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Abstracting and Indexing Coverage

PsycINFO

Editorial

Heather Sequeira

THE FOCUS OF THE current edition is much on the Division of Counselling Psychology. We have coverage of the highly successful Annual Conference of the Division of Counselling Psychology: 'Resonances of Childhood: The makings of a person' held recently in Chester. We cover the papers given by the invited keynote speakers and diverse reflections on the conference from a range of members.

Featured in this edition are the winning papers of the Trainee Counselling Psychology Prize 2007. I would like to congratulate the winner, Maria Vella, and runners-up Morag Anne Taylor and Edith Steffen, on behalf of *CPR*.

On a different note, I must highlight Ralph Goldstein's courageous piece in Talking Point: Introducing 'efficiency' into a health 'market'. Here Ralph highlights apparently unconnected developments in the NHS. He builds a convincing argument that these 'modernisations' hang together and that there is a wider Government agenda to be faced. Ralph concludes with the view that the Government cannot be moved by rational argument on these issues and calls us to question the kind of political activity that will be necessary to safeguard both our profession and the quality of psychological services in the NHS.

This coming year, this journal will continue to emphasise academic papers. Readers are reminded that *CPR* is now covered by PsycINFO. This means that abstracts published in *CPR* are accessible to clinicians and academics the world over. In line with this, a call goes out for academic papers on all aspects of Counselling Psychology.

Dr Heather Sequeira

Counselling Psychologists' TalkShop

TalkShop is an Internet-based forum for Trainee Counselling Psychologists. Its aim is to act as a vehicle for communication between trainees to discuss Counselling Psychology and to provide support, information and networking opportunities. If an issue is important to you, the chances are it is important to others too.

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Chair's Notes

Ralph Goldstein

An example of the Chair's activities

AS MY PARTING HOMILY on leaving the honourable role of Chair, I thought I might indicate one of the activities the Chair undertakes periodically and also give you my opinions concerning that activity. Chairs of Divisions are often asked to particpate in designing conferences and writing papers concerning current issues facing psychologists. One such project is improving access to psychological therapies [IAPT], which is an issue that affects all psychotherapists, not just psychologists.

Accordingly, the UKCP initiated and hosted some discussions concerning the development of a strategy for widening access by maintaining a range of psychotherapeutic options. The debate hinged in part on whether reason and evidence, or more overtly political strategies, would advance the Government's apparent desire to improve access to pyschotherapy. Some of the discussants were experts on the NICE guidelines and were arguing from that basis. I argued a contrary position, which I thought might interest members of the Division.

The relevant and important background is the Government's ideological position and its chosen strategies for implementing its views. The Government believes in competition as a central mechanism for improving efficiency in public services. But like all Governments it wants to keep expenditure quite tightly controlled whilst fulfilling electoral promises. The present Government promised to improve Health Services and to make them more 'patient-centred', which seems to be a borrowing from private enterprise, which further justifies the introduction of competition as it operates in the private sector. We can leave aside the very real problem of how effective competition can operate in the absence of a true market and concentrate instead on the financial rationing, or limiting, side of the argument.

Psychological therapies would be a requirement on the part of a Health Service, which truely offered cradle-to-grave care, but this service cannot be unlimited, untried and inefficient. We know it is an inefficient service by virtue of the fact that the Government makes this idea a central premise in any argument. There is no empirical testing of the claim, other than the powerful post-code lottery data.

The brilliant stroke was to take up the empirical side of the argument and insist that there should be a sound evidential basis for all treatments. Clinical Scientists were always going to support this idea and clinicians rarely dared oppose the setting up of NICE solely on the basis of subjective clinical judgements.

The success of this step, which forced closer scrutiny of pharmacological claims for efficacy and efficiency, encouraged the introduction of cost as a variable in the treatment approvals process. This is more dangerous politically as we have seen with recent public protests. This step also confounds two independent [orthogonal] ideas; the empirical basis for whether a treatment alleviates suffering and the management of costs of the service [actually public and private, in practice!].

This background sketch has direct relevance when we come to consider CBT as a treatment meeting the criteria of NICE. CBT offers several enticing and glittering veils to cover the nakedness of the psychotherapeutic endeavour. The first layer is that of testing by means of RCTs, the second layer is the claim for being a brief treatment [and

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the length of treatment can be specified in advance; a dress-maker's dream], the third layer is that the protocols were devised by a highly-trained profession, influenced by American ways of doing things and willing to train others in these protocols [bringing psychology to the people was the Society's centennial motto]. Another subtle veil is provided by the apparent link between the technical apparatus and the dominant branch of academic psychology.

If I were the relevant Government minister the veil whose artistic design I would find most appealing is the second; CBT offers a brief treatment whose length is often pre-set. This fulfils the dream of keeping some control over expenditure! Now, if there is a powerful set of arguments for meaningfully extending the acceptable evidence base beyond RCTs, I will concede soon enough, as long as CBT, *or any other treatment whose length is tightly controlled*, continues to be amongst the winners. [Let's leave aside the fact that CBT is a label for such a variety of procedures that it is almost emptied of meaning. The veils offer sufficient disguise.]

Accordingly, I believe the discussions concerning the widening of the scope of NICE guidelines on evidence are valuable, but futile from the point of view of improving access to patients. The Government will give in to this kind of pressure eventually, because it will not change the underlying economics, nor require a basic change of political premise.

What are we left with as levers to influence access of patients to the psychotherapies [plural usage deliberate]? I suggest we have to examine the consumerist and competition agendas of the Government. Put the patient at the centre of the argument, offer better trained and more receptive, but rigorous, practitioners of more than one 'technique', or approach to therapy. Astonishingly, this is the conceptual basis of the Counselling Psychology syllabus! In terms of evaluation, we could extend the CORE data set to include economic activity in association with length of treatment.

The effective unit in psychological therapies appears to be the therapist-patient alliance and all schools and modes of therapy apparently acknowledge this empirical datum. As a consequence, a great number of varied trainings make this fact of the importance of relationship the centrepiece of their training programmes. To the extent that this is true [and increasingly so], then the name of the school of therapy in which the trainee graduates becomes almost irrelevant. We are converging on some centralities in our therapeutic enterprise and this is a direct benefit to patients, who should not need to concern themselves overmuch with what school their therapist belongs to. In turn, the ways of testing outcomes would be more meaningful, since we could retreat from the fiction of rigid adherence to a canonical manual.

Postscript

Very late in the day it has dawned on me that I may still be missing the point. I referred to the idea of competition and suggested we could leave aside the problem of how effective competition can operate in the absence of a true market. Perhaps the market we should be looking at is a market in competencies and their relative costs! Particular kinds of skilled work requiring a lot of education [as distinct from training by such means as classical apprenticeships] were considered to be professions – and the professions are under sustained attack. For us this means that the competences involved in 'psychological therapies' can be restated as occupational standards and the training handed to bodies who have no traditional *professional* interests.

And I now see that the Government's reluctance to multiply registration bodies is not for administrative reasons, as claimed, but to take away the meaning of the word 'professions' in *The Health Professions Council*. And do notice that these changes will apply to private as well as publish provision!

It is in principle possible for the Society to lose all influence on training standards

[and other aspects of professional practice], so we have to ask ourselves how we can best protect what we have nurtured – and we grew our profession not just for ourselves, but for our clientele and the wider community. One possibility is to establish the degree of difficulty of our work and the role of experience; so we need to sustain post-qualifying registers such as neuropsychology and specialisation in psychotherapy and in supervision. Of course, the HPC will need advice on training standards – and that poses a nice ethical problem for anyone tempted to offer their services, I suggest.

Ralph Goldstein
Chair, Division of Counselling Psychology.

WRITE FOR *COUNSELLING PSYCHOLOGY REVIEW*

Counselling Psychology Review (CPR) is NOW covered by **PsycINFO**.

A special call goes out from *CPR* for wide ranging contributions on all aspects of Counselling Psychology. *CPR* supports freedom of expression and welcomes high quality academic papers, thoughtful comments on professional practice, controversial perspectives and lively contribution to public debate. 'Letters to the Editor' are also warmly invited.

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Trainee Counselling Psychologist Prize: Winner

Psychoanalytic reflections on suffering, loss, and life that leads to death

Maria Vella

An ongoing life challenge for human beings is to face suffering, various sorts of loss, and life itself, that ultimately leads to death. This paper is an attempt to reflect on these existential givens from a psychoanalytic perspective.

I will begin this paper by sharing a personal experience about my observing myself getting older, both on an ontic and ontological level. I also reflect on how the people around me react painfully and squirm on coming face-to-face with this natural life process. This reaction in turn, leads me to investigate how psychoanalytic contributors, not least, the founder, Sigmund Freud, together with modern contributors like Adam Phillips and Matthew von Unwerth, perceive and interpret beauty, joy, and life in relation to loss and transience. Under Phillip's influence I again ask two fundamental, recurring questions, namely: 'Is there the right amount of suffering in the world?' And, 'Does life ask more of us than we can bear?'

In this paper, I am focussing exclusively on how we tend to perceive beauty and joy as tarnished and destroyed by transience, loss and death. Moreover, I will focus on our difficulty to endure the constant tensions and conflicts that life bestows on us, especially with regard to the process of mourning. More specifically, I will draw on my experience as a counselling psychologist in training, my work with a particular client, and the affects this triggers in me. I conclude this essay by quoting Phillips' contention about the uncanny paradox of suffering.

WHITE AND BRIGHT, it shines and sparkles; catches the eye; flickering and flapping in the breeze. It grows longer and longer, dwarfing the surrounding darkish neighbours that look stunted in its peculiar presence. It fiddles and tickles, it is a taunting tease. An avid nagger and attention seeker, whose consequence on others is to say the least, remarkable. Every attention that it draws reacts, rebels, demands it out of sight. One quickly attempts to have a go at it, attack it, eradicate it. As if … out of sight, out of mind.

While the shiny white gives it an air of a twinkling star, its obtrusive, sickle like contour, imbues it with a wistful tone. In its creepy weirdness it encapsulates a blatant manifestation of the embodiment of the reality of my ageing. Like Socrates' gadfly that stings the lazy horse, it acts as a relentless ontic affirmation of my constant threat of non-Being.

This description depicts nothing but a freak eye lash that inhabits my left eyelid. It is white, and its length is about three or four times that of an ordinary eye-lash. It is quite inconvenient and my being bespectacled adds to the awkward situation, since every time I close my eyelid, it slowly grazes the lens of my glasses until it settles on, and tickles my cheekbone as if it has to act as a constant reminder that the longer it grows, the closer I move towards my end.

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The most striking experience is, however, my observation of people's reaction to it. A 'throe of the unbearable' best describes their reaction. On detecting it, they squirm and order me to pluck it out or cut it off in an instant. Unbelievably enough, they cannot even bear to look at it, to see it, to let themselves witness and attest to this capricious phenomenon. They seem to believe that it is painful or frustrating. On my lack of reaction, some even attempt to have a go at it themselves. Basically, they cannot understand my eccentric tolerance for this idiosyncratic endowment. Repetitive observation has put before me people's low tolerance for pain, imperfections, faults, blemishes … it seems to me that they [imperfections] bring us face to face with the stark ultimate reality that we are all dying bit by bit.

> … *And so, from hour to hour,*
> *we ripe and ripe;*
> *And then, from hour to hour, we rot and rot;*
> *And thereby hangs a tale.*
> William Shakespeare
> 'As You Like It' – Act II Scene VII.

Psychoanalyst Margot Waddell interprets this quotation in her book *Inside Lives* (2002, p.238). She nicely intimates that the 'tale' is the most significant of all tales – it is that of the human condition. We cannot separate death from life and from time, and maybe rather than about death, it is wiser to speak about *life that leads to death*. In this paper, I will be discussing issues around death affecting the living, which in turn set in the affects of suffering and loss.

In his book, *When Bad Things Happen to Good People* (1987), Rabbi Harold Kushner describes his experience of a deep, aching sense of unfairness in the face of his son's Progeria, a rare condition of premature ageing that begins in childhood or early adult life and leads to death within a few years. His son Aaron died two days after his 14th birthday. As the title suggests, Kushner seems to believe that there is an amount of injustice and unfairness in the world in relation to suffering and loss. He thinks that some people suffer more than others and cannot fathom why bad things should happen to good people.

Is there the right amount of suffering in the world? It is to an examination of suffering (and loss) that we now turn.

In attempting to shed light on this tough question, I turned to Analytical Psychotherapist Adam Phillips, whose splendid book, *Darwin's Worms*, is so enlightening. He introduces his book by quoting musician John Cage contending (and contradicting) other persons' views that there is just the right amount of suffering in the world. Could or should there be less suffering in the world?

Phillips (1999, p.4) writes, that in a nutshell, Darwin and Freud tell us that to be alive is to be subject to certain inescapable tension 'it is to be ineluctably involved in conflict'. This idea seems to resonate with Heidegger's (1962, p.230) perception of anxiety, when he argues that 'Being-in-the-world is a basic state of Dasein. That, in the face of which one has anxiety, is Being-in-the-world as such.' Whilst in the past, religion constantly assured people of an afterlife and thus exalted suffering as the token to a joyful afterlife, with Nietzsche and his idea of the death of God, this was shattered. Freud made us face the reality of the harshness we find ourselves in when we are created. In fact, argues Phillips (1999), Darwin and Freud 'are only pessimists compared to certain previous forms of optimism, the belief in redemption, or progress …' (pp.11–12).

From a psychoanalytic point of view, it is the individual's venture to ensure that they have the right quantity of suffering, because their natural desires imbue them with unconscious guilt which leads to the need for punishment to atone for this guilt. And the individual contends Phillips (1999) 'suffers more simply because she desires, and desire entails conflict and frustration. Both Darwin and Freud describe our bodily lives… as astonishingly resilient, but also excessively vulnerable, prone to many deaths and shadowed by the reality of death' (pp.7–8).

Does life ask more of us than we can endure? What is the maximum amount of burden one can bear?

I think that Freud's brilliance lies in the nuances and positive connotations he can present to seemingly oppressive yokes and unbearable burdens. Whilst acknowledging that certain kinds of suffering are just part of life, partly constituting what it is to be a human being, the phenomenologist in him wonders why suffering and death have always been, and continue to be so daunting. Somehow, in his genius, Freud wants to convince us of the sophisticated elegance of transience. This ephemeral phenomenon makes good fodder for our next argument.

Among the papers I read in Freud's *Standard Edition* of his works, I came across a terse paper Freud had written in 1915 during World War I in tribute to the poet Goethe. This essay is called *On Transience*. In it, Freud poignantly depicts a typical stroll he used to take in the countryside by the Dolomites. In August, 1913, Freud writes, he was in the company of a 'taciturn friend and of a young but already famous poet' (1916, p.305).

As Freud and his companions wandered along the paths in the countryside, inspired with awe by the beauty around them, their conversation took a melancholy twist. Everywhere the poet turned, he saw beauty, but in this radiance, the poet foresaw the coming of sorrow. To him, the splendour of the magnificent scene was tarnished by transience, infirmity, and ultimately death and negation. This eradicates the value and meaning of the beauty and grandeur of nature.

In his most touching book, *Freud's Requiem*, Von Unwerth (2005, pp.3–4) interprets that the poet with whom Freud walked is recognised as Rainer-Maria Rilke, and the taciturn friend as Lou Andreas-Salome, who was an enduring, powerful presence in both men's lives. Furthermore, von Unwerth argues that that afternoon walk may not have been a walk at all. They had probably met at the 1913 Psychoanalytic Congress in Munich, in which Freud and Jung were in the midst of their arguments. However, this encounter left a conspicuous mark on Freud.

While Freud strove hard to understand the poet's and the taciturn friend's glum and misery, he could not come to terms or agree with their morose conclusion. As the poet rightly argues, earthly things do pass away, and we experience their sheer loss, but rather than subtract from their beauty, Freud protested, this evanescence only added to beauty's increase. Freud (1916) suggested that 'Transience value is scarcity value in time that gave what is precious its worth. Limitation in the possibility of an enjoyment raises the value of the enjoyment' (p.305). Freud, despite the major losses he himself experienced in his lifetime, remained adamant about this view all throughout his days.

Later, Freud definitely pondered on the provenance of his companions' outlook. This conversation made Freud aware of what he perceived in his comrades as 'a revolt in their minds against mourning' (p.306). The transience we attest to in whatever lies around us, reminds us of our own mortality. Once we get stuck into this pessimism, we lose sight of the beauty of ephemera and scarcity as Freud wrote. In so doing, our life becomes devoid of sense and meaning.

Freud disagreed with Rilke's opinion that the transience of what is beautiful involves any loss in its worth. 'On the contrary, an increase! Limitation in the possibility of an enjoyment raises the value of the enjoyment' (p.305). Phillips writes that according to Freud, we hamper and destroy our joy by wishing it was otherwise, maybe more long lasting. Freud emphasises the necessity of transience: 'The beauty of the human form and face vanish for ever in the course of our own lives, but their evanescence only lends them a fresh charm' (pp.305–306). Phillips (1999) further contends that,

> *It is life as provisional and therefore pleasurable, that Freud celebrates. Love at its strongest is an acknowledgement of transience, not a wilful denial of it. Death makes life lovable; it is the passing of things that is the source of our happiness. For the young poet,*

> *because there is death, because there is transience, there is only tantalisation* (p.26).

In spite of these assertions, Freud himself was equally baffled and saddened by mourning, which he considered to be love's rebellion against loss. Freud writes in *On Transience* that when we love … our love goes out from us to the object of our affection, where it dwells in the beloved as if in ourselves. Therefore, when we lose a loved one, our love is drawn back into us. In the first two decades of the 20th century, we see Freud developing his ideas on mourning and loss. By this time, Freud was in his 50s and life had definitely left its mark on him. During this period, we see papers like *On Narcissism*, *The Ego and the Id*, and *Mourning and Melancholia*. In these works, one also witnesses the origins of object relations theory in that one's sexual instinct seeks an object – the other, the not myself, the lover – to whom it looks for, for the discharge and satisfaction of one's needs. Freud argues that love is the repetition of one's history of love, i.e. the love we expressed to the people around us during infancy, the love we invested in ourselves and probably a combination of both. This is perhaps what influenced Freud to give such importance to the phenomenon of Transference, since our early relationships with our love objects cast the mould for later relationships that we have in life. For Freud, love leads us to exhaustion, to the expenditure of our libido, or sexual energy and to go back to a merger with lifeless matter, thus love takes us back to death.

In *Mourning and Melancholia* (1917) which Freud wrote in more or less the same time he wrote *On Transience*, Freud fully explicates and elucidates his ideas about mourning. Freud argues that during an ordinary process of mourning, the lover manages to take back their libido from their lover who is now dead. Thus the mourner gets filled with this energy again, but together with this, unconsciously, the person still carries an image of the person they loved with which they identify. Thus this other person becomes part of themselves via identification. Freud contends that some people fail to mourn and isolate themselves in their fantasy world cut off from the rest of the people around them. Freud concludes in *On Transience*, that it was the difficulty to face the sheer reality of grief that led the young poet and his taciturn friend to experience stuckness and failed to welcome and value the natural splendour offered by their environment.

Freud believed that every act of mourning conceals a betrayal, a kind of killing of the loved person by letting the person go, and explains why so many refuse, unconsciously to mourn. Phillips (1999) argues that it is a question of our attitude to mourning. 'For the young poet, mourning is deemed to be unbearable; so for him to love what ultimately disappears – unlike God or eternal Truth – is to torment himself. Because he cannot mourn, he cannot afford to love' (pp.26–27).

Furthermore, Philips concludes that refusal to mourn is refusal to live. Mourning leads us to suffer but suffering makes us experience the possibility of life. Another interesting assertion that Phillips makes is, that those whom Freud labels as 'melancholic', thus, those persons who are not letting the process of mourning being worked through in them, are mistakenly but faithfully adhering to an eternal mourning that can never be resolved. In this illusory permanence, they deceptively believe that if nothing is everlasting, especially good things like beauty or joy, then mourning Is. 'Loss [is not perceived as] the acknowledgement that creates pleasure, but as the addiction that kills it' (1999, p.28). Freud contends that healthy mourning enables people to move on in their life, 'bad mourning becomes something akin to an ascetic personal religion. It is impossible to love life, Freud intimates, without loving transience' (p.28).

In his paper, *Mourning and Melancholia* (1917) Freud writes that mourning is regularly the reaction to the loss of a loved one. Some people react to the loss of a loved one by means of melancholia rather than mourning. Freud further explicates how we

rely on mourning taking its natural course without the need for any intervention. This is different from melancholia. He writes that the distinguishing mental features of mourning and melancholia are very similar, except for one, namely:

> *profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. These same traits are met with in mourning except for one – disturbance of self-regard is absent in mourning* (1917, p.244).

Freud intimates that this extraordinary diminution in the 'melancholic's' self-regard, and their ego impoverishment occurs on a grand scale. Here, I believe Freud reaches the culmination of his paper when he brilliantly distils the distinction between mourning and melancholia, ***'In Mourning, it is the world which has become poor and empty, in Melancholia, it is the Ego itself'*** (1917, p.246).

Freud writes that in 'melancholia, dissatisfaction of the ego on moral grounds is the most outstanding feature'. The shame, guilt and need for punishment that the patient experiences are hardly applicable to the patient themselves, but more aimed towards the identification with the loved one in which the libido was previously invested. This libido is now absorbed back on to the patient's own ego by means of identification. In this identification of the ego with the abandoned object, Freud intimates, 'the shadow of the object fell upon the ego … an object loss was transformed into an ego loss. (1917, pp.248–249).

I think the following excerpt from my working with one of my clients who is going through a tough depression depicts the self-revilings and emptiness in the ego that Freud describes with regard to Melancholia, which more or less stands for what we now call Depression:

Client: I only know that I cannot be with myself (crying).
Therapist: What do you mean 'cannot be with yourself'?
Client: I mean that if I were a man, I wouldn't choose to live with someone like me. I feel I have nothing to offer. I have no one. With my boyfriend, I had thought that I had finally found it – the relationship with the man of my life, but now I've lost that as well.
Therapist: Seems like your way of relating to others, leads people to reject you and that's very painful.
Client: I see these gorgeous women in shops with their baby, they look so happy and their men waiting for them at home. Obviously a man would choose them not me. It seems like I don't know how to be in a relationship … I don't know, maybe I have different chemicals, different hormones. The man who is with me has to keep going up and down with me.
Therapist: You feel very needy, and maybe guilty that your partner has to work very hard to take care of you.
Client: Yes. I have this fantasy of a man looking after someone who is disabled … If I could, I'd just not get up, and stay in bed crying and eating all day.

This client, who is in her mid-30s, obtrusively displays the extraordinary diminution in her self-regard. Whilst going through the loss of her boyfriend, she cannot mourn, she is stuck in a phase of melancholia. She cannot abandon her libidinal position thus excessive clinging to the lost object turns her away from reality and she indulges in *fantasy* to try to cling to the lost love object like when she describes him as being a carer to her as a disabled person.

My role as a trainee counselling psychologist is, amongst others, to help this client understand the value of suffering and of transience, which is not easy to do at all. When working with people suffering from depression, I also experience negative transference and heavy projective-identification

at times. My first reaction would be to become bored or experience my work as too painful. However, with the help of my supervisor, I am trying to make of these situations good opportunities to expand my own container that holds suffering, both my own, and that of my clients. I think this is a crucial experience in my process of development. I must also however, keep in mind that I have my limitations. The following section describes another experience of mine that was quite poignant to me.

I was utterly shook up on learning from Dr Baker about the suicide of Petruska Clarkson as an introduction to her lecture on Death and Dying. It was difficult for me to come to terms with the committing suicide of a person who works in the helping profession. In 'Tribute to Petruska Clarkson', Riccardo Draghi-Lorenz (2006, pp.55–57) writes in the *Counselling Psychology Review*.

> *Yet Petruska killed herself … I remember her saying, more than once, that one should respect a person's desire to leave this world … She had been suffering a lot on several important life fronts for many years. There was a sense in which as a result of that she had been slowly drawing the curtains on her show for some time (and what a show!). In the great theatre of life, her departure felt a somehow natural end of her act – however sad for us … Maybe some can also see her ending her life as consistent with the way she lived it. She had an exceptional presence and went the same way she lived, with a bang.*

Petruska was definitely highly aware of these notions of suffering, loss, and death. She actually wrote profusely on these topics. Does her suicide reflect that it was hard for her to put it into practice? Does it say that all this is mere speculation? Is our longing for permanence more alleviating than sheer sticking to ephemera? How do we find grounding beneath our feet? I am not writing this from a judgemental position but rather from a curious, inquisitive stance. Is it always possible to live up to these beliefs especially when one is really in the throes of depression? Maybe there is too much suffering in the world, or rather, a mistaken perception of transience and suffering …

As expressed in the introduction, one tries their best to avoid suffering. Our world goes to any length to avoid getting in touch especially with ageing. It would like to cling on to the illusory permanence of juvenility and beauty. People pluck out a white hair, wear all sorts of cosmetics, colour their hair even when the contrast of the dark hair with wrinkled skin makes appearances look more artificial and ridiculous. It is basically unbearable to face a 'ripening body' at this day and age.

Why did I come to a decision to let my white eye lash be? Speaking of ephemera, I'd like to experience the stark gluttony of change. I want to be able to bear the reality that I am growing older bit by bit and to let myself acknowledge and experience the transience of youth. After all, older generations had the capacity to endure the forces of evanescence. Modern society is shattering our psychological resilience, akin to the antibiotics that have weakened our natural immune system. I'm afraid that we do not know how to tolerate suffering anymore. As Phillips (1999, p.124) brilliantly captures it:

> 'Indeed the implied paradox would be:
> Sometimes we suffer most from
> being unwilling to suffer enough.'

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References

Draghi-Lorenz, R. (2006). Tribute to Petruska Clarkson. *Counselling Psychology Review, 21*(3), 55–57.

Freud, S. (1916). On Transience. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. XIV. London: Hogarth Press.

Freud, S. (1917). Mourning and Melancholia. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. XIV. London: Hogarth Press.

Freud, S. (1923b). The Ego and the Id. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. XIX. London: Hogarth Press.

Heidegger, M. (1962). *Being and time.* New York: Harper & Row.

Kushner, H.S. (1987). *When bad things happen to good people.* New York: Avon Books.

Phillips, A. (1999). *Darwin's worms.* London: Faber & Faber.

Shakespeare, W.A. (1991). 'As You Like It' – Arden Shakespeare. London: Routledge.

Von Unwerth, M. (2005). *Freud's requiem.* London: Penguin Books.

Waddell, M. (2002). *Inside lives: Psychoanalysis and the growth of the personality.* London: Karnac Books.

Maria Vella receiving her award from Malcolm Cross.

Trainee Counselling Psychologist Prize: Joint runner-up

What constitutes change?

Morag Anne Taylor

Morag Anne Taylor & Edith Steffen

Facilitating beneficial change is the main thrust of therapy. Possible factors contributing to change are illustrated in work with a client using the model of brief psychodynamic therapy. Precursors to change, such as engagement in pre-therapy and working alliances, are discussed. The point of change seemed to be instigated through an accurate, empathic interpretation. The implications of this sensitive and appropriately timed understanding of a core issue in the client, which sparked release of emotional distress and subsequently aided insight and change in her behaviour, are critically evaluated. Consideration is also given to the relevance of the context and setting within which this change occurred. Differences in perception of change between client and trainee counselling psychologist are noted. Alternative hypotheses for the series of changes are explored and reflections given on my learning.

