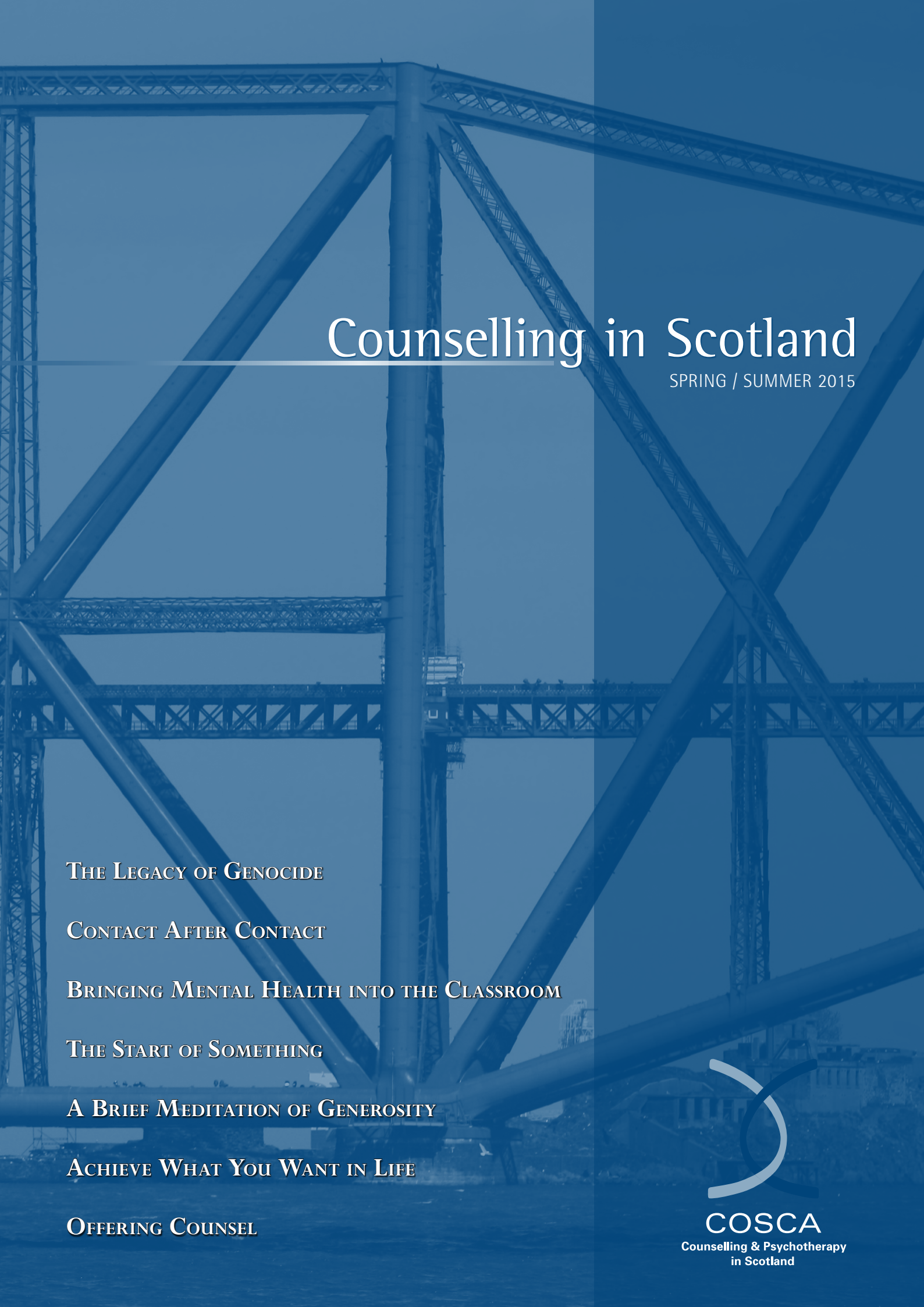

Counselling in Scotland

SPRING / SUMMER 2015

The Legacy of Genocide

Contact After Contact

Bringing Mental Health into the Classroom

The Start of Something

A Brief Meditation of Generosity

Achieve What You Want in Life

Offering Counsel

COSCA
Counselling & Psychotherapy in Scotland

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Editorial

John Dodds

As I was gathering material for the current issue news stories started appearing about how the 70th anniversary of the liberation of Auschwitz. It seems apposite, therefore, that we include Sue Lieberman's powerful piece on genocide and the Holocaust, linked to her new book on the subject. Many counsellors, no doubt, have worked with survivors, or families of those who perished, and Sue raises important questions about how we might begin to think of the issues against such a background.

Still on the subject of war, David Harford offers some reflections on research into combat-related post traumatic stress disorder and new findings on the high percentage of soldiers suffering from PTSD who also had previous trauma in their lives.

Chai Jones offers an uplifting piece about the therapeutic relationship as it might apply to teachers. He talks about being encouraged to sing as a primary school child, and how that both inspired him and enhanced his confidence. I'm sure we can all relate to that. I, myself, recall how my secondary school English teacher inspired me in a similar way—his humour and cleverness, how he would draw out students' personal interests to engage them in learning the principles of the language, and so on.

Journal regular, Benet Haughton, writes beautifully about generosity and abstinence in the counselling room. His quotation from Simone Weil effectively sums up what he has to say: "Those who are unhappy have no need for anything in this world but people capable of giving them their attention."

I'm always happy to receive reflective writings for people undertaking COSCA courses. Aiden Duffy writes with honesty and a great deal of personal insight which he has been generous enough to share with us here.

Gary Davis of the adoption agency, Birthlink, looks at a subject we haven't previously touched upon: intermediary services for adopted people, birth parents, relatives or adoptive parents and relatives.

Michael Dillon introduces us to his new book, *Achieving What You Want In Life* which suggests approaches to self-development using meditation and self-awareness exercises. While not core counselling, the issues he touches on can sometimes manifest in the counselling room and also in ourselves as counsellors.

As I write this editorial, I have just learned that the renowned neurologist and writer, Dr. Oliver Sacks, has terminal cancer. He writes movingly in The New York Times about his feelings and I was especially touched by this section:

"I feel intensely alive, and I want and hope in the time that remains to deepen my friendships, to say farewell to those I love, to write more, to travel if I have the strength, to achieve new levels of understanding and insight.

"This will involve audacity, clarity and plain speaking; trying to straighten my accounts with the world. But there will be time, too, for some fun (and even some silliness, as well).

"I feel a sudden clear focus and perspective. There is no time for anything inessential."

Following on from the Kelpies image last time, we have as this issue's cover the Forth Rail Bridge. This year is the 125th anniversary of the bridge, which is now regarded as Scotland's most famous landmark and nominated for World Heritage status.

John Dodds, Editor

The Legacy of Genocide

Sue Lieberman

The Holocaust looms large over twentieth-century history. Even seventy years afterwards, its impact continues to be felt: in the traumatic experiences of survivors, still echoing through their children and grandchildren; in the political landscape of the Middle East; in the legacy shaping modern Germany. But the more immediate effects on the groups and individuals most closely involved are only part of the postwar story. What are we, in the wider European and world community, to make of an event which arouses so many uncomprehending and appalled feelings? How has it shaped the way policies and thinking – about race, citizenship and Otherness; about how governments conduct themselves; about the relationship between law and morality – have developed since? How are the present-day heirs in the community targetted by this particular genocide affected, whether or not their parents or grandparents were caught up in it? Is there such a thing as "collective trauma"? And if there is, what relevance or implications might it have for the clinical encounter with individuals which counsellors and therapists are engaged in?

Questions such as these lay behind my decision several years ago to begin researching for a book, finally completed and due to be published at the end of 2014, that would consider the wider impact of the Holocaust on "ordinary Jews" – Jews with no direct family connection to the Holocaust. Here I discuss some of the themes explored, and why it is that the 'stuff' of the world outside the consulting room not only cannot but should not be cut off from our clinical work. Realities of history and geography are part of the material of our lives, and the traumas of other people can intrude into our own worlds in mysterious ways.

