Counselling in Scotland

SPRING 2010

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Editorial

Communicating the invisible

John Dodds

I RECENTLY READ Oliver Sacks' book, *An Anthropologist on Mars,* accounts of people suffering various brain injuries (what Sacks calls "deficits"). Sacks never talks about disability in the way we understand the word, but instead demonstrates through the case studies the indomitability of the human spirit, and how body, mind and soul can create order out of chaos, a new way of being following what at first seems catastrophic cerebral injury.

One of Sacks' challenges was to empathise with, or attempt to understand, what the subjects of these studies were experiencing. The colour-blind painter in one story talks about his world being muddy and grey. We can visualise that, yes, but when the painter makes artwork that gives a little insight into his world, we may discover it's nothing like we imagine (the experience of the blurriness of objects, the problems associated with distinguishing different shades of grey, how some objects cease to have meaning without their colour, for example).

And so it must be, at times, with us as counsellors. Many of our clients struggle to communicate the shades of grey that make their lives so difficult, and we can struggle to wrestle meaning from that communication. But communication happens, somehow, empathy emerges, mutual understanding and a means to help our clients to help themselves to move forward in their lives.

One trainee counsellor here has attempted to "communicate the invisible". Theresa Keicher offers us a piece which tries to convey the emotional journey she undertook on the counselling skills course.

Narrative appears for a second time this issue, in Benet Haughton's poem, "Air". It's the first time I've run a poem here, but I felt it worthwhile, since it speaks to emotions we can all recognise.

Dr David B Lingiah's "An Inspiring Story" illustrates how someone effectively communicates something which is literally "invisible" to him.

Another invisible world is, of course, that of the Internet, and other forms of virtual communication (I include the telephone in this notion). I interviewed online counsellor and author, Kate Anthony, about Internet counselling and psychotherapy, which I am sure journal readers will find fascinating. I would be interested in comments and questions to the journal on this whole arena, which some of you may already be working with, and for others may be alien territory. I recently moved somewhat into this field myself, with a personal-development podcast series called "Get a Life!" (available free from www.podiobooks.com or podcatchers like I-Tunes and so on).

While technology makes it possible to conduct a remote therapist-client relationship, the majority of our work is still carried out face to face. With all the benefits and challenges that entails. One of the most difficult issues in such relationships is when our clients move beyond help. Such is the case with client suicide. Margaret Grant's searching piece attempts to "cast client suicide in a new light – one that demands an exploration of ourselves, the ways in which we value and evaluate our existence and which encourages us to think about suicide with an awareness of how our theoretical, moral and personal values impact upon our understanding and experience of the death of a client to suicide."

I hope you enjoy these, and other articles in the journal. This issue was originally intended to be published for the Winter, but for a variety of reasons it mutated into the Spring edition. So, may I take the opportunity now to wish you all a happy and rewarding 2010.

Working
from Home

Rob Watson
Sales and Marketing Director
Towergate Professional Risks

Most therapists in private practice in the UK work from home, a decision usually driven by a combination of economics and practicality. Many who have practices at home do not always work full-time, combining their work with clients with another job outside the home, or with other home-based activities. In Towergate's experience, therapists who are just starting out in practice are uncomfortable about making a commitment to renting consulting rooms outside the home as this often means having to fork out for the cost, regardless of whether or not the clients actually show up.

Towergate understands the complicated factors that support working with clients at home, and we want to support those of you who believe you must work from home to be aware of the potential risks of letting clients into your personal space.

Therapists who work from home need to hold in mind the concept of the therapeutic frame. The 'frame' is more than a room or a physical setting. It is also a set of conventions about how therapy should be conducted. It needs to be a safe enough place for psychotherapeutic work to occur, a place where clients can feel comfortable speaking about things that are too painful or taboo or shameful to speak about elsewhere. However private a garden may feel to the gardener, a client can feel very awkward and exposed when there is no door to close.