CHANGE HAS BEEN considered the raison d'être for therapy (Leiper & Maltby, 2004). Therapy exists because clients want change but have found change hard to achieve on their own (Hoyt, 1995). Change is, therefore, central to therapy (McLeod, 2003), being primarily the motivating factor, the task and the goal for both client and therapist. Although change is generally desired, not least to provide relief from current distress, its meaning is individual to the client. Similarly, what constitutes change and how change is facilitated varies according to the model of therapy.

This paper discusses the point of change with Amy (a pseudonym), a client whom I saw for brief therapy (six sessions) in an NHS general practice.

Presenting concerns

Amy was referred by her GP because of stress at work. At first, when offered appointments, Amy was 'too busy' but eventually agreed to a lunchtime appointment. Although I speculated on Amy's hesitancy as being ambivalent towards therapy or symptomatic of her underlying distress, I chose to remain 'not knowing' (Casement, 1985) and meet her without assumptions. Eighteen months previously Amy had 'broken down' at work, weeping uncontrollably over her 'impossible workload'. She had subsequently spoken to her bosses but they had 'done nothing' about her situation. This had angered Amy. Since that point, she had lost her appetite, had difficulty in getting up in the morning and was not socialising. As these signs indicated depression (*DSM-IV*; American Psychiatric Association, 1994) she had been prescribed antidepressants (Fluoxetine*)

*Fluoxetine is a serotonin selective reuptake inhibitor (SSRI) which was prescribed in a low dosage. Considering the half-life of this drug and the time between stopping the drug and contact with myself would have meant that no pharmacological effects would be present. This drug was chosen as it tends not to have gastrointestinal side effects, which may have worsened Amy's irritable bowel syndrome. However, side effects such as agitation have been shown to occur (Emslie *et al.*, 1997).

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with slight benefit. Unwilling to take more drugs, she agreed to her doctor's suggestion to try counselling. Amy had divorced her violent husband, two years earlier, and had experienced this as relief rather than loss. It seemed in some ways that Amy was coming to therapy as a result of change (Budman & Gurman, 1988), rather than looking to change.

Establishing working alliance

Initially, through providing an uninterruptible space with clear time boundaries, and ensuring confidentiality within agreed limits, I created a place where Amy might feel safe and secure. A warm rapport had been easily established between Amy and myself. Amy (38) was personable and interacted well with me in the first session. I gained the impression of someone of greater potential than was being expressed as an assistant manager in a travel agency. She opened up with little prompting from myself. However, on my suggestion to meet for more sessions, Amy became quite tense and then declined my offer due to her work schedule. In reply I was accepting of her decision, saying how I understood her sense of pressure. Later that day, however, Amy sent a message, requesting to attend, having cleared things at work.

Initial formulation

Amy appeared to have significant workplace stress, where the demands of her job outweighed the available resources (Lazurus & Folkman, 1984). Also, Amy's work relationships were problematic; difficult interpersonal relationships are a common source of workplace stress (Ellis *et al.*,1997). Specifically, Amy felt that despite her best efforts to explain her predicament she felt unheard by her bosses. This sense of 'learned helplessness' (Seligman, 1975) may have provoked her decline into a depressive state. In her relationships at work and with her ex-husband, Amy showed a tendency towards self-denigration.

Amy's turn-around and acceptance of our contract (with agreed limits to confidentiality and five more weekly sessions) indicated a desire to participate. In considering which approach to offer Amy I was aware that cognitive behavioural therapy (CBT) can be effective in treating workplace stress (e.g. Cartwright & Cooper, 2005). However, I was mindful that Amy wished to 'make more sense' of her difficulties. Also as Amy's capacity for self-reflection was strong, I considered a reflective and interpretative approach would be more appropriate than the structured approach of CBT. Given that demand outweighs supply in general practice, only time limited therapy was available. Thus, I chose brief psychodynamic therapy (e.g. Coren, 2001), with the agreed focus on Amy's interpersonal issues.

Process of therapy leading to point of change

Attuning to Amy's difficulties, before the first session, helped initiate a pre-therapy alliance (Talmon, 1990). Further, acceptance of her right to autonomy (Shillito-Clark, 2003; British Psychological Society, 2005) in choosing whether or not to continue, perhaps contributed to Amy's decision to return. This early positive engagement with a reinforced commitment to work together signalled a good working alliance. Assessment with Amy was also part of the therapeutic process, where as well as gathering information I was giving therapeutic benefit through my empathic and sensitive comments (Budman & Gurman, 1988).

Looking at her past history, Amy felt that her parents had been strict but loving and affectionate. She felt she had a good relationship with them. However, Amy was not close to her sister, whom she felt belittled her. While talking about the difficulties with her sister, Amy recalled how she believed that her sister had been preferred by grandmother. She suddenly remembered her grandmother saying that if Amy had not come along then her sister would have got more. This memory triggered others.

She recalled how terrified she was of her grandmother who would shake with anger. At this point, I felt I was with a very young Amy. She started to look fearful. Amy was beginning to re-experience her earlier feelings. Amy would hide in the cupboard when there were arguments between her mother and grandmother. Her grandmother could be demanding and critical. Amy had felt 'upset' by her demeaning remarks. However, I felt a sense of pain and spoke about my sense of her hurt. Voicing this counter-transference (Heimann, 1960), where I was resonating more with Amy's feelings than her words, triggered a response in Amy. My recognition of her distress led Amy to speak about her feeling not as good as others. Amy felt unaccepted and judged by others. I commented that she had mentioned feeling like this with her sister, her grandmother and currently with her boss, which she acknowledged. I then offered the interpretation that it's as if you feel less than others, as if you do not matter. Amy paused to think about this. Then her expression changed to sadness and tears started to roll down her face. I wanted to reach out and comfort her at this point. This seemed to be a 'sacred moment' (Winnicott, 1971) where Amy felt understood by myself. The interpretation was not so much an explanation but an experience. These moments are also referred to as 'good moments' (Mahrer *et al.*, 1987), where change occurs.

Critical analysis of the change

This insight seemed to touch Amy; she had never realised that this was how she felt. In the here and now of the session, understanding was taking place with a therapist who was supportive, caring and acting in the client's best interests. Although Amy had re-experienced feelings of fear and her pain at feeling worthless, this time she was offered emotional understanding, something she might have hoped for from her grandmother. Thus recalling the thoughts and feelings within such an attentive relationship can be thought of as a 'corrective emotional experience' (Alexander & French, 1946). Coren (2001) considers that the positive emotional experience of being with the therapist is more important to the client than learning about themselves from interpretation.

Nevertheless, the interpretation has a place in change. The more accurate the interpretation is, the better the outcome (Crits-Christoph *et al.*, 1988). Although the interpretation may objectively be accurate, it is how the interpretation is received that contributes to change (Garfield, 1990). Further, the timing of interpretations, in facilitating change, has been considered as important for some time (Freud, 1926).

It seemed that Amy was almost taken unawares by the interpretation. Surprise, as a potent feature in therapy, was first described by Winnicott (1971) in his work with children in the 'squiggle game', where something unexpected would be revealed. Amy and I had gone through a process of joint enquiry; exploring themes, clarification, sensitive responding, acknowledgement, linking emotional experiences past and present to a point where something new was discovered. More recent authors have placed value on surprise as a significant point in therapy. Bollas (1992) considers that it can be like 'a key fitting a lock' (p.37).

Enid Balint called this 'erlebnis', where a novel positive emotional experience is created with the client, which helps change their view of themselves (Balint, 1973). Mitchell (1997) considers that clients can, as a result of this experience become open to new experiences. This felt like a domino effect, where one movement set in motion a cascading set of changes in Amy.

Amy returned, after this third session, having thought about what had happened. It seemed to precipitate a capacity to reflect on her past and present to an extent that had not been possible before. She began to see how this feeling of worthlessness permeated her life. Over the next sessions, Amy started to understand how this feeling might drive her to work excessive hours. Amy realised how little she expressed her feelings.

Although angry with her boss at his apparent dismissal of her excessive workload and her assistant's poor time-keeping and regular absences, she did not tell them how she felt.

By the final (sixth) session, Amy had spoken to her assistant about persistent late coming, which she had been unable to do before. She began to make several important changes to reduce her stress. Whenever she got anxious at her desk she would get up and take time away. Amy now started to delegate tasks. A greater capacity to reflect on her responses developed, where Amy became less driven by the need to please others. Awareness of her options opened up in Amy. She began to recognise her feelings and act on them. She also started to care more for herself by creating a better work/life balance.

The main aims in psychodynamic therapy are to help the client gain insight through making conscious the client's mental processes, which have been causing conflict (Brown & Peddar, 1991). This is mediated through the therapeutic relationship, usually as part of the transference , where the client reacts to the therapist as if they are a significant other, usually a parent, in the client's past (Greenson, 1965). I helped Amy gain insight through interpretation but primarily through the therapeutic relationship, which could be seen more as reparative (Clarkson, 1995) than as transference/counter-transference. In brief psychodynamic therapy, although the therapist is aware of transference, transference interpretations are not generally made as length of treatment precludes working on the meaning of the transference in depth (Frances & Perry, 1985). Instead of offering a neutral stance, I was actively engaging with Amy in a humanistic way with empathy, genuineness and respect as in providing the core conditions (Rogers, 1951). Some psychodynamic practitioners, such as Hobson (1985) in his conversational model and Jacobs (1999) consider these conditions as a pre-requisite for change. However, unlike Rogers (1957), psychodynamic practitioners do not consider these conditions as sufficient and an interpretive stance is also necessary to promote change. Change is considered possible in brief psychodynamic therapy if there is a boundaried therapeutic frame, a strong, quickly initiated working alliance and where the therapist actively facilitates understanding of the client's core issues or 'idiom' (Coren, 2001). Coren considers understanding the client's core issues enhances the therapeutic value of the therapy and therapist. Essentially, I elucidated Amy's 'idiom', which gave her a deep sense of being understood. The extent to which the client feels understood determines the outcome of therapy (Garfield & Bergin, 1986). As much research has shown the critical factor in determining a favourable outcome of therapy is the therapeutic relationship (e.g. Gaston, 1990; Horvath & Symonds, 1991).

Although these factors contributed to change, Clarkin and Levy (2004) consider that client characteristics are also important. One of these is the client's ability to think about their difficulties, which Amy demonstrated. Another is the client's motivational state, where clients are in a condition, primed for change. By over-turning her decision and returning for the remaining sessions, Amy demonstrated her motivation.

Therefore, prior to the described the point of change in the therapy, preparation for change was happening. The positive contact with Amy, before and during the first session, seemed critical in making Amy ready for change. These factors indicate that Amy and I were synergistically producing change.

Reflection on the implications of change

What had changed in Amy? She did not appear to go through characterological alterations to her personality, traditionally the aims of long-term psychoanalysis (Brown & Peddar, 1991). However, she had increased her self-awareness, opening up her options and choices and was gaining a 'constructive identity' (Sugarman, 2003). Is it possible that psychological healing,

defined by Weinrib (1983) as restoring the capability to function more effectively after wounding, had started in such brief therapy?

Some practitioners consider that brief therapy is only effective with clients, who have minor difficulties with recent onset (Rosen, 1990). Amy had moderately incapacitating, long standing difficulties, which other practitioners (e.g. Mander, 2000) claim can be improved in short-term therapy. Dozier *et al.* (1999) have shown that the process and outcome of therapy is positively related to the degree of security in the client's attachment pattern. Amy's close, affectionate relationship with her mother as a child is likely to have resulted in a secure attachment pattern (Ainsworth *et al.*, 1978). This secure relationship may have accounted for Amy's positive transference to myself early in the therapy (Fonagy, 2001).

From my perspective as therapist, Amy's change started when she remembered her difficulties with her grandmother and realised how this made her feel about herself at a core level. However, Amy thought that she only began to change when she went became assertive at work and started to improve her work/life balance. Research by Llewelyn *et al.* (1979) has illustrated the differences in perception of therapy between therapist and client. Clients find having painful thoughts and feelings most difficult. However, therapists, particularly those using the psychodynamic approach, consider expression of feelings is necessary for change.

Alternative explanations or consequences

Research has shown that clients consider their improvement greater than that estimated by their therapists (Neilson, 1994). I had reservations about this change as linear change like this is not common (Lieper & Maltby, 2004). Was it a flight into health (Jacobs, 1999), where clients suddenly get better and leave therapy thus avoiding any painful work? Amy had a quick recovery. It is possible that a 'transference cure' (Leiper & Maltby, 2004) occurred? This is when the client positively responds to the therapist like a reassuring parent in the client's past, particularly in the early stages of therapy. This positive transference towards me may have aided Amy's rapid improvement. Further, there were some important aspects that were not addressed such as her separation and divorce. I spent time in supervision discussing my concerns that I may have missed something. Brief psychodynamic therapy entails using selective neglect (Malan, 1979) where certain issues that may have relevance are not investigated. Was I lacking in beneficence, not promoting the client's best interests by not looking at certain issues? Or was I acknowledging Amy's right to autonomy by accepting that she did not wish to look at, particularly her relationship with her ex-husband in any depth? I brought my ethical dilemma to supervision. My supervisor helped me clarify my position as being a 'good enough' therapist. It seemed that some parallel processing (Jacobs, 1999) was taking place, where I felt, similarly to Amy, the need to get things right.

I was also aware that Amy had been encouraged to come by her doctor. She had a very good relationship with him. Perhaps this enhanced the therapeutic effect of the relationship with myself. It is also possible that she wanted to improve in therapy as a way of wishing to please the doctor and myself. This could be unconsciously, as part of the transference, where he and I would be seen as Amy's supportive, caring parents (Jones *et al.*, 1994). This illustrates that the change in Amy may be superficial and that more work would be needed to help understand her deeper, less conscious, inner processes.

Amy had not wished to take more antidepressants. This then limited her therapeutic options. Therefore, success in therapy may have become more critical.

Time was limited, not only by the practical restraints of working in a NHS general practice but also by Amy. This may have helped focus both our minds and so create a rapid change (Mann, 1973). Indeed, short-

term psychodynamic therapy has been shown to be effective with lasting change (e.g. Gelso & Johnson, 1983; Lambert *et al.*, 1986). However, it is also possible that Amy felt reluctant to bring up deeper issues within this time-frame (Regan & Hill, 1992).

Although as therapists we like to consider that we are catalysts to change, we have to acknowledge that clients can get better on their own. Indeed, Lambert (1992) has shown that external sources produce more change than a therapist's skills.

Learning

Working with Amy underlined how quickly some clients can make changes in their lives. It caused me to reflect on my contribution to the process. Particularly it made me consider my personal qualities that I bring to my work with clients, such as my warmth, empathy and sensitivity, which help me understand my counter-transference responses and enable me to work at emotional depth. I am now more aware of the pre-therapy aspects, as therapy starts even before the therapist has met the client (Talmon, 1990). Also I had not considered fully the transference relationship that clients may have with their general practitioners. I am more aware of the effect, positive or negative, that this may have on the therapeutic relationship. This, in turn, influences the potential for change in therapy. Although Amy returned after the first session, it was uncertain at the time. This underlines the necessity to be as constructive as possible in the first session as it can possibly be the last (Talmon, 1990).

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References

Ainsworth, M., Blehar, M., Waters, E. & Wall, S. (1978). *Patterns of attachment: Assessed in the strange situation and home.* Hillsdale, NJ: Erlbaum.

Alexander, F. & French, T.M. (1946). *Psychoanalytic therapy.* New York: Ronald Press.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington: American Psychiatric Association.

Balint, E. (1973). *Six minutes for the patient.* London: Tavistock.

Bollas, C. (1992). *Being a character. Psychoanalysis and self-experience.* London: Routledge.

Brown. D. & Peddar, J. (1991). *Introduction to psychotherapy. An outline of psychodynamic principles and practice* (2nd ed.). London: Routledge.

British Psychological Society, Division of Counselling Psychology (2005). *Professional Practice Guidelines.* Leicester: British Psychological Society.

Budman, S.H. & Gurman, A.S. (1988). *Theory and practice of brief therapy.* New York: Guilford Press.

Cartwright, S. & Cooper, C. (2005). Individually targeted interventions. In J. Barling, E.K. Kelloway & M.R. Frone (Eds.), *Handbook of work stress* (pp.607–622). London: Sage.

Casement, P. (1985). *On learning from the patient.* London: Tavistock.

Clarkin, J.F. & Levy, K.N. (2004). The influence of client variables on psychotherapy. In M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behaviour change* (5th ed., pp.194–226). New York: Wiley.

Clarkson. P. (1995). *The therapeutic relationship in psychoanalysis, counselling psychology and psychotherapy.* London: Whirr.

Coren, A. (2001). *Short-term psychotherapy: A psychodynamic approach.* Basingstoke: Palgrave.

Crits-Christoph, P., Luborsky, L., Dahl, L., Popp, C., Mellon, J. & Mark, D. (1999). Clinicians can agree in assessing relationship patterns in psychotherapy. *Archives of General Psychiatry, 45*, 1001–1004.

Dozier, M., Stovall, K.C. & Albus, K.E. (1999). Attachment and psychopathology in adulthood. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp.497–519). New York: Guilford Press.

Ellis, A., Gordon, J., Neenan, M. & Palmer, S. (1997). *Stress counselling: A rational emotive approach.* London: Continuum.

Emslie, G.T., Rust, A.J., Weinberg, W.A., Rowatch, R.A., Hughes, C.W., Cardmody, T. & Rinntelmann, J. (1997). A double-blind randomised placebo-controlled trial of fluoxetine in children and adolescents with depression. *Archives of General Psychiatry, 54*, 1031–1037.

Frances, A. & Perry, S. (1983). Transference interpretations in focal therapy. *American Journal of Psychiatry, 140*, 405–409.

Freud, S. (1926). *Inhibitions, symptoms and anxiety. Standard Edition, Vol. 20.* London: Gray Hogarth.

Fonagy, P. (2001). *Attachment theory and psychoanalysis.* New York: Other Press.

Garfield, S.L. (1990). Issues and methods in psychotherapy process research. *Journal of Consulting and Clinical Psychology, 58*, 273–280.

Garfield, S.L. & Bergin, A.E. (Eds.) (1986). *Handbook of psychotherapy and behaviour change.* New York: Wiley.

Gaston, I. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27*, 143–145.

Gelso, C.J. & Johnson, D.H. (1983). *Explorations in time-limited counselling and psychotherapy.* New York: Teachers College Press.

Greenson, R.R. (1965). The working alliance and the transference neurosis. *Psychoanalytic Quarterly, 34*, 155–181.

Heimann, P. (1960). Counter-transference. *British Journal of Medical Psychology, 33*, 9–15.

Hobson, R.E. (1985). *Forms of feeling: The heart of psychotherapy.* London: Tavistock.

Horvath, A.O. & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy. A meta-analysis. *Journal of Consulting and Clinical Psychology, 38*, 139–149.

Hoyt, M.F. (1995). *Brief therapy and managed care.* San Francisco: Jossey-Bass.

Jacobs, M. (1999). *Psychodynamic counselling in action* (2nd ed.). London: Sage.

Jones, H., Murphy, A., Neaman, G., Tollemache, R. & Vasserman, D. (1994). Psychotherapy and counselling in a GP practice: Making use of the setting. *British Journal of Psychotherapy, 10*(4), 64–71.

Lambert, M.J., Shapiro, D.A. & Bergin, A. (1986). The effectiveness of psychotherapy. In A. Bergin & S. Garfield, *Handbook of psychotherapy and behaviour change* (3rd ed.). New York: Wiley.

Lambert, M.J. (1992). Psychotherapy outcomes research: Implications for integrative and eclectic therapists. In J.E. Norcross & M.R. Goldfried (Eds.), *Handboook of psychotherapy integration.* New York: Basic Books.

Llewelyn, S.P., Elliot, R., Shapiro, D.A., Hardy, G.E. & Firth-Cozens, J. (1988). Client perceptions of significant events in prescriptive and exploratory periods of individual therapy. *British Journal of Clinical Psychology, 27*, 105–114.

Lazarus, R.S. & Folkman, R. (1984). *Stress, appraisal and coping.* New York: Springer.

Leiper, R. & Maltby, M. (2004). *The psychodynamic approach to therapeutic change.* London: Sage.

Mahrer, A.R., Nadler, W.P., Dessaulles, A., Gervaize, P.A. & Sterner, I. (1987). Good and very good moments in psychotherapy: content, distribution and facilitation. *Psychotherapy, 24*, 7–14.

Malan, D.H. (1979). *Individual psychotherapy and the science of psychodynamics*. London: Butterworth.

Mander, G. (2000). *A psychodynamic approach to brief therapy*. London: Sage.

McLeod, J. (2003). *An introduction to counselling* (3rd ed.). Buckingham: Open University Press.

Mann, J. (1973). *Time-limited psychotherapy*. Cambridge, MA: Harvard University Press.

Mitchell, S.A. (1997). *Influence and autonomy in psychoanalysis*. Hillsdale, NJ: Analytic Press.

Neilson, J. (1994). Therapist-client concordance on therapy process and outcome and its implications for service evaluation. *Clinical Psychology Forum, 73*, 5–7.

Regan, A.M. & Hill, C.E. (1992). Investigation of what clients and counsellors do not say in brief therapy. *Journal of Counselling Psychology, 39*(2), 168–174.

Rogers, C.R. (1951). *Client-centred therapy: Its current practice, implications and theory*. Boston: Houghton Miffin.

Rogers, C.R. (1957). The necessary and sufficient conditions for therapeutic change. *Journal of Consulting Psychology, 21*, 95–103.

Rosen, B. (1990). Brief focal psychotherapy. In S. Bloch (Ed.), *An introduction to the psychotherapies* (2nd ed.). Oxford: Oxford University Press.

Seligman, M.E.P. (1975). *Helplessness*. San Francisco: Freeman.

Shillito-Clarke. C. (2003). Ethical issues in counselling psychology. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.615–636). London: Sage.

Sugarman L. (2003). The life course as a meta-model for counselling psychologists. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp.303–321). London: Sage.

Talmon, M. (1990). *Single-session therapy: Maximising the effect of the first (and often only) therapeutic encounter*. London: Jossey-Bass.

Weinrib, E. (1983). *Images of self*. Massachussetts: Sigo Press.

Winnicott, D.W. (1971). *Therapeutic consultations in child psychiatry*. New York: Basic Books.

Trainee Counselling Psychologist Prize: Joint runner-up

Death and mid life: Why an understanding of life-span development is essential for the practice of counselling psychology

Morag Anne Taylor & Edith Steffen

Edith Steffen

The clients that come to counselling psychology do not live in a vacuum. They are located in time and space and are faced with the particular challenges presented by their contexts and their interactions with these contexts. This essay tries to show that an awareness of life-span development is essential for counselling psychologists in order to contextualise their clients' experiences and use this understanding as a resource for therapeutic work. It argues in particular that the existential theme of finitude needs to be considered as impacting on life-span development. It starts by introducing the life-span perspective and its implications for practice and goes on to exemplify this view by focusing on the subject of death – particularly on death awareness and death anxiety – and its influence on people's lives, especially during what has been called 'the mid-life crisis', before applying some of the ideas to the fictional character of Ivanov from Chekhov's eponymous play. It tries to show that death assumes special significance in mid life and that this is not merely a challenge in counselling psychology practice but also an opportunity for growth.

In the midst of life we are in death.
The Book of Common Prayer, 1662: The Burial of the Dead (as cited in Knowles, 1997)

I DID NOT WANT to be reminded of the number. Every time I opened another envelope and pulled out the card, I prayed silently, 'Please don't spell it out!' But it could not be helped. One card after another showed me in shiny metallic and vibrant colours that, like it or not, I was now 40 years of age. The big 'Four-O' on the kindly-sent birthday cards was laughing in my face like Death dressed up as a clown. I was slightly annoyed with myself for feeling so glum. 'What's the big deal?' I thought. 'It's only a number. And anyway, why should this signify the middle of my life or the beginning of a decline? Who knows, perhaps my 'best years' are still to come. And anyway, how do I know how long my life will actually be?' In spite of all my good thoughts, I could, however, not escape the sense that my youth was finally over and that I had to come to terms with being 'on the other side' now. Fortunately, I was not the first to feel depressed in the light of beginning middle-age and an increased awareness of finitude,

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and the writings from literature, philosophy and psychology that I turned to for explanation and consolation were able to provide me with a richer understanding of my experience and also helped prepare me for the encounter of similar experiences that clients would bring in the years to come. While I had no answers or solutions, I hoped that – being perhaps somewhat less in denial about my own mortality – I would be better able to *be with* a client struggling with questions of ageing, dying and finding meaning and that this would add something valuable to the person I was in the therapeutic relationship in general. It seemed to me that although death awareness may become more prominent in mid life, it is of existential and developmental significance throughout life and that this is worth reminding ourselves of in our daily practice.

While a developmental perspective has been at the heart of psychotherapeutic practice since its early Freudian beginnings, the view of development as a process spanning from birth to death is relatively recent. According to Sugarman (2001), the emphasis on childhood during much of the 20th century reflected prevailing restrictive notions of what constituted 'development', as only changes that were 'sequential, unidirectional, universal, irreversible, and end-state or goal-directed' were seen to count as development. Developmental theories have increasingly expanded beyond these confines, however, and since the 1980s it has been possible to talk of a whole life-span perspective (Baltes, Reese & Lipsitt, 1980) which shares certain underlying principles, formulated by Baltes (1987, cited in Sugarman, 2001) as the seven tenets of this orientation. These can be summarised as viewing development as a lifelong process which is multidimensional and multidirectional, shows plasticity, involves both gains and losses, is interactive, culturally and historically embedded, and the study of which is multidisciplinary.

While such a view of development broadens the scope both for the researcher and the practitioner, it also entails that there is no one 'correct' way of development, something that places particular demands on counselling psychologists. We need to be open-minded and able to embrace complex and contradictory notions of development on the one hand, and be improvement-orientated on the other, so changes are inevitably evaluated, i.e. measured against some ideal. While these challenges are met differently by different approaches to counselling and psychotherapy, Sugarman (2001, p.6) points out that there is overlap between different perspectives, as they describe 'common themes if not of perfection, then at least of successful ageing'. Across different therapy models, the practitioner – like the life-span researcher – is involved in 'finding, co-constructing and interpreting the stories people create and use to describe and understand their lives' (Sugarman, 2003, p.316). How the story is constructed is influenced by the practitioner's orientation, but the goal is ultimately to help the client make their own choices. Evaluating some events as negative does not entail being concerned with eliminating negatives, as, for example, in a 'disease' model (Sugarman, 2001). In the life-span approach, negative events are rather viewed as necessary parts of life that provide the opportunity for growth (Sugarman, 2003).