The Holocaust is far from being the only racially-driven genocide in known history, but it has unique properties within a western/European context and mindset. A genocide ultimately pursued through the calculated application of industrial systems to the mass killing of civilians is chilling enough as an absolute expression of the dehumanising potential of industrialisation. What seems to bewilder people most, however, is the fact that it was carried out on European soil by a nation once admired as the epitome of modern cultural achievement, in what was assumed to be the rational and enlightened era of the modern age:

> *"The first word that comes to mind is atrocity. The most shocking thing… how can you?… there's no scale… [O]ne of the most disturbing things is the medical experiments. I'd say for people who were doctors to do the things that they did […] it's absolutely beyond belief in terms of its insanity."*
>
> Research Interviewee, Jonathan

Yet it is *because* the Holocaust happened when and where it did that it had and has the power to break through conventional protective mechanisms in the western mind: mechanisms which generally help westerners avoid noticing the genocidal policies and practices carried out in far-distant lands by Europeans, under European (including British) colonialism. The most obvious of these – the explicit genocides perpetrated over several centuries against indigenous people in the Americas and Australia, as well as those implicit in slavery and the slave trade – subsequently acquired theoretical sanction through racial theories developed during the mid-nineteenth to mid-twentieth centuries, a period which A. Dirk Moses (2002) calls "the racial century." These

histories sit subliminally in present-day British consciousness, but they are present in the demographic make-up of modern British society and occasionally burst through in racist attacks and killings. People who are different, or who occupy land which a more powerful people wants, can be seen as threats; genocide, with its underpinning conceptualisation of another people as primitive, uncivilised, of inferior or no value, becomes a useful strategy to deal with such perceived threats to a nation's desires and self-beliefs. Against this inherited background, racism and its associated mechanisms of splitting hover uneasily in the background of the therapeutic engagement. The Holocaust, as the racist genocidal project closest in time, location and system of organisation to present European experience, thus forces us into a closer confrontation with the darkest aspects of the human psyche and brings complex challenges, sometimes obviously, sometimes less so, into the consulting room.

As a 'local' European event which cannot be split off in the way that more distant colonial oppression has conventionally been, the Holocaust occupies disquieting territory for all westerners, irrespective of their background, who identify with the 'enlightenment' project of modern European culture. But for Jews, the Holocaust has a much more personal meaning. As members of a longstanding and small minority, such a recent history of being targetted for deliberate extinction in lands where they lived for two millennia is not an easy inheritance. Whether or not the Holocaust represents a collective trauma *as such* for Jews in general, traumatising elements exist. It was in order to unravel those elements and consider their implications that in 2006 I began interviewing a number of "ordinary Jews" across all age groups, exploring with them their emotional and psychological reactions to what they knew of the Holocaust.

From a clinical perspective, two key implications arise from this study. First is the observable fact that even when people have no immediate personal or familial connection to an event of outstanding horror, intense feelings are still triggered which can be extremely confusing to the sufferer. Through many hours of interviewee testimony, I saw that ordinary Jews' feelings in relation to the Holocaust correspond to clinically-understood dimensions of trauma. Here are examples of how, in people's own words, painful and difficult reactions were powerfully felt:

LOSS: *"A profound sense of loss."*

"Loss… I do grieve… I do grieve about the loss of… when you think of how many… how many people there would be now."

"[It's] a loss of security, a loss of… people. A loss of the ideas in the civilisation that went with it. […] It's a concrete loss of who was lost, but it's also loss of hope."

FEAR: *"It's all very frightening."*

"You don't know what people's prejudices are. […] There's whole areas of my life that don't know I'm Jewish."

"It's very hard, isn't it, for [Jewish] people to conceive of an anti-semitism that isn't genocidal?"

"[It's deeply frightening]. Somebody else controlling your life: one you're imprisoned; two, when are you going to die? So little control. You can just identify with that."

ANGER: *"I am angry that very few individuals and not a single nation came to our rescue. I am angry that we could not help ourselves. I am just angry."*

"When I see survivors, some visual stimulus—seeing somebody's face, watching something on TV, or a film, The Pianist for example, … [I feel such] a diffuse anger that it happened."

"An appalled disgust—how could so many people have stood by and not done more to protest?"

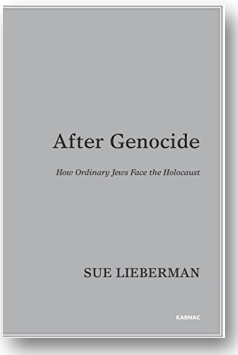
GUILT: *"I feel guilty now. I don't think any of us British Jewish girls were particularly understanding about the plight of these other girls. It sounds awful, doesn't it?"*

*"One of the questions I ask myself again and again is, "what would I have done in 1933?" Would I have closed my eyes…? Or would I have said, "f**k this, I'm out"? I don't know […]. Do I have some guilt about being untouched by it?"*

Such reactions are far from being relevant only to Jews. Not everyone has genocide in their immediate collective history, but everyone comes from a collective history of some kind which forms part of their personal history and sense of identity. The social, economic, cultural and political contexts of our lives influence the family matrix in which each of us spends our vulnerable years; they profoundly impact on our sense of belonging and identity, and inform our struggles to discover and accept who we are. For Jews, the Holocaust acts as a powerful magnet posing sometimes impossible questions to do with hatred, envy, cruelty, rejection, denial, as well as the polar opposites of those questions. These are serious issues to be held in clinical consciousness and addressed when working with somebody Jewish, or Romany, or gay, or descended from slaves, or anyone whose sense of self today is partly configured by histories of institutionalised collective violence. The Holocaust can provide a reference point for anyone struggling with such issues in their own lives, and my explorations of how interviewees articulated their own feelings, sometimes with great clarity and sometimes with immense confusion and difficulty may shed important light on why it is that feelings of being hated, unseen or unwanted can be so complex for the individual living with them.

The second key implication arising from my study is that of Otherness. Jewish history in the Diaspora over two thousand years is intrinsically one of Otherness: of being 'Other than' – different from – the majority of people in the countries where they lived. To marginalise or murder Jews or any group which does not conform to mainstream requirements sends out a powerful message to the population in general, that certain 'deviancies' from accepted 'norms' are dangerous to own and must be repressed. Jews and Jewish history in general, and the Holocaust in painful particularity, embody an intrinsic human dilemma concerning one's own self-acceptance and ability to live fully the fact of 'Otherness', as well as one's acceptance of external 'others': this is a question at least as much of one's inner 'Otherness' as it is a matter of social relations. When interviewees speak of their profound sense of loss, or their grief, or their anger, or their guilt, at the deliberate elimination of so many related human 'Others', it also signals how painful it is when we, or our clients, inflict murder on the 'Otherness' inside our selves.

Sue Lieberman's book, *After Genocide – How Ordinary Jews Face the Holocaust* is published by Karnac Books, price £25.99.



It is available direct from Karnac at **www.karnacbooks.com**, through Blackwell Books bookshop. **www.blackwell.co.uk** and Amazon, and at Word Power **www.word-power.co.uk** and other independent bookshops.

(Endnotes)

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Contact After Contact:

Reflections on Research and Treatment of Combat-Related Post Traumatic Stress Disorder

David Harford

Following completion of a quantitative and qualitative outcome analysis into the effectiveness of transactional analysis (TA) in treating combat-related post traumatic stress disorder (PTSD) (Harford & Widdowson, 2014), I have been pondering over a loose assortment of observations, inferences and unanswered questions arising from the results gathered and conclusions formed. There is little purpose in repeating here what can be found in considerably more depth in our research paper. Instead, I would like to suggest a few interesting departure points for further discussion—and, ideally, extensive research—including an appeal for greater attention to the interplay between the therapeutic and political domains, as explored by the radical psychiatry movement and, earlier, the likes of R.D.Laing and Wilhelm Reich.

To begin at the beginning, then, consider the prominent influence of childhood trauma as a predisposing factor in the aetiology of combat-related PTSD. Nine of the fifteen male veterans studied in our research revealed histories of abuse, neglect, or other family dysfunction prior to joining up (Harford & Widdowson, 2014, p.39); a feature highlighted by Jo Stuthridge, based on her own clinical observation that "in every case in which post traumatic stress symptoms escalated over time... the client revealed a history of childhood trauma" (Stuthridge, 2012, p.239) and, also, the U.S. Department of Veteran Affairs, which noted that "increased risk of PTSD... is associated with... early conduct problems, childhood adversity (e.g. parental loss, economic deprivation) [and] family history of psychiatric disorder" (Schnurr & Friedman, 1997, p.13) before suggesting a distinct diagnostic category of "complex PTSD" to reflect this more fundamental psychopathology.

We might say, then, that these veterans, subjected to extreme, or repeated misattunement during childhood and then, later, exposed to military trauma, have doubly-dissociated, multiply-fragmented selves. They exhibit traits of personality disorders that predate their trauma symptoms, arising from an underdeveloped hippocampus, limited capacity for impulse control and affective self-regulation, the lack of a secure base (Bowlby, 1969), object constancy (Mahler, Pine & Bergman, 1973) as yet unattained and so on. As such, they are ill-equipped to withstand combat scenarios, without a fully-functioning neocortex—or Integrating Adult (Tudor, 2003), in TA parlance—to soothe limbic reactivity, render implicit memories of those trauma explicit, or autobiographical and, therefore, unable to be "aware of and accept disowned parts (i.e. ego states)... [or] contact other people while maintaining a sense of self" (Korol, 1998, p.115).