We understand that it is not unusual for some therapists to work with their clients in the open air. Sometimes the original contract includes this as an option, as in the case of one counsellor who lives and works near a large river, and who helped her client overcome a fear of bridges by accompanying her on her first attempts to cross one on foot. We know of other practitioners who offer to walk around their garden with a client to pick a flower as part of a gestalt experiment. Still others sometimes offer to have the therapy session at a table in the garden during a prolonged heatwave. In light of the increase in civil actions against practitioners of talk therapies we think that the first example contains a clear contract to work outside. The second carries more risk as, although contracted as part of a clinical experiment, the 'contract' was spontaneous. The third example concerns us most as it could – and has been – misinterpreted by clients as a gesture of friendship.

The essence of the safety of the therapeutic frame is largely psychological. The client needs to be able communicate thoughts and feelings – not necessarily verbally – to the therapist, which are held and processed by the therapist and given back in due course in a form that can be held and processed in awareness by the client, leading to integration and change. The point is that the frame should make the therapeutic space that it bounds a suitable place for this kind of psychological work. It should be quiet and as free as possible from the sort of interruptions that are in the therapist's control, such as answering phone calls, text messages or the doorbell. It should not have pictures or other mementoes in view that reveal personal matters or relationships. It should be pleasant and comfortable. It should, as far as possible, remain the same from one session to the next.

This last point was driven home to one practitioner who was complained against for having re-decorated the consulting room without telling the client. The client claimed that the therapist ought to have known that she had traumatic associations with the colour.

When working at home with people who have been neglected or abused or otherwise betrayed, it is wise to remember how fragile clients can

enact envy. These are people whom, to defend themselves against their unbearable feelings, have come to believe that 'everyone else' has something that they haven't got. This defence against feeling so alone may take the form of attacking the therapist's home or even developing fantasies about the therapist's life. These may include the idea that the therapist has a perfect life and a perfect family. Just the noise of children in another room, or the therapist showing affection for a pet in the client's presence, can often evoke envy. For some, the feeling of being 'only a client' is intolerable. We have seen many examples of what could be seen as envy played out in complaints that turned out to be, in part, based on elaborate fantasies about the therapist's private life that had no basis in truth, but did have some basis in chance encounters with others, including clients.

We do not believe it is possible to prevent encounters with others when practising from home but we do have some tips about how to prevent or contain any fallout that may occur:

- Be clear with new clients that the therapy will take place in what is also a private home.

- If there are likely to be other people, such as workmen, in the home when you are working with clients, tell them that this is the case and allow them the option to complain about noise and so on. And be sure to tell the workmen that your home is also your place of business and ask them not to engage your clients in conversation.

- Family members need to be briefed to respect the boundaries of your work. If for some reason a family member is going to be in the house they should wait until your client arrives before leaving, as well as being familiar with the arrival times of your clients, and to avoid entering the house until the coast is clear. However tempting it may be to see clients when you've got someone at home like a partner or child who might need you because they are ill – think again. It might be better to re-schedule the session.

- The telephone is another possibility for chance encounters. It is best to have a separate line for your clients to call to avoid it being answered by someone other than yourself. If this is not possible do not include the names of your partner or children in the answer-phone message.

- Be clear about how you and the client will manage the boundaries of working in your home. Do you have a waiting room? What provisions, if any, do you make for a client who arrives early? And how early is acceptable? You need to think of the client you're with who does not need to be interrupted by you answering the door to the next client, who also has a right not to run into another client leaving as he or she is arriving. Tight time boundaries are a must, particularly when there is no waiting room or receptionist.

My Experience

of the Counselling Skills Course

Theresa Keicher

My name is Theresa Keicher. I am 38, married, have two children and one on the way. I live in Fife and I am a staff nurse within a palliative care ward at the local hospital.

I recently completed the COSCA counselling skills course. As part of the course we had to present what we thought we had learned throughout the four modules. I had the idea that I would present what my understanding of counselling skills was in a short story format that would hopefully have the audience visualise my experience. The following article is my story.

The story began in 1971 and the good ship Theresa set sail for new adventures along life's oceans, and for the first part of the journey there was relatively smooth sailing, with what appeared to be blue skies and calm waters. I was dropping anchor at various ports and I was learning all the basics like those great explorers before me.