The move from development as something occurring only in childhood to a continuous process spanning from birth to death brings the subject of death itself to attention. If death is merely the endpoint of the life span and of development, it could easily be discarded as a subject of interest. However, even if we see death as nothing more than the 'end' of life, as its destination, then it follows that the life course is a movement towards death and that death is in some sense present throughout life. One fundamental existential truth is that we must die. This certainty in life is also the most incomprehensible truth for us to come to terms with, as, in the philosopher Herbert

Fingarette's words (1996), 'in our consciousness [we] will never know death first hand' (p.6). Freud (1915, as cited in Fingarette, 1996, p.150) wrote similarly: 'At bottom, no one believes in his own death. Or, what comes to the same, in the Unconscious, each of us is convinced of his immortality.' This also suggests that we have a tendency to deny death, something that according to Yalom (1980, p.59) occurs not only in the client but also in the therapist and, as he claims, 'there is collective denial in the entire field of psychotherapy.' There may also be denial in the study of life-span development, as Sugarman (2001) makes scarce mention of death throughout her otherwise authoritative text on the subject. This seems odd considering that not only the structure of the life course is determined by our expectation of death but also the meanings we attach to life. In fact, as Fingarette explains, our conceptions of life and death can be seen as mutually influencing each other:

> 'A mirror, too, is empty, without content, yet it reflects us back to ourself in a reverse image. To try to contemplate the meaning of my death is in fact to reveal to myself the meaning of my life.' (p.5)

Death awareness thus sharpens our awareness of life, and making sense of death involves making sense of life, as, for example, through constructing our life story, an activity that requires a sense of authorship. For Yalom (1980, p.31), who bases his thinking partly on Heidegger, *'death is the condition that makes it possible for us to live life in an authentic fashion.'* Death awareness is then worth facilitating in Counselling Psychology practice, as it helps clients re-evaluate life and make important changes towards a more fulfilled life.

There is ample literature promoting a positive view of death, e.g. Kübler-Ross (1975), who describes death as 'the final stage of growth' and 'the key to the door of life' (p.164). She believes that growth is the purpose of living and that we all have an inner source of love and strength which connects us with the eternal and that we live more fully when we are aware of this source. Stephen Levine (1986) takes this perspective further and encourages the reader to prepare to die by letting go of their sense of self, something that can be practised through meditation and through accepting and even welcoming pain. Both authors may be over-optimistic but they have something to teach all practitioners of psychotherapy and counselling about openness and compassion. Levine thinks that therapists can only give what they have got themselves and that how they deal with their own suffering determines the depth at which they are available to the client. A completely open relationship towards pain and death may only be possible for a fervent religious believer, but Yalom (1980) warns that faith may also act as a defence against death anxiety. According to Yalom, we cope with death anxiety by employing more or less healthy defences, and it is neither possible nor desirable for the therapist to completely eliminate death anxiety in the client, as some anxiety is necessary for life-enhancing death awareness. Instead it is the therapist's task to facilitate a 'sense of certainty and mastery' (p.189) through enabling the client to create a coherent structure out of their life events. This would be in line with the above-mentioned goals formulated by Sugarman (2003) and indicates how death awareness can enhance life-span awareness and promote a more conscious narrative reframing in counselling psychology practice.

While death awareness and anxiety are relevant themes throughout life, they assume particular importance in mid life. The term 'mid-life crisis' was coined by Jaques (1965), who conducted a biographical study of over 300 major artists and found a marked increase in the death rate between the ages of 35 and 39 as well as a definite change in the quality and content of creative output. It has to be noted here that due to an increase in longevity, 'mid life' would now occur at a later stage, so a definition of this phase in terms of a specific age range must be viewed with caution on account of histor-

ical changes alone. Furthermore, rather than trying to determine an exact period at which mid life occurs, researchers now tend to see it as an 'ageless' phase, characterised more by themes and contexts (Biggs, 2003). However, Jaques' general observations regarding the differences between an artist's early productions and those later in life may still be of interest today. Specifically, he notices a 'hot-from-the-fire creativity' during the artist's youth and more of a 'sculpted creativity' as of the late thirties (Jaques, 1965, p.503). To achieve the greater serenity of mature work, the artist is seen to undergo a 'mid-life crisis'. Jaques regards this crisis as arising from depressive anxieties due to an awareness of one's own inevitable death on entering the second half of life. Coming from a psychoanalytic perspective, he views youthful idealism as arising from the unconscious denial of human mortality and destructiveness (what Freud called the 'death instinct') and argues that 'constructive resignation' (p.505) to these inevitable truths at mid life can lead to mature creativity. However, this requires the painful working-through of a depressive crisis. While Sugarman (2001) comments that only a minority of people actually experience a crisis of such proportions, counselling psychology clients are more likely to be among this minority. However, Kleinberg (1995, as cited in Biggs, 2003) has observed that many mid-life clients enter therapy to deal with 'stagnation' rather than a crisis, although issues around ageing and finitude are also present.

A more comprehensive approach to mid life has been presented by Levinson *et al.* (1978), whose stage theory of the 'seasons of a man's life' has particularly illuminated the developmental tasks of the 'mid-life transition' (p.191), a term based on Jung's description of the divide between the first and second halves of life, the 'noon of life' (p.33). According to Levinson – whose theory is restricted to men, although much could apply to women too – this is a time of disillusionment, as the current life structure and the self need to be modified and some fundamental polarities, i.e. young/old, destruction/creation, masculine/feminine and attachment/separateness, need to be resolved in preparation for middle age. Similar to Jaques (1965), Levinson emphasises that the illusion of one's immortality must be given up, a painful process that may, however, lead to greater maturity: 'Slowly the omnipotent Young hero recedes, and in his place emerges a middle-aged man with more knowledge of his limitations as well as greater real power and authority' (p.218). While Levinson has been criticised for not paying attention to factors such as gender, race or class (Sugarman, 2001), the depth and breadth of this study not only provide unique insights into a range of issues mid-life clients may present with, but also allow a linking of life stages and themes from early to middle adulthood, thus enabling counselling psychologists to view clients during mid-life crisis on a developmental continuum.

A common thread among the perspectives presented here is the story-like character of the view of the life-course and the therapeutic aim of co-constructing a coherent life story. According to McAdams (1993, as cited in Biggs, 2003), mid life lends itself particularly well to a narrative 'putting together' because of a 'growing realisation that good lives, like good stories, require good endings' (p.377). While this is the focus of an approach in itself, i.e. Narrative Therapy, Sugarman (2001) has pointed out that a narrative approach can be consistent with other perspectives too. Comparing different mid-life authors, Murray (1986, as cited in Sugarman, 2001) has compared their own narrative structures to different narrative forms as distinguished by Frye (1957, as cited in Sugarman, 2001), i.e. tragedy, comedy, romance, etc. Levinson's account of mid life is viewed as tragic because of the described need to face up to one's own destructiveness. However, if this human flaw can be accepted and integrated, the story need not end in despair (Sugarman, 2001).

A story that does end in despair and suicide and that vividly and dramatically portrays the raw emotions of a man at mid-life crisis point is the play 'Ivanov' by Chekhov (1964, written in 1887). The 35-year-old Ivanov, a landowner without money, is deeply depressed, and his account of his mid-life transition is bleak:

> 'I used to be young, ardent, sincere, intelligent […] I did the work of ten men, and had the hopes of ten men, too; I tilted at windmills, beat my head against a wall […] And now, […] I'm old, I've put on my dressing-gown. With a heavy head, an indolent soul, exhausted, depleted, broken, without faith, without love, without aim, drifting like a shadow among people, I don't know who I am, why I live, or what I want' (p.99).

His wife, who converted from Judaism to Christianity for him and was then disowned by her wealthy parents, is terminally ill, and Ivanov's former youthful idealism has collapsed in the light of financial ruin and her impending death, also a reminder of his own mortality, as Yalom (1980) would point out. He is unable to integrate his sadness and destructiveness into his sense of self and reacts with intense self-loathing: 'I'm a rotten, pitiful, worthless man. […] My God, how I despise myself! How profoundly I hate my voice, my footsteps, my hands, these clothes, my thoughts […]' (p.75). He feels no more love for his wife, which inspires guilt and despair:

> 'Here she is suffering, her days are numbered, and I, like the worst coward, run away from her pale face, her shrunken chest, her imploring eyes … It's shameful, shameful! […] What's wrong with me then? What is this abyss that I am propelling myself into?' (p.75).

When a young girl, who happens to have a large dowry, offers him love, he first rejoices in the chance: 'Can it mean beginning life anew?' (p.64). He hopes to allay his death anxiety through a younger woman and work, a way of hoping for a 'magical protection against death' as Gould (1978, p.231) calls it. However, on their wedding day some time after his wife's death, Ivanov is overcome by dread: 'I looked at myself in the mirror, and I saw … grey hair on my temples […] I cannot!' (p. 94). In the end, his intense terror about his own decay and the sense of his own destructiveness, which he can neither deny nor accept, leads him to break off the wedding and shoot himself.

In spite of the tragic ending there is something heroic about Ivanov. He refuses to give up his idealism and would rather die than live with his destructiveness. 'The nobility and the defect [the internal flaw of the tragic hero] are two sides of the same heroic coin', writes Levinson (1978, p.226), and if Ivanov had accepted his flaw, personal transformation and ultimate victory would perhaps have been possible. However, there is something else we can learn from Ivanov. As a 43-year-old myself, I wonder whether my own struggle with this transition may reflect not merely a fear of ageing, death and destructiveness but also a fear of a 'living death', as the philosopher Christopher Hamilton (2001, p.154) puts it. 'Our compromises and ways of betraying ourselves can gradually corrode us until we are dead within: it is as if death were within our life, eating away at it, never to be escaped just because it is already inside.' The example of Ivanov shows that a crisis can actually put us in touch again with our most deeply-held values, the nobility side of the coin, which may need to be modified and integrated in new ways too. In counselling psychology practice, this could mean that instead of trying to overcome the crisis as quickly as possible, we can welcome it as an opportunity for exploration and growth and help the client re-construct their life course more positively and authentically.

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References

Baltes, P.B., Reese, H.W., Lipsitt, L.P. (1980). Life-span developmental psychology. *Annual Review of Psychology, 3*, 65–110.

Biggs, S. (2003). Counselling psychology and mid-life issues. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (pp.363–380). London: Sage.

Chekhov, A. (1964). *The major plays*. New York: Signet.

Fingarette, H. (1996). *Death: Philosophical soundings*. Chicago and La Salle: Open Court.

Gould, R.L. (1978). *Transformations: Growth and change in adult life*. New York: Simon & Schuster.

Hamilton, C. (2001). *Living philosophy: Reflections on life, meaning and morality*. Edinburgh: Edinburgh University Press.

Jaques, E. (1965). Death and the mid-life crisis. *International Journal of Psychoanalysis, 46*, 502–514.

Knowles, E. (Ed.) (1997). *The Oxford dictionary of phrase, saying and quotation*. Oxford: Oxford University Press.

Kübler-Ross, E. (1975). *Death: The final stage of growth*. New York: Touchstone.

Levine, S. (1986). *Who dies? An investigation of conscious living and conscious dying*. Dublin: Gateway.

Levinson, D.J., Darrow, C.N., Klein, E.B., Levinson, M.H. & McKee, B. (1978). *The seasons of a man's life*. New York: Ballantine Books.

Sugarman, L. (2001). *Life-span development: Frameworks, accounts and strategies*. Hove and New York: Psychology Press.

Sugarman, L. (2003). The life course as a meta-model. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (pp.303–321). London: Sage.

Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.

Conference – Keynote paper

Working with those affected by the 'Troubles' in Northern Ireland; risk factors and vulnerability

Áine Thompson

'Each one of us journeys alone into this world – and each one of us carries a unique world within our hearts. No-one experiences your life as you do; yours is a totally unique story of experiences and feelings.' (O'Donohue, 1997).

WORKING WITH THOSE affected by the 'Troubles' in Northern Ireland is not something entered into lightly. The often complex world of trauma, its treatments, successes and failures is further confused by the social, cultural and political context in which counselling psychologists may find themselves working in.

We may travel into this world alone, however Yalom (2001) tells us that we are all in this together and there is no therapist and no person immune to the inherent tragedies of existence. It can often be a challenge for counselling psychologists to carefully and gently balance what is in the room, and in my experience a greater understanding of the issues of the past in Northern Ireland is essential to promote a positive therapeutic alliance.

The 'Troubles' is a euphemism that has been used for decades in Northern Ireland, to refer to the most recent period of civil and political unrest. The term 'Troubles' was frequently used in a social context at 'wakes' or funerals where people who wanted to express condolence would often say 'sorry for your troubles' to the relatives and friends of the deceased. It may be that the use of the term was extended from this context to cover wider social and political conflict (cain.ulst.ac.uk, 2007).

Firstly, anyone who attempts to understand what has happened in Northern Ireland must appreciate that for 30 years the visitor to the region would not necessarily have had any contact with the violence but they almost certainly, would have experienced a day-to-day normality in which children were engaged in normal childhood pursuits of schooling, sport and all the other past times which are available to the European child (Trew, 1995).

This peaceful reality, however, coexisted with the reality of the violence of the region. Some people would see the police or army patrolling their areas daily, whereas this would be a rarity in other areas. Some people would be more exposed to the violence than others, and even if they were not exposed to it or a witness to it, they most definitely would have been aware of it, before the ceasefires of 1994. Still the point remains, that the violence has touched the everyday lives of people in Northern Ireland. However, the way in which the violence manifested itself, has changed over the years and has varied from place to place and from person to person.

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- Since 1969, 3585 people have been killed in Northern Ireland. This means that at very least 6800* people have the experience of one of their immediate family – parent or sibling – being killed in a troubles-related incident.
- More Catholics than Protestants have been killed. The death rates for civilians are 3.01 per 1000 population for Catholics and 1.26 per 1000 for Protestants.
- Republican paramilitaries have killed almost 59 per cent of the total killed, 704 of whom were civilians, Loyalist paramilitaries have killed almost 28 per cent of whom 818 were civilians, and the security forces have killed just over 11 per cent, 204 of whom were civilians, with the British army accounting for over 9 per cent of that total.

If we can generalise from all this, we conclude that the 'Troubles' have been a killer of young males from North and West Belfast, Derry Londonderry or the border areas, and who are rather more likely to be Catholic. This is also the group, which was among the most likely to become perpetrators of acts of violence (Fay *et al.*, 1999). Since 1969 the death toll of the 'Troubles' in the North has amounted to over 3000 people killed, 36,000 injured and 22,000 charged with terrorist offences or detained under the Prevention of Terrorism Act, 16,000 explosions, defusings and incendiaries and 33,000 shootings (Rooney, 1995). Children have been greatly affected as a result of the conflict in Northern Ireland; children were caught up between two powerful groups, the paramilitaries and the security forces. I feel it is necessary to look at the effect of these 'Troubles' on children and young people to be able to make any kind of prognosis on the future of the North. The effects, as well as the probable direction of a condition of rapid political change, are most readily reflected in the personality dynamics, behaviour and attitudes of the children within that milieu.

Is the conflict over?

Many people believe that the current period of violent conflict, the 'Troubles', in Northern Ireland is (almost) at an end. However, Northern Ireland in recent years has experienced continuing violence not only from those paramilitary organisations which are 'active' (that is, did not declare a ceasefire), but also from some organisations which are supposed to be on ceasefire. So the period of 'peace' since the first ceasefires has been an imperfect one. (cain.ulst.ac.uk, 2007). This is important to note as those attending our services may have been victims of beatings, shootings, death threats, etc., in the last five years and these people often feel overlooked with the positive publicity that goes with the peace process.

In the introduction of his book *The Gift of Therapy* (2001) Irvin Yalom tells us that he 'advises students against sectarianism and suggests a therapeutic pluralism in which effective interventions are drawn from several different therapy approaches' (p.xv). This mirrors precisely the current peace process and devolved government which is drawing together people from diametrically opposed views, cultures, ideologies, and only time will tell whether this will work.

Northern Ireland research

Over the last 30 years or so, while the question of the impact of political violence in Northern Ireland, has attracted a certain amount of attention, empirical research has been limited (Cairns & Wilson, 1985).

The initial difficulty with a study on this topic is the almost total lack of literature on the subject. Over the past decade research on the Northern Irish situation has increased, various issues have been looked at but this really has been slow and gradual. Cairns (1987) tells us that researchers in Northern Ireland had to face the criticism, that by asking questions about views, they were engaging in acts which were 'destructive of community relations'. A prime

* Fay, M.T., Morrissey, M., Smyth, M. (1999). *The Cost of the Troubles Study.* Derry Londonderry, Ireland: Cost of the Troubles Study/INCORE.

example of this would be when Trew and McWhirter (1982), reported that their study resulted in a local politician calling for a public enquiry and claim and counter-claim by local politicians in the local press as to the merits or otherwise of their research

Initial studies were small-scale investigations conducted by psychiatrists during the first years of the conflict. One of the first systematic studies of children was conducted by Dr Morris Fraser, a child psychiatrist affiliated with the Royal Victoria Hospital, Belfast. Dr Fraser correlated the 1969 riots with effects on mental health and found that in many dimensions there had been significant detrimental effects on adults and on children. He found that in some instances the effects were similar to those occurring during a condition of war (Fields, 1973). After appraising the clinical effects on children, Dr Fraser said *'It is not surprising in the situation, that lots of children develop problems … they cry, they can't sleep, they wet their beds'* (Fraser, *Newsweek*, 1971, cited in Fields, 1973).

Lyons (1971) told us that *'the children seem to quite enjoy the excitement of the present troubles …'*, and that on the whole children in troubled areas were not psychologically disturbed by violence in the short term. He also said that the troubles in Northern Ireland could be reducing mental illness.

However, O'Malley (1972), found that cases of attempted suicide had risen during the troubles, and that this rate (75 per cent increase) might be a better measure of the effects than the data on death by diagnosed suicide on which Lyons (1971) had based some of his conclusions. Since these series of studies in the early 1970s, further reports of data relating the impact of political violence to psychiatric morbidity have been sporadic and often largely tangential (Cairns & Wilson, 1984).

Drawing together the results of these studies and presenting any clear conclusions is not a straightforward task, though certain trends do appear to emerge. Fraser and Lyons appear to agree that it is unlikely that political violence caused any increase in psychotic illnesses, that there may have been an increase in what Lyons labelled 'normal anxiety' (Cairns & Wilson, 1984).

Since that early debate, although there has been some investigation of the impact of the troubles on attitudes and moral development, there has been remarkable little consistent interest in the specific mental health, post-traumatic stress or other effects of the 'Troubles' on the population. Nor is there any generally recognised and reliable measure of the general effects of the 'Troubles' on the population of Northern Ireland. However, since the ceasefires of 1994 and the Omagh Bomb there has been an increased interest in the psychological effects of troubles-related events (Fay *et al.*, 1997). Dorahy and Lewis (1998) suggest that most, if not all, people in Northern Ireland are psychologically affected by its recent history and current instability. This would be similar to findings by Swartz in South Africa arguing that apartheid resulted in pathological chronic stress responses (Swartz, 1998).

Children: Abuse by paramilitaries and security forces

Helsinki Watch, a human rights watchdog organisation, in 1992 found that many young people in the North had been abused physically and psychologically by both the police and the paramilitaries. They found that the police and the army had harassed young people on the street *'hitting, kicking and insulting them'*. They also found that police officers in interrogation centres insult, *'trick and threaten … and sometimes physically assault them.'*

Helsinki Watch also discovered that on the other side, the paramilitary groups – the IRA (Irish Republican Army) and the UDA(Ulster Defense Association), act as alternative police forces, punishing children they believe to be 'anti-social' by punishment shootings (knee-cappings) and severe beatings, and sometimes banishing children altogether from Northern Ireland. The Police also try to turn young people into informers; informers who are found out by

paramilitary groups run a strong risk of being killed.

Helsinki Watch came to several conclusions about the abuse of children and young people in the North, namely:

- that children below the age of 18 in Northern Ireland have been improperly detained in adult interrogation and remand centres;
- have been physically and mentally abused in Castlereagh Holding Centre;
- have been psychologically tricked, threatened and pressured by police during interrogations;
- are denied immediate access to solicitors;
- are incarcerated in inhumane conditions in Castlereagh Holding Centre and Belfast Remand Prison;
- are physically and mentally abused and harassed on the street by security forces.

As to the mistreatment of children by paramilitary forces, Helsinki Watch has concluded that:

- the RUC (Royal Ulster Constabulary) has largely abandoned normal policing in many troubled areas, and the paramilitary groups have filled the resulting vacuum with alternative criminal justice systems;
- paramilitary groups inflict on children arbitrary and cruel punishments, including punishment shootings, severe beatings and expulsions.

Helsinki Watch (1992), also informs us that *'the abuse of children that we have documented is forbidden by international law. International agreements and standards forbid torture, inhuman and degrading treatment of children (as well as of adults) by security forces … moreover, in circumstances of armed conflict, international humanitarian law (the laws of war) forbids the abuse of civilians, including children by paramilitary groups as well as by Government.'*

Their report is a damming condemnation of paramilitaries, the police and the army in Northern Ireland. The case studies they have documented give accounts of horrific experiences of children and young people, and one can only imagine the psychological impact of some of the physical and mental abuse. The psychological-test and clinical-interview data collected by Fields (1973), on a sample of 125 reveals that *'no man or boy who has undergone interrogation, whether or not imprisonment has followed, has not suffered a damaging personality change.'* Depending on their physical and mental condition at the time of interrogation and, to a lesser extent, their age, the effects are varied in degree and permanence. These are some of the clients presenting in our therapy rooms now. Helsinki Watch and the like have named some of the unspeakable things, they have recorded some of our history and allow us a glimpse into the world of some of our clients.

> *'… the total destabilisation is a plague of internal locusts attacking us through our insecurities, vulnerabilities, doubts and fears, but they do not come from inside. They are not a phantasy construction from the conflicts and prohibitions of the unconscious and a harsh superego … they come as a chilling reminder that the real world can be as bad as anything that can be imagined…'* (Hinshelwood, 2007).

Socio-economic conditions slide

The socio-economic conditions in Northern Ireland suggest that many children growing up in the North are vulnerable to psychological distress (Trew, 1995). The media image of Northern Ireland has been one of a war-torn region with a simple two-sided problem, but anyone who has lived in our society will know that this is a gross over simplification. The media seems to have ignored the fact that Northern Ireland has many problems which effect its people other than those of political and sectarian violence.

> *'Perhaps the single most important fact ignored by the media about Northern Ireland is that it has the unenviable reputation of being the least affluent region of the United Kingdom and is officially recognised as one of the least prosperous areas within the European Economic Community'* (Simpson, 1983).

The most economically deprived areas are frequently characterised as regions of high levels of political conflict and violence. The poverty of war causes suffering, psychological damage, social deprivation, family breakdown, ill health and even death (*Belfast Telegraph*, 27 March, 1995). Poverty can have as great an impact on peoples lives as violence, if not greater. Cairns (1987), tells us that children in Northern Ireland face potential hazards such as growing up in large families, in over-crowded homes, and in homes where unemployment is a relatively common fact of life for about 25 per cent of the adult population.This social deprivation most certainly has an effect on the children growing up within it, yet the violence in the North has always been of more interest to researchers and the media.

Vulnerability and risk

Placing our work in context is a helpful starting point but it is also important to look at the broader world of psychological research on trauma to inform our practice and guide us in working with our client group. We need to ask questions such as; Why this person? Why now? How did they get here? etc.

> *'… the issue that is raised by the demonstrated role of vulnerability factors is that decompensation following trauma is neither a random process nor an outcome entirely predictable by the nature of the traumatic event. This observation appears to call into question the most fundamental assumption of PTSD as potentially occurring in any individual as a result of a traumatic event'* (Yehuda, 1995).

Yehuda and McFarlane (1995) elaborate on this in suggesting that trauma is not a sufficient determinant of PTSD, which in turn raises the possibility that there may be risk factors which account for a given individuals vulnerability to developing this disorder.

Breslau *et al.* (1991) studied a variety of types of stressors and identified factors for both exposure to traumatic events and the development of PTSD given exposure. Breslau *et al.* (1991) found that exposure was associated with low education, male gender, early conduct disorders, extraversion and family history of psychiatric disorders or substance abuse. Much research on exposure risk factors has identified similar issues, therefore, for the purposes of this paper it seems more pertinent to examine factors or stressors which may be predictive of the development of PTSD following exposure. Again, in their paper Breslau *et al.* (1991) found that some of these risk factors included, female gender, early separation from parents, pre-existing anxiety or depression, and family history of anxiety or antisocial behaviour.

Scott and Stradling (1992) tell us that whether a person remains distressed after a major trauma seems to depend on the following five factors:

1. High levels of stress or exposure.
2. Pre-existing personality or emotional disorder.
3. Family history of psychiatric disorder.
4. Adaptive coping style.
5. Effective support.

Schnyder *et al.* (2001) found that one-third of the variance of PTSD symptoms at one year follow-up in their participants was predicted mainly by psychosocial variables. However, the research by Maes *et al.* (2001) seems best to explain that the development of PTSD is determined by the effects of pre, peri- and post exposure risk factors.

Maes *et al.* (2001) explains these terms as follows:

- Pre-trauma risk – e.g. female gender, previous trauma, family history.
- Peri-trauma risk – e.g. the horror of the trauma, threatened death.
- Post-trauma risk – e.g. the physical injury caused by the trauma.

The examples given by Maes are not exclusive or exhaustive, as Yehuda and Giller (1996) give a more detailed explanation of each area of risk. However, by using these categories, the plethora of research available can be more readily understood.

Pre-trauma risk

Weiseath (1996), tells us that compared with the number of PTSD studies that have addressed the stressor-response relationship, there are fewer investigations of the role of predisposing individual characteristics. The difficulty with this type of research is that much of our knowledge of the short and long-term effects of traumatic stress and disasters has been developed through the study of victims/survivors *after* the event (Reid, 1990). This being said it is important to examine some of the current available research whilst taking into consideration its limitations.

Maes *et al.* (2001) carried out a study on 127 victims trapped in a ballroom fire and data was collected seven to nine months after the traumatic event. Results from this study support Weiseath's (1996) research that female gender, number of previous trauma, past history of simple phobia increased the odds of PTSD. Weiseath (1996), however, also suggested that some other pre-trauma risk factors included age, family history, and childhood trauma. Many studies have had similar findings, however this current piece of work will focus briefly to examine some of the suggested risk factors which are relevant to Mrs X.

Childhood trauma and PTSD

Yehuda, Hallig and Grossman (2001) studied adult offspring of Holocaust survivors, and found significantly higher levels of self-reported childhood trauma, particularly emotional abuse and neglect. They also found that self-reported childhood trauma was related to severity of PTSD in subjects. Breslau *et al.* (1999) also examined several features involving previous exposure to trauma. The authors concluded that subjects who experienced multiple events of assaultive violence in childhood were more likely to experience PTSD in adulthood, i.e. previous exposure to trauma signals a greater risk of PTSD from subsequent trauma.

Udwin *et al.* (2000) studied a group of 217 young adults who survived a shipping disaster in adolescence and followed up at five and eight years later. The authors of this study found *'for those survivors who developed PTSD, its duration and severity were best predicted not by objective and subjective disaster-related factors, but by pre disaster vulnerability factors of social, physical, and psychological difficulties in childhood'* (p.969).

Kessler, Sonnega and Bromet (1995, cited in Weisaeth, 1996) found that childhood physical abuse was associated with PTSD in 22.3 per cent of men who reported the trauma in a national sample study and 48.5 per cent of women.

Female gender

Breslau *et al.* (1999) examined potential sources of the sex differences in PTSD in the community. Although the lifetime prevalence of exposure and the mean number of traumas were lover in females than in males, the overall risk of PTSD was approximately twofold higher in females than in males. This evidence is further supported by a study carried out by Kessler, Sonnega and Bromet (1995, cited in Weisaeth, 1996), who found that women were more than twice as likely as men to develop PTDS: 20.4 per cent of women compared with 8.2 per cent of men.