All too often, this vulnerability to PTSD deriving from insecure attachments is exacerbated post-active service by "poor social support" (Schnurr & Friedman, 1997, p.12) and a lack of appropriate care and reparation from the military, health authorities and governmental agencies. As one veteran reported of a protracted dispute with the UK Department of Work and Pensions, "they send you another batch [of forms], then another batch...then they say they've lost it... you go from one office to another to another... they keep on passing you—like pass the parcel" and, thus, "the unintegrated experience of trauma is re-enacted through... repetitive patterns of transference" (Stuthridge, 2006, p.275), the client's relational expectations rigidify and symptoms deteriorate. If this complex co-morbidity weren't challenging enough, therapists will often be contending with the pernicious impact of addictions and other lifestyle problems that attend veterans' understandable desire to "disengage from [unmet

relational] needs and emotions and... evade the memory and its devastating impact" (Erskine, 1993, p.184). Eight of the fifteen men examined by our study, for instance, disclosed problematic relationships with alcohol, prescribed medication and recreational drugs (Harford & Widdowson, 2014, p.38).

In these potentially lethal circumstances, an effective multidisciplinary approach is indicated and, as such, consensual contact between the client, specialist health and support agencies and the therapist concerned is the only ethical way forward. Ideally, any active addictions and lifestyle problems should be addressed first. The therapist, meanwhile, focuses on co-creating a mutually trusting therapeutic relationship, strengthening the veteran's Integrating Adult (Tudor, 2003) capacity for self-regulation and self-reflection and working through any emerging transference, rather than addressing their PTSD head-on. Of course, treatment won't necessarily proceed in this tidy sequence. As one veteran recalled, "I was the teacher and you were learning from me," or, as another commented, "It seems as though I can pick the topic; what I want to talk about, what's important to me," and, often, it is therapeutic to follow their lead—though always mindful that the "first goal of any trauma therapy must be helping the client to contain and reduce hyperarousal...[or] putting on the brakes" (Rothschild, 2003, p.4). Nevertheless, designing treatment in this way is consistent with established TA models, where the highest priority is "Stabilization...establishing physical and emotional safety" (Pomeroy, 1998, p.337) and, also, psychoanalytic approaches, where, instead of self-medicating with alcohol, or drugs, clients are taught "any of a number of deep-relaxation exercises [and] processes akin to self-hypnotic techniques that promote a form of physical and mental self-control" (Davies & Frawley, 1994, p.205-6).

The latter calls our attention to the crucial role of psychoeducation in this work. Psychoeducation strengthens the Adult ego state, the neocortex, which veterans need to quell their permanently activated fight-flight-freeze response and "learn to reflect upon and integrate their... archaic states as well as past introjects, and to draw on them in the service of present-centred relating" (Tudor, 2003, p.202). So, why is it that I hear of veterans being prescribed breathing exercises with little explanation of their neurological affect-regulating purpose? I can understand, therefore, why some veterans are reluctant to try them. Veterans are highly-skilled and resourceful individuals, with detailed knowledge of intricate weapons systems, navigation tools and the arcane bureaucracy within the military. Further, it is not uncommon for them to be more expert in managing people—often in chaotic life-or-death situations—than the supposed experts providing their care and rehabilitation. Consequently, I believe we do them a patronising disservice if we assume that the discourse of trauma—the intertwined functions of the limbic system, hypothalamus, left-brain and right-brains, implicit, explicit and autobiographical memory, adrenaline and cortisol—are beyond their understanding. For example, one veteran remarked, "You've explained to me the processes that are taking place in the body... and [my brain and thinking] have been...defragmented like a computer... and things slowly, but surely are starting to... find their place again." Notice, too, that five of the fifteen-veteran cohort presented with paranoid features (Harford & Widdowson, 2014, p.39) and, therefore, thorough explanation of the psychobiology behind my interventions and any associated "homework" proved essential to engendering mutual trust, openness and respect.

In particular, I have found the wealth of diagrams furnished by TA theory invaluable in strengthening veterans' neocortical capacity to bring coherent meaning to their phenomenological experiences; one individual emphasising in typical fashion the importance of "the transactional [diagrams]... I'm a visualisation kind of person... There's your Parental [ego state], there's the Child and... you can see how it overlaps and how it all fits together." By way of illustration, take the veterans' recurring motif of the army as a substitute parent figure—sometimes compensating for past misattunements with structure and discipline, while, at other times, compounding relational failures with bullying and abandonment. It was often helpful, here, to sketch out the Cultural Parent model (Drego, 1983) and complete the respective: "Etiquette... the transmitted [rules] for thinking, behaving and valuing... the Technicalities, or... actual organization of the material and social life [and]... Character... socially programmed ways of feeling, handling biological needs, emotional expressions" (Drego, 1983, p.225) that captured the nature of their surrogate introject [see

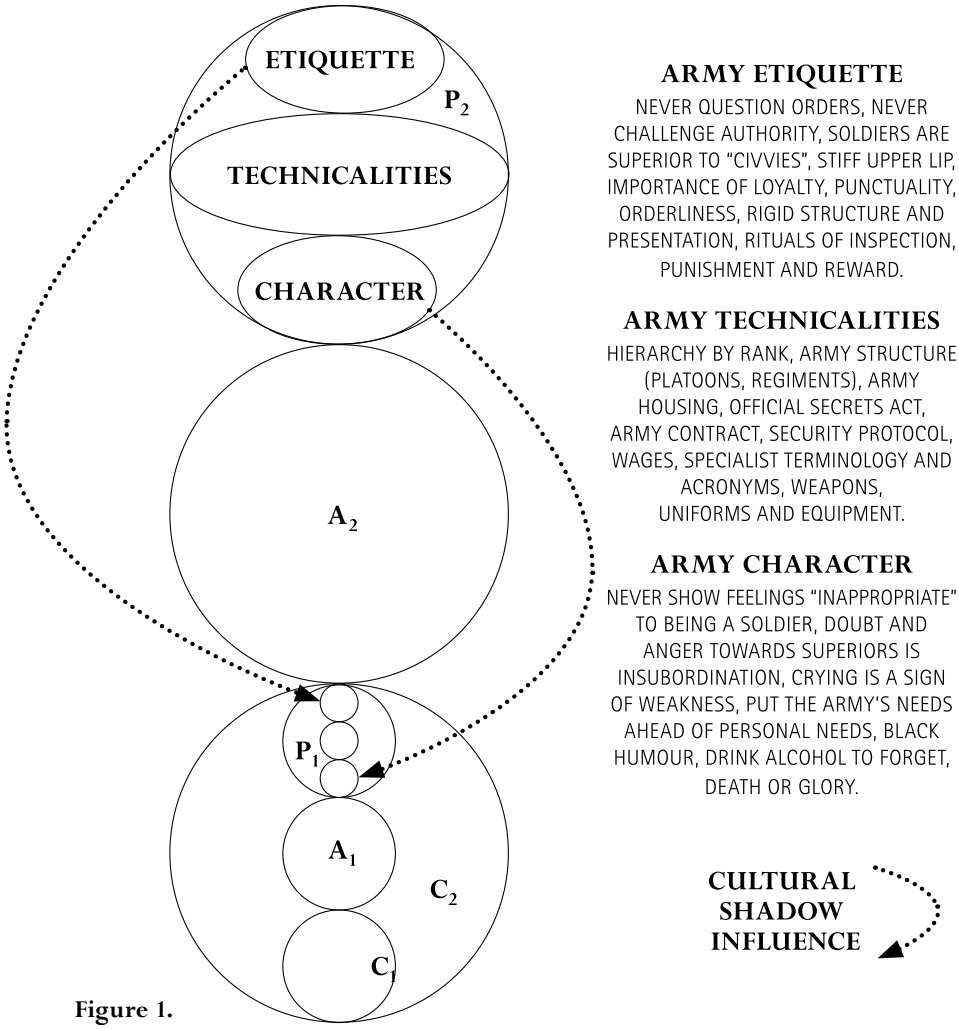

Figure 1.

Cultural Parent of the British Army

(Harford, 2014—after Drego, 1983)

What of the prevailing Cultural Parent within the health and social care services veterans encounter in the aftermath of trauma? And that of the wider civilian and political society they find themselves immersed in upon returning home? I would like to make a plea here for greater application of the social model of mental illness, whereby "levels of mental distress among communities...[are] understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing" (Friedli, 2009, p.III). Several veterans participating in our study were beleaguered by the debilitating side-effects of psychiatric medication- including highly addictive benzodiazepenes, which, in some cases, had been prescribed for years with scant improvement in their mental health and precious little attention to intrapsychic and interpersonal reintegration. Compounding this situation, I noticed what appeared to be "a direct causal relationship between enforced attendance at benefits eligibility assessments and related health assessments, [including] the arrival of related written correspondence" (Harford & Widdowson, 2014, p.61) and worrying spikes in the anxiety and depression measures gathered during their therapeutic journeys.