One day, whilst in the Pacific, I decided to go for a swim and the water was lovely, warm and beautifully crystal clear, I suddenly felt an almighty bite with pain raging right through me. When I looked down I could see no bleeding and I had all of my body parts, I was totally physically intact. I was not drowning and my lungs were not full of water. However, I felt like I could not breathe. I was choking. I had pain inside that was like no other. I had previously burned, bumped, cut and got infections but this was an injury which ended with deep emotional wounding. Physically there was no scarring but a deep emotional scar seemed to be, and indeed was, greater to heal. No one was able to see the wound and therefore it could not be tended to physically and this encouraged the wound to grow deeper and deeper and therefore it became more difficult to heal. No one appeared to notice this event, so I carried on. The anchor was lifted and I continued to sail on.

Although the anchor was fully reeled in I felt that I was going slower, not travelling at full steam ahead. The waters that I was entering were becoming murkier and more difficult to sail through. On this ship I isolated myself, carrying out all the chores independently and became pretty much a ghost ship. The sails were becoming worn with holes and the deck was becoming shabby and, like my internal self, the hold was getting empty.

One day I picked up a new passenger and off we travelled, having a little fun along the way but I always felt like I was still drowning, like the anchor was still dragging and there were times when I forgot about my internal scarring and emptiness but I would also at times get caught in a ripe tide and I would be pulled off course. Starting to share the ship with another provided some plain sailing and distraction for me and I thought that our crew could be increased. So in quick succession two new members were recruited. My little pirates! And indeed pirates they were. I was always on my toes trying to keep them in line and wondering what other sailors would think if they came into contact with us. Trying to keep everything ship shape was increasingly draining, but I continued.

Then one day, just as we were bobbing along nicely there was an almighty storm, the sky became thunderous with colours ranging navy blue, silver, darkest grey and black. The rain started lashing and whipping at my skin while I tried to baton down the hatches. The mainsail was starting to crack and finally, there was an earth shattering noise and the sail lay half way over the ship and half in the water. The sea was in violent flow and nothing could be done to stop it. And all the time the storm was raging I was aware that this ache, this internal choking was going to be the death of me, not the storm or the sea. I had to think of my little pirates and my ship mate before we all ended up as fish food!

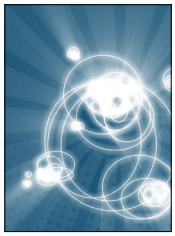
So I jumped ship and swam to the nearest island. Exhausted by the swim and the storm I lay still for a while wondering what I should do. I wandered on my own and all the while I looked out to sea and could see my lovely ship bobbing around with my ship mate taking care of all on board including the little pirates. But I could not go back into the water for fear I would most definitely drown.

I looked around and discovered a woman who appeared to be glowing and seemed mystical in some way. She had an air about her that was difficult to describe but she seemed to be very wise and was able to see right through me. She just knew what to do and say. We had several meetings and I discovered that I was beginning to say things that I hadn't discussed with anyone before. She was a bit motherly but not overly so. She was firm but fair, she maintained her boundaries. We spoke about my parents and events in my life, my relationships with my ship mate and my little pirates. She was warm and caring and showed this by listening, being empathic, attentive and genuine, she needed nothing in return except for me to show up on time and finish on time. She showed me respect and I respected her in return. A great deal of the time she mirrored me and I was able to see that what I was describing in others was actually what I was displaying myself. I was able to laugh and sometimes cry. I was able to practice different scenarios and not feel stupid and indeed my confidence grew as I was able to go back to my makeshift shelter and carry out tasks that we had set during our time together. She walked with me along the wet and dry sand through the undergrowth and over the stony terrain through my past experiences, and I made connections on this and present behaviours. I felt safe to say a whole manner of things without feeling judged. And as time went on I sensed that I was no longer drowning or choking and as this sense lifted I was able to come out of isolation. I began to dip my feet in the water again.