Many other researchers have found various other pre-trauma risk factors such as pre-existing personality or psychological disorders (Helzer *et al.*, 1987, cited in Scott & Stradling, 1992), family psychiatric history (Weisaeth, 1984, cited in Weisaeth, 1996) and age (Green *et al.*, 1990, cited in Weisaeth, 1996). However, McKenzie, Marks and Liness (2001) tell us that family studies of PTSD have given inconsistent results to date. The aim of their study was to identify predisposing factors in PTSD compared to anxiety disorders, in order to clarify the classification of PTSD as a diagnostic entity. The method of this research was a retrospective case note study of PTSD patients and agoraphobic patients. The results of this study found that PTSD patients had significantly

less family history of anxiety disorder in general, and that they had significantly less personal history of mental illness prior to the traumatic incident.

Peri-trauma risk

Having examined some pre-trauma risk factors, and whilst acknowledging this research, we can see that there are obviously risk factors for PTSD other than trauma exposure. However, it is also important to look at the impact peri-traumatic factors which also may have an influence on the development of PTSD. In other words we are really asking to what extent is the actual traumatic event responsible for the development of PTSD.

Tucker *et al.* (2000) examined 85 adults seeking mental health assistance six months after the Oklahoma City bombing in the US. The authors of this study found that PTSD symptoms were more likely to occur in those who reported feeling nervous or afraid at the time of the bombing (peri-traumatic response).

Schnyder *et al.* (2001) also found that the sense of death threat, during the exposure to trauma contributed to the predictive model for PTSD. Maes *et al.* (2001) research would support the findings of Schnyder *et al.* (2001) whilst also finding that trauma exposure and loss of control during the trauma increased the odds of developing PTSD.

In contrast Scott and Stradling (1992) inform us *'that the correlation between the amount of stress in a traumatic event and the resultant psychopathology is usually low'* (p.22). Nevertheless it seems possible that a trauma would have to be of sufficient intensity for individuals to begin to ask fundamental questions about their view of life and their world. Janoff-Bulman's cognitive appraisal model might help us understand this situation. Dagleish (1999) tells us that Janoff-Bulman argues that PTSD is the result of certain basic assumptions about the self and the world being shattered. The assumptions being:

1. Assumption of personal invulnerability.
2. View of self in a positive light.

Post-trauma risk

Brewin, Andrews and Valentine (2000) carried out an meta-analyses on 14 separate risk factors for PTSD. Individually, the effect size of all the risk factors was modest, but factors operating during or after the trauma, such as trauma severity, lack of social support and additional life stress, had somewhat stronger effects than pretrauma factors.

Brewin, Andrews and Valentine (2000) found that a primary predictor for the development of PTSD were people who reported that counselling helped. The results from this study add to the debate over critical incident stress debriefing and the lack of clarity in this paper as to the definition of 'counselling' raises many questions.

Regehr, Hemsworth and Hill (2001) completed a study on Canadian fire-fighters and found that while some emotional response to disturbing events may be normal, the severity of symptoms covaries with the ability of the individual to develop and sustain supportive relationships to buffer the impact of the traumatic event.

> *'It seems likely that an individual without support is both more vulnerable to the effects of a trauma and more at risk that the distress will be maintained'* (Scott & Stradling, 1992, p.26).

To sum up, questions have been asked on whether the risk factors for PTSD suggest a specific predisposition to PTSD or reflect a general predisposition to mental illness (Yehuda & McFarland, 1995). Available evidence suggests that both explanations are valid. (Weiseath, 1996).

With regard to future research we need to acknowledge the problems inherent in post-hoc or retrospective research. Common problems include the difficulty in specifying baseline adjustment, necessary reliance on retrospective data and difficulties in recruitment of victims after a traumatic event. Reid (1990) suggests that these problems could be circumvented by using ongoing longi-

tudinal research, which would allow the researchers to study the effects of severe and traumatic events as they occur to subjects during participation in such studies. Thus, providing us with more reliable data in the future.

All of the previous evidence can be expanded on and developed further, however, in giving such an overview we can see the importance of educating ourselves, broadening our knowledge base and learning more about the context and the people we work with. Whether therapists or supervisors, it is imperative that we bring awareness to our work and be open to the lifelong journey, that is, being a counselling psychologist.

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References

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders – 4th ed. (DSM–IV).* Washington DC: American Psychiatric Association

Belfast Telegraph (1995). 27 March.

Breslau, N., Davis, G.C., Andreski, P. & Peterson, E. (1991). Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48*, 216–222. In B.L. Green (1994), Psychosocial research in traumatic stress: An update. *Journal of Traumatic Stress, 7*(3).

Breslau, N., Chilcoat, H.D., Kessler, R.C., Peterson, E.L. & Lucia, V.C. (1999). Vulnerability to assaultive violence: Further specification of the sex difference in post-traumatic stress disorder. *Psychological Medicine, 29*(4), 813–821.

Breslau, N., Chilcoat, H.D., Kessler, R.C. & Davis, G.C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: Results from the Detroit Area Survey of Trauma. *American Journal of Psychiatry, 156*(6), 902–907.

Brewin, C.R., Andrews, B. & Valentine, J.D. (2000). Meta-analysis of risk factors for post-traumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748–766.

Cairns, E. (1987). *Caught in the crossfire: Children and the Northern Ireland conflict.* Belfast: Appletree Press.

Cairns, E. & Wilson, R. (1984). The impact of political violence on mild psychiatric morbidity in Northern Ireland. *British Journal of Psychiatry. 145*, 631–635.

Cairns, E. & Wilson, R. (1985). Psychiatric aspects of violence in Northern Ireland. *Stress Medicine, 1*, 193–201.

Cairns, E. & Wilson, R. (1989). Coping with political violence in Northern Ireland. *Social Science and Medicine, 28*, 621–624.

Cairns, E. & Wilson, R. (1992). Trouble, stress and psychological disorder in Northern Ireland. *The Psychologist, 5*, 347–350.

Dalgleish, T. (1999). Cognitive theories of post-traumatic stress disorder. In W. Yule (Ed.), *Post-traumatic stress disorders: Concepts and theory.* Chichester: John Wiley & Sons Ltd.

Dorahy, M.J. & Lewis, C.J. (1998). Trauma-induced dissociation and the psychological effects of the 'Troubles' in Northern Ireland: An overview and integration. *The Irish Journal of Psychology, 19*(2–3), 332–344.

Fay, M.T., Morrissey, M. & Smyth, M. (1999). *The Cost of the Troubles Study.* Derry Londonderry, Ireland: Cost of the Troubles Study/INCORE.

Fields, R.N. (1973). *A society on the run: A psychology of Northern Ireland.* Middlesex: Penguin.

Fraser, R.M. (1971). The cost of commotion and analysis of the Psychiatric Sequelae of the 1969 Belfast Riots. *British Journal of Psychiatry, 11*, 237–264.

Green, B.L., Lindy, J.D., Grace, M.C. & Leonard, A.C. (1992). Chronic post-traumatic stress disorder and diagnostic co-morbidity in a disaster sample. *Journal of Nervous Mental Disorder, 180*, 760–766. In B.L. Green (1994), Psychosocial research in traumatic stress: An update. *Journal of Traumatic Stress, 7*(3).

Green, B.L., Lindy, J.D., Grace, M.C. & Leonard, A.C. (1992). Chronic post-traumatic stress disorder and diagnostic co-morbidity in a disaster sample. *Journal of Nervous Mental Disorder, 180*, 760–766. In B.L. Green (1994), Psychosocial research in traumatic stress: An update. *Journal of Traumatic Stress, 7*(3).

Green, B.L., Lindy, J.D. & Grace, M.L. (1990). Buffalo Creek survivors in the second decade. Stability of stress symptoms. *American Journal of Orthopsychiatry, 60*, 45–54. In L. Weisaeth (1996), PTSD: Vulnerability and protective factors. *Bailliéres Clinical Psychology, 2*(2), May.

Green, B.L. (1994). Psychosocial research in traumatic stress: An update. *Journal of Traumatic Stress, 7*(3).

Helzer, J.E., Robins, L.N. & McEvoy, L. (1987). Post-traumatic stress disorder in the general population: Findings of the Epidemiological Catchment Area Survey. *New England Jounal of Medicine, 317*, 1630–1634. In M.J. Scott & S.G. Stradling (1992), *Counselling for post-traumatic stress disorder.* London: Sage.

Hertzig, M.E. & Farber, E.A. (Eds.) (1996). *Annual progress in child psychiatry and child development.*

Helsinki Watch (1992, July). *Children in Northern Ireland: Abused by security forces and paramilitaries.* New York: Human Rights Watch.

Hinshelwood, R.D. (2007). Foreword. In A. Alayarian, *Resilience, suffering and creativity. The work of the Refugee Therapy Centre.* London: Karnac Books.

Irish News (1998). 12 February.

Kessler, R.C., Sonnega. A. & Bromet, E. (1995). Post-traumatic stress disorder in the national co-morbidity survey. *Archives of General Psychiatry, 52*, 1048–1060. In L. Weisaeth (1996), PTSD: Vulnerability and protective factors. *Bailliéres Clinical Psychology, 2*(2), May.

Lazarus, R.S. & Folkman, S. (1984). *Stress appraisal and coping.* New York: Springer.

Lyons, H.A. (1971). Psychiatric sequelae of the Belfast riots. *British Journal of Psychiatry, 118*, March.

Maes, M., Delmeire, L., Mylie, J. & Altamura, C. (2001). Risk and preventive factors of post-traumatic stress disorder (PTSD): Alcohol consumption and intoxication prior to a traumatic event dimishesthe relative risk to develop PTSD in response to that trauma. *Journal of Affective Disorders, 63*(1–3), 113–121.

McKenzie, N., Marks, I. & Liness, S. (2001). Family and past history of mental illness as predisposing factors in post-traumatic stress disorder. *Psychotherapy Psychosomatic, 70*(3), 163–165.

O'Donohue, J. (1997). *Anam Cara; spiritual wisdom from the Celtic world.* London: Bantam Books.

O'Malley, P.P. (1972). Attempted suicide before and after the communal violence in Belfast, August 1969. *Journal of the Irish Medical Association. 65*, 5.

Orner, R.J. (1992). Post-traumatic stress disorders and European war veterans. *British Journal of Clinical Psychology, 31*, 387–403. In B.L. Green (1994), Psychosocial research in traumatic stress: An update. *Journal of Traumatic Stress, 7*(3).

Reid, J.B. (1990). A role for prospective longitudinal investigations in the study of traumatic stress and disasters. http://www.trauma-pages.com/reid90.htm

Regehr, C., Hemsworth, D. & Hill, J. (2001). Individual predictors of post-traumatic stress: A structural equation model. *American Journal of Psychiatry, 46*(2), 156–161.

Rooney, E. (1995). Political division, practical alliance: Problems for women in conflict. *Journal of Womens History, 6*(4)/*7*(1) (Winter/Spring).

Scott, M.J. & Stradling, S.G. (1992). *Counselling for post-traumatic stress disorder.* London: Sage.

Schnyder, U., Moergeli, H., Klaghofer, R. & Buddeberg, C. (2001). Incidence and prediction of post-traumatic stress disorder symptoms in severely injured accident victims. *American Journal of Psychiatry, 158*(4), 594–599.

Simpson, J. (1983). Economic development: Cause or effect, in the Northern Ireland conflict. In J. Darby (Ed), *Northern Ireland: The background to the conflict.* Belfast: Appletree Press.

Swartz, L. (1998). *Thinking about culture and mental health; A Southern African view.* Cape Town: Oxford University Press. Cited in D.J. Stein (1998), Psychiatric aspects of the Truth and Reconciliation Commission in South Africa. *British Journal of Psychiatry, 173*, 455–457.

Trew, K. (1992). Social psychological research on the conflict. *The Psychologist, 5*, 324–344.

Trew, K. (1995). Psychological and social impact of the troubles on young people growing up in Northern Ireland. *Conference Proceedings: The International Association of Juvenile and Family Court Magistrates. Regional Seminar.* Belfast, April.

Trew, K. & McWhirter, L. (1982). Conflict in Northern Ireland. A research perspective. In P. Stringer (Ed), *Confronting social issues. European monographs in social psychology, Vol. 2.* London: Academic Press.

Tucker, P., Pfefferbaum, B., Nixon, S.J. & Dickson, W. (2000). Predictors of post-traumatic stress symptoms in Oklahoma City: Exposure, social support, peri-traumatic responses. *Journal of Behavioural Health Service Resources, 27*(4), 406–416.

Udwin, O., Boyle, S., Yule, W., Bolton, D. & O'Ryan, D. (2000). Risk factors for long-term psychological effects of a disaster experienced in adolescence: Predictors of post-traumatic stress disorder. *Journal of Child Psychology and Psychiatry, 41*(8), 969–979.

Weisaeth, L. (1996). PTSD: Vulnerability and protective factors. *Bailliéres Clinical Psychology, 2*(2), May.

Yalom, I. (2001). *The gift of therapy.* London: Piatkus Ltd.

Yehuda, R. & Giller, E.L. (1996). Diagnosis and assessment of individuals who have experienced traumatic events: A review of conceptual and practical issues. *Bailliéres Clinical Psychiatry, 2,* May.

Yehuda, R., Halig, S.L. & Grossman, R. (2001). Childhood trauma and risk for PTSD: Relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion. *Journal of Developmental Psychopathology, 13*(3), 733–753.

Conference – Keynote paper

Making a person: The lasting impact of babyhood

Sue Gerhardt

THE OTHER DAY I was walking my dogs on the canal towpath, and a jogger came along, so I pulled the dogs aside to let him pass, and he smiled and thanked me. My gesture was acknowledged, which made me feel that I could go on being the co-operative person I would like to be. However, if he had scowled at me or abused me, I might have felt rather different: more fearful when I set off on my walks, more defended and wary: in other words, in future I might have become less of a co-operative person, and more of a tense, aggressive person. We're made and unmade by other people all the time.

The impact of other people is continuous, but I think that in adulthood it is largely about trying to *sustain* a sense of self in various contexts – or possibly enlarge the repertoire. As an adult, I had some choices about how to respond. I could contribute to keeping my co-operative self going, by performing an inner mental operation about the aggressive man on the towpath – I could reduce his impact on me by telling myself that perhaps he had had a bad morning, or maybe he was afraid of dogs. This would also be a way of regulating and calming myself.

But here I want to make the case that the way that each of us might deal with an aggressive jogger will have a lot to do with how our self got made in the first place. In my view, childhood doesn't just *resonate* in our adult lives, it is *embedded* in who we are and how we behave. The way we react – particularly the way we react to stressful social situations – has a great deal to do with our experiences in babyhood, however distant a prospect that now seems to most of us. The reason for this is that babyhood is a time of massive learning, when all sorts of systems get set up in the brain. Babyhood has a disproportionate influence on the rest of our lives because the earliest experiences actually shape our brains in particular ways. The impact of other people on our *baby* selves is magnified because they're not just sustaining us, they are actually bringing a self into existence, and teaching us how to relate to others in fundamental ways.

The way we react to stress, such as an aggressive encounter, is one fundamental aspect of who we are. But these important aspects of self largely come out of how others regulated us in infancy. For example, if I'd been pushing a baby in a buggy along the towpath, and a stranger had started to shout at us, the baby might be fearful and start to cry. In effect, this cry would be a signal to his caregiver to calm and reassure him – because he would not be capable of organising his own feelings and thoughts, to regulate himself. If I failed to soothe him, the most he could do would be to turn his head away from the unpleasant arousal, or suck his fingers to calm himself.

I wish I could show you some video I took recently of a five-month-old baby, Nina, with her father, where I saw exactly these defensive behaviours already in play. The father was a very emotionally cut-off sort of man who could not manage eye contact at all and was very rigid and easily angered. I dreaded

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having to spend an hour with him myself, and so apparently did his baby (who was only seeing him a few hours a week as she was in foster care). Although she was a lovely, lively baby with other people, when she lay on a mat in front of him, she behaved very differently. He had a way of talking to her in a mechanical, monotonous voice and didn't seem able to engage her in any sort of play. Clearly, the whole experience was very aversive for Nina, and she reacted by turning her head away from him for most of the entire hour-long session – something I have never before encountered in working with many families over many years. Later on, when she started to fret, he tried to comfort her by picking her up and woodenly patting her on the back. This obviously didn't feel good either as she didn't sink in to his body in a relaxed way, but again turned to her own defences to manage her own distress. First she sucked her thumb and then after a while fell asleep – to her foster mother's astonishment, when she came to collect her and found her asleep, as she had already had a long sleep just before the session. It seemed that Nina had nowhere to go except inside herself.

If these sorts of interactions had been repeated on a daily basis, they could well have shaped Nina's developing brain systems. Because during this critical period of development, too much stress can oversensitise the developing stress response or HPA Axis and made it much more reactive throughout life (Essex *et al.*, 2002).

Equally, if Nina habitually used the neural pathways that switch off and self-comfort rather than those of being comforted by others, she would be much more likely to use these types of defences as an adult, albeit in more complex forms like self-comforting through food, drink or drugs, or by dissociating.

On a psychological level, babies of Nina's age are not yet aware of themselves as selves. They do have a sense of agency, but it is focused outward, mostly on how they can get some control over their environment – whether that is kicking a mobile and making it move, or crying and getting someone to come and feed them. Parents who respond sensitively to babies' cues, who notice their needs, and cuddle them when they need reassurance, affirm that they have a self which has an effect on others and can get help from others when needed. But if a baby like Nina has parents who ignore her feelings, she will learn that she too should ignore her feelings. These early non-verbal communications are incredibly potent, shaping the baby's physiological reactions as well as her basic sense of self-worth.

Going beyond a basic sense of self rooted in regulation, the more sophisticated awareness of oneself as a unique person (and of separate, unique others too) is an added on, higher level of development. In a sense it's a gift given by parent figures who invest their time and effort into building such a self, an activity that goes beyond meeting the baby's immediate needs. I'm drawing on the work of George Gergely (2007) here, because he has made this process very clear through his research and thinking.

The way Gergely describes it is that just as a parent teaches a baby to use a spoon by exaggerating her movements and voice and demonstrating in various ways what to do, so a parent teaches a baby who he is as a person through a physical demonstration of his emotional state. She does this by 'marking' his states, exaggerating her expressions and slowing down her actions, to show him what she thinks he feels.

It's the parent's own active interest in the baby's feelings and intentions that directs the baby's attention back to his own feelings and intentions and enables him to learn to monitor his own states, and eventually make choices about how to act.

This awareness of feelings is largely processed by an area of the brain called the medial prefrontal cortex, particularly the orbitofrontal part, which matures approximately between six to 18 months. It seems that the parental awareness of her baby's states, and her pleasure in interacting with

him, helps to facilitate its growth through pleasure biochemicals (Schore, 1994).

Many research studies have shown how central the orbitofrontal area is for the social self. It has been linked to 'agreeableness' (Rankin 2005), the capacity to trust, to have empathy and – later on – a theory of mind. It also plays an important role in selecting behaviours and in self control.

But if this early period goes wrong, the individual can be left with both a weakened sense of self based in the orbitofrontal cortex and also an impaired ability to manage stress based in the biochemical stress response. These handicaps may not become really visible until adolescence or early adulthood, when behaviours like self-harm, suicide and depression start to appear in people who despair of regulating themselves.

Rather than explore a range of outcomes when early development goes wrong, which I sketched in my book, *Why Love Matters: how affection shapes a baby's brain*, here I want to highlight the neuroscientific research that throws light on the borderline personality disorder in particular. I think this will help to illustrate how difficulties in being a self and relating to others have roots in very early experiences.

Defining borderline personality

Those of you who work with people at this end of the spectrum will recognise the 'feel' of these particular types of client. Often it is an intangible feeling of being with someone intense and unpredictable, walking on eggshells or having a mild feeling of dread when these clients are about to arrive. And indeed what has been found in recent research is that the part of the brain which reacts to threats and dangers , the amygdala, is indeed over-reactive to emotional stimuli (Donegan, 2003) in patients defined as borderline.

For example, one of my patients – Mandy – was upset by her boss putting her down, and she raged about him as if he were an 'abuser' – as her father had been. I believe that what was happening was that an old sense of powerlessness and fear had triggered off associations in her amygdala and it went into overdrive as if he was her father. She clearly felt highly threatened and couldn't understand why others saw her as over-reacting. Mandy had lived through a perilous and fearful infancy and childhood, one of extreme stress which had most likely affected her amygdala. Many borderlines have amygdalas which are reduced in volume by up to 16 per cent, possibly as a result of stress in the womb or in the first year of life whilst it is still maturing.

Like many other borderline individuals, Mandy almost certainly had a disorganised attachment to her parents in infancy (Liotti). I believe that what this means in practice is that her parents themselves had poor regulation and poor control of themselves – in her case, they were alcoholic, they fought each other, they were depressed, as well as abusive in various ways. I think the essence of it is that the parent himself or herself is not fully grown up and able to take on the parent role in the sense of consistently acting as if he or she were 'older and wiser'.

Such parents often use the child to meet their own needs in a variety of ways – this might be quite crude as in bullying or coercing the child, but it could also include more subtle forms of dysfunctional parenting such as treating the child as an extension of themselves, being over-involved, or seductive. These are often parents who can't control their anger or despair and end up saying and doing frightening things – such as threatening to abandon the child . They are often unable to respond sensitively to their child's feelings (regulation), and unable to think about the child as a separate person (mentalisation).

So a child like Mandy gets caught up in what has been called a 'traumatic bond'. As a small child, she is programmed to instinctively seek out her 'safe base' when she is upset, i.e. the protective adult who is her attachment figure. But what does she do if the attachment figure herself is the source of threat and danger? Where does she go then?

She is thrown into confusion – and also physiological disarray. This is what Jeremy Holmes calls the 'approach/avoidance dilemma' – and when a child can't get away from the source of anxiety, like Nina, or Mandy, sometimes he solves the dilemma by dissociating.

Let's look at a father and his baby son to see a bit of this in action. This is Russell, who has been diagnosed as borderline personality disorder by a forensic psychiatrist, after being in prison for assault. He was being monitored by the social services to see if he was safe to live with his son Darren, and I was working with the family to make an assessment of his parenting. (He has given permission for his video to be used for training professionals.)

I think what we are seeing here is a father who feels vulnerable, and regulates himself by projecting his discomfort into his child. Just as his son starts to play with a toy, he startles him with a 'BAH! – scared you!' and he teases the child, pulling a toy away from him as he leans towards it. He laughs at the child's confusion. The child sits very still as if unsure what to do next. This is a loving dad but he is also a frightening dad, and a dad you can't predict. This is only the beginning of their relationship.

Most importantly, Russell doesn't *soothe* his child's anxiety. He is actually the source of it. He isn't helpfully regulating the child's affects but is stirring up negative feelings and leaving the child feeling bad. Although many borderline adults have been abused as children, one piece of research (Patrick *et al.*, 1994) found that it wasn't actually trauma that led to borderline personality, it was the 'failure to *resolve* the trauma'. Russell doesn't sort out his son's confusion or consider his son's state of mind.

Children in this double-whammy situation of poor regulation and poor mentalisation often behave oddly, have tics, bang their heads, and basically don't seem to know whether they're coming or going. But after a few years, they do often develop a strategy. They often become controlling. This can take two forms. One is the punitive mode, taking charge of the parent. An example of this is given by Solomon and George: Kate, who's nearly three, is playing with her mother as part of a research programme. As she plays, she chatters on whilst her mother is silent and sitting at a bit of a distance. Then the researchers intervene and ask the mother to help Kate complete a set of tasks. *'On three different occasions when Kate completed one of the tasks incorrectly, her mother moved a piece to illustrate the correct procedure. Each time Kate screamed "No!" and ordered in a threatening tone, "Put it back!" On each occasion, her mother obeyed.'*

Alternatively, they may use the caregiving mode, trying hard to keep the parent happy. These children can be seductively sweet and helpful, sometimes coy, in their efforts to please the dominant parent and avoid her hurtful, frightening side. They are the good girls and boys who often grow up trying to be perfect (and often have eating disorders, in my experience). Jane Fonda describes in her autobiography how her inner mantra was 'I can make it better'. When they reach adulthood, quite a few of these children will be diagnosed as borderline personalities, if they have still not found a way to get their attachment needs met by other people.

In a way these painfully crude attempts to have either total control over the self or total control over the other, are attempts to regulate unilaterally. But they don't work. Babies and young children can't actually soothe themselves, or lower their own levels of cortisol; they need a caregiver to manage it for them. In a secure relationship the biochemical balance is restored with a look, or a hug, or some exchange that settles the arousal down. But the experience of disorganised children is that their caregivers leave them feeling bad, and research has indeed found that disorganised children have the highest levels of stress hormones.

It is these high levels of stress hormones over a period of time that have a toxic effect on the child's developing brain. We know that brain systems are most vulnerable to

influence during the period when they are maturing, which in infancy includes many parts of the brain involved in emotional regulation.

Effects on the brain

Cortisol does particularly affect the stress response itself, partly through a reduced number of cortisol receptors hampering its delicate feedback mechanism. This prevents the stress response from being turned off quickly. But high levels of cortisol can also affect other biochemical systems like the serotonin and dopamine systems which are both sending connections into these pre-frontal cortex areas at this early stage of development (De Bellis, 2005). Both can be dysfunctional in borderlines.

Most of the systems affected in borderlines are very early developing. I just want to mention a few of the less well known – for example, the cerebellar vermis which is one of the earliest parts of the brain to develop, maturing at around five weeks post-natally.

It has been described as 'exquisitely sensitive to stress'. And there is some evidence that the vermis may be affected in both ADHD and borderline personality. Decreased vermal activation is linked with impulsivity and irritability. So here is a first piece in the jigsaw.

Then there is some evidence that the middle of the corpus callosum which is the bridge between the left and right hemispheres of the brain, is affected by early stress. Children who have been abused or neglected have been found to have corpus callosums up to 30 per cent smaller depending on how long the abuse goes on. This too is suggestive of very early problems in the mother/baby relationship, because the corpus callosum has a major growth spurt around three months and again further substantial myelinisation at six months – and then carries on more slowly maturing.

The corpus callosum allows the right and left brain to exchange information in a rather haphazard and inaccurate way, but usually very fast. But some researchers have speculated that when there is a less developed corpus callosum, there may be a tendency to allow one hemisphere to dominate, rather than rapidly moving backwards and forwards and integrating information from the two (Teicher *et al.*, 2004). Although there is not a substantial body of evidence on this yet, there is speculation that this may be what we are seeing with borderline individuals. It could make sense of the borderline person's often remarkable tendency to be articulate and high functioning whilst the left hemisphere is dominant – but when stressed, to react intensely and emotionally more with the right hemisphere network based on emotional memories.

However, this effect might also be the result of stress damaging the orbitofrontal area and the amygdala which both have a lot of cortisol receptors. And most research now suggests that it is problems in the amygdala/orbitofrontal circuit in particular which are at the heart of the borderline difficulties in regulation. One way of describing it is that the threat system – amygdala – is overaroused and the soothing system – orbitofrontal and anterior cingulate – is too weak and sluggish to do a good job of managing it. The pre-frontal area, including the orbitofrontal and dorsolateral parts, goes off-line under too much stress and leaves the amygdala to it, as happened when Mandy reacted to her boss in the way she did.

In the grip of the amygdala, she just wanted to fight or run away. The pre-frontal ability to put social experience in context was too weak to function, so she just couldn't consider why he was acting the way he was. At these times, there is no platform in the mind from which to consider different perspectives, including other people's minds and other people's motivations. This is where Peter Fonagy's idea of mentalisation comes in.