More controversially, several veterans reported being fully aware of the dubious political motives for their presence in the second Iraq war of 2003 and, more recently, Afghanistan; of their difficulty reconciling extreme traumatic experiences with the doubtful necessity of experiencing them at all. On a personal note, I have felt increasingly uncomfortable lately with my perception of a growing fetishisation of militarism in our culture for political, or commercial ends: the red poppy infamously co-opted by the far right (Dearden, 2014), the government's programme of World War One "celebrations" and a festive television advert by a supermarket (Fogg, 2014) all leaving a bitter taste in the mouth. I wonder what this means for my ongoing work with the traumatised subjects (grammatically and constitutionally) of all this geopolitical, party political and consumerist opportunism? I am curious to know more about how the veterans themselves view their place in our current epoch. And I wonder, too, what the radical psychiatry tradition would make of it all?

Radical psychiatry posits that much psychopathology originates not in the individual's deficits and dysfunctions, but, rather, "the mystified oppression of people who are isolated from each other" (Steiner, 1981, www.claudesteiner.com/rpbrief.htm). This results in alienation- or, in traumatic terms, dissociation- from their cognitive, affective and somatic selves and, also, their interpersonal capacity to enjoy mutually beneficial relationships. Steiner (1981) goes on to outline the introjective power of such internalised shame and oppression, whereby, "When a person has incorporated in [their] own consciousness the

arguments that explain and make legitimate [their] oppression, then mystification and alienation are complete. People...will blame themselves for their failure, accept it, and assume that they are the source and reason for their own unhappiness" (Steiner, 1981, www.claudesteiner.com/rpbrief.htm). Reading this, a specific veteran comes to mind who astonished me by reporting that their traumatic story had been dismissed as fabrication by medical professionals on account of its disjointed and contradictory chronology. Of course, trauma impairs autobiographical memory and, with it, the ability "to organize remote events into a verbal narrative...to form a narrative self, a 'me' who persists over time... [allowing] integration of conflicting experiences" (Stuthridge, 2006, p.273). Thus, the veteran is blamed for their unconscious defensive response to the inescapable kill, or be killed dilemma, transferential expectations of misattunement are confirmed and hope for recovery retreats further from view. To borrow from a precursor to *The Radical Therapist*'s deconstruction of the mental health industry, "the medium is the message" (McLuhan, 1964, p.7), which, for me, underlines the necessity that we therapists, with our variously ambivalent Cultural Parents, are not complicit, unconsciously or otherwise, in our returning veterans' battles.

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Biography

David Harford, CTA(P), UKCP Reg, MBACP Accred, Dip. TA Counselling and a member of COSCA (ACMCOSCA/BACP). David has worked in private practice in Edinburgh since 2008; his clinical work evenly divided between the provision of TA psychotherapy to Scottish armed forces veterans experiencing combat-related PTSD and a similar service for "civilian" individuals and couples from premises located in Leith. Current projects include assisting in building a service to provide psychotherapy and associated support services for veterans of the current conflict in Eastern Ukraine. David's research can be downloaded free from the foot of this web page:

www.harfordtherapy.com/aboutme.htm
harfordtherapy@gmail.com
www.harfordtherapy.com
www.ijtar.org/article/view/13801

Bringing Mental Health

into the Classroom

Chai Jones

Bertrand Russell and Ludwig Wittgenstein were both primary school teachers of a sort. Russell and his wife ran an alternative humanistic school from a large house. Wittgenstein taught at a more traditional establishment in Austria. The former seems to have been a little more successful connecting with children. This is not what brought them to the public attention and their work at this level is largely forgotten. Russell seems to have been warmer and connected whereas Wittgenstein in photographs looks a little rigid and out of place as a rural elementary teacher in Austria. The establishment of the connection will be familiar to therapists everywhere. Teachers are not therapists but there is a similarity and teachers can begin the work by connecting with children at all levels, the earlier the better.

The mention of primary school will set a number of memories racing in your head. Let me stop you for a second and ask you to flip back to your 'best' primary teacher.

I remember one teacher in particular who stood out. She let me sing. I've sung every day since. I didn't just sing when I got to her class. I was singing as far back as I can remember but she gave the singing prominence. She made the singing important. She created a space for the singing to happen. She made the space and took the time to let this part of me grow. I was no great shakes but it brought me out. She made it commonplace for me to sing. The other children accepted that at some point in the week I would get up and sing and they would go wild, some with counterfeited glee. It was a moment to be free in the week of strict Jesuitical discipline.

She had given me the tool. She had helped me unpack part of the toolkit of my life. We had all opened our tool-boxes in Primary five and she had spotted me picking up the singing tool. There were other tools in there and she helped these grow too. We say in counselling that it's about the quality of the relationship. So too in teaching. She had spotted what made me function, and this was how she built the relationship. It made me happy to sing in an otherwise fairly dour and serious world of schooling.

Knowing how to be mentally healthy should be something we teach in schools. We need to help children find the tools they need for their lives. We need then to find the tools to be resilient and mentally healthy. The activity of being mentally healthy needs to be on the curriculum. Some of us are lucky and a teacher spots us. A teacher recognises us. The teacher identifies what we need at a particular point in time and helps us find it. If we don't build in time to reflect on life with young adults and make it explicit that we are doing this then many will miss recognising that individual forms of relaxation, mindfulness, and contemplation or distraction are what we need to keep us mentally healthy. The connection between mental and physical health would also need to be made explicit during the process.

The tools to this activity need to be taken out of the box and used. In order to use the tools we must first learn from someone who has a basic grounding in how they work. This takes time and the space needs to be created. The teacher needs to have an idea how the tools work, and the wit to use the tools that the children find in their own boxes. The teacher will need to have the skill to sharpen tools that have become blunted for whatever reason either in themselves or in the children they teach. This then is a combination of care and learning—with a spark.

A View of the Current Position

The *Children and Young Persons Act 2014* abandoned the commitment to have counselling available for all children in Scottish schools.

This does not stop schools introducing skills in mental health courses for children. Emotional literacy is commonplace in Scottish schools through such approaches as "circle time." These types of approaches have produced huge benefits in my own school where Jenny Moseley visited about 15 years ago. The techniques transformed behaviour. I trained with Caroline Webster-Stratton in Seattle and have used the *Incredible Years* training course with parents in various locations and this improved partnership working and consistency in parenting. So we combined a co-operative approach with children and a co-operative approach with parents. We generated emotional literacy, as Daniel Goleman calls it. What is needed now is a systematic approach to teaching some simple skills in personal mental health.

If the link can be accepted then it would be legitimate to substitute curricular time from the mandatory two hours a week imposed by government to help children improve their physical fitness and reduce obesity. The link is of course that physical and mental health, are two sides of the same coin. The children are inactive and obese for a reason. Exploration of the mental health implications of inactivity are investigated in Morgan Spurlock's documentary film, *Supersize Me*, which children enjoy watching. Briefly, he measures his physical and mental health, then he eats Macdonald's meals exclusively for one month and then measures again. Not only has he put on weight, but he feels lethargic and miserable. Accepting the connection should not be a big step.

The *Curriculum for Excellence (CfE)*, which is used in every school in Scotland, has these outcomes in particular:

- I am aware and able to express my feelings and am developing the ability to talk about them. (HWB2-01a)
- I understand the importance of mental wellbeing and that this can be fostered through personal coping skills and positive relationships. I know that it is not always possible to enjoy good mental health and that if this happens there is support available. (HWB 2-06a)
- I am learning skills and strategies that will support me in challenging times, particularly in relation to change and loss. (HWB 2-07a)

For the uninitiated HWB stands for Health and Well Being, 2 is the level that should have been reached by many at P7 or the end of primary education and 07 is the number of the outcome of which there are 18!

Most mental health problems manifest in early secondary and are rooted in events that occur during primary school. Our government having rejected a counsellor in every Secondary School what should the path forward be?

- Training for teachers in identifying and teaching basic mental health skills
- Continued introduction of "circle time" type approaches
- Continued development of "emotional literacy'" themes
- Development of flexible 10-week classroom programs linked to the CfE
- Linking of physical and mental health
- Use of mental health themes in literature school courses
- Introduction of mindfulness sessions to schools
- Increase access to counselling for employees.

Should we have a greater emphasis on mental health in the curriculum? The above would be more cost effective in the long term. Including weekly lessons in mental health could reduce pressure on children and adult mental health services and guidance staff as children learned better to cope. It would reduce pressure on physical education departments if gym time could be thought time. It might address some issues underlying inactivity and obesity. It would help a little by closing the gap left by lack of counselling services in the short-term. It could improve the skill set of some teachers. It would help address issues whose roots are in primary school life. It would help bring the discussion of mental health into common acceptable conversation. It may encourage the adults involved to be more mindful of their own mental health.