I noticed that this woman no longer appeared mystical to me. She was not glowing as I had once thought she was simply emitting compassion. Both she and the environment we were in were a holding place, somewhere for me to regain myself. When I realised she was not some higher being, that she was equal to me and I was actually responsible for myself I knew that it was time to go back into the water, to take a few risks, see what would happen. I could always go back to the island to take stock of my experiences and recharge my batteries if needed. So taking a few deep breaths off I went into the waters once more. I climbed back on board my ship and when my feet touched the deck the crew commented on how well I looked. I thanked them all for waiting for me and once again the anchor was reeled in and we set sail.

The ship seemed lighter and the sails were repaired with brightly coloured material, the hold seemed full of incredible riches that the crew had stored whilst I had been away and I had brought with me from the island. We would look over the riches and dip into them at times, experiencing the wonderful exotic tastes and viewing a whole new range of delightful textures and colours that I had never been able to see before. I appeared to be having a completely different experience of life now and, where once I had limited vision, I now had the ability to look deeper at things see things in a different light and share this way of being with my crew!

The oceans continue to have a range of the most beautiful colours and vary from the deadly calm blues to the turbulent waves of dark greys, silvers and blacks but all the time I have been able to hold on. There are times when I am just clinging for life where my fingers are so numb that I feel like I cannot hold on anymore. And at other times I have all the strength and passion of a true sailor and fight the perfect storm to come out the other side a bit ravaged but in one piece. I have my invisible life jacket on at all times and I know I have a whistle to call for help should the seas become dark and treacherous and too dangerous to sail through.



Client Suicide

Margaret Grant

In both the popular and professional literature suicide has been the topic of many books, research articles and philosophical treaties and often appears on stage, theatre, opera and film. Undoubtedly, the literature on the subject of suicide is extensive, lively and prolific and has advanced to include information on such areas as bereavement after suicide, theories of suicide, causes of suicide, assessing risk, risk factors, intervention and prevention, assisted suicide and euthanasia. Yet in this vast literature on suicide scant attention has been paid to the experience and effect of a client's suicide on the therapist who worked with that client. Within this sparse literature the experience of client suicide for a person-centred therapist remains unknown. As death and suicide creeps into the headlines, this silence is especially noteworthy.

I am a doctoral research student at the University of Edinburgh and a person-centred counsellor. The task of my research is to explore the experience of the intentional death of a client to suicide from within a person-centred framework and to cast client suicide in a new light – one that demands an exploration of ourselves, the ways in which we value and evaluate our existence and which encourages us to think about suicide with an awareness of how our theoretical, moral and personal values impact upon our understanding and experience of the death of a client to suicide. My research aims to speak to the personal, professional and practical impact of the experience of the death of a client to suicide for a person-centred counsellor.

Death, Dying and Suicide

Death is the most private, the most subjective fact of life and at the same time is one of the facts of life we refuse to accommodate even when death is imminent and can no longer be resisted. Advances in medical science and technology have perhaps contributed to our denial of the reality of death and in our death denying society death has become the principle enemy in life, an enemy to be fought to the bitter end. But dying is also a condition of life and perhaps the principle enemy in life is not death but fear; we fear death more than anything because nobody can tell us from the inside what it is like to die. We have to experience it ourselves. We have reliable and detailed statistics on life expectancy, age at death, and place and cause of death, but we know little about the experience of death.

Suicide forces us to get as close to death as possible, maybe even too close for comfort. End-of-life issues are contentious enough in physical medicine, but as therapists we are faced, on the one hand, with an increasing acceptance of euthanasia and assisted suicide for those who are suffering unbearably as a result of physical illness, and on the other with the contrary trend in relation to those who are physically well; an expectation that we intervene to prevent our clients from ending their lives by suicide. At the same time that societies are campaigning for measures to allow controlled death for the terminally ill, the same societies are demanding greater attention to the prevention of suicide in the physically well. While judges are content to permit patients to be allowed a dignified death when *doctors* conclude that their lives are no longer worth living, to accept such decisions from the person whose life is under scrutiny rather than doctors seems to be more difficult.[1]