It does seem that the ability to recognise the existence of separate minds and inner lives is a particular difficulty for the borderline personality. One crucial piece of

research has found that it is central – low 'reflective functioning' is much more diagnostic of borderline personality than trauma (Fonagy *et al.*, 1996).

You might imagine from the terms themselves that mentalising and reflective function are a kind of left brain thinking activity, maybe to do with putting feelings into words. But recent research casts doubt on this, and implies that mentalising may be much more a non-verbal capacity based on early experience of a parent providing the kind of attention and 'biosocial feedback' that Gergely talks about. The studies show that empathy and mentalising are based in the emotional *right* hemisphere (Shamay Tsoory, 2003, 2005) and in the orbitofrontal cortex and some other very early developing right brain areas (Ohnishi). They are abilities to do with being aware of feelings as they are being felt in the body. Jon Allen has suggested that this awareness comes from having a loving, secure relationship with another person who notices and validates our feelings. If they are aware of us, we can be aware of ourselves and can 'feel more clearly' as he puts it (Allen, 2006). In a sense, we are then able to develop a loving, secure relationship to ourselves (and to transfer this to others).

Parental input seems to be vital to our ability to pay attention to the outside world as well as the inner world. The parent who manages her baby well through techniques such as distraction helps him to build up his capacity to control where he puts his attention, partly using a neighbouring part of the pre-frontal cortex, the dorsolateral pre-frontal cortex.

But if the baby doesn't *receive* much attention, or is neglected or stressed, then his dorsolateral pre-frontal cortex may receive fewer dopaminergic inputs – which are crucial to its functioning well.

This part of the brain develops in babyhood, but it really takes off and increases in density in toddlerhood and the third year of life, ultimately building up a capacity for working memory. This is essential to developing a more conscious sense of self. As the base for working memory, the dorsolateral pfc is also vital to enabling the individual to think about his emotional experiences, to play with reality and consider different points of view, as well as being used to repress information and stop memories from surfacing. It works with the hippocampus to store and retrieve these personal memories, so together they are probably important in creating a narrative self, and managing that personal story.

But once again, both can be damaged by early stress.

The hippocampus is particularly vulnerable because it has so many cortisol receptors and it has been found to be 17 per cent smaller in borderline adults (Driessen, 2001; Lange, 2005).

And the dorsolateral pfc can also be relatively inactive when it should be helping to manage emotional experiences, although it has been found to be highly active compared to normal controls when memories of abandonment are stirred up (Schmahl, 2004).

Clinical

I hope it's clear by now that neuroscientific research is really pointing us back to very early development – to babyhood as the source of many of the difficulties borderline people have in regulating themselves and being a self. How does this affect the way we approach our clinical work?

My own clinical experience suggests to me that it might mean that these early phases of development might need to be re-done. For example, we know that babies in the first three months of life like responses that are perfectly contingent. They want perfect mirroring, as in the Winnicottian idea that a baby wants to feel his needs are met instantly, as if by magic. This seemed to me to be something my client Mandy was asking me for in the first years of our work (a lot longer than three months). She got absolutely furious with me when she felt I had failed to be perfectly attuned to her. She just wanted me to validate her feelings.

She wasn't ready to make links to her childhood which was pretty traumatic with a mother who drank, spent days lying around in a darkened room, and often forgot to feed her children, whilst her unstable father periodically went on a rampage and attacked them all physically and verbally. It was as if she felt I was abandoning her when I made any sort of interpretation.

She also got furious when I expected her to think about *other* people's feelings or motivations. When she fell out with her boss, she couldn't bear me to wonder what might be going on in her boss's mind, and she told me quite explicitly that she didn't feel strong enough to think about his motivations. She wanted me to feel for her, and her alone.

Perhaps Mandy was instinctively telling me that at that time she needed me to be a developmentally early kind of mother, providing very basic soothing and regulating and mirroring to develop her orbitofrontal cortex, before she could become capable of developing enough self-soothing and enough sense of herself to begin to consider other people's minds. (which she has now started to be able to do).

Certainly if you are aware your client is likely to have an oversensitive stress response and an amygdala primed to interpret others as threatening or hostile to them, then the priority might be to tread softly in creating a safe base and some capacity for regulation before attempting to regulate extremely arousing memories of past abuse or neglect, as many clinicians have agreed (Van der Kolk, Herman, Allen, Fonagy, Liotti, Kalsched, Schore).

But Paul Gilbert in his book *Compassion* (2005) suggests that we might need to go further even that that, and try to create what he calls 'safeness', which is not just the absence of threat, but a *positive* state, something quite maternal, conveyed by the warmth and acceptance of the voice, the face, and pleasure in interactin – i.e. all the early mentalising and regulating behaviours which also support the growth of the orbitofrontal cortex.

However, it's not always that easy. When a person has not had good experiences of early dependency, maybe had disorganised attachments, they usually don't feel comfortable using an attachment figure for regulation. They may have got used to trying to regulate with drugs, with being self-sufficient, self-harming or whatever seems to work – but not through relating. Allan Schore has helpfully drawn attention to the importance of reactivating interactive regulation. He argues that treatment is above all else about re-establishing the capacity to take in comfort, to allow someone to soothe you, and this may not be accepted that easily.

When Mandy attacked me for cancelling a session, flipping into an extreme state of rage, during which she attacked me for not being there for her as I had pomised, I froze. I felt like the vulnerable child she had been with a terrifying and inconsistent father who unpredictably attacked her.

But I knew that I had to be capable of regulating myself sufficiently to tune in to *her* dysregulation So I didn't defend myself. I acknowledged how angry she felt. I recognised that I had not anticipated how strongly she might feel. My priority was to do whatever I could to keep our emotional connection going – mostly with non-verbal communication through body language and a few inadequate words. Very slowly her arousal died down, and she started to talk to me again.

Once she was calmer, I felt able to wonder with her about the source of her rage, in a gentle and 'not-knowing' frame of mind, trying to direct her back to her inner experience without imposing my mind on her. This was enough to get her pre-frontal cortex back on line, in a mild way. As she started to think again, it emerged – just before the end of the session – that her parents had just cancelled the special day out she had offered them that they had planned together. She had tried so hard to be a good daughter but they always had other more important things to do. She would never get the care she needed, the

mothering she got was always inadequate. Clearly, my cancelling a session had merged with her mother cancelling their special day together.

But there was no need to make an interpretation. What was more important was that she could see that she had affected me, and yet- unlike her experience with her mother- we had been able to re-connect. She could discover that a painful psychobiological state could be tolerated and survived, without dissociating from it. Unlike previous traumas, she had the opportunity of regulating high arousal within a relationship, she was not left to feel abandoned, isolated, and alone with her dysregulation.

I think it is likely that research in the future will confirm that it is this sort of process of rupture and repair, which most effectively builds new brain structure. This is another way of saying that it is probably the experience of high emotional arousal being met with a new experience of regulation and mentalisation that provides healing and which might be able to build the the new connections that are needed, particularly between the amygdala and the orbitofrontal cortex. The more we understand about these processes in the future, the better we are going to get at 're-making' a person through the social process of counselling and psychotherapy.

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Recommended reading

Sue Gerhardt (1994). *Why Love Matters: how affection shapes a baby's brain*. London: Brunner-Routledge.

Eric Lis *et al.* (2007). Neuroimaging and genetics of borderline personality disorder: A review. *Rev Psychiatr Neurosci, 32*(3).

Conference – Keynote paper

Loosening chronology's collar: Playing with the tension between time and agelessness

Léonie Sugarman

This is an edited version of the Keynote Address given at the Annual Conference of the Division of Counselling Psychology – 'Resonances of Childhood: the makings of a person' – York, 19 May, 2007.

THE VERACITY OF this year's conference theme – that resonances from childhood experiences permeate our adult life – cannot be denied. Far from it. Nonetheless, I do believe that searching for explanations of human psychological functioning primarily in the history of the individual adopts an unduly restrictive perspective on time. By loosening the collar of chronology and playing with the tension between time and agelessness I believe we liberate our thinking in ways that can impact creatively and positively on work with clients.

This afternoon I will first of all be suggesting that we loosen chronology's collar by thinking of time as not necessarily either one-directional or linear. Then I will question the model of the life course as a sequence of ordered, cumulative and universal steps, directed towards a particular end; proposing, instead, that we focus more on the life course as a system of dynamic relationships. And, having done all that, I will then seek to reinstate the notion of life stage, lest we fall for the false equality offered by the concept of agelessness.

Loosening chronology's collar by thinking of time as neither one-directional nor linear challenges some very powerful theories of lifespan development, and I take up this challenge in full awareness that all theories are interpretive paradigms, and necessarily limit as much as they reveal. All theories have their blindspots; and in psychological theories of lifespan development, one blindspot has often been to search for accounts of human development primarily in the form of sequential, cumulative and universal life stages. If you look in mainstream textbooks on lifespan development, you will find most of them to be organised chronologically, paying homage at the shrines of Freud, Piaget, Erikson, Kohlberg, and the like.

It is, however, worth noting how these theorists are frequently less dogmatic in their theorising than brief summaries generally imply. Thus, Erikson (1980) acknowledged the overlapping of stages and the ways a strength evolving at one stage may continue to develop throughout life. This was taken up by Michael Jacobs (1998) when, in the second edition of his book *The Presenting Past*, he depicted Erikson's theory as a sprial staircase rather than a step ladder – albeit before more or less abandoning stages altogether in favour of the themes of dependence, independence and interdependence.

Similarly, Levinson (1978, 1986), whose book *The Season's of a Man's Life*, became a best seller during the 1980s, emphasised through the use of his seasonal metaphor how one stage (or season) should not be seen as 'better' or 'more important' than another. Winter, for example, cannot be

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considered of greater significance or value than, say, Spring. Each has its role, and its place in the yearly cycle. Nonetheless, visual representations of both Erikson's and Levinson's theory seem often to depict some sort of psychological stairway to heaven.

I do not wish to dismiss such theories out of hand. Throwing them out, like babies with the proverbial bathwater, would be arrogance indeed. But I do believe that, along with their undoubted strengths, they have been both a consequence of and a contributor to psychology's over-concern – one might say obsession – with prediction and, as a consequence of this, with searching in the past for explanations of the present.

I also believe that much theorising (particularly early theorising) about lifespan development frequently failed to acknowledge the gendered and culturally limited nature of the popular metaphor, which casts life as a solo heroic quest. Despite their claims to universality, many of the most well known theories of lifespan development are overwhelmingly based on the experience of wealthy, white, 20th century, and often North American, males. These theories have not been very good at dealing adequately with dimensions of difference other than age – for example, gender, class, race, culture or cohort.

I am far from unique in making this point. Much feminist research and theorising suggests that step-wise models of lifespan development fail adequately to describe women's experience. Studies have often shown women's development to be fragmented and improvisational rather than linear and fixed – a function of the contingencies of women's lives and the necessity of integrating the public and private spheres. But I would further suggest that the metaphor of the solo heroic quest was always a minority experience, and is increasingly out of synchrony with men's lives as well. Nonetheless, much psychological discourse continues to discuss, understand and explain human existence in fundamentally individualistic, sequential terms. It is for the benefit of all that we invoke some alternative, instructive metaphors.

I believe that in the 21st century, when relationships are far less stable than in the past, there is a particular need for lifespan developmental psychology to embrace more fully the inter-subjective turn, and start from the assumption that:

> We do not exist as individuals first and then come together with others to form relationships. Rather … we exist with others first and only after that come to develop some notion of individuality and separateness (Mearns & Cooper, 2005).

I quote Mearns and Cooper here as major players in the counselling field, but they echo the words of many others.

I would like to join Ruth Ray and Susan McFadden (2001) – researchers in women's spiritual development – in replacing or, at the very least, supplementing the metaphor of the life course as a solo, heroic quest with one that is grounded more in relationships and connection than in autonomy and separation. Images that come to mind include the weaving of a web, the construction of a quilt, or the sewing of a tapestry.

All are suggestive of an intricate structure, made up of many strands, strong but flexible. A web, for example, can be extended indefinitely and, if damaged or disrupted, can be repaired. It emphasises complexity and interconnectedness, with individual threads becoming meaningful and comprehensible by virtue of their position in the overall pattern. Perhaps the most sophisticated and elaborate example in the world is the internet (world wide web) – built on a network of relations, all of them interdependent. Images such as this provide an alternative, relational model of development based on becoming a *part of* rather than *apart from*.

I took the phrase 'loosening chronology's collar' from a 2004 paper by Alex Pomson, a Canadian educational researcher investigating the career patterns of school teachers. Pomson found that when the teachers were asked to talk about their careers, only a minority produced linear, chronological

narratives with an obvious beginning, middle and end. Rather than focusing on a *life history*, or even a career *story*, most created a *portrait* – 'an ethnographic sketch in which the person's life is seen as an individually composed whole – a complex knot where past, present and future are bound together' (Pomson, 2004).

Like the metaphor of the web, portraits emphasise an interconnected whole, with complexity taking precedence over temporality, sequentiality and the never ending progress from place to place. This figurative shift (from history to portrait, from change to complexity) invites the possibility of seeing development not as something that must move forever forward, but as a construct that is continually reworked, layered or deepened.

In searching for a grand theory to encompass this complexity I think we should look to dynamic (or developmental) systems theory (Smith & Thelan, 2003) as a metamodel of lifespan development. Dynamic systems theory proposes a non-linear dialectical system in which each element can both modify its predecessor and be modified by that which follows. Rather than endowing infants with genetically programmed and pre-existing mental structures trapped in an immature body, dynamic systems theory suggests that development be understood as the emergent product of many decentralised and local interactions leading to more adaptive levels of functioning. In other words, the developmental process is viewed as change within a complex dynamic system. What distinguishes this perspective is its assumption that systems can generate novelty through their own activity and its commitment to seeing individuals as self-organising, self-constructing open systems fused with their environments.

Here we have a perspective that honours the capacity of individuals to construct, create and reinterpret their own reality – a lynchpin, it seems to me, of the values underpinning counselling psychology. I do not propose dynamic systems theory as a panacea, but as what Alvin Marher (2004) refers to as a 'convenient fiction' – and a plausible and morally sound one at that. But I do bear in mind my earlier caveat that all theories are interpretive paradigms, and necessarily limit as much as they reveal.

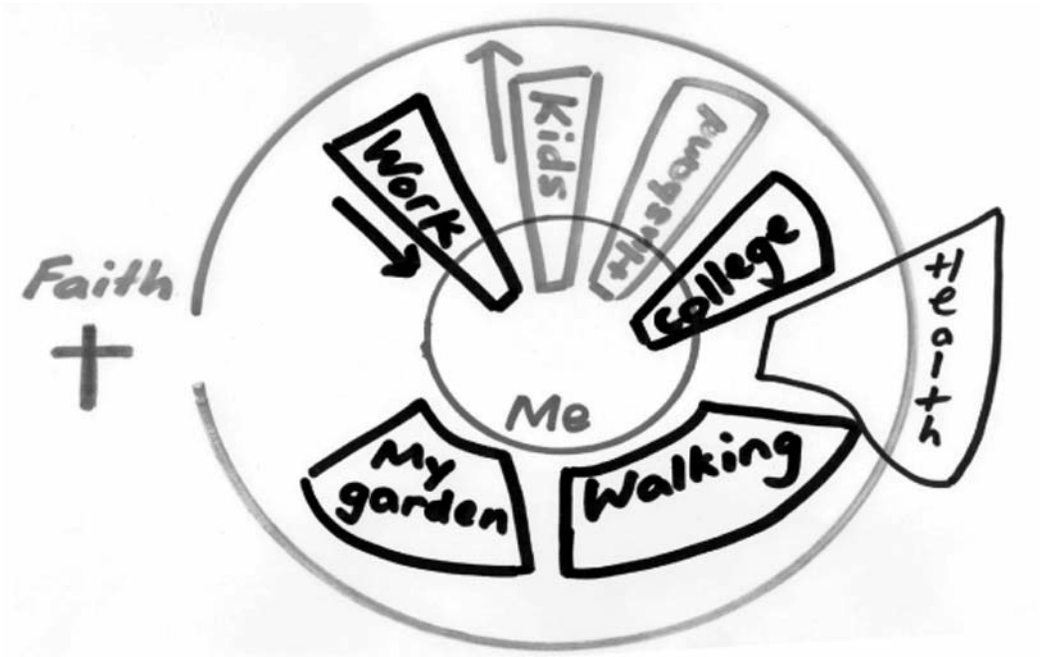
Nonetheless, I am suggesting that one way forward is to replace, or at least supplement, the concept of the self (so closely associated with the metaphor of the life course as a heroic and solo crusade) with that of the personal life space – a mental space that includes the person and the segment of the social, cultural, and material environment that is meaningful to them and with which they interact. The life space (Peavy, 2004), personal niche (Willi, 1999), or life structure (Levinson, 1978) is a multifaceted network of people, relationships, experiences, places, activities, ideas, and things, along with the meanings that the focal person attaches to them.

The personal life space, like webs and portraits, is better presented visually than through words. It is better presented as a snapshot or a map, with the relationships between its different elements indicating how a person makes meaning of their world. Figure 1 (overleaf) is an example.

Although superficially quite straightforward, on examination of this map a more complex picture emerges. There is a strong emphasis on relationships with people, but also with activities (walking), places (my garden) and organisations (college). The whole life space is embraced by a strong Christian faith, although even this is being challenged by some major health concerns that are making themselves felt.

One assumptive cage that the concept of the life space rattles is what might be termed the 'nowness' of the present. In Figure 1 movement and change are indicated by arrows alongside 'kids' and 'work'. As children are growing up and becoming more independent, so career issues are moving centre stage. Standing alongside the self of the present are ghosts of selves past and ghosts of selves still to come.

Figure 1: Map of the personal life space.



This co-existence of present, past and future also occurs within the therapeutic space. The client who reconnects in therapy with their two-year-old self becomes in that moment their two-year-old self. They are not merely talking about that person. They are that person. At that moment childhood and adulthood are correlative and mutually defining.

The separation of the present from the past and the future that life space mapping disrupts is a distinctly cultural phenomenon, and, again, I am far from the first to challenge it. Not all cultures begin their folk tales 'Once upon a time …'. 'It was, and it was not …' is one evocative alternative. In many African languages the noun for 'being' includes both the living and the formerly living, depicting a world where ancestors live among their descendants, unseen but very much involved with the daily affairs of their families. Like Maori culture, a focus on the life space welcomes ancestors of the self into the fold.

Such loosening of chronology's collar also meshes with current theorising about the process of coping with loss – in particular bereavement. In twentieth century Western societies, disengagement from the past was frequently seen as the mark of successful grief resolution, with continued attachment to the deceased being labelled pathological, and interpreted as symptomatic of psychological problems. More recently, however, 'letting go' has been reconstrued as a renegotiation rather than a severance of ties. Attention has turned to the ways in which a dead person is lost and then refound, rather than clung onto before being ultimately relinquished (Walter, 1996).

Thus, Worden, in 1995, amended the last of his well-known list of the tasks of mourning. The first three remained the same: accepting the reality of the loss; working through the pain of grief; and adjusting to an environment in which the deceased is missing. But what had been fourth task – 'withdrawing emotional energy

from the deceased and reinvesting it in another relationship' – evolved into 'emotionally relocating the deceased and moving on with life'. The message here is that physical separation from another person, place or role, even if permanent, does not mean that we must inevitably leave them behind. This thread of continuing and re-negotiating rather than breaking bonds links together a person's life course experience into a more coherent whole. That which has been lost is integrated into a durable biography that has meaning for the person in the present. From this perspective development is a discursive and creative act as well as a psychological construct.

Another consequence of loosening chronology's collar is to complicate our concept of age – suggesting that we can be many ages simultaneously. A birthday card I recently received from my niece summed up this point, congratulating me on being 'Old enough to give advice …' and '… young enough to set a bad example'. This use of humour challenges stereotypes of age, and acknowledges that the question of how old we are does not necessarily have a clear and ambiguous answer. Carl Rogers (1980), approaching his 80th year, made a similar point when he wrote in *'Growing old; or older and growing?'*:

> As a boy, I was rather sickly, and my parents told me that it was predicted that I would die young. This prediction has proved completely wrong in one sense, but completely true in another sense. I think it is correct that I will never live to be old. So now I agree with the prediction, I believe I will die young.

As Bob Dylan (1964) plaintively sang, 'Ah, but I was so much older then. I'm younger than that now.'

Loosening chronology's collar is also consistent with the breaking down of normative order in the 21st century life course. Back in the 1960s Bernice Neugarten and colleagues asked a large sample of adult Americans about age norms. Questions included: What is the best age for a man/woman to marry? What is the right time to finish education and go to work? What is the right time to become a grandparent? When is the prime of life for a man/woman? There were a good number of other questions as well – addressing issues such as career choice, responsibilities, accomplishments, and retirement.

In 1965 there was a high degree of consistency in people's responses, providing substantial evidence for the existence of culturally shared age norms. When the study was repeated in the 1980s, (Passuth *et al.*, 1987) there was still some, albeit less, consensus. However, I find that current generations of students find the questions silly, unanswerable and, on occasions, offensive.

We can conclude that for some time now, rigid timings in the organisation of the life course have been unfreezing. This, too, was picked up by Neugarten and her colleagues some 30 years ago. They noted how the sequence and rhythm of major life events has altered, with puberty coming earlier than before, and death later. They described how social timing is also changing, and how:

> Increasing numbers of men and women marry, divorce, then remarry, care for children in two-parent, then one-parent, then two-parent households, enter and re-enter the labor force, change jobs, undertake new careers or return to school. All this adds up to what has been called the fluid life cycle, one marked by an increasing number of transitions, the disappearance of traditional timetables, and the lack of synchrony among age-related roles (Neugarten & Hagestad, 1976).

Arguably, the extent of this fluidity and its speed of flow have both increased during the ensuing 30 years.

In other words, life stages identified by shared tasks and transitions are, most particularly in the years beyond puberty, somewhat illusory. They do not represent anybody's reality. We need to be wary of life stages, especially the labelling of them. That is something that should perhaps be left to the

marketing and advertising industries – with their WOOPies (well-off older people); DINKYs (double income, no kids yet); and the ubiquitous YUPPies (young, upwardly mobile professionals).

If normative life stages are largely fictitious, does that mean that we live, as has been suggested, in an increasingly age-irrelevant society? The answer is yes and no.

The suggestion that we loosen chronology's collar could be seen as a clarion call for agelessness: 'Be yourself! Don't act your age!' This leads us into issues much debated by gerontologists. In her book *The Ageless Self: Sources of Meaning in Late Life*, Sharon Kauffman (1986) writes:

> I have heard many old people talk about themselves … (and) I have observed that when they talk about who they are and how their lives have been, they do not speak of being old as meaningful in itself … To the contrary, when old people talk about themselves, they express a sense of self that is ageless – an identity that maintains continuity despite the physical and social changes that come with age … Being old *per se* is not a central feature of the self, nor is it a source of meaning.

Promulgating the idea of an 'ageless self' can, at first blush, be seen as a laudable anti-ageist stance, and as an appealing resistance to and challenging of negative stereotypes of late adulthood – with age (especially 'old age') consigned to being nothing more than a mask concealing the essential identity of the person beneath (Featherstone & Hepworth, 1991).

However, it is not as simple as that. We cannot ignore age, even if we want to. Age is used, albeit inconsistently, as a benchmark for allocating rights and responsibilities throughout society and as a gatekeeper guarding access to services. Many services, including those offered by counselling psychologists, are defined directly or indirectly by clients' age or life stage.

It could, and indeed, it has been argued, that that the concept of the ageless self is itself ageist, denying the value of the experience with which our life time has been filled. Molly Andrews (1999), a strong advocate of this position, argues that we are not only as old as we feel, we're as old as we are. Andrews rails against the tyranny of agelessness:

> While difference is celebrated in axes such as race, gender, religion and nationality, the same is not true for age … (And yet) years are not empty containers: important things happen in that time. Why must these years be trivialised? They are the stuff of which people's lives are made.

For Andrews, age is an important diversity, with the concept of agelessness being a sleight of hand – a pretence that age is irrelevant. She suggests that, instead, we celebrate late adulthood as being ageful – as does Clarissa Pinkola Estes (1993) in *Women who Run with the Wolves* when she writes:

> 'How old are you?' people sometimes ask me. 'I am 17 battle scars old,' I say. Usually people don't flinch, and rather happily begin to count up their battle scar ages accordingly.

The concept of the ageless self can also be interpreted as expressing a potent societal script that overvalues the activities and achievements characteristic of the middle years, and sees the prolongation of midlife as a *leitmotif* of contemporary society. It may also reflect a deep seated unease on the part of the young and middle-aged; a personal revulsion to, and distaste for, growing old, for disease and disability; and a fear of powerlessness, uselessness, and death. This unease may reinforce the under-representation of older clients in many therapeutic practices, and the oft cited preference of therapists for working with YAVIS clients: those who are Young, Attractive, Verbal, Intelligent, and Successful.

So now we can see how age – and with it, the concept of time – occupies an anomalous and contradictory position in the consideration of later life. Loosening chronology's collar may bring risks as well as opportunities.

The pitfalls of ignoring age are perhaps even more apparent when we focus on the early years of the life course. The erosion of childhood periodically emerges as an issue of public concern. Ernesto Spinelli in 2002 raised concerns about how the denying of distinctions between child and adult ways of being, in particular with regard to sexuality, can encourage adult abusers of children to convince themselves that their wants and needs are of an equivalent kind and are shared by the children whose hold on a childhood they bring to a sudden and infelicitous end.

Similarly, the Director of the Play Association of Tower Hamlets, along with 19 other play-work professionals, wrote eloquently in a recent letter to *The Guardian* (Murray, 2006) of the need for the creation and protection of free time and space for children in which they can direct their own play without 'adulteration'.

These are all pleas to recognise the distinctiveness of different life stages and are consistent with Margaret Crompton's (1992) advocacy for 'childist' counselling, counselling that demands respect for the idea of childhood as well as for every individual child. It begins with the idea of seeing each child, of whatever age, as a complete person rather than an immature version the adult he or she will become:

> An acorn is not an immature oak tree; an acorn is perfectly an acorn. It contains everything necessary for growth into an oak tree but neither acorn nor tree contains greater or lesser value and virtue. Each is entire unto itself, both are of use to other forms of life (Crompton, 1992).

So here we have plea, not for the ageless self, but for acknowledging and celebrating the separate existence of distinct life stages.

So, what might a counselling psychology that loosens (but does not totally cast aside) chronology's collar look like?

First, I suggest that we remain mindful of and value the distinctiveness of different phases of the life course – whilst remembering that passage through these years need be neither ordered nor predictable. We forget at our peril that childhood is not the same as adulthood, and that adulthood itself is not a homogenous, unchanging plateau. We must avoid also the chauvinistic assumption that midlife represents some sort of gold standard of functioning from which we inevitably fall as we move into later life.

Secondly, I suggest that we supplement the concept of the self with that of the personal life space, and think about life portraits as well as life histories. This ties in with a dynamic systems model of the person – with its crucial elements of emergence and agency – as an alternative to the organic, mechanistic or social constructionist meta-models. It is consistent with a relational view of the person (e.g. Mearns & Cooper, 2005), and with pleas (e.g. Soth, 2006) that we think of counselling as a relating rather than a talking cure.