Where do we start?

I have created and tested a 10-week mental health planner and it's free to anyone who emails me to ask for a copy. I'm hoping that other people will email me their planners too and I wont have to plan the other 30 weeks on my own. It's not perfect by any means but it's a start. It doesn't stand-alone there are many other resources available.

What do you need? The links are in the planner to various clips in YouTube that might be useful. So you might find an internet connection useful. Apart from that you need some young people to work with and a positive attitude. If you are a teacher reading this then you probably have a class. If you are a counsellor you could volunteer to train a teacher by delivering the course with him or her.

One technique used to open the discussion involved paper and pencil and a promise that no one would have to read out anything they didn't want to. They could say "I didn't put anything down." I read out a list of questions and created time for them to answer. Some we passed over and some we discussed. I looked at their faces to see how interested they were in the questions and how much they wrote and then used a bit of educated guesswork to get someone to open the discussion. None of it went to plan. It was more like a group. I had no idea what they wanted to talk about but they talked for Scotland. My school day is not regimented by a bell; so we can let the chat run, have a break and come back to it.

Couched inside all the questions was the killer. I didn't know it was coming, it just grew and I wrote the responses on the board. What was the killer question? There were lots of questions: Who's your best friend? What's your favourite dinner? When's your mum at her best? What's good about your dad or the person who looks after you? What's the best thing a friend's ever done for you? The killer question was none of these. I should say that all these children have been on residential trips with me skiing, gorge walking and abseiling and have encountered difficult outdoor situations. The killer question was: When you're scared, what do you do to make it less scary? The pencils melted, and the silence was palpable. I wiped the board and the hands flew up. Twenty minutes later we had *Rules for Resilience or How to Get out of a Sticky Spot*.

The session, which was akin to group work in its approach, was led; so I was not a therapist. This was not therapy. However the willingness to let it run from all the material in the room might be the skill a teacher needs in bringing this material into the class. So much of what I've seen before is patronising and disrespectful without really meaning to be. The results from this were as varied as in any group of adults and they were very insightful. This all came at the end of their "course." Much of the vocabulary was in place. Their experience at school has been varied and rich.

To make something like this work we need to share the skills of both teacher and therapist. We need to bring the language of mental health into play early in the life of a child. We need to help make what is often unexpected and a crisis into something that is a challenge we will cope with together. The children shared this in class. We now need to share it amongst ourselves a little more.

My moment of calm now returns. I'm at home. On a spit of land piercing a remote Atlantic bay my fingers settle on the piano. This playing is not for public consumption, this is not for their benefit; but then again maybe it never has been.

Chai Jones, a former Secondary Head, is now a Primary Head teacher and therapist working in the highlands.

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The Start
of Something

Aiden Duffy

It was always going to be difficult to write this personal statement.

As I sit and try to write an opening sentence I think of my study group and the individuals who it is composed of. I imagine I am not the only one sitting at my laptop with writer's block. Perhaps though, that is a good place to start, with the group.

When one embarks upon a counselling skills course it is difficult to picture whom your fellow pupils will be. Birkenstocks and tie dye? Bald heads and turtlenecks? The stereotypes hover in your mind's eye. It was with a great surprise that I entered into Room 620 all those weeks ago and was met with a collection of warm and diverse people. People who would challenge me and engage me, who would hold me in their warmth and in turn be held in mine. All the theory I had pored over before starting this course, all the Unconditional Positive Regard, all the Rogers, the Maslow. Here, now, brought to life by thirteen strangers with all but a shared interest in self-reflection and helping relationships.

The journal which I now complete weekly has allowed me to chart my moods and feelings across the last couple of months and has drawn attention to any shortcomings I may have. I feel without the journal I may have skimmed over these fears and attributes without reflecting on them and in doing so becoming ever more self-aware. It provides tangible evidence of the past, my past. The initial struggle I had in writing my thoughts down in such a permanent way remains, I am going to monitor this and see if over the remainder of the course my standpoint on this changes. I often think any emotions I have are so fleeting that it is best to avoid marking them in time as tomorrow I may feel quite the opposite, however, I remain open to the idea of keeping a journal.

I find the course challenging on a level quite unlike any other. It challenges more than the brain; it challenges the mind. The preconceived ideas we hold about others but, more importantly, ourselves. The early weeks when we first began to listen in a new way, a way that was true and without motive, were taxing. I never knew it could be quite so challenging to hear what somebody was really saying. Sitting in my first ever triad in the position of "listener" I felt so false and as if I was playing a role, nervous perhaps that I would stifle the speaker or be a distraction. I still feel that strange awkwardness when I take my chair opposite the speaker but now I feel I am quicker to relax and to invite the speaker to join me in doing so. I have a long way to go but I am happy with the progress I have made in this area.

We soon began to learn about the Essential Qualities and, whilst I had read up on these before beginning the course, they were brought alive in new ways. Group discussions were an opportunity to thrash out alternative viewpoints which I learnt to embrace and to reflect upon for myself. Some I took to heart and keep with me in my expanding beliefs and concepts of what makes a good counselling relationship. These discussions brought to my attention my capacity to seek the rational and the logical which whilst sometimes positive can also prevent a true two-way therapeutic relationship developing. I plan to develop my abilities in this area and to expose myself to using more emotive language.

Acceptance, empathy and congruence were pushed to the forefront of my mind as I sat in the triads. I found particularly in the role of 'speaker' that congruence had to be found in my own words and thoughts before I could relay them to the listener. My words chosen more carefully to reflect my current brain waves. Equally, when listening to the 'speaker' my own

prejudices and perceptions had to be erased in order to allow a purer, more accepting version of my psyche to emerge.

Away from the course I have tried to use my counselling skills training in everyday life, which is not to say in a therapeutic setting but more when interacting with friends, family and work colleagues. I am now more aware of truly listening to people and not demeaning their thoughts or brushing them aside. I feel this has provided mixed results but more positive than otherwise. The times I have struggled have, I feel, been due to the counter-cultural way of operating that counselling skills training teaches you. People often look for others to provide them with answers and to give them advice whereas it is decidedly better to allow individuals to take time and provide their own solutions. Weekly I come away from the lessons wondering how much more balanced the world would be if completing the COSCA Counselling Skills course was a prerequisite for being a member of society.

Module One will be concluding in just over two weeks and I am excited to see what the future holds. Currently I am looking at the COSCA validated diplomas available after this course ends so it is safe to say I am enjoying exploring this field. I have a certain apprehension about how I will fill my Thursday evenings during the end of term break but I will use the time to review everything I have learnt so far and to reflect on my journey to date. It is with great pride I can say I am a COSCA convert.

Biography

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A Brief Meditation on Generosity

and Abstinence in Psychotherapy

Benet Haughton

"He from whom the act of generosity proceeds can only behave as he does if his thought transports him into the other."—Simone Weil, *Waiting on God*

"Then meeting a young man… his confession of desire to commit suicide throws me until I recall that such states are a form of self hatred and I wonder with him if he can learn to love himself... again!"—A dream fragment, Benet Haughton, August 2014

Introduction

The following reflection has its roots in the question, "What is it that makes a psychotherapist a healing agent?" This meditation, really thoughts *en route* to more thoughts, are perhaps best understood as an attempt to summarise where I have got to in understanding this project.

Generosity

I have gradually come to the conclusion that whatever else goes on in psychotherapy little else matters except a willing generous offering of myself to the patient* as a person in the fullest sense. Simone Weil says this: "Those who are unhappy have no need for anything in this world but people capable of giving them their attention." (*Waiting on God*)

Being generous in head and heart are so crucial in our work that, without them, nothing of importance can happen. The very idea of psychotherapy is then a lie. So I must ask myself what gets in the way, what stops me participating fully in a relational flow with patients? I find the questions that impede me are ideas, ideas of right and wrong, right and wrong ways to practise, to be a good therapist, what is safe or unsafe for patients, for me, what indeed constitutes psychotherapy and what does not, what makes for healing and what does not.

If I look at these ideas of practice I might conclude it is better to throw them away and free up the self that is generous. But this is a mistake. What I must do instead is find creative acts that bypass them or, put another way, use the rules judiciously knowing that they exist as guides only. The truth is I can offer anything I like, say anything I want, if it is offered as a part of a relationship bounded not by rules and theories but by a desire for the other as paramount subject. St Augustine said, "Love God and do what you will." This was sometimes interpreted as permission to persecute enemies of Christianity but it is really talking of the possibility of a freedom not bounded by narrow egotistical concerns hung up on regulations and protocols but embedded in the belief in the freedom of the other.**

The Other is Never Whom I See

What follows from this is the imperative that I see my patient as other than who I may imagine them to be. With out this awareness of the *otherness of the other* I may well impede him/her from their own journey towards freedom. If I do not see them is finally an unknowable mystery but a projection of my fantasy of them, I take away the infinite number of ways in which a freedom can be discovered. My desire is of course that the *other* becomes capable of sustaining a new vision of themselves, like opening a door into a territory never seen, but then viewed and then…a step more…walked into. But, paradoxically I must forget in the moment of open generosity that this thought ever existed! If I do not, this reification of desire can also block my patients' paths to their own freedom. Wilfred Bion said that we must enter the consulting room "without memory, desire or understanding."