We are afraid to confront suicide without the familiar religious and psychiatric defenses against it; because we are afraid to recognise that suicide, especially in the absence of terminal or chronic illness, can be an existential option, a rational choice. We deny suicide by attributing its cause to nearly everything, from natural disasters to rock music and, above all else, to mental illness, anything except the person's own rational decision; we are unable or perhaps unwilling to accept suicide as suicide. But we all know what suicide

is. From Emile Durkheim's (1897)[2] groundbreaking study of suicide to contemporary dictionaries, suicide is defined as a death which is voluntary, intended, and self-inflicted. Whether we judge suicide to be good or bad, rational or irrational, permissible or prohibited is important; but it is another matter. What we need is a new approach to death; "it is time to break the taboo and to take back control of an area [death] which has been medicalised, professionalised, and sanitised to such an extent that it is now alien to most people's daily lives."[3]

The aftermath of suicide

One of the least commonly explored areas in the vast literature on suicide is the reaction of mental health professionals when one of their patients or clients suicides.[4] The few studies that have recognised that therapists might also be considered amongst those affected by suicide have focused on psychiatrists and psychologists. Common reactions by these health professionals are disbelief, grief, guilt, depression, anger, personal inadequacy, feeling vulnerable, and loss of self confidence, most of which are very similar to those reported in studies of family survivors of suicide.[5-8] But in addition to the personal responses, the suicide of a client can trigger a sense of failure and injury to professional identity, expectations of negative judgements by colleagues, feelings of professional inadequacy, and self doubt.[9] Those working in the area of mental health are often less prepared than other medical professionals to deal with the death of a client. Whereas death may be viewed as an inevitable and unfortunate consequence of medical illness, it is viewed as a therapeutic failure when a client suicides.[10,11] Indeed, it has been suggested that by Jones (1987) that the suicide of a client is "the most difficult bereavement crisis that a therapist will have to encounter and endure."[12]

The studies of the impact of client suicide on the mental health professional described in the literature have focused on psychiatrists and psychologists and failed to take into account the impact of the theoretical model, the value base, underpinning their practice may have on the meaning, experience and understanding of client suicide. As a person-centred counsellor and researcher, I find it difficult to relate personally or professionally to the negative, damaging 'impact' of suicide the literature describes; the search for meaning, the shame and self-blame, are not part of my experience or my understanding of suicide.

Suicide and the medical model

The professions of psychiatry and psychology, and arguably some practices of counselling, are powerfully influenced by the medical model. The modern medical model is built upon the problems of illness or injury, and its beneficient goals include saving lives or prolonging them. Indeed, among the highest values of the medical model is the preservation of life. Our society has embraced the medical model, and with good reason. Rather than seeing people who want to end their lives as criminals or sinners, the medical model understands suicide (in the absence of physical illness) to be the final, irrational thrust of a degenerative mental illness and, as such, as something that is ultimately preventable through the institution of drug therapy and/or counselling with the intention of 'treating' or 'curing' the mental illness that drives the wish to suicide. If suicide is understood as something that can ultimately be treated, cured and prevented, it is not surprising that suicide is understood in terms of 'therapist's failure' and experienced by psychiatrists and psychologists in the traumatic way depicted by the literature; after all, their job is to save lives. Indeed, Lesse (1975) contends that the goal when working with people who are suicidal is, "to save a patient's life, nothing more, nothing less".[13]

Perhaps what is needed when we are interacting with suicide is "a consciousness that does not see

these people as in need of fixing, but honours them for what they are being".[14] Suicide in the presence or absence of physical illness *can* be an authentic, rational choice. Ellenbogen and Gratton (2001) reflect that "we may question the logic of lumping together all suicide survivors into one group, assuming that the act of a completed suicide should always elicit a specific set of reactions. It is possible that the bereavement after a suicide is unique and if its uniqueness has not yet been discovered it is because of research limitations".[15] One such research limitation can be found in the fact that the experience of client suicide has only been described in the literature from the perspective of psychiatrists and psychologist; the experience of client suicide underpinned by an existential, person-centred framework remains uncharted as neither the medical, psychological, sociological, philosophical or counselling literature has specifically addressed how a person centred therapist experiences the suicidal death of their client. Fine (1997) states that, "Some survivors experience a sense of relief when a suicide ends the physical or mental suffering of a loved one."[16] If suicide can be personally experienced in anything other than the negative way depicted in the literature, then perhaps it can be experienced differently professionally too.