Thirdly, I would suggest that we adopt a moral stand that values relationship and shared responsibility alongside autonomy and individual freedom. Relational theorising challenges the notion of separation and individuation as the *sine qua non* of development, and, I would suggest, is not only a more accurate but also a more ethical stance. At a time when relationships in couples, families, and the work place have become less stable, therapy might need to expand its focus away from the problems of autonomy and emancipation from social constraint, toward considering the more effective organisation of relationship processes. Changing times call for new therapeutic goals and models.

And finally, I would ask that in our thinking about these issues we retain a little playfulness. As counselling psychologists, I have no doubt that you engage with serious, life changing issues on a daily basis. This is an awesome responsibility, from which I believe it is important to take a break. It is not always essential to be 100 per cent serious and po-faced when talking about serious things. I would further suggest that a background in literature and the arts

is as important as an appreciation of statistics and RCTs in enabling us to engage with clients not as disembodied collections of symptoms, but as living, creative beings.

I promised in my abstract for this talk a touch of magical realism, but feel I have only implicitly acted on this promise. I want to suggest that the underlying notion of magical realism – that the real and the fantastical can co-exist – is an important mind set with which to approach work with clients.

The counselling space is a space of magical realism – a space in which we can, like Pi Patel in *Life of Pi* (Martel, 2002), share a small rowing boat with a fully grown Bengal tiger and where, as in *One Hundred Years of Solitude* (Marquez, 1967), clouds can be made up of yellow flowers, and an iguana found in a woman's womb.

The contradictions in the life space – things like the co-existence of the magical and the realist and the knotting together of past, present and future – give the life space a potent energy that can fuel learning and change. It enables us to recognise and confront the anomalous nature of age. We all know that age tells only part of the story; and the part that it tells it may not tell clearly or accurately. And yet, it can be difficult to get a clear picture of a person if we do not know their age. Age hints at the social, economic, and political times a person has lived through. Knowing a person's age can tell us whether they were alive during the Second World War, and suggest whether they will remember where they were when President Kennedy was shot, when Princess Diana died, or when New York's Twin Towers collapsed. Age can tell us whether someone was a child of the Thatcher era, has only known life under Tony Blair's New Labour government, or is a baby boomer who grew up in the swinging sixties. Such experiences infiltrate our life space, making age, somewhat mercurially, crucially important as well as totally irrelevant.

Writing this paper has been an odyssey – and I am grateful for the opportunity it has provided to take this journey. That I don't think I have reached my destination is consistent with the view of development that I am proposing here today – and, indeed, Carl Rogers talks not of *being* but of *becoming* a fully functioning person.

In this talk I have engaged in what I have been told is a postmodern troubling of the concept of time. I have frolicked amongst the contradiction between, on the one hand, the irrelevance and, on the other hand, the crucial importance of age and life stage. I have played with the tension between time and agelessness.

For my final quote I cite from Ford and Lerner's 1992 book on dynamic or, as they term it, developmental systems theory, where they define human development as:

> A continuous and somewhat unpredictable journey throughout life, sailing from seas that have become familiar into oceans as yet uncharted toward destinations to be imagined, defined, and redefined as the voyage proceeds, with occasional, often unpredictable, transformations of ones vessel and sailing skills and the oceans on which one sails resulting from unforeseen circumstances.

Perhaps this afternoon I have both challenged and supported T.S. Eliot's (1944) claim – so resonant with the conference theme – that 'in my beginning is my end'. More prosaically, perhaps I have simply illustrated that what goes around comes around, or that, like Spike Milligan (1956) 'I'm Walking Backwards for Christmas'.

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References

Andrews, M. (1999). The seductiveness of agelessness. *Aging and Society, 19*, 301–318.

Andrews, M. (2000). Ageful and proud. *Aging and Society, 20*, 791–795.

Crompton, M. (1992). *Children and counselling*. London: Edward Arnold.

Dylan, B. (1964). My back pages. On *Another Side of Bob Dylan*. Columbia.

Eliot, T.S. (1944). East Coker. In T.S. Eliot (Ed.), *The four quartets*. London: Faber.

Erikson, E.H. (1980). *Identity and the life cycle: A reissue*. New York: Norton.

Estes, C.P. (1992). *Women who run with wolves: Contacting the power of the wild woman*. London: Rider.

Ford, D.H. & Lerner, R.M. (1992). *Developmental systems theory: An integrative approach*. Newby Park, CA: Sage.

Featherstone, M. & Hepworth, M. (1991). The mask of ageing and the postmodern lifecourse. In M. Featherstone, M. Hepworth & B.S. Turner (Eds.), *The body: Social process and cultural theory* (pp.371–389). London: Sage.

Jacobs, M. (1998). *The presenting past: The core of psychodynamic counselling and therapy*. Buckingham: Open University Press.

Kaufman, S. (1986). *The ageless self: Sources of meaning in late life*. New York: Meridian.

Levinson, D.J. (1986). A conception of adult development. *American Psychologist, 42*, 3–13.

Levinson, D.J., Darrow, D.N., Klein, E.B., Levinson, M.H. & McKee, B. (1978). *The seasons of a man's life*. New York: AA Knopf.

Mahrer, A.R. (2004). *Theories of truth, models of usefulness*. London: Whurr Publishers.

Marquez, G.G. (1967). *One hundred years of solitude*. London: Penguin (1972, Translated from the Spanish by Gregory Rabassa).

Martel, Y. (2002). *Life of Pi*. Edinburgh: Canongate.

Mearns, D. & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy*. London: Sage.

Milligan, S. (1956). I'm walking backwards for Christmas. On *Goons on CD Volume 3: I'm Walking Backwards for Christmas*. BBC Radio Collection and EMI.

Murray, R. (2006). More childish behaviour. *The Guardian*. 16 September.

Neugarten, B.L. & Hagestad, G.O. (1976). Age and the life course. In R.H. Binstock & E. Shanas (Eds.), *Handbook of aging and the social sciences* (pp.35–55). New York: Van Nostrand Reinhold.

Passuth, P., Maines, D. & Neugarten, B.L. (1987). Age norms and age constraints 20 years later. *Psychology Today, 21*(1), 29–33.

Peavy, R.V. (2004). *SocioDynamic Counselling: A practical approach to meaning making*. Chagrin Falls, Ohio: Taos Institute.

Pomson, A.D.M. (2004). Loosening chronology's collar: Reframing teacher career narratives as stories of life and work without end. *International Journal of Qualitative Studies in Education, 17*, 647–661.

Ray, R.E. & McFadden, S.H. (2001). The web and the quilt: Alternatives to the heroic journey toward spiritual development. *Journal of Adult Development, 8*, 201–211.

Rogers, C.R. (1980). Growing old: or older and growing? In C.R. Rogers (Ed.), *A way of being*. New York: Houghton Mifflin.

Smith, L.B. & Thelan, E. (2003). Development as a dynamic system. *Trends in Cognitive Science, 7*(8), 343–348.

Soth, M. (2006). *No 'relating cure' without embodiment*. Paper presented at the Annual Conference of the British Association of Counselling and Psychotherapy, London.

Spinelli, E. (2002). Paradise lost? *Counselling and Psychotherapy Journal, 13*, 15–19.

Willi, J. (1999). *Ecological psychotherapy: Developing by shaping the personal niche*. Seattle, WA: Hogrefe and Huber.

Walter, T. (1996). A new model of grief: Bereavement and biography. *Mortality, 1*, 7–25.

Worden, J.W. (1983, 1995). *Grief counselling and grief therapy*. London: Routledge.

Bibliography

Bateson, M.C. (1990). *Composing a life*. New York: Plenum.

Bee, H. & Boyd, D. (2006). *Lifespan development* (4th ed.). Boston: Allyn and Bacon.

Berk, L.E. (2006). *Development through the lifespan* (4th ed.). Boston: Allyn and Bacon.

Bowers, M.A. (2004). *Magic(al) realism*. Abingdon, Oxon: Routledge.

Butler, R.N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9*, 243–246.

Bytheway, B. (2000). Youthfulness and agelessness: A comment. *Aging and Society, 20*, 781–789.

Feldman, R.S. (2006). *Development across the life span* (4th ed.). Prentice Hall.

Greene, S. (2003). *The psychological development of girls and women*. Hove, East Sussex: Routledge.

Lewis, M.D. (2000). The promise of dynamic systems approaches for an integrated account of human development. *Child Development, 71*(1), 36–43.

McHugh, K.E. (2000). The 'ageless self'? Emplacement of identities in Sun Belt retirement communities. *Journal of Aging Studies, 14*, 103–115.

Klass, D., Silverman, P. & Nickman, S. (Eds.) (1996). *Continuing bonds: New understandings of grief*. London: Taylor and Francis.

Neimeyer, R.A. (Ed.) (2001). *Meaning reconstruction and the experience of loss*. Washington, DC: American Psychological Association.

Noppe, I.C. (2000). Beyond broken bonds and broken hearts: The bonding of theories of attachment and grief. *Developmental Review, 20*, 514–538).

Jordan, J.V. (1997). *Women's growth in diversity: More writings from the Stone Centre*. New York: Guilford Press.

Jordan, J.V., Caplan, A., Miller, J.B., Stiver, I. & Surrey, J. (1991). *Women's growth in connection*. New York: Guilford Press.

Kohlberg, L. (1980). *The meaning and measurement of moral development*. Worcester, MA: Clark University Press.

Seifert, K.L., Hoffnung, R.J. & Hoffnung, M. (2000). *Lifespan development* (2nd ed.). New York: Houghton Mifflin.

Conference – Keynote paper

There is nowhere to hide

Camilla Batmanghelidijh

I LAY ON A psychoanalytic couch for 17 years, five days a week. I also did 10 years' worth of academic work towards my psychotherapy training. Although I learnt much from both these experiences I was ill-equipped for working at street level.

Having founded two children's charities, Kids Company and The Place 2 Be, I have realised that despite the sophistication of my therapeutic training I walked away from the world of academia poorly skilled to embrace the challenges hurled at me and my team by children who operated from an alternative psychological system and world order. A catastrophic divide between what I had learnt and what the children needed forced me into re-evaluating. This paper is an exploration of that journey.

In 1996 we took over two railways arches in South London. Our intention to build a therapeutic provision servicing vulnerable children when school was closed and they risked being deprived of the attentive care of teachers. We were a group of aspirational white therapists from the schools of Hampstead, where Freud and Jung had not conceptualised Peckham!

Within a period of three weeks the word spread in the neighbourhood and a group approximately 100 boys began coming on our premises. Their intention to challenge our boundaries; their communication only possible in the context of persecution. They victimised us, delighting in ripping the furniture with their knives, rolling their spliffs, setting alight cushions and curtains, and sticking their chewing gum wherever they could imprint their sense of disgust. As workers we felt de-skilled, terrified, therapeutically paralysed and completely out of our depth. I didn't even understand a word they said, as their use of language had evolved to incorporate street slang. Nobody told me that 'bad' meant good, 'bling' was gold, and 'grills' was a set of gold teeth. The centre was open from 3.00 p.m. to 7.00 p.m. and they turned up without fail!

We had no money, we had not expected such a large client group with complex needs. Very soon approximately another 100 children, aged under 12, arrived. Whereas the adolescent boys were surviving through crime, robbing, burglary, and drug dealing, the under 12s were less physically robust, so they resorted to shop lifting, and scavenging in bins for food. I kept being repeatedly shocked by their life stories, their living conditions, and their nihilistic attitude to life. A local forensic psychiatrist visited and remarked that we had worse cases than the ones they had at the local psychiatrist hospital, 'and we can inject ours'.

In such demanding environments the preoccupations of service users and providers is primarily one of needing to acquire safety. The children rolled up their trouser legs to show stab wounds. They were threatened with firearms, and sometimes shot at. The staff were exposed to similar challenges. Everyday it felt as if we were negotiating a war zone. In Britain, the fourth richest country in the world, we discovered an alternative citizenship condemned to the ghettoes within the underbelly of the capital.

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To enhance everyone's survival we employed some males from the community. The job description entitled 'Muscle Factor'. It brought its own challenges. Workers from similar backgrounds to the kids with no history of employment ended up becoming therapeutically brilliant. Alongside them the highly-trained psychotherapists had to 'get real' and apply their exquisite training to a setting which could not be controlled to the 50-minute consulting room boundary. The staff alone presented with emotional challenges which could have been debilitating. As a leader, my role became one of trying to define a theoretical framework which honoured the realities of the street and the insights of therapeutic thinking.

Very soon I discovered that much of the wisdom rested in the children. I began interviewing them on their own. We peeled away the layers of defence to discover narratives, sometimes too unbearable in their devastations of childhood. Having now written down some 400 of these life stories I realised an emerging pattern which pointed to an interactive developmental dynamic. The personal and emotional created in the perverse intimacies of parent child relationships came into contact with equally perverse social and cultural tools for expression.

It invariably began with a young child chronically abused and neglected. The boys resisted tears as they described having to sleep with knives under their pillow to fend off drug dealers who would burst into the house and force their drug addicted mother into sexual contact as a payment for her drug debt. The same mother at the receiving end of such loyal protection would slam her own son's head into the wall whilst in a state of withdrawal. Children described the indignities of losing control and defecating because they were so terrified. They described having to nurse a parent who had vomited blood whilst too drunk. Little seven-year-old girls would pick up the baby in the house and walk around the estates pushing the broken pram, hoping that the mother's fury would subside, making possible a safe return to the house. Nine-year-olds would show the palm of their hands pointing to evidence of having been burnt on the cooker as a punishment. As they recounted their horrific stories their courage and dignity kept us glued together.

But then as if to show me what happened they entered the next phase of this developmentally painful journey. Their eyes would glaze, their facial expressions would acquire a flatness, and their muscles would let go of the fury. It was despondency personified. After the begging and the pleading proving redundant when they knew no change would be effected through their tears; the children universally described an emotional shutdown; 'I didn't care, f*** it". They described not feeling anything.

In the short term such disassociative measures are a useful tool in preserving energy and focusing on basic survival, but over a long period of time such disconnected and disengaged states of mind can create a depletion in the emotional repertoire. The coldness of the children, their frozen emotional states, resulted in experiencing themselves as feelingless and perceiving others to be similarly emotionally cold. Those who came into contact with them unwittingly agreed to this emotionally impoverished contract. The children could not remember anyone breaking through and thawing out their lethal coldness with some warmth or compassion, in fact, the onlooker's gaze was often perceived to be responsible for generating humiliation.

The human eye was conceptualised as the space where the gaze of 'another' would act as a precursor for attack or a witness to the child's catastrophic powerlessness. It is more hopeless than shame because in the experience of shame there is an expected level of personal self-esteem from which we fall short, hence the regret in having generated a discrepancy between personal aspirations and personal outcomes. But humiliation is public. In it rests no sense of personal self-esteem. The lack of an intervening, 'compassionate saviour' means the child internalises a sense of personal disgust. No one thought

them worth protecting, no one stopped to honour their childhood and exercise responsibility in restoring safety.

Civil society is also perceived as bleakly absent. The abused child cannot see where the social worker, the GP, or the teacher stepped in, so a perception grows of being a 'lone soldier' responsible for your own survival, owing no one because what you needed wasn't provided. The making of a potential perpetrator has its beginnings in being such vulnerable victims.

The next phase presents itself when the vulnerable child discovers their own strength; a punch, or a stab, which they deliver as opposed to being on the receiving end of. Young people described feeling euphoric at the realisation that they could now be more like the perpetrator rather than its victim.

Of course, the savagery of the street affords you no such clear hierarchies. All perpetrators continued to be victimised by those stronger than themselves, but at least the sense of catastrophic hopelessness and the apathetic diassociation could give way to more proactive states of mind.

As the children left behind being victims behind closed doors, they created more victims in order to acquire 'ratings'. A personal credit rating needed to be accumulated through being seen to be violent so that the reputation of your savagery would spread on the street sending out a message that you're not a good potential victim as your revenge is likely to by lethal. Some children affiliated themselves to street gangs to create an enhanced image of their defence strategies. If one attacked a gang member the fury of the rest would be unleashed in loyalty.

The depleted child through drug couriering and dealing began meeting his own basic needs. The long sought after designer clothes could now be acquired with the day's earnings. But it's not an easy trade. There is risk and you are dispensable, like rubbish, so you have to police your patch and your reputation through surviving and distributing harm.

Your personal goal is not survival or longevity, your preparedness to die is what gives you your power against another human being who seeks to preserve life. The aspirations are pathetic. Humankind lowered to basic functioning: savagery for survival and simply staying alive as an aspiration. Sometimes the effort outweighs the gains and children take excessive risks driven by a sense of suicide. Every two years one of ours died, machine gunned down, stabbed to death, suffocated in a perverse sexual contact and forced to take an overdose alongside their mother. A boy reaching his 17th birthday remarked with surprise that he had managed to reach this milestone in south London.

The developmental narratives the children shared with us presented with parallels in the scientific literature, Complex Post-traumatic Stress Disorder, Personality Disorders evidencing neglect and abuse, depression so profound that sometimes its manifestation even challenged our sense of purpose and meaning. It could have been a bleak debilitating claustrophobic and paralysing encounter, instead when you walked onto our premises the sense of joy and camaraderie amongst the children was surprising.

Even though we worked with some of the most dangerous young people and we were frequently shot at by outsiders the children themselves got on remarkably well. We all shared a sense of flight. The kite symbolised the assail above the condemnation we could have all been imprisoned within, attached to reality and seeking a rise beyond it to better things.

The children's pain was transformed into something extraordinary through the compassionate acknowledgement of their experiences. As workers we began the task of re-parenting these lone children. Even though some of them had biological parents they often lived with worry for the parent's well-being. Their love for their mothers was touchingly loyal and profound. They often disguised the damage the mother had

caused and tried to preserve her in an idealised but vulnerable way.

Of their fathers who were absent they were dismissive, projecting onto them all the hate both for themselves and on behalf of their mothers. In adopting a protective role towards their mothers, the boys were further frustrated because this parent would inevitably reject them from the family home due to the boys' bad behaviour and a sense of disappointment that yet another male had fallen short of expectations. The relationship between mothers and sons could best be described as toxic yo-yoing. The girls, in contrast, fought and often stayed on to protect their younger siblings. For those who walked out of the family home, the hostels became sarcastic refuges, harbouring drug dealers, psychiatric patients, traumatised refugees, mingling with rats and cockroaches. There was no adult supervision, no staff to create safety, the girls would sometimes be raped, rooms got robbed, children left one 'night terror' often to embrace another.

Against such unforgiving chaos where can one find the relevance of the therapeutic encounter?

Talking of loving your patient or client is not considered professional or trendy. Our humanity towards each other which forms the basis of any successful therapeutic relationship is often intellectualised as if to apologise and disguise the passion of it. But the love I am talking about needs to be vocational. It has to be perceived as a gift we impart without expecting it in return. It's not a transaction, it's a kind of love where our need as practitioners is subdued and the needs of the client takes up the dominant space. It's what good parents do for their children, and it's what young people who turn to us for help need. It places demands on the worker. There is nowhere to hide. Children who have visited the depths of their own pain acquire an expertise about the human condition, which makes them savvy and instantly dismissive of 'emotional fakes'. No professional doctrine or boundary can facilitate one's disguise. The young people demand absolute presence, unwavering integrity and vocational commitment.

It's going to take something extraordinary, something different to encourage their emotional re-engagement with a fellow human being. They need the practitioner to be profoundly honest, both in their despair and in their concern, so that the child begins to see possibilities beyond the rotten humans they have often come into contact with. Past negative experiences make them vigilantly suspicious. Sometimes the worker is used like an emotional punch bag. Any sign of failings in care are perceived as eternal betrayal. Workers need to be looked after so as not to despair like the children, yet the children forgave a lot of our failings too.

The ideal is the creation of a substitute family structure in order to provide a framework for attachment. Staff of varying ages and abilities function like mothers and fathers, brothers and sisters, whilst acknowledging the biological parent and siblings as holding a unique and special position which can neither be mimicked nor usurped. However, the children are acknowledged in their desire to be parented and in their yearning for attachment once their defensive resistance has been lowered.

Our service at Kids Company was evaluated independently by London University. The children gave it a 97 per cent effectiveness rating. This is because we had developed a model in which both emotional and physical needs were met within our limitations. Where we fell short we minimised the potential humiliation by acknowledging that it was our problem and that the flaw did not reside in them. They connected and ruptured attachments as they felt need and terror. But we were patient and left the doors always open.

Over the last 10 years many have gone on to to university, college and employment. Some develop psychotic illnesses and use us like a day hospital. Others are having a second childhood and will only move towards independence in their late 20s.

Both children and workers have been enriched by explicitly acknowledging the contract between us as one of loving care. The control the surveillance camera hopes to achieve, we managed to facilitate by loving the children so that they would think their own life was worth preserving, therefore, they should refrain from harm, both to themselves and to others.

My years on the psychoanalytic couch and rummaging through academic papers on my psychotherapy training taught me there is intelligence behind every behaviour. The children taught me that it wasn't enough to know where the pain came from, that knowledge on its own doesn't heal, the reparation rests at the meeting point of two human beings who engage in the creative task of care, the vehicle for which is unconditional love and an apology for the wrong by acknowledging the pain. Defensive neutrality is offensive, escapist and only serves to repeat the harm. There is nowhere to hide.

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Camilla Batmanghelidijh, trained in Fine and Performing Arts, is a Psychotherapist, and founded Kids Company, and The Place 2 Be.

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Reflections from Conference 2007

CONFERENCE IS JUST LIKE CHRISTMAS!

Anthony Crouch

ONCE UPON A TIME the British Psychological Society was a dark and dreary, pseudo-scientific kind of a place with a large sign nailed to the front gate 'no hippies, dogs or psychologists practicing counselling and psychotherapy'. Over the years, I became very tired of that snotty attitude and was about to resign my Membership when I happened to notice another sign nailed on top of the old one: 'You are cordially invited to an experiential conference, organised by the Counselling Psychology Section'. I remember the moment I arrived at that conference and the joy of realising that I had found my professional home.

The early conferences were 'intimate': looking back I believe that this was partly because they were held in a residential centre *where only we were attending and we, therefore, felt free to be our weird and wonderful selves* and partly because we all had such fun playing with this thing called 'counselling psychology', oh, and there was hardly a word whispered on 'regulation'. In later years I missed a few conferences and then, to my horror, discovered that many of my old, small-furry-animal friends were too busy to attend. So – to the older generation of CPs – my message is COME BACK NEXT YEAR!

I attend conferences because I love meeting up with my fellow professionals and still feel that, what is now the Division, is my professional home. For me, therefore, the annual conference is a bit like Christmas – it's when the family all get together to warm our hands and hearts around the log fire. And, for me, this year's conference was an *exceedingly* good get together – I met *some* old friends but also many new people. Just like in any close family, however, there was also a big argument in the AGM – I'm not sure what it was all about because I'm not 'in the know' but it was really exciting!

Now to the papers: normally I get just a teeny weeny bit bored with papers – what with one person talking at you – but this conference I found many of them surprisingly engaging. For me there was a common theme of the dreadful horrors, even today, of so many people's childhoods and the work of some special professionals in relieving that suffering: for example, Camila Batmanghelidijh's Kid's Company, Áine Thompson's service for those damaged by the 'Troubles' in Northern Ireland, and Susan Darker-Smith's integrative service for severely traumatised children. I also found my developmental theories challenged by Léonie Sugarman's paper Loosening Chronology's Collar, by Sue Gerhardt's paper on the lasting impact of babyhood, and by Riccardo Draghi-Lorenz's wonderful presentation on the reality of social emotions in infants.

Ralph Goldstein's AGM address to conference courageously spoke out against the highway robbery of our profession currently being attempted by our Government. It is time for the psychological therapy professions *as a whole* to stand up and, non-violently, fight for what we cherish. We cannot allow the Government to divide and bully us into submission – not only for ourselves but because this particular profession, perhaps more than any other, is safe *only* in our hands.

Finally, my expectations of conference food are low and, unfortunately, this year's offerings fell far, far below them. Despite this I can, hand on heart, say that I found the 2007 conference most inspiring – both

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professionally, intellectually and socially and will, therefore, recommend a large dose of next year's knees-up to all my fellow Members of our most esteemed, but genuinely threatened Division.

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LETTER FROM AMERICA: A VIEW OF COUNSELLING PSYCHOLOGY IN THE UK

Michael Duffy & Clare Marie Duffy

WE APPRECIATE THIS INVITATION for us to write a reflection on the Chester conference which we recently attended. Firstly, having participated in many conferences, we were impressed by the crisp organisation of this event. The Society's logistical support seemed flawless, honed by experience and delivered in a very courteous and helpful manner. The content of the meeting was challenging, creative and both humanistic and strengths-based in the best tradition of counselling psychology.

Michael can claim a 'long view' of the development of counselling psychology in the UK. He was an invited speaker (representing then APA Division 17 President Leo Goldman) at the first (?) meeting of the British Psychological Society Section of Counselling Psychology held in the Birmingham Conference Centre in 1990. His talk 'Counselling Psychology USA: Patterns of continuity and change' was later published in *Counselling Psychology Review* (1990, *5*(3), 9–18). The conference invitation was extended by Ray Woolfe who later attended our APA Convention in San Francisco. Michael was also at that time appointed by our Division 17 as Liaison to the British Psychologial Society Section of Counselling Psychology (of which he is also a Chartered member), our opposite numbers over time being Ray Woolfe, Mary Watts and Susan Van Scoyoc. At present we do not believe there is an appointed liaison from your Division to ours.

At the Chester conference we were struck by the vast changes over the intervening years. At the 1990 meeting there was an interesting mix of members: those transitioning from clinical psychology, from counselling, and several 'seekers' of a new identity and home as well as some who seemed disconnected and at the margin. There was the concern of a young association for the special character and identity of counselling psychology – thus the invited address which conveyed the then emerging (now mainstream) view that our identity was not in 'what' (types of clients/services) but on 'how' (philosophy/mindset). Counselling psychology in the US is increasingly a leader in the growing national health emphasis on prevention, positive psychology perspectives such as a developmental and strengths-based view of disorder and intervention. At Chester we found colleagues who are completely au fait with this perspective and acting in a similar leadership role in the UK.

We also found a UK Division that is (perhaps *because* it is becoming a force to be reckoned with) struggling for a place and resources in the British health care system and often experiencing a second-class citizen role vis-à-vis clinical psychology. Clare attended the pre-conference workshop on the National Health Service and received a relatively pessimistic impression of NHS careers for counselling psychologists. Clare is a dual (UK/US) citizen and was interested in opportunities in the UK. During the conference colleagues also spoke to us informally about decreasing NHS support to attend the annual conference and other

necessary training events. We did notice a related similarity with the US; the participants at the Chester conference, as in our US Division 17 events, were predominantly academics. As Vice President for Practice (and a practitioner as well as an academic) Michael is much concerned with increasing the practitioner input and attendance in US. Chester colleagues were surprised that we in the US have similar struggles although perhaps a little further along the road. There is hope. Over time in the US we have been perceived as (at least) equally competent alongside our clinical colleagues and the clinical/counselling distinction seems greatly minimised. There is, for example, a less sharp distinction between clinical and counselling in the practice arena. However, in the US the clinical/counselling distinction is alive and well (and defended) in academia.

