attention is what people need because they have a deficit of it? I have certainly reached this conclusion when listening to people who are profoundly depressed and take overdoses and people with an eating disorder such as anorexia nervosa. Both these groups of people are frequently described as seeking attention. How strange that the response seems to be to withhold attention in the belief that people will learn to do without it! Does it not occur to medical practitioners that if people become more demanding, the treatment of ignoring them might be at fault?

Then the parents can tell us what they observe, because in the newspaper article a mother described going onto an American website and learning to adapt her own behaviour to respond correctly to her son. She states ‘I don’t automatically tell him off now for every little thing’, and his behaviour has improved. This is common sense not rocket science and I cannot believe that it is not possible for everyone in psychiatric services to explain to families what they are doing wrong and how they could do better. Instead I suspect that psychiatrists collude with a more comfortable scenario that the child has an inexplicable disease and nobody is at fault. This viewpoint seems to be confirmed by the search for a defective gene which once identified, will enable a search for specific drugs to correct the fault.

I recall Alan Bellamy’s comments in CPR about counselling psychologists occupying uncomfortable places and Sheelagh Strawbridge’s comments on professionalism, identity and self-doubt when we fail to conform to established ideologies. It can be equally uncomfortable when we fail to conform to the expectation that we should not criticise the beliefs and practices of other professions as I have done. If we conform to this standard, how will our unique perspective and our particular insights influence others? Does psychology, and our branch of it, have something to contribute to the wider society even if it may be uncomfortable to say and difficult to hear? Is there an ethical issue of social justice to be addressed when psychological knowledge about people who are vulnerable when distressed or puzzled by the response to them of their children, is kept to ourselves while we privately wring our hands in despair?

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**CALL FOR PAPERS**

**Division of Counselling Psychology Conference**

York – May 2004

Please submit papers, posters or workshop presentations to the DCoP 2004 Conference Co-ordinator via the BPS Leicester office.
Conference
WORKING WITH REFUGEES/ASYLUM SEEKERS

The morning will comprise of presentations and a panel discussion on:

- **Legal and Mental Health Aspects** – *Stuart Turner*, Traumatic Stress Clinic;
- **The Cultural Meaning of Rape** – *Ann Douglas*;
- **Political Aspects** – *Nimisha Patel*, Medical Foundation for Victims of Torture;
- **Systemic Issues in working with Refugees and Asylum Seekers** – *Renos Papadopoulos*, Tavistock Clinic.

In the afternoon there will be a choice of three workshops on:

- **Working with Interpreters** – *Rachael Tribe*;
- **Working with Traumatised Refugees** – Traumatic Stress Clinic;
- **Clinical Issues** – *Aruna Mahtani*.

The HIV and Sexual Health Faculty AGM will follow for members.

**Date:** Friday 5 December 2003  
**Time:** 9.30 am – 5.00 pm  
**Venue:** The Resource Centre, 356 Holloway Road, London, N7 6PA.  
Tel: 020 7700 0100 (nearest tube: Holloway Road)  
**Cost:**  
Students/Affiliates/Assistants: £30.00  
Members of Race & Culture SIG/Sexual Health/HIV Faculty/DCP: £60.00  
Non-Members: £75.00

For further information, contact **Liz Shaw** on: 020 8442 6464.
FINAL CONFERENCE PROGRAMME

9.00–9.30  Registration
9.30–9.40  Chair’s Introduction
9.40–10.15  Legal and Mental Health Aspects – Stuart Turner
10.15–11.00  The Cultural Meaning of Rape – Ann Douglas
11.00–11.20  Coffee Break (20 minutes)
11.20–11.55  Political Aspects of working with Refugees/Asylum Seekers – Nimisha Patel
11.55–12.30  Systemic Issues of working with Refugees/Asylum Seekers – Renos Papadopoulos
12.30–1.00  Panel Discussion
1.00–2.00  Buffet Lunch
2.00–5.00  CHOICE OF WORKSHOPS (to be decided on the day)
   1. Working With Interpreters – Rachel Tribe
   2. Working With Traumatised Refugees: A phased model of intervention – Traumatic Stress Clinic
   3. Clinical Issues in working with Refugees/Asylum Seekers – Aruna Mahtani
3.00–3.30  Coffee Break (30 minutes)
5.00–5.30  AGM Sexual Health/HIV Faculty Members (Reports, Elections)

We hope you enjoy the day.
Notes for Contributors to
Counselling Psychology Review

Contributions on all aspects of Counselling Psychology are invited.

**Academic Papers:** Manuscripts of approximately 4000 words excluding references should be typewritten, double-spaced with 1” margins on one side of A4, and include a word count. An abstract of no more than 250 words should precede the main body of the paper. On a separate sheet give the author’s name, address and contact details, qualifications, current professional affiliation or activity, and a statement that the paper is not under consideration elsewhere. This category may also include full-length in-depth case discussions, as well as research and theoretical papers.

**Issues from Practice:** Shorter submissions, of between 1000 and 3000 words, are invited that discuss and debate practice issues and may include appropriately anonymised case material, and/or the client’s perspective. As with academic papers, on a separate sheet give the author’s name, address and contact details, qualifications, current professional affiliation or activity, and a statement that the paper is not under consideration elsewhere.

These two categories of submission are refereed and so the body of the paper should be free of information identifying the author.

**Other Submissions:** News items and reports, letters, details of conferences, courses and forthcoming events, and book reviews are all welcomed. These are not refereed but evaluated by the Editor, and should conform to the general guidelines given below.

- Authors of all submissions should follow the Society’s guidelines for the use of non-sexist language and all references must be presented in APA style (see the *Code of Conduct, Ethical Principles and Guidelines*, and the *Style Guide*, both available from The British Psychological Society).

- Graphs, diagrams, etc., should be in camera-ready form and must have titles. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

- Three hard copies of papers subject to refereeing should be supplied, together with a large s.a.e. and a copy of the submission on disk or CD-ROM (if possible save the document both in its original word-processing format and as an ASCII file, with diagrams in their original format and as a TIFF or an EPS). Two hard copies of other submissions should be supplied. Subject to prior agreement with the Editor, however, items may be submitted as e-mail attachments.

- Proofs of papers will be sent to authors for correction of typesetting errors, and will need to be returned promptly.

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

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**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.