Existential suicide

Within the existential paradigm the person-centred approach is far removed from the medical model with the two worlds holding different values, assumptions and practices. As an alternative framework to the medical model of suicide, the existential paradigm draws suicide as a less pathological and more rational act and presents an understanding of suicide in terms of authenticity and alienation rather than mental illness.[17] From within this framework, life itself ("the human condition"), not merely life gone astray, is the basis for suicide. Suicide becomes a resolution to existential dilemmas, an act of *freeing* oneself from the constraints of the world, from anxiety, and from the impossibility of discovering an authentic way of being.[17] The desire for suicide then becomes the condition of seeing life as impossible, intolerable precisely because there are no authentic possibilities available. From here, suicide can be viewed as the actualising tendency giving a clear message as the best thing to do in the circumstances; ultimate potential has been reached, in other words, to be life closing rather than enhancing. Suicide in this framework becomes a rational choice resulting from an existential awareness that the possibilities of life, the choices available, no longer allow for the development of an authentic self.

If we step outside the understanding of suicide as the irrational act of a mentally ill person espoused by the medical model and the associated value of 'saving lives', accept the concept of rational suicide, the philosophical underpinnings of the person-centred approach, the centrality of the actualising tendency and commitment to non-directivity, the question becomes, how might therapists working within this paradigm understand and experience client suicide?

How might a person-centred therapist experience client suicide?

As a person-centred counsellor and doctoral research student at the University of Edinburgh, my research is underpinned by a constructivist epistemology and a commitment to phenomenology and will use auto ethnography and creative interviewing to provide a dialogue between myself and a person-centred counsellor in private practice who has experienced the intentional death of a client to suicide. In so doing I aim to give an insight into the experience of client suicide and to the person centred model as a whole; I am reaching for knowledge connecting head to heart, knowledge that might affect my audience intellectually *and* emotionally that will introduce a new voice into

the literature; a voice that asks that we listen to a different, if controversial, understanding of suicide, one that teaches us not to fear death and to live life to the full. Such knowledge and understanding might help develop one of the most essential attributes of practice in various professional disciplines: practice wisdom.

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The Air

Benet Haughton

I have always had air round me
Always ever since I was born
And other things of course like clothes
And people, and houses.
But this blanket I cannot lean in to
Its insubstantiality
Its innocent buffeting absence
Is a kind of permanent communion
A shoreline
That has been with me all day and night
Ever since my Candlemass day in 1951.

What more can I say?
In the collection of possible comments
What has not been said better before
Without becoming a scientist (impossible)
Or more of an artist than I am (impossible)
Or more of a therapist than I have become
What can I say?

But the air says to me
"I am your house
Your invited guest
Your host
You are my tent
My dwelling
My walls
You are muscled around me so
I am poured in
And poured out like the sea to and from the land.
I am your breast
Your sucking life
Your opening to the stage door.
I am the faithful keeper of all anniversaries
The one recalled in the lull after the storm.

When, a week after your father died,
Your tears came and you found the moment
The long breaths after the long walk
Then we both sang
Drawn companion like to settle.

And as you are on your death bed
I will be your last supper
Conscious
Unconscious
Taken in and returned
Left out
Deep
Felt
Ignored
I am
But know this
Breathing you is child's play.
You are a walking miracle
A human breathing
Who sheds himself as he is housed
Who is less responsible for the experiment than
he may imagine
Who can be brave
And clear faced
Overcast and laugh
Wild and calm
At peace
Still
Breathing.

Technology

in Counselling and Psychotherapy

John Dodds

While face-to-face counselling and psychotherapy are still the predominant modes for the therapeutic relationship, the Internet and other forms of electronic communication, have ushered in a new era for therapists and their clients. On the one hand a range of new tools and options have become available. On the other a new set of challenges and opportunities present themselves.