William Blake said:

He who binds to himself a joy
Does the winged life destroy;
But he who kisses the joy as it flies
Lives in eternity's sun rise.

If I am practising well I hold the promise
of a new land lightly.

Cultivating generosity in heart and mind

What does it mean in practice? From a practical perspective there is no mystery. The patient experiences a deficit. I seek to support them in overcoming it. For example, if you have had a traumatic childhood then what answers is someone who does not repeat the damage. Not repeating the damage for long enough so that it becomes history. I simply need not to repeat it for as long as this process takes. This requires steadfastness, a patience and a capacity to endure. This self giving is deeply generous and at times can be experienced as a self abnegation as, repeatedly the patient, trained in overstimulation attempts to reignite us both in the search for closure on the past.

But I am not an absence in my self-abnegation. Generosity is not exemplified by my refusal to speak. I have to be alert and attentive. I have to be curious, show my empathy, be willing to be carried along by the other. I have to agree to participate in the others highs and lows, their misery, fury and hate, disasters and triumphs, dull and insignificant places, sad and seasoned cynicism. But through all this I must remain still, still enough so I can listen, amidst all the content to a place where everything is understood.

What does this mean, I hear you say, "where everything is understood"? I recall David Wallin describing a monk who had practised meditation so deeply that he was unmoved in his meditation even by a gun going off in his presence (*Attachment in Psychotherapy*). He was unusual. Richard Eberhart, the American poet. says it like this: "A man of massive meditation is like a man looking at death, looking at death as at a bulls eye. He watches before he crosses the track." (taken from online quotations.)

To be still in the face of another's suffering at this deep level requires that I have been my own patient. I have sat with my own wounded self long enough for it no longer to mean anything important. If I have arrived at this place then nothing that my patients will throw at me will disturb me unduly. I may be ruffled, upset, angry and hurt but the experience of these feelings does not crucify me. I can react but the moment is a passing phenomenon. I do not remain caught in the flow back of my own potency. I have reacted but I remain available. It is perhaps like the cubists' attempt to paint life in the round in all its facets, breaking up the picture plain so the viewer can see all around the object. Then I am not viewing from one perspective but have all round vision. Everything is understood when I am able to see all around because then I see what is.

Carl Jung said that "anyone who perceives his shadow and his light simultaneously sees himself from two sides and thus gets in the middle." (*Good and Evil in Analytical Psychology*, 1959).

With such moments of insight I can be delighted. But as a human being most of the time I remain problem to myself. I cannot escape from having to take responsibility for my angry, hateful, snide, lustful, perverse thoughts, my gross appetites, the way I can corrode myself and others in lapses of taste and word. At times in this self awareness I may realise I am like St Paul who says.

Oh wretched man that I am
Who will deliver me from the
Body of this death.
(Romans 7:24)

But then, once again, having lived through the maelstrom of self questioning, doubt and anguish, I am able to move on. I become aware that I am not just an alienated self. Maturity has this flavour…I have done some inner work, lived some life, survived, have scars but they are just scars and most importantly they have happened on this planet which is a cause for wonder all itself and can freshen the cup I have been given to drink.

Such maturity is reflected in psychotherapeutic and religious language: Melanie Klein talked of "achieving the depressive position." In Gestalt sometimes people talk of the middle mode as the capacity to hold the whole self/field, the ego and the id in tension. In Buddhism it is "being" the Buddha nature. In Christianity it is symbolised by the cross where all contradiction is held. To live on this planet as a person in the fullest sense it seems I have to experience a duality and hold them willingly in tension. This not easy but perhaps occasionally I will be graced with knowledge of complete union. Then living on this planet assumes a grace and a blessing.

Abstinence

So there is a balance to be struck between my generosity and abstinence. Without, a judicious

abstinence the price of giving can destroy me. To be really open to the others is risky and costly.

In *Totality and Infinity* Emmanuel Levinas says, "The presence of the Other is equivalent to this calling into question my joyous possession of the world," ." . . the face presents itself, and demands justice" and "The Other faces me and puts me in question and obliges me."

Josef Tischner says this: "The encounter of man with man has such persuasive force that it is capable of radically changing a person's attitude toward the surrounding world, to refashion his way of being in th2is world and to call into question the hierarchy of values he hitherto expressed. (*Thinking in Values Journal* No.3 p.68.)

Don Paterson the poet puts it even more starkly and melodramatically: "The truer we sing the more we violate our own boundaries and the more our bodies protest; those who sing truest are all suicides."(Don Paterson, *The Blind Eye*)

Who among us has not been challenged and felt obliged by the other facing us? Even felt unhinged or taken over. Perhaps I do not yet have to give the cloak off my back but I do have to give "the other" real place and importance in my life. Does this extend beyond the consulting room door? It is no wonder then that I am on occasion filled with trepidation in meeting others because when I am really willing to be taken up by the other I have to face the possibility of death.

Two areas of practice where abstinence is obliged: the sacrifice of my Dionysian tendencies (Adam Philips said once that "the essence of the analytic encounter is intimate talk without sex") and the Apollonian, the endless imaginative interpretations and revelations of the intellect a particularly psychoanalytic tendency perhaps. Simone Weil says the "Imagination, the filler up of the void is essentially a liar." It can hide us from reality and create dependencies.

Through embracing abstinence the tension that exists in meeting the other is increased and can become more focussed. But it can bring forth great creativity. I can take comfort from the thought that, "...to use restricted means is the sort of restraint that liberates invention. It obliges you to make a sort of progress you cannot imagine in advance." (Picasso *In His Words*). Through this I learn to see my patient as they are not as I would have them be. To embrace my chosen restrictions fully is to become aware of my choice of psychotherapeutic discipline, my personal temperament and personality, my philosophical tendencies and history. Without awareness of where I come from and what frames me I can blind myself to the other. This can make me a less than useful agent of healing. For example I can become immersed in my own greatness like an adolescent in full swing. Or, tired of dealing in the quagmire of my patients life, I find myself unable any longer to think in terms of the others freedom but how to get them out of the door as fast as I can! An unfashionable aphorism "Enter by the *narrow* gate; for wide is the gate and broad is the *way* that leads to destruction" is pertinent here. The more I am alert and take responsibility for my choice of abstinences and embrace them the more I can see the true richness of the real encounters they support.

And from all this, at root I understand, as Simone Weil says in *Gravity and Grace*, that justice (what an extraordinary word to use in this context) is "to be ever ready to admit that another person is something quite different from what we read when he is there...perhaps something completely different."

My decision to abstain, to stay with a visual metaphor, a room with four walls two chairs, a table and a light supports moments of deep creativity. We collaborate in something that neither of us foresaw but which nevertheless fits the heart of what it is that is being addressed. Buber (*I/Thou*, 1987) talks about this as the transition from an I/It to I/Thou stance in relationship. The movement is one of object to subject. I place my faith in the paradox that Buber sums up in the phrase "If Thou is said, the I of the combination I/Thou is said along with it."

*I use the word "patient" as it seems to me more accurate as a description of the reality than the word client. The etymology of patient is from the old French meaning to endure suffering calmly. The capacity to endure suffering is an underlying expectation of psychotherapy, whereas the word client assumes an ego in the patient that is perhaps only available after therapy. It also has commercial connotations that are antithetical to what I am suggesting here.

** Looking through a specifically Christian lens is for many anachronistic, if not verging on nonsense, but I hope that it is not so difficult to understand that human longing for freedom has found many expressions and that our humanist psychotherapeutic one is not in essence a million miles from the longing of St. Augustine.

Achieve What You Want In Life:

Whole Mind Experience

Michael Dillon

Achievement in life is essentially about awareness of the basic mental resources we require to manage our mind for success. The basic psychological concepts included in this article can be used in moving us towards our personal goals.

While reading self-development books can be interesting, it may be difficult to know how to integrate that knowledge into the fabric of mind and behaviour. The guidance really needs to be set out in a comprehensible, clearly-signposted pathway if we are to achieve success in our goals. The conscious mind helps us in a logical and analytical way with our thoughts, decisions and actions. However, the subconscious can spontaneously challenge our good intentions, causing agitation and emotional disturbance.