We saw the childhood theme of the conference reminiscent of a growing interest in working with children in quite a few of our counselling psychology programmes in the US. Counselling psychology had been largely focused on a young adult clientele in the US, probably because university counselling centres were (and still are) major training and employment settings in the US. However, our developmental and lifespan tradition has allowed us to smoothly extend into other age groups. Clare completed a Master's degree course in Counselling at Sam Houston State University in Texas where she had excellent training and clinical experience including using play therapy with children which was the subject of our joint workshop in Chester. Michael's original training was with children at University College, Dublin, and yet he now also directs a programme in geropsychology (ageing) in our counselling psychology programme at Texas A&M University. So we believe that counselling psychology will increasingly address lifespan issues and clients.

With regard to training we were impressed by the rapid growth of Masters and Doctoral programmes in counselling psychology (the most recent in Scotland) which surely will positively eventually affect the job market. Michael attended the pre-conference workshop on the qualification in counselling psychology and was impressed by the development of an independent route to the qualification which seems both rigorous and flexible. This programme is similar to our APA Accredited respecialisation programmes which, however, have to take place within participating training programmes, thus decreasing the desirable flexibility found in the UK.

We seem to have less contact between the UK and US Divisions in recent years. As liaison to the UK Division over the years Michael has had the impression that UK counselling psychology perceived a more natural fit with Europe and looked to establish connections there. But after the Chester conference he saw a very independent UK Division with many possible natural links with the US. One obstacle has been the US requirement for the doctorate as the practicing degree leading to psychology licensure. Michael has also been involved in NAFTA discussions in the US attempting to solve similar problems where in Mexico and Quebec the Master's is the practicing degree. We noticed a tendency to establish more Doctoral programme tracks in the UK (e.g. Glasgow Caledonian University) and also maintain a doctoral equivalence in the independent route to the qualification in counselling psychology. So, our overall impression is that we can have useful UK/US discussions between our Divisions. We welcome Heather Sequeira's suggestion of greater contact and co-operation and much appreciate the related invitation for Michael to join the Editorial Advisory Board of *Counselling Psychology Review*.

We felt very welcomed by our UK colleagues and had a clear sense of the character and values of counselling psychology across our two cultures. We offer special thanks to Chair Ralph Goldstein who welcomed us so graciously. We were impressed by his leadership skill at the

conference and at the AGM where we got a taste of the very British 'directness' in dealing with important issues! The greater 'gentility' of American professional debates in psychology is often at the expense of reality and closure!

In closing we would extend again an invitation to join us in Chicago, for the 2008 International Counselling Psychology Conference, 6–9 March. Our President Elect Linda Forrest asked me especially to extend this invitation to our British colleagues and was delighted that new Chair Malcolm Cross will likely attend. We hope he will not be alone and that we will hear many British accents in Chicago!
International conference website:
http://icpc.test.sierraweb.com

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GROWING PAINS?

Muriel Churchill

ANYONE COMING TO CONFERENCE for the first time in Chester may have been somewhat surprised by events. I was and this was my sixth since 1994. At times life has intervened and I have not felt able to attend. However, I am glad I was at Chester as I think this could be a significant time in the history of counselling psychology.

As anticipated I heard excellent keynote speakers, people presenting from both heart and head: Camila Batmanghelidjh informing and challenging my understanding of 'hoodies', Áine Thompson described the psychological aftermath of the euphemistically named 'troubles' in Northern Ireland, and Sue Gerhardt and Léonie Sugarman portraying the complexities of life from infancy to old age. The guest speakers were backed up by various papers and workshops – too many to mention. But I enjoyed the breadth here too and would like to thank everyone for their presentations that provided examples of both qualitative and quantitative research, and at least one discovering the vagaries of research when outcome is not in line with personal expectation. The enthusiasm of the contributors was palpable and energised me.

At any conference I try to balance each morning and afternoon session so that some of my learning is interactive – I find it easier that way! Unfortunately, one or two of the 'workshops' turned out to be extended papers – not what I'd bargained for, but I remained and listened despite my disappointment. So one point for aspiring contributors and organisers in future years – please be sure of the nature of presentations and allow participants to make informed choices!

So why if I am so happy have I entitled this piece, **Growing Pains?**

Conference 2007 will remain in my memory not only for the above, the new people I met, and acquaintanceships rekindled, but for its AGM. Let's be honest, some people chose not to attend because AGMs can be rather tedious. Not this one!

The tone was set by the outgoing Chair's warnings of manipulation and deskilling politically motivated and underpinned by the NHS, if you can reframe the skill set and avoid the term 'psychologist' (Applied or otherwise), and wrestle control away from professional bodies be that the Society or Royal Colleges – just think how much more control you can have!

It was suggested that many NHS colleagues were not attending conference because they cannot get time off and are unable to gain funding. Now as an independent practitioner, I find this argument risible and somewhat offensive. Am I to believe that a *salaried* Counselling Psychologist cannot afford to come for a day-and-a-half at the weekend or do not wish to give up a day or so of their leave entitlement to attend the whole event. *If* that were the case, I think it shameful. Each year students aspiring to qualify come to conference and want to know what life after training will be like. This is an opportunity to be absorbed and influenced by *the family* of counselling psychologists.

As someone who left academia 20 years ago and has worked with occupational, educational, clinical and forensic psychologists, I am keenly aware of what it means to me to identify as a *counselling psychologist* and I come to conference to be refreshed. Also being able to explain one's identity is a necessary aspect of the Qualification viva. Surely one's identity is as important once qualified, and those who progress and profit from being counselling psychologists need to come back and contribute, or this *unique* family will die out. Looking down the list of attendees, it is clear that about 20 participants came from the NHS – this is a clear under-representation given the numbers who work there.

This issue of funding and the difficulties surrounding voluntary activity appeared to lie behind changes in the committee structure. Most of us will remember the misfortune of 18 months ago when the Chair and Honorary Secretary resigned because of pressure of work. A few weeks ago papers were issued that proposed a change to the Division's structure. The majority who voted agreed and it was passed. However, the validity of this vote must now be in doubt since what emerged over the vote for a new Chair suggests serious organisational errors at the Society's office. I do not wish to replay the emotion and anger surrounding the question of missing ballot papers or the subsequent events outside the meeting. It is enough to say the rules were not followed. Positive comments about the number of people voting for Chair, completely missed the point that some people were disenfranchised. It must have been extremely painful for those standing for election to witness the debacle, I would not have wanted to change places with either.

But, was I alone in leaving the AGM feeling aggrieved that discussion was closed down so quickly, and wondering about the wisdom of reducing the size of the committee so that power was now in far fewer hands? I have to admit I do not really understand the ramifications of such a major change, and it was only after the meeting that on reflection I began to question the desirability of such a change being achieved without any debate among the membership. Without wishing to criticise the reasoning behind the new structure, I realised I should have liked to have heard comments from those who took *our* family on the journey from Section to Division. As I understand it, the old Division Committee was large and somewhat cumbersome but within it there was a good deal of support for the Chair, and it connected the English *family* across the borders with the Scottish and Welsh families. It seems somewhat incongruous to suggest that fewer people will be better positioned to cope.

It *is* essential for members to take personal responsibility for making the Division successful. I feel sure I am speaking for the many who found the papers thought-provoking and edifying in wishing to publicly thank the Conference Organiser and Committee. So long as the Division

exists *many* will come forward at different points through their career, and there is a need to move down through the generations without losing the insights gained on the journey. Of course, many weren't there for the annual reunion: hopefully, when they talk to those who were, they will consider how best they can contribute in the future. When approached, I agreed to submit an application to become the Independent Trainees' Representative on the Division Committee. I have a feeling that this could be a challenging and lively year for me, since an Extraordinary General Meeting will be convened to explore the electoral difficulties exposed at Conference.

So there it is – a very personal reflection that suggests that members of the Division *family* had a mixed, at times trying, weekend with lots of enthusiasm and emotion, (factors that underpin *our* family's very existence). I might be wrong but I think it was Léonie Sugarman who spoke of using 'power for *good*' rather than *controlling* 'power over'. I hope the Committee takes time to consult more widely in future so that I understand the reasoning behind radical changes and that *we all* find a way to move forward together, that the divisions apparent at conference are quickly healed. I chose to be a Counselling Psychologist because of the values and ethics that underpin our Division. For the future I should like to feel that I would not witness again any breach of these at conference.

Dr Muriel Churchill
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REFLECTIONS OF A FIRST-TIMER

Jenny Gatt

I WAS FILLED WITH excitement and anticipation at the prospect of attending this year's counselling psychology conference, my first despite having wanted to attend for a number of years. Unfortunately lack of finances whilst being an independent route trainee had prevented me, and now as a recently-qualified counselling psychologist I had finally made it. However, although it is often recognised that trainees struggle financially, newly-qualified psychologists do too. I found myself unable to stay in the hotel chosen as the venue and had to find more economical accommodation nearby. In my enthusiasm and eagerness to be fully involved I attended the sponsored dinner, to later discover that I was in fact ineligible for this and was subsequently invoiced!

There was a tantalising selection of interesting, engaging workshops and papers making it very difficult to select just one at a time. These were interspersed with inspirational keynote speakers whose passion and integrity I found moving. Then there was my first AGM – a rather heated affair.

Meeting so many fellow counselling psychologists, some familiar faces, many unknown, was a thoroughly enjoyable experience. I came away feeling fired-up, energised, invigorated, a sense of belonging, having shared experiences and made new friends. I am already looking forward to the next one.

Jenny Gatt
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REFLECTIONS OF A FIRST-TIMER

Jeremy Rowe

AFTER THREE YEARS of training and a year away from Chartership, I decided to broaden my horizons and attend the Annual Conference. I was slightly apprehensive about a whole weekend of counselling psychology; however, I was surprised just how much I enjoyed it.

The keynote addresses were as I had hoped – inspiring and informative. I was reminded of the lasting impact of our early years on our development, and of the need for us to be flexible and creative in our therapeutic practice. However, the most stimulating and exciting aspects of the conference for me were the workshops and research presentations of fellow counselling psychologists. I was stimulated by their enthusiasm, knowledge and diversity as practitioners and researchers. One of the main things that I took away from the conference was that by working relationally and not being restricted to one model of practice or research, we are in a strong position to make a unique contribution to our clients and the services we work in.

It was a privilege to learn from and alongside the counselling psychologists whose work I read and quote, without the pressure of being a trainee. I enjoyed spending time with colleagues, discussing and sharing our learning. If you are a trainee, I strongly recommend that you attend next year. You might be reminded, like I was, of why you chose counselling psychology, and that the stress that we experience as trainees might just be worth it!

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Conference Plenary Summary

Barbara Douglas

RESONANCE IS A rich word conjuring up images and sounds of echoes, vibrations and reverberations. This richness has been mirrored in the presentations we have been privileged to attend, and which invited us to consider issues and evidence of attachment, vulnerability, and resilience. Resonances of childhood are indeed powerful; for some who attended, their personal resonances of childhood have been brought into focus; I have found my own knowledge and understanding enriched both personally and professionally, and I think all of us who attended have found resonances in the papers and workshops for our work as counselling psychologists.

On Friday Camila Batmanghelidjh's paper, 'Kites: A theory of mind for childhood', invited us into the world of some of London's most vulnerable young people; children for whom street culture firstly introduces a world of organised drug activity then increasingly absorbs them further into it. Camila outlined the work of Kids Company in its attempt to intervene in this destructive process and I particularly liked her imagery of the kite in this, as something that is both able to be released to explore but simultaneously to be safely held. Kids Company, as Peter Martin commented, aims to make a difference to the resonances of these childrens' childhoods.

In Áine Thompson's paper, 'Working with those affected by the 'Troubles' in Northern Ireland; risk factors and vulnerability', we were introduced to the therapeutic resonances of the 'troubles' in Northern Ireland. I was immediately struck by the image of the book 'lost lives' which sits on Áine's desk and it vividly brought home to me the lived experiences of the conflict. I reflected too on her acknowledgement of the consequences for children of regularly experiencing the dissonance between everyday childhood activity and co-existent violent reality. The lasting resonances of the 'troubles' for many of these children were vividly portrayed in the reasons for referral to the service offered by Áine and her colleagues. I'd like to thank Áine for enriching my understanding of the meaning of therapeutic pluralism for counselling psychology in Ireland as an important aspect of mirroring a need for groups to come together.

In Alan Frankland and Yvonne Walsh's workshop, 'Schemas and conditions of worth: A workshop investigation', I saw in action ways of working in two different models of therapy. Resonances of childhood were apparent in person centred conditions of worth and cognitive therapy's schemas. In the live therapy session we were privileged to share it was interesting to see how each way of working resulted in similar points of content with differences perhaps in the 'timbre' of the session. Most importantly for me perhaps was that it confirmed the importance of professional communications, without which we risk becoming very dogmatic about our approaches.

The AGM on Saturday held resonances of systemic rather than individual development. Organisations are by definition organic entities. The early years offer common focus via goals of identity formation within, or alongside, existing organisational systems. But formation, and subsequent successful growth, inevitably brings about a need to renegotiate the developing direction of a broader and larger organisation that is contained within similarly developing and changing organisations. Systemically I believe we are at just such a point; that organisational, just as individual, processes have a habit of refusing to be

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rushed, and that by remaining an open system we facilitate our further organic growth.

On Saturday afternoon, Léonie Sugarman presented a fascinating paper entitled 'Loosening chronology's collar: Playing with the tension between time and agelessness' in which she suggested we challenge the linear and individualistic structure of human development. Her emphasis on continued interrelatedness within the life space was, for me, graphically illustrated by her visual presentation of life space maps and the suggestion that we consider not so much life history as life portraits. During the course of Léonie's paper I found myself reconsidering linear assumptions underlying processes of assessment within therapy.

Vanja Orlans' workshop entitled 'The contribution of neurobiological and infant observational studies to relational perspectives in therapeutic work', highlighted the importance for the developing brain of relatedness in the first few weeks and months of life. The implications and evidence for our work disseminating from the combination of neuroscience and infant observational studies is something we have a professional duty to be aware of. Arguing for the evidence of the neurobiological importance of communication Vanja suggested we consider therapy not as the talking cure but the communication cure.

On Sunday, Sue Gerhardt, from the Oxford Parent Infant Project, was our final keynote speaker. In her paper, 'Making a person: The lasting impact of babyhood', she emphasised the interdisciplinary nature of attachment research. She demonstrated how the intensity of parent/child relatedness in the very earliest weeks of infant life, acts to embed particular emotional pathways in the brain, pathways which profoundly influence developing patterns of relating. In this I was reminded of the psychodynamic phrase 'introjecting the good object' and considered that perhaps the evidence from neuroscience supported the very physicality of this experience.

What this conference has demonstrated to me is that resonances of childhood are experienced in all aspects of our lives and our work as counselling psychologists. They are apparent in the therapy room, as integral to the cultural context, within our organisational structures, in research and in international relatedness. On this last, we have been invited to Chicago for the International Conference in Counselling Psychology next year and we have a joint conference next year in Dublin, extending our relationship with PSI. I would like to thank PSI delegates for coming to Chester this year as I for one have gone away with food for thought from this participation and look forward to more.

Finally, I would like to thank Jill Mytton, Katrina Alilovic and the Conference Committee for enabling us, through their hard work, to enjoy such a rich conference which for me is certainly the beginning of renewed intention to explore resonances of childhood further.

Barbara Douglas
University of the West of England.

Resonances of Chester

Jill Mytton and the Conference Committee

THE FINAL TASK of the Conference Committee associated with the 2007 Conference in Chester has been to review the feedback and present it to you.

Firstly, though, on behalf of the Conference Committee I would like to thank all the keynote speakers for the time and effort they put into their talks: Camila Batmanghelidjh Áine Thompson, Léonie Sugarman and Sue Gerhardt. They each provided a quality presentation unique to their specific area of expertise. We would also like to thank Lorna Savage and Kerry Wood from the Society's Conferences office for their hard work and supportive assistance throughout.

Summary of feedback from delegates

Of the 164 delegates who attended the conference, 63 returned feedback sheets and provided us with comments we will do our collective best to incorporate in to the planning of Conference 2008. Of these, 35 were chartered counselling psychologists, 23 were trainees and four other.

Table 1 (overleaf) summarises the quantitative data. Actual numbers have been transformed to percentages for comparison.

From this quantitative feedback, which is largely positive, and from the qualitative feedback, we have selected several topics that require a detailed response.

Keynote speakers

It was good to see that generally the invited speakers were well received and enjoyed. Finding good speakers is not an easy task – the best known ask for high fees or are not available. The Conference Committee always welcomes ideas from members so if you have heard someone speak at a conference or elsewhere who you believe would be suitable for our conferences do let us know. You can e-mail us on dcopconf@bps.org.uk.

The AGM

The quantitative responses to the AGM indicated that less than half of you were satisfied and the comments demonstrated why this was so. The Division Committee is aware of the issues that have been raised and intend to respond to them.

Structure of the programme

The quantitative data indicates a high level of satisfaction. However, responses also indicated that more time for discussion would be appreciated. But, of course, more of one thing has consequences in that there then has to be less of another. However, delegate participation is important so a possible model is to have longer session times to allow discussion and debate of papers following their presentation. This would mean though that fewer papers could be included in the programme.

Some also commented on the need for 'comfort breaks' between the longer sessions. This makes sense to us and the committee will take this into account but again these breaks will eat into the time available for papers and workshops.

Content of the programme

There were some comments requesting a more clinical/practice focus, more experiential 'stuff', a greater choice of presentations, etc., and that papers presented were not at a high enough level, So it's over to you – the delegates! We received 41 submissions of which three were symposia, 17 were papers, nine were workshops and 12 posters (three later withdrew). The abstracts of all 41 submissions were deemed by the reviewing committee to be of a high enough standard for inclusion. The content of the conference really does depend on the members of the counselling psychology division so please

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Table 1: Summary of quantitative feedback.

	Number responding	*Not acceptable or poor*	*Adequate*	*Good to to Excellent*
Relevance to study or future work	60	5%	17%	78%
Opportunity to network and meet others	62	2%	11%	84%
Social activities	41	7%	29%	63%
Camila Batmanghelidjh	45	2%	4%	93%
Aine Thompson	44	5%	9%	86%
Leonie Sugarman	49	8%	18%	73%
Sue Gerhardt	39	8%	10%	82%
AGM	44	28%	27%	45%
Structure of the programme	59	0%	12%	88%
Length of programme	59	3%	10%	86%
Value for money	59	15%	37%	51%
Time available for discussion and participation	61	13%	36%	51%
Quality of delegate pack and programme	59	2%	27%	71%
Food	58	17%	16%	67%
Venue layout	60	2%	13%	85%
Venue location	59	10%	15%	75%
Time of year in which event held	58	3%	12%	84%

start thinking now about what you could offer next year.

We would also like to encourage Course Directors to persuade their trainees to present their doctoral research. Perhaps the universities concerned can offer these trainees grants so that they can attend.

The free workshops run by experienced practitioners offered on Friday morning were well attended. We would like to thank all those who provided these additional workshops.

Cost and value for money

Despite attempts to reduce expenditure, running a conference is a costly enterprise. In this case we did not manage to secure sufficient revenue to cover costs. This is not entirely unusual for this type of event. We do manage to restrict costs by having a Conference Committee who freely give of their time, often several hours a month, otherwise the amount of revenue required would have been even greater.

This year the conference was particularly affected by a reduction in the provision of NHS funding. We were not aware of this problem at the time of organising the venue. Our budget was based on 200 delegates and going on past experience we expected most to be residential. Feedback at previous conferences has indicated that delegates like to have the conference in a hotel where they can also live for the duration. This fosters the opportunity for networking and discussion with colleagues. Perhaps some of the feeling this year around the lack of time for discussion is because relatively few opted to take

the residential option. Those of us who did found ample opportunity to meet and talk.

However, times change and we must change with them. Of course there are consequences of choosing cheaper and maybe non-residential venues. The balance between finding good quality venues that tick all the boxes including good facilities, good food, etc., is a difficult one. Next year the conference is in a university where the facilities are cheaper. Accommodation will not be included in the conference registration fee but choices will be given for the delegates to take up and these will include the very good student accommodation available at Trinity College.

Another change that affected us this year is the lack of interest from publishers. I remember in the 'good old days' that there would be a number of publishers' stands at our conferences and these always created a buzz as well as a meeting place. But the publishers now say that 'we do not attend conferences anymore as we don't have the relevant resources to fund staff attendance'. Essentially it is not worth their while unless the number of delegates is high enough to ensure profit from the sales. Nevertheless this year thanks to the sponsorship by Howden Insurance we did in fact exceed the target we aimed for in the initial budget.

It is clear to the Conference Committee that a constant theme running through the feedback was the question of cost. We already offer 30 bursaries to trainees but even so some of them felt they needed more with one even suggesting that those in employment should pay more for the conference in order to subsidise them. On a point of accuracy the bursaries are not funded by the conference delegates but by Division funds.

Venue location and timing of conference

The quantitative data suggests a high level of satisfaction with the venue location and time of year that the conference is held. As one delegate noted, counselling psychologists come from all over Britain so we aim to choose venues in a variety of places and some will inevitably be easier to get to for some than others. Those members in Scotland nearly always have a long way to go as do those in the far south west. We have had one conference in Glasgow and one in Torquay both of which were well attended. We do try to take travel into consideration and will be looking again at this. Again if anyone knows of an excellent value-for-money venue with good travel from all points of the UK we would be delighted to hear from you. Central locations seemed to be the preference. The Conference Committee has previously attempted to alternate the location of conferences so that it is equitable as possible for our members from all over the UK.

Traditionally our conferences have been held in May and this does seem to be the most popular month.

Conference 2008 in Dublin

And now we look forward to 2008 – the Conference Committee has already commenced work on this programme. As most of you probably know by now, Conference 2008 is being held in Dublin on the 20th and 21st June. This is a joint enterprise with the Psychological Society of Ireland (PSI). The conference theme is being developed and honed and in line with this several keynote speakers have been approached. Irvin Yalom has been invited and may be able to speak to us via video conferencing – this has successfully been done by him before at other conferences.

The rationale for a joint conference was firstly to open our eyes to a more outward looking, international, perspective, rather than an inwardly preoccupied vision. There are developments worldwide towards an internationalisation of counselling psychology. This has led to increased contacts and exchanges among counselling psychologistis worldwide (Savickas, 2007). Secondly we aim both to help our Irish colleagues in their struggle to establish their place in Irish psychology and health services by raising

their profile and credibility, and also to see what we can learn from their experiences and a sharing of knowledge. Members of PSI have been attending our conferences for some years now and have built up good connections with our division.

So please put 19th June to 20th June 2008 in your diaries now. Why not make a short holiday out of your trip. Ireland in June is a beautiful place to visit.

Delegates were asked what would encourage them to attend the proposed joint conference in Dublin next year. Their responses focussed again on costs. Ryanair, at the moment, are advertising return flights from London Stansted to Dublin in October with total fares being less than £40. I would encourage people to keep an eye on their website as early booking keeps the costs down.

We appreciate the comment made by one delegate about carbon footprints and cheap flights, however, wherever we hold the conference some will have to use this method of travel. There are, of course, alternatives such as several travelling in one car, travelling by coach or using the train and the ferry.

We thank those that have provided feedback and wish to reassure you that it is all considered. You may find that we've made some changes in response to your feedback. Yet, you may also find that your specific feedback appears to have gone unheeded. If this is the case, we appreciate this might be frustrating. The choices we make are based on careful consideration of competing demands. It feels important to see the process of conference organising as a development one with a longer term view.

Jill Myton and the Conference Committee

Reference

Savickas, M.L. (2007). Internationalisation of Counselling Psychology: Constructing Cross-National Consensus and Collaboration. *Applied Psychology: An International Review, 56*(1), 182–188.

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Talking Point

Introducing 'efficiency' into a health 'market'

Ralph Goldstein

THERE HAVE BEEN a number of apparently unconnected developments in the provision of a well-trained, well-paid and effective workforce in the health professions. In different degrees, depending on the maturity of the profession, there have been moves towards registration, changes in training, changes in pay scales and changes in job evaluation and description. Why all at once, and is there in fact a Governmental coherence at work here? And all the time our attention was divided amongst an apparent multitude of disparate 'modernisations'…

It is now apparent that there is a wider agenda and these modernisations all hang together. The link is the notion of the 'market place'; a way of talking that has been with us some time. And the point of thinking about the market is that the notion of competition is the sole and favoured device for improving efficiency on the part of Government.

Here is how one might go about introducing a competitive market in health provision.

1. Reduce the costs of the workforce – especially expensive 'professionals' by
2. attacking the power-base of all guilds or professions – in particular, open up access to doing hitherto preserved tasks [sub-parts of the profession].
3. Thus it is necessary to analyse jobs in order to extract the relevant competences and then
4. these competences may be matched via – Knowledge and Skills Frameworks say – to various paybands.
5. It will be necessary to refine the content of KSF [competency standards]. This should be done by any group other than the original professional body, for they have a vested interest [in standards, including pay!].
6. Therefore, introduce regulatory bodies who will be responsible not only for professional conduct, but for training standards. Such a body is HPC.
7. There remains one more requirement; to change the working culture that newly-trained people will enter, so we develop New Ways of Working. Some of the working groups established under this umbrella are producing basic competencies for particular modes of therapy…

Hence the real competition in the market place is not really between health providers at all – that is essentially an unbreakable monopoly – but between bodies [Quangoes] prepared to develop National Occupational Standards [e.g. Skills for Health].

If there is no scope for competition, as with medical training, then the Government creates a new quango – PMETB – to carry out the task, almost certainly with some future reference to the other health-related quangoes. [This amounts to a predictive test of the progressive argument presented here; let's monitor the direction of PMETB.]

NEWSLETTER SECTION

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External comparisons

Is there a precedent in the attack on Trades Unions by analogy with the 'closed shop'?

Other professions, such as accountancy and law are in a different position; they have greater power, because of the way economic activity is constructed — such activity is framed and monitored by these professions, making them far more important than health! But they each have a delimited set of tasks which can be carried out by cheaper workers with less training, whose activity only needs professional intervention at well-defined points in the cycle. Conveyancing, for example.

Conclusion and question

Rational argument about what works is unlikely to move the Government. We have to ask what kind of political activity will prevent this gadarene rush down the hill and into the swill of late-model Taylorism?

Ralph Goldstein

Outstanding Contribution to Counselling Psychology Award

CAROL SHILLITO-CLARKE received the Outstanding Contribution to Counselling Psychology Award 2007. The panel of judges spoke of her contribution to the founding of the Division from the Special Group and also of her outstanding contribution to both ethics and supervision.

Carol joined the Counselling Psychology Section in 1986. She had been accredited as a counsellor by BAC(P) in 1985. In 1992 was one of first members to be awarded SoE to DCoP and Chartered as a Counselling Psychology. She was made a Fellow of BACP in 2001.

Carol has given many years of service to the British Psychological Society. This includes:

- Honorary secretary: BPS Counselling Psychology Section;
- Conference Organiser: First Annual Conference, BPS Special Group in Counselling Psychology;
- Executive member BPS Special Group in Counselling Psychology;
- Chair of Standing Committee for Practitioner Member Affairs;
- Executive representative to BPS Professional Affairs Board and Membership and Qualifications Board Counselling Psychology Training Committee;
- Conference commentator, 3rd Annual Conference;
- Supervisor and Co-ordinator of Training;
- Member of BPS Division of Counselling Psychology subgroup on supervisor recognition;
- Sen Pract Memb of the BPS RPSP and an Assessor;
- Facilitator of workshops on supervision, ethics (and retirement!) for DCoP;
- Co-author of the *Divisional Guidelines for Supervision* with Margaret Tholstrup.