The Subconscious Mind

An important activity of the subconscious mind is to protect us, to keep us safe and secure. It wants to be on our side, but at the same time pays little attention to conscious mind logic and reason. If we don't tell our subconscious what we want it to achieve, in a way it can understand, it will just do the best job it can in its own haphazard way.

Subconscious Mind Exercises

Employing subconscious mind exercises in a quiet, relaxed state is the easiest way to change deeply-ingrained negative beliefs, habits and behaviour. When our awareness is focussed inwards it is possible to deal with negative emotions and behaviour in a relaxed way. The subconscious is a storehouse of memories, knowledge and possibilities which can be used to naturally change doubt into, "I can achieve what I want to achieve."

Subconscious exercises encourage a conditioned response. The more we engage in them and the techniques we learn, the more we gain from them. The better we get at using our mind in a new, creative way, the more useful it becomes to us. The more useful it becomes, the more we want to do it. The better we get at it, the quicker we get into a positive feedback cycle. The more we relax, the easier it is to use positive mind patterns in a beneficial way and the quicker it helps bring into reality any changes we desire to make.

Relaxation

Relaxation is an essential part of the subconscious mind exercises. By the regular use of a deeper relaxed state one can focus on resources hidden from conscious awareness and discover skills and abilities quite separate from those of our conscious mind. We can then consider our true feelings in a relaxed and controlled way, release unwanted thoughts and emotions and encourage positive ones to replace them.
The following *Six Mental Laws of Success* can be used to our endeavours to achieve what we want in life:

1. Self-Awareness
2. Cause and Effect
3. Belief
4. Control
5. Attraction
6. Expectation

These laws are simple but effective when used in a positive and supportive way. They are "mind tools" to help us achieve things we have in the past only dreamt of doing.

To start positively managing our mind to achieving what we want in life, we first need to deal with negative emotions and what we perceive as disappointing behaviour. Overcoming these things can seem a daunting prospect. However if we study how our mind works in a

psychological context, it becomes much easier to handle and to use the knowledge to begin our journey of personal achievement. All we need is a readiness to think, observe and explore. With the busy life we all lead, it is essential we make our achievement goals a priority. As a first step, self- awareness and negative inner dialogue need to be dealt with. We all have these challenges, but if we don't deal with them we won't even get off the starting block.

The following are short summaries of those resources I believe we must face in our quest to be an achiever in life.

Self-Awareness

The more self-awareness we have, the more options we have and the more flexible we can become. It is critical to have a true knowledge of our self, to recognise our strengths and weaknesses. The capacity for ongoing change and self-development is crucial on the path to achieving our goals. If we project our true self we automatically attract to us the things that make us feel good, that are right for us. If we answer questions honestly about the challenges we can begin to close the gap between what we believe we can achieve now and our potential for greater achievements in the future.

Inner dialogue

The most important question to ask about our inner dialogue is: "Are there any past negative experiences that still affect our ability to achieve what we desire in life?

Our inner dialogue is very relevant to our personal development and beliefs. It is a cause and effect process. If our inner talk is negative we are focussing on how we don't want to be and our mind will focus on that. Positive self-talk is imperative as we seek those achievements in life we desire.

It is important always to ask ourselves questions. Questions have a magnetic quality that compel us to answer them. But, to effectively gain from our response to them, we must be scrupulously honest with our answers when dealing with feelings, using our mind to overcome negative mental chatter. It is amazing how our life changes when we take control of our negative thinking and change it into positive empowering inner dialogue.

Having dealt with the negativities, we can embed the following mental resources deeply into our mind:

Self-belief

Self-belief is paramount in fulfilling our desires and aspirations. It is very important that what we believe about ourselves is true and valid because, accept it or not, sometimes what we believe about ourselves may not be the truth, and just the way our mind has been influenced and programmed as we grew up, from infancy to adulthood. That is why it is necessary to thoroughly examine what we believe about ourselves. Whatever we believe with feeling and desire then becomes our reality.

Sharing in the abundance of life

The more we achieve the more we are sharing in the abundance of life. It seems to me that society's idea of abundance offers us little choice in what has genuine worth. It is, instead, a continuous roundabout of consumerism and not much else. If we move away from material stereotypes and take control of our life we can achieve those things that are right for us. Find out what we really want to achieve and obtain it, that's where real control of our life lies. If we manifest abundance in a way that suits us and fully focus on what we desire to enrich our life, we can stop hoping and dreaming and start believing and achieving.

The confidence to be you

By using your mind in an achievement-orientated way you can gain great benefit from it. You can move steadfastly towards the most important aspect of your psyche, the confidence to be you**.** This is when you realise at a profound level of consciousness that what you think about yourself as a person actually dictates almost every thought you have, including your actions, beliefs and behaviour. This can then provide an irresistible springboard for achievement.

Creating the future you desire

The next stage of the journey is creating the future we desire. A key part of that is surely what we want to achieve. We can then give our self the opportunity to design our direction and destiny. We can create a vision for the future, visualise all those things we want to achieve as having already been accomplished. Whatever we allow to persistently dwell in our mind with belief and conviction we can manifest.

Detachment

Another essential element in striving for achievement is to consider the concept of detachment. Detachment can relieve tension. The use of subconscious mind exercises illustrate the power of detachment when engaged in mental activity. It is often difficult to recognise the value of a quieter, more relaxed way of psychological achievement. Instead of the old "do or die" method, detachment helps us attain our desires in the ways that best suit us.

We can then continue along our pathway to achievement in a new and creative way. Each of us has our own idea of what success means. We can progress through all the necessary processes and acquire the resources needed to become mentally resilient and take our life forward in a way that suits our personal goals. Our conscious mind can respond to all that is logical and analytical, while our subconscious mind can respond to subconscious mind exercises, creating a balanced way of learning, so we can cope with all that life throws at us and still achieve all we want.

Throughout my 23 years as a professional therapist, I helped my clients overcome the problem they came to me for. They frequently asked, too, if I could help them in a more general way to be successful in life. I therefore created a course on self-development that I describe fully in my book, *Achieve What You Want in Life*.

Some clients from my private practise were interested in my course, and with them I used the motivational therapy I talk about in my book, taking them on personal journeys which I hoped would be absorbing, imaginitive, creative and unique to each of them individually. I encouraged them to believe, not to worry where they currently were in life, just to know the important thing is where they would be in the future. In time clients came for the self-development course alone. This was also the case with clients I worked with for 16 years at the GP Medical Centre and at the Longfield Health Care Centre, where complementary therapists worked alongside National Health Therapists.

Michael Dillon's book *'Achieve What You Want in Life'* can be purchased from Amazon. (ISBN paperback 978-1-910394-02-1 and ISBN hardback 978-910394-03-8)

Biography

Before becoming a professional therapist Michael Dillon was a chartered shipbroker and was for eight years the UK representative of The International Leipzig Trade Fair. He is a Fellow of The Institute of Freight Forwarders, Member of The Institute of Chartered Shipbrokers and a Member of The British Institute of Management. After becoming professionally qualified he started his therapy practice as a stress manager in Rochester, Kent. Shortly afterwards became the Medical Practice Stress Manager at Gun Lane Medical Centre in Strood, Rochester. In September 2002 he started working at the integrated Care Centre in Longfield, Kent, a pioneering project that involves medically-trained health care workers, within the NHS, working together with complementary therapists, at a single health care centre.

Poem

Isobel Hill, 2010

‘I am your counsellor’

I am not your friend,

Yes I am friendly and approachable,

I am not your parent,

Yes I do care for you and your wellbeing,

I am not your doctor,

Yes I can sense and hold your pain

I am not your teacher or instructor,

Yes I help you see what you know to be true

I am your counsellor

I use my skill to contain the troubles you bring to me

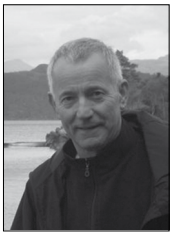
I hold certain ethical boundaries to keep you and me safe

I shine a light in your darkest places and highlight your spoken aims

I walk a while along side you ’till you’ve found what you were seeking

I wish you farewell as you say goodbye and go on your chosen way

Isobel Hill, 2010



Offering Counsel:

the intermediary work of Birthlink, Scotland's leading after-adoption support service for adults

Gary Clapton

Introduction

The provisions of the Adoption and Children Act 2002 in England and Wales and the Adoption and Children (Scotland) Act 2007 extended support services to birth relatives. This meant that after-adoption work now encompasses all parties in adoption, whereas previously much of the work in this field had been done on behalf of adopted adults.

What follows is a discussion of a particular aspect of after-adoption services, the work of the intermediary in making and sustaining contact between adults that have been separated by adoption.