Through the latter 1980s and 1990s Carol was involved in counselling and counselling psychology education (teaching and quality assurance) up to Masters level. She has worked as an inspector with the Further Education Funding Council and has been a presenter with the British Association of Supervision Practice and Research (BASPR).

Since 1989, Carol has worked privately as a Counselling Psychology therapist, supervisor and trainer with contracts in education, health and commercial sectors. She has written on ethics for a number of books including the *Counselling Psychology Handbooks*. With typical modesty Carol comments: *'I do not see myself as a paragon of ethical virtue – rather as a struggling practitioner trying to do her best and constantly learning from her mistakes!'*

The final words lie with Carol. *'I like to think that my main work has been behind the scenes, developing and promoting Counselling Psychology'.*

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Carol Shillito-Clarke being presented with the Outstanding Contribution to Counselling Psychology Award 2007 by Ray Woolfe, at the DCoP AGM, Saturday 19 May, 2007.

Trainee Column

DEAR TRAINEES,

I WOULD LIKE TO introduce myself as the new Representative for Trainees on the Course Route, officially succeeding Katherine Poole at the Annual Conference in Chester. I am entering into my final year of training, and have placement experience in the voluntary sector and the NHS, and have an understanding of the diverse issues and challenges that face trainees.

My role is to represent course route trainees within the Division, and work with the Representative for Trainees on the Independent Route in developing resources to support you in your training. If you have any particular needs or ideas regarding resources that you would like us to develop, please let us know. I am keen to continue the work started by Therese Paterson in developing the TalkShop Internet forum into a widely-accessed resource for all trainees in which to network, share ideas and discuss relevant issues. If you have not already joined, I encourage you to do so.

I can only fulfil this role if I know what your concerns and needs are, so I invite you to contact me with your ideas of how I can best represent and support you. I strongly encourage you to keep abreast of the issues that are not only of concern to you currently as trainees, but also of the wider issues within the Division and the Society, as these will affect you when you qualify. This will be an interesting and challenging year, not only because of the transfer of the course route qualification into a PsychD, but also because of the current Health Professions Council proposals and the continuing developments within the NHS. I look forward to representing your concerns and promoting your interests within the Division during the forthcoming year, and to working alongside the Representative for Independent Route Trainees, who, because of the timing of this *CPR*, will introduce herself in the next Trainee Column.

Jeremy Rowe
Representative for Trainees on the Course Route
E-mail: rowejf@roehampton.ac.uk

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Letters to the Editor

Counselling Psychology Review supports freedom of expression and welcomes controversial correspondence, thoughtful comments and lively contribution to public debate. 'Letters to the Editor' provides a forum for readers to: (1) debate issues pertaining to counselling psychology; and (2) extend the peer review process with comment on earlier published papers. Where a letter refers to a previous publication, the original author will be offered the right of reply.

Correspondence to the Editor is warmly invited on all matters pertaining to counselling psychology – heathersequeira@onetel.com

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Dear Editor,

Further to our recent three-month trip to work in Eastern and Southern Africa, I am just writing to give an update on the work we undertook.

On arrival in Kenya I joined my husband and several other people from the UK, Ireland and the US at a school and orphanage as it was not possible to commence work at the Youth Counselling Centre straight away. Seeing the circumstances of the Orphanage and School was a shock because it was apparently one of the most 'basic' settings in Mombasa and as such one of the most difficult things was adjusting to the level of poverty. One example was that there was no running water as the water company has turned it off – and apparently this is commonplace in Kenya.

This project involved two separate areas – one is a school and the other is the actual home of the orphanage. The school is a long building made of wooden frames, a metallic room and mud. There are about 60 kids in the Kindergarten class. Then Standards 1, 2 3 and 4 all fit in the other half of the big room – separated only by torn sheets. As you can imagine it is hard to be heard, hard to hear and so communication is difficult. Add to that that Swahili is the first language and these children are learning in English it is a marvel that they learn anything – but my Standard 3 class was a whizz with Division – quicker than I am. Standard 4 was in the next room. The other room is split into two with the aid of yet another sheet for the Standard 6 class and Standard 7 class.

So for that first week I acted as a locum teacher in the school. I found the heat rather oppressive and not conducive to learning and so I brought the children outside under a big mango tree to have lessons in the breeze. This was great until the cow moo'd behind me making me jump or the Department of Health drove by playing music. But it was interesting to see children trying to attend to their lesson while their heads were rocking to African hip hop.

The Orphanage itself is very deprived and houses two adult carers, their children and 15 orphaned children. The children sleep two or three to a mattress on four bunkbeds in the boys' room and similar in the girls. It was quite a shock to us but what is reassuring is that the kids still muster energy, friendliness, and care for each other. They can make a toy out of anything and really do respond to each others needs. It is quite heart-warming.

I was then based in the Youth Counselling Centre for the rest of the period in Mombasa where one of the things I did was run workshops for peer educators on topics such as 'Counselling Skills'and 'Sexuality'. The peer educators were a joy to meet – they were bright,

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they new their material well and they were thirsty for learning. I was particularly impressed when I suggested small group activities because of the sensitive nature of the material and unlike so many British training groups they resisted small group work because they value the learning that the entire group allows. I also joined these young people in doing outreach work in a range of schools across the city every week day for the rest of our time in Mombasa. This was on a range of health and psychological issues such as 'Relationships', Assertiveness', 'Safer Sex', etc.

As well as contributing to these programmes the time at MYCC also allowed me the chance to learn about Kenyan training, health systems and the like. I was lucky enough to meet the co-ordinators of two Counselling Training Institutes in Mombasa and also to meet with a group of counselling trainees with whom I was very impressed.

Why am I sending you this report? Well of course it is to say Asante Sana (Swahili for 'Thank you very much') to the Division of Counselling Psychology for sponsoring us. The school and orphanage that we worked with had very little in the way of infrastructure and resources and so the donation was incredibly helpful and this is where we targeted the money. It was the equivalent of … a First Aid Kit needed for the school, plug and four-way extension cable, coloured chalks, magnetic letters and words, marbles, footballs, ledger, register, rulers and pens, printing for the school and orphanage and the transport for one of the groups to travel to an ecological park for lessons and lunch as well as the transportation of the stationary and supplies from town to the orphanage.

More than the financial support though, the sponsorship also meant a lot to us as it was wonderful to know that the work we are doing is valued by colleagues.

With thanks and best wishes.

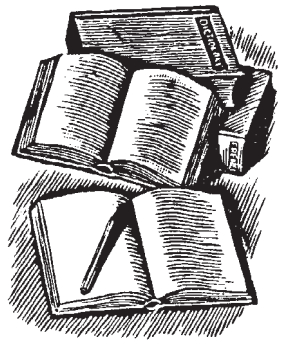
Yours sincerely

Martin Milton

NEWSLETTER SECTION

Book Reviews

Edited by Kasia Szymanska



Handbook of Professional and Ethical Practice for Psychologists, Counsellors and Psychotherapists
Rachel Tribe & Jean Morrissey (Eds.)
Hove: Brunner-Routledge. 2005.
Paperback. 339 pp. £17.99.

📖 **Reviewed by Ralph Goldstein**

This volume has been successful in provoking thought – at least in this reviewer! Several kinds of questions arise, including the question of what constitutes a *Handbook* and what a reader should expect of a *Handbook* in an area such as ethics. I will expand on some of these questions as the review proceeds, which means that this review will both be longer and somewhat different from more conventional approaches to reviewing.

The critical consequence of an ethical system based on principles, rather than injunctions, is that when dilemmas arise the starting point is one's own reasoning rather than obedience to an injunction. Accordingly, the question that must be posed of the content of this book is this – do the authors by and large exemplify ethical *reasoning* in their writings? One might go further and ask if the authors generally help the reader to navigate alternative ethical systems, for the volume is aimed not only at psychologists, but psychotherapists and counsellors whose parent organisations have published quite different ethical codes.

It is important to note that these systems – that of BACP and UKCP – are very different from either the Society's code or the American Asscociation of Psychologists' code. The Society adopts four [and only four] ethical principles and an associated statement of values – the moral philosophy – from which are derived a list of standards of behaviour, which psychologists 'should' adopt. Reflexively, these include a standard of awareness of professional ethics.

This framework makes for an impressive structure, which appears simple because of its hierarchical nature and this, I think, is the distinctive aspect of the Society's 2006 position. Furthermore, by using the term 'should', the Society avoids forcing behaviour down fixed paths, but also avoids directly explicating the current Law where the relevant behaviour may come into contact with statute; the Data [non-]Protection Act being one such example, which is covered in this *Handbook*. Of course, supplementary guidance is in fact available from various Divisions.

On the other hand, the BACP has produced an 'ethical framework for good practice in counselling and psychotherapy' (2002). There is a description in the following order of nine Values, six Principles and 10 Personal moral qualities. Is this in tune with the requirement of the White Paper on Regulation (2007) that we should be of 'good character'?

But note that these keys to the BACP framework are organised in an entirely flat manner – there is no hierarchy. Because the framework is unidimensional there seems to be little scope for deriving an ethical position from any superordinate guiding light, or principle.

The APA's code is neither quite a hierarchy nor a flat structure; one wonders how a *standard* is derived from a *principle*. The 'shoulds' of the Society have become 'oughts', however!

Given these profound differences in philosophical approaches to ethical systems,

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it is reasonable to expect to have to read more than one text, in order to find one's way through to the resolution of ethical dilemmas. Perhaps the job of a *Handbook* is to be a reliable and comprehensive travel guide in a field, whose implications for practice — and for reflecting upon practice — are widening all the time. There are interesting cultural and political reasons for this growth, which will be left aside in this review, except for the question of registration. Of course, this *Handbook* is both a product of, and a response to, this growth, but it is timely in the light of the work that has been done in producing ethical systems within the Society, UKCP and BACP.

Clearly, the fundamental divide is this: statute law has the force of injunction [and punishment] upon us, whereas ethical systems put us in a position of making decisions for ourselves. There is a distinction between an ethical system of thought and a code, or body of law. But note that the Society's document is called *Code of Ethics and Conduct*; there seems to be an appeal to both codification and professional reasoning. For the APA, the 'oughts' have the force of injunction by virtue of legal registration. How are we to wrestle successfully with these issues, especially when they come into conflict, or become truely paradoxical?

With this background in mind, we turn to the structure of the book. There are five major parts:

1. Professional Practice and Ethical Considerations;
2. Legal Considerations and Responsibilities;
3. Clinical Considerations and Responsibilities;
4. Working with Diversity — Professional Practice and Ethical Considerations; and
5. Research, Supervision and Training.

Since there are 25 chapters in total, I will not comment upon all of them individually, but the first section of the *Handbook* is the most wide-ranging and interesting, since some of the the broad issues are laid out here.

The job of opening with the question of 'Why Ethics?' falls to Tim Bond who points us toward a number of critical issues, without perhaps the space to develop them. In particular, he notes the historical shift of responsibility from individuals to professions as a whole and demonstrates why there are benefits to a principles-based system, rather than a rules-based system. There is a hint of why a comparative approach to ethical thinking might be beneficial in that he sums up the American experience of *Enron's* failure; no rules were apparently broken, so it must be permissible to continue. However, it is worth noting that the English and Scottish institutes of accountancy have principles-based systems in place which might repay careful attention by psychotherapists; for example, issues of conflict of interest.

Tantam and Van Deurzen, in surveying the situation across Europe, not just the EU, make clear that '*Registration* is based on a tripod of training standards, ethical commitment, and CPD (which includes supervison very often).' They go on to state 'However, registers, whether voluntary or statutory, are only useful if they not only attest to training but to ethical standards.'

The point here, it seems to me, is that one needs a Conduct Committee, a body that will investigate complaints and develop both standards and case-law. In effect, users of a professional service have to be given a voice in counter-balancing the power of professional members, especially if their practice falls below a certain standard. This, surely, is the counterpart to the historical shift noted by Bond. Clearly, one must establish a framework of training competences ['outputs'], before one can regulate anything at all and then a conduct committee is set up to judge whether a practitioner has fallen short. For example, has a psychologist offered a service beyond their competence? There is a serious danger of circularity in such arguments.

There is also a much broader consequence of such considerations – training courses must include a carefully considered

programme of ethical *education*. And *Handbooks* will become an indispensable part of the kit!

In the next chapter, Michael Carroll makes a useful distinction between a covert or 'psychological' contract and a formal or explicit contract and claims that these distinctions may give rise to ethical breaches. It is a pity that this idea is not worked out in some detail, with examples, and with cross-referencing to the very useful papers by Peter Jenkins in Part 2. The next paper by Cross and Wood is similarly tantalising in that they recognise one ethical principle may be in collision with another, but give no example.

Cross and Wood devote much of their limited space – and limitation of space is a freqent and perhaps inevitable problem – to the interesting idea that ethical thinking can be modelled by Kelly's construct theory. The trouble is that they neither show that construct theory is a superior model to others for this purpose, nor do they exemplify reasoning one's way through an ethical dilemma from start to finish.

This omission raises a question about the purposes of this text and the meaning of the word *Handbook*. One legitimate purpose of such a volume is to orient the would-be ethical practitioner to the range of issues that s/he needs to be aware of and then one may, with the benefit of references and index, make one's own further inquiries. To this degree, the book is a success, but what if the reader, concerned with understanding a principles-based system, wants extended examples of ethical reasoning? For it does seem to be the case that a major necessity in defending oneself against an accusation of ethical malpractice is to make explicit one's chain of reasoning in arriving at any decision. Accordingly, a student of ethics is likely to want detailed examples of such reasoning.

Actually, this demand is a compound of at least two further questions. One is a practical matter of review; do the chapters in the subsequent sections provide such examples and the second is a question of deciding whether the reader should be provided with a comparative analysis of the existing ethical systems produced by the different parent bodies. I showed in the introductory paragraphs that that the bodies 'regulating' psychotherapy and counselling in this country do not operate equivalent principles-based, or, alternatively, rules-based, ethical systems.

Continuing in reviewer's mode, Part 2 begins most helpfully with two very clear and concise papers by Peter Jenkins on the legal frameworks surrounding therapy with particular emphasis on confidentiality where some of the direct conflicts between duty to one's client and [legal] requirements on behalf of external considerations have taken place. Subsequent papers in this section by Allan Winthrop and by David Purves are also clear and concise, but aimed at a readership coming to these areas – being an expert witness, record keeping – for the first time.

While very helpful to trainees, these contributions come no nearer to answering the questions posed above. Part 3 on clinical contributions may reveal more.

The opening chapter in Part 3, written by Haworth and Gallagher, concerns referrals and whilst this is an issue which can raise ethical dilemmas, the problems are not resolved by their simple listing of good referral practices. The same authors address the issue of complaints in the next chapter, but they are unfortunate in their timing since much of what they write has been superceded by the 2006 Society's *Code of Ethics*. This rather neatly illustrates the problems of both writing ethical codes and relevant textbooks; new laws and new social developments can easily supercede previous positions. A reasonable question to be posed in considering a code of ethics is whether it is likely to be rendered obsolete by likely developments in the Law.

In considering suicide Boden suggests that principles are a guide rather than rules, indicating the burdens of reasoning placed on individual therapists. Critically, she also points out that the different ethical codes

have different consequences for one's own reasoning, especially if the ethical guideline in question is opaque and/or contradicted by another value in the same set of values. This is a contribution that will be of especial help to trainees.

A strength of this *Handbook* lies in the width of its coverage and this is best illustrated in Part 4 on working with diversity, where that often problematic word is granted a very wide meaning. Thus the part opens with a chapter by Gersch and Dhomhnaill on working with children and adolescents. They conclude by writing that 'reflective practice is at the core of ethical conduct', but they have too little space to work out the important implications of this position.

O'Leary and Barry refer to the philosophy underlying counselling psychology as a basis for enhancing ethical practice with older adults and, as with other chapters, there is an overlapping of ethical considerations with technical practice in the management of sessions. Perhaps there is an appropriate justification in that *competence* is one of the ethical principles specifically embraced by the Society's *Code* [and not by either BACP or UKCP].

The chapters by Moon on lesbians and gay men and, especially, by Forster and Tribe on learning disability both exemplify ethical reasoning in various contexts, which should gratify any reader troubled by the steps involved in finding ways through these particular ethical dilemmas – or even recognising what constitures a dilemma.

Finally, Part 5 addresses research, supervision and training. Again, the main beneficiaries will be trainees and others beginning to find their way through the minefield that is research relevant to clinical practice. Coyle and Olsen give significant space to problems in dealing with distress and the importance of not making things worse by reopening old wounds in questioning participants – the principle of non-maleficience. This is an issue which is common to all schools of psychothearpy and counselling and will be very helpful to to trainees approaching research for the first time.

Martin Milton discusses evidence-based practice and raises a non-obvious issue; is evidence-based practice inevitably synonymous with ethical practice? There is strong face-validity for the assumption, but surprisingly few other reasons for believing the claim.

Shirley Morrissey raises questions of teaching ethics; should ethics be taught to undergraduates if their courses have options in counselling, for example? She presents the basics of a postgraduate introductory module of her own design, which might have challenged the reader a little further if she had made an attempt both to link her outline to the competency-based approach of the counselling psychology syllabus and to show how ethical thinking should pervade a well-designed course.

The *Handbook* is aptly concluded by an editor, Rachel Tribe, who presents us with trainee perspectives, which is to say, trainees' concerns and puzzlements as they begin to practise. Not all these concerns are anecdotal as some concerns have been more systematically researched. Many of the concerns are not surprising and probably have their basis in fears of an incompetence which may be implicitly punished by the trainee's client or organisation. Many of the trainees' concerns are in effect topics of individual chapters in this book — but not all!

Conclusion

This is indeed a *Handbook* in the sense of its wide coverage, but is it also a reference work? One may always begin the exploration of an ethical issue by reference to the appropriate chapter or by starting with the Index, but the unevenness [in terms both of depth and of referencing] of the chapters makes this enterprise somewhat uncertain – this edition is not yet a reference work, although it is a good place for trainees to begin. But the Editors and publishers may well decide on a second edition, provided the present volume sells well, as it should. The timing of

a second volume could helpfully coincide with the likely emergence of clarity about regulation and also the unifying code [unifying the codes of member organisations] that may emerge from UKCP, in particular, since this organisation is currently reworking its ethical code.

In a new edition more space could be given to reasoning through ethical dilemmas and, finally, a section on *comparative ethics* would not only be most welcome, but perhaps necessary as might be a section explicitly directed to the links between technical practice and competency as an ethical principle.

Ralph Goldstein

Counselling Survivors of Childhood Sexual Abuse (3rd ed.)
Clare Burke Draucker &
Donna Steele Martsolf
Sage Publications. 2006.
Paperback. 176 pp. £18.99.

📖 Reviewed by Julia Hutchinson

The third edition of Draucker and Martsolf's well-known book begins with an introduction which sums up some relevant research about child sexual abuse (prevalence, impact, characteristics of abuse situations etc.), outlines two theories which explain the effects of abuse, and points out some basic questions relating to counselling survivors of sexual abuse (counsellor qualifications, gender). The second chapter goes on to address some of the implications for counselling of the 'false memory' debate and outlines some professional guidelines to help counsellors through this tricky area. Next, there is a summary of the empirical evidence regarding outcomes currently available for different therapeutic approaches with this client group. The main body of the book describes and discusses significant healing processes theorised to be necessary for people to recover from the experience of sexual abuse: disclosure, focusing on the experience of abuse and reinterpreting it from the perspective of an adult, addressing the context of the abuse, making desired life changes and resolution issues. There follows a chapter on addressing the dynamics of, and ruptures in, the therapeutic relationship using an attachment theory perspective and by exploring core relationship themes as outlined by Safran and Muran (2000). The book ends with a case study and looks at some future trends: how we are learning more and more about the impact of trauma on the brain's anatomy and neurobiology; a brief nod to counselling within a multicultural context; and a section on 'complementary treatment approaches' which is a mixed bag looking at effective treatments for PTSD, creative and narrative therapies.

I found the book sometimes illuminating, but sometimes frustrating in its brevity and its tendency to be conventional and safe in both what it has included and how it talks about the theory and research chosen. It is often thorough in what it covers but does have some surprising gaps. For example, the introduction covers theories of abuse effects, but does not include Finkelhor's model of traumatic sexualisation. Instead they cover Briere's self-trauma model and Gelinas' framework, which is fine, yet without any critical analysis of their strengths and weaknesses. In fact, that would be my strongest criticism of the book, that having chosen to stay on very well-trodden path in trauma work, it is uncritical and unreflective of much of the content. I thought another gap in the introduction is the omission of frameworks for understanding why abuse happens: such a big question for both those who have experienced abuse and society as a whole. There have been many different attempts to answer this question, from analytic to feminist to systemic to integrative perspectives. There

has been much work in recent years in both research and treatment of people who sexually offend, and I think therapists need this knowledge base to help clients unpick what kind of thinking they might want to free themselves from. The book is also very biased towards a medical model framework and it would have been more useful to balance this with more recent awareness about resilience and post-traumatic growth. On the plus side, the use of case material throughout the book is excellent and helps to illustrate what are occasionally dense and often brief descriptions of approaches and techniques.

The chapter on false memory provides a thorough and up-to-date summary of cognitive and neurobiological research and covers all the relevant issues. However, I was disappointed that, having included a chapter on outcome research, the authors take a conventional and narrow perspective of what kind of outcome research is useful, perhaps reflecting the US and UK obsession with Empirically Supported Treatments, and without any critique of this. The chapter briefly reviews the available studies, all of which, unsurprisingly, were successful, despite being different models. I think it could have been more helpful to look at effective common factors in therapy, and how we can use these with this client group to maximise their value. The authors do discuss the importance of the therapeutic relationship in a later chapter. They focus on Safran and Muran's (2000) method for attending to ruptures in the relationship, which is clear and again interspersed with examples of interventions from case material, though it would have been useful to have looked at some of the more typical dynamics when working with trauma.

The main body of the book offers a thorough description of a phase-oriented approach to trauma work with useful interventions at each stage/for each issue, well-illustrated with examples and dialogue. As a narrative/solution-focused therapist I was frustrated with the narrow approach to the work, for example, the idea that AA is for everyone, though I like the emphasis on the importance of pacing and the therapeutic window. Sometimes the theory presented seemed a bit out-dated; for example, the part about family functioning is not only pathologising of the non-offending family members but also not backed up by any relevant research. There are alternative models that can help make sense of non-offending parents' behaviour. Counselling survivors who also offend is covered as well but not in any detail; there is no mention of, for example, the importance of a statutory framework, issues around denial and minimisation or relapse prevention and no pointers as to where to find out more about recent intervention and research with this client group.

The best chapter is the case study, especially as it focuses on client strengths, competence and growth post-trauma that I had missed in the rest of the book. However, the discussions could highlight other possible interventions, and this again brings me back to what I feel is the main strength and weakness in the book. As a description of a traditional phase-oriented treatment to counselling people who have been sexually abused, it is thorough. But, in the main, its attempts to address recent understandings, research and approaches are piecemeal; they are perhaps included for the sake of completeness but are too brief and unquestioning to be of any real use for the practitioner.

Julia Hutchinson
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Counselling Psychology Review Networking

If you are interested in networking with other Counselling Psychologists within your area of specialty or geographic area, please send exact details that you wish to be published to the Editor, Heather Sequeira, by e-mail to: **heathersequeira@onetel.com**

REGIONAL NETWORKING

North West Branch:
Sylvia Dillon is looking to establish a North West branch.
Contact: sylviadillon@tiscali.co.uk

Central England Forum for Counselling Psychologists:
E-mail: brian.simpson@jsmail.net

Contacts in East Midlands (Nottingham/Derbyshire)
Contact:
E-mail: michelle@mewickes.co.uk Tel: 07770 752377
E-mail: jennifer.gatt@ntlworld.com Tel: 01159703526

Contacts in South East (Kent):
E-mail: Katherinepoole1978@yahoo.co.uk Tel: 01892 557808

Private Practice in Northamptonshire:
Richard Alexander: Tel: 07876 386141

CAMHS North West/Preston Area:
Suzanne Jones. Tel: 07947 232175

NETWORKING: FIELD OF WORK

Personality disorder, vicarious trauma, sexual abuse and energy psychology
Contact: E-mail: michelle@mewickes.co.uk Tel: 07770 752377

Dissociation, primary care, private practice, abuse issues, depression
Contact: E-mail: jennifer.gatt@ntlworld.com Tel: 01159703526

CAMHS North West/Preston Area:
Suzanne Jones. Tel: 07947 232175

CALLS FOR RESEARCH STUDY PARTICIPANTS

I am currently researching how counselling psychologists think about and use their personal therapy within clinical practice. I would like to contact counselling psychologists who have qualified between 2000 and 2004 and who are using predominantly cognitive-behavioural, psychodynamic or integrative models of practice.

I am interested in a wide range of experiences, and am particularly hoping to interview those counselling psychologists who feel they have had a negative experience of personal therapy in training.

Please contact Rosie on: rosierizq@tiscali.co.uk

Have you had experience of working with clients who have been diagnosed with borderline personality disorder?

I am conducting a qualitative study in this area and am looking for qualified psychologists who are willing to participate in individual interviews regarding their experiences with this client group.

If you may be interested please contact
Jonny Brough on 07813 644849 or e-mail: JonnyBrough1@gmail.com

This is part of a Counselling Psychology Doctoral research project supervised by Dr Jacqui Farrants, Department of Psychology, City University, London.
Email: j.r.farrants@city.ac.uk

EXPLORING JOY – PHD RESEARCH PROJECT

What is your experience of joy? What does joy mean to you, to your personal life and clinical practice?

Lunch, travel/child-care expenses provided. Please contact Monia Brizzi, School of Applied Social Science, University of Brighton. Tel: 07737 821881. E-mail: m.brizzi@brighton.ac.uk

Notes for Contributors
Counselling Psychology Review

Submissions should conform to the guidelines below.

Academic Papers: Research, theoretical papers, critical literature reviews and in-depth case discussions. Approximately 3000 to 4000 words. Abstract of no more than 250 words. Longer papers occasionally considered. Subject to anonymous peer review.

Issues from Practice: Approximately 1000 to 3000 words, that discuss and debate practice issues. Can include anonymised case material, and/or the client's perspective. Abstract of no more than 250 words. Subject to anonymous peer review.

Newsletter and Other Submissions: News items, reports, controversial perspectives, letters to the editor, book reviews and details on forthcoming events. Not refereed but evaluated by the Editor.

Submissions guidelines:

1. The front page (which will be removed prior to anonymous review) should give the author(s)'s name, current professional/ training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.
2. Apart from the front page, the document should be free of information identifying the author(s).
3. Authors should follow the Society's guidelines for the use of non-sexist language and all references must be presented in APA style (the Style Guide, available from BPS).
4. Graphs, diagrams, etc., must have titles. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.
5. Submissions should be sent as e-mail attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add 'CPR Submission' in the e-mail subject bar. Indicate whether your submission is submitted as an Academic Paper, Issue from Practice or Newsletter/Other Submission. Please expect an e-mail acknowledgment of your submission.
6. Proofs of accepted papers will be sent to authors as e-mail attachments for minor corrections only. These will need to be returned promptly.

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

For publication in	*Copy must be received by*
February	1 December
May	1 March
August	1 June
November	1 September

All submissions should be sent to:
Dr Heather Sequeira. E-mail: heathersequeira@onetel.com

Book reviews and books for review should be sent to:
Kasia Szymanska (CPR Book Reviews Editor),
Centre for Stress Management,
Broadway House,
3 High Street,
Bromley, BR1 1LF.

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