History of adoption intermediary work

Some brief background details are necessary before the actual nuts and bolts of the work can be discussed. Firstly, the scenarios in adoption contacts between adults are much more varied than the classic depiction of an adopted person meeting with their birth mother (often called "reunions") and can include meetings with birth fathers and other birth relatives such as aunts, and between siblings, one of whom who has been adopted and the other not.

Secondly, in England and Wales, adopted people have only had the right of access to their birth names (and thus identifying details about their birth parents) since 1975; adopted people in Scotland have always had access to their original birth records.

Historically, friends, relatives and private investigators have been used as intermediaries and still are (see *In search of the source of my family* by Katherine Norbury in *The Observer*, 1 February 2015). However, there is evidence to suggest that the process is not only made more successful if an intermediary is used (Armstrong and Ormerod, 2005) but that an intermediary is preferred. Expressions of the desire to use an intermediary to establish contact were recorded in a study of adopted 500 people who had accessed their birth records following the 1975 change in the English legislation. This study found that "the great majority of those who intended to trace a relative" planned to use an intermediary (Day, 1979, p 24). The adopted people in Stanaway's research felt the same and that it was "crucial for the [adoption] agency to act as an intermediary" (1996/7, p 24, see also Feast and Philpot, 2003). Armstrong and Ormerod's research in Australia confirms the usefulness of engaging an intermediary, arguing that it "does give a better chance of ongoing contact being established" (2005, p 7). So what is entailed in intermediary work and what is its relationship to counselling?

The intermediary role defined

> " …in many instances the parties appreciate the assistance of a neutral third party in reaching an outcome which best accommodates their varying needs. The neutral person works to assist each to appreciate the other person's perspective, to prevent avoidable problems, to generate options and to empower the parties to make choices which balance their own needs with the needs of others." (Armstrong and Ormerod, 2005, p 2)

Armstrong and Ormerod also talk about the intermediary acting as "buffer", as well as "sounding board" in assisting the sought persons "to deal with the issues one at a time, and at their own pace" (ibid, p 9). This notion of the seeker and the sought is one that is a major theme in the work.

The seeker and the searched for in adoption contact—balancing needs

The Department of Health's (2000) guidelines on intermediary services for birth relatives state that "The primary responsibility of the intermediary is to try to balance the needs, wishes and expectations of all those involved" (p 27). The DoH document sets out some key principles and aspects of the task, such as maintaining confidentiality, promoting partnership, negotiating how much information may be shared and discussing the possible duration of the work (2000, p 27). Armstrong and Ormerod add the importance of impartiality and the promotion of safety (2005, pp 3–4).

Exploring support needs and assessing risk

Armstrong and Ormerod also draw attention to the importance of assessing support needs: "How much support do they [the searcher] have for search and contact?" (2005, p 15). It is equally a responsibility to establish whether these exist for the person who is contacted and if they do not, to advise about how to secure help in coping with the "bolt from the blue." They go on to discuss another dimension of the intermediary role that has received little attention, namely risk assessment: distress may be experienced by the person seeking contact if this is rejected, distress may be suffered by the person being approached and there is the possible risk to either the person contacted or contactor of abuse (mental or physical) by the other party. Armstrong and Ormerod suggest that in some cases, if risk of abuse, fear or duress is detected by the prospective intermediary, "mediation may not be able to proceed" (2005, p 4). In such cases the DoH guidelines recommend that the counsellor should seek consultation before making any decision to withhold a service (2000, p 20).

The bolt from the blue

Surprise and shock are a constant feature in intermediary work. Trinder describes the unexpected letter from a birth relative – even via an intermediary – as "an unexpected and unsolicited approach that is highly likely to be a considerable bombshell" (2000, p 20). Should they respond, much can happen in the space of the first telephone call. While the person who has instigated contact has gone through a process of readying him or herself, the person who gingerly, angrily or in a state of devastation picks up the phone to talk to the mediator has had no such preparation. Armstrong and Ormerod (2005, pp 21–2) provide a comprehensive list of emotions ranging from shock to anger. They go on to note that some factors may influence initial reactions, including whether or not the adoption has been discussed, who else may be at home during the initial contact and current family circumstances, such as whether there is conflict, ill health or a bereavement. Armstrong and Ormerod also note that the "found person may not hear all that is being said in the initial phone call" (2005, p 23). Once contact has been established, according to Armstrong and Ormerod, "there are significant numbers of cases where the two parties have compatible expectations and are comfortable about commencing an exchange of information immediately" (2005, p 34). With regard to after-contact scenarios, they provide a comprehensive discussion of the variety of developments that may occur (ibid, pp 37–41). These include disappointment, the influence (negative or positive) of relatives and differences regarding expectations of intensity and frequency of contact. Here it should be noted that in correspondence between parties, the matter of how to address someone and be addressed and what titles to use are recurring dilemmas. This is especially so in initial communications. The intermediary can be engaged in long discussions revolving around whether to sign a letter "your mother", "mum" or to use a first name. Clearly, the issue is not simply a technical one of nomenclature but, rather like most discussions in after-adoption work, involves "opening the can of worms", for example, how a birth mother has (privately) thought of maternal status in the years since the adoption of her child.

Duration of support

Where does intermediary work end? First of all, support and counsel might never be sought. It can also be concluded at any time by one or both parties. In one extreme case of mine, both father and son agreed that they wanted to have each other's mobile phone numbers. The intermediary work took an hour. At another extreme two years after contact, mother and daughter were content to

have monthly telephone discussions with me and communicate with each other only by letter via me. More usually, for either party, the literature suggests that reaching some adjustment to contact and establishing some kind of face-to-face relationship takes a while: "The process of adjustment to restored contact may be complex and lengthy" (Feast and Smith, 1993, p 40). In a later evaluation, the same authors suggest that "people may need access to counselling over a period of years and not just at the point of contact" (Feast and Smith, 1995, p23). For Smith and Wallace, "Following contact, the counsellor will be available to provide support and assistance to all parties as needed" (2000, p18). Rather than years or an open-ended arrangement, Armstrong and Ormerod talk of months: " …the mediator may feel it sufficient to telephone both the parties for a follow-up after several months" (2005, p 34). This work can be complex; the intermediary may never see either party. It is not unusual for two people separated by adoption to be helped to negotiate the potential beginning of being in each other's lives whilst they living on different continents, for example a birth mother in Penicuik, Scotland and an adopted son in Perth (Australia). All by phone.

Buffer, go-between, intermediary or counsellor?

It is widely acknowledged that intermediary work will raise sensitive issues for the parties involved and that in many cases counselling will be required. In the words of Feast and Smith (1993, p 38), "The role of the counsellor is to help each party explore the issues and possible outcomes renewed contact will present" and "to ensure that all parties have considered the risks versus the opportunities" (ibid, p 39). Armstrong and Ormerod are in no doubt that "counselling skills are needed" (2005, p 40). Regulations following the adoption legislation are clear that counselling must be made available (Crown Office, 2005). If counselling is necessary before, during and after contact and meetings, how is this to be done and by whom? This is not addressed by Armstrong and Ormerod (2005) who, together with Feast (1992), Feast and Smith (1993) and Smith and Wallace (2000), assume that counselling and intermediary work are virtually synonymous and will be undertaken by the same person. Intermediary and counsellor roles are often used interchangeably. Armstrong and Ormerod opt for the catch-all term of "professional go-between" (2005, p 1, see also www.adoptionsearchreunion.org.uk for the use of "go-between"). The DoH (2000) guidelines are helpfully clearer on this matter and suggest that counselling, support during tracing someone and intermediary work are all separate tasks and may be undertaken by different people or agencies (p21). However, they include follow-up support in the intermediary's remit, which rather extends into post-contact counselling. Furthermore, it is clear from the description of some of the intermediary's possible tasks that counselling skills may be needed by them at any stage (ibid, p 33).

Conclusion

My blow-by-blow account of a piece of intermediary work (Clapton, 2006) has added to the small body of literature suggesting that not only is intermediary work desirable, but also benefits from being undertaken by a professionally trained practitioner capable of engaging with the nuances and subtleties of the work of re-connecting two people who have never met but are intimately related, and the, from time-to-time, competing demands of each, for example to go faster in the contact process, or to cool it off. I also describe the role as something of a moveable feast, the worker navigating between various roles such as that of a contractual-like nature as in a solicitor that "acts for" their client, to one that contains the responsibilities of a social worker in communicating sensitive information from adoption records and working with the emotions that are generated, and other roles including advocate for the searching party but protector of the found person's privacy and emotional well-being.

But is it counselling? The most mainstream form of counselling our intermediary work approximates is that of couple counselling, for instance in the "shuttling diplomacy", however it is hard to find another example where such sensitive work is done with people, who in the classic words are "relative strangers."

It is always a privilege to be instrumental in this process. It is not classic, professionally-endorsed, counselling with a capital C. However, in the words of one of my Birthlink colleagues, we offer counsel.

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