In 2003 an excellent book was published on the subject, *Technology in Counselling and Psychotherapy: A Practitioners Guide* (Palgrave MacMillan), edited by Stephen Goss and Kate Anthony.

Kate Anthony

On the eve of the publication of her latest book *Therapy Online: A Practical Guide,* I took the opportunity to interview Kate, who now lives and works in Scotland, and runs www.onlinecounsellors.co.uk. Hopefully the interview will give COSCA members an insight into the issues and prompt them to explore the fascinating subject of virtual counselling further.

Kate, can you briefly describe what you mean by the term technology in counselling and psychotherapy?

Technology in counselling and psychotherapy covers all use of electronic means of imparting therapeutic services. Therefore it can cover basic communication like email, through videoconferencing, podcasts, blogging, etc right through to computerised cognitive behaviourist therapy programmes by download or on CD-ROM.

What are the benefits of remote counselling as opposed to face-to-face counselling?

The main ones are convenience (no need to be physically present at a specific location), flexibility (no need to be physically present at a specific time) and disinhibition (the ability to talk without feeling inhibited by another person being physically present).

Unlike face-to-face counselling there are elements missing: body language, tone of voice, use of silences (if you are not using a webcam, for example). What does a counsellor need to consider while working in this way, and does the approach need to be radically different, or are there real world techniques which can be applied in the virtual world?

Training in how online communication works will give a therapist the tools to compensate for any missing elements – even silences. It doesn't need to be radically different than face-to-face communication – people still smile

:) or <<smiling>>

or cry

:'o(or [[crying]]

and hugging can be positively encouraged ((((Kate)))))! Silences can be used in chatroom sessions – the point is to be clear for the reasons for the silence – a good use of acronyms (such as pft, k? –'pause for thought, ok?') indicates where the client needs to use silence rather than there having been a technological breakdown, for example.

Changes in tone of voice is also perfectly possible, using changes in fonts, emphasis, and other enhanced keyboarding.

The book stresses that technology should be embraced, not purely for its own sake, but as an additional practitioner's tool. Can you say more about what you mean here?

We stress that technology should not be used for technology's sake but that it can be embraced and used where appropriate as a useful tool, either in addition to other services or as the only way of offering services. For example, sometimes it is the case that the therapist has a physical disability and finds face-to-face work impossible. BACP is now addressing accreditation in light of this at the moment. It should be said, though, that therapists who practice online usually have a face-to-face or telephone service as well.

There seem to be two main types of technology in use: time delayed, such as email; and immediate, like online chat. What are the pros and cons of each, and which is the most commonly used at the moment?

Email is more commonly used because of the convenience of being able to time-shift around other commitments (albeit in a boundaried way). However, the possibility of experiencing the "black hole" of not getting an expected reply can be uncomfortable. Chatrooms still suffer from lag – it's still more stilted than a verbal conversation. But many therapists prefer this because it is more dynamic, and organisations such as Relate use nice features in their software that brings up mental health websites in half the screen while the chat is going on.

Is email, for example, a potentially richer experience because the client and counsellor have time to think through what they want to say?

I don't think it makes it necessarily richer, it's just a different way of working. You gain the chance to reflect and rewrite, but you lose the spontaneity of chat discussions. Emails tend to be kept and reread by the client – more so than chat – which is another reason why clients choose asynchronous platforms.

Can technology be used equally well for couple and group therapy?

Yes. I have a chapter specifically on couple and group therapy in the new book published at the end of the year. It can be harder work – particularly facilitating asynchronous group forums – because of the speed at which flame wars flare up due to misunderstandings. A good case example of this is in Yvette Colon's chapter in my 2003 edited book.

What assurances can counsellors and clients be given about confidentiality, given the security risks of the internet?

At the Online Therapy Institute, we have a list of stipulations around confidentiality and encryption that our members have to meet before we will list them in our annotated directory. We stipulate that the services offered must be encrypted services for email, chat and web conferencing. We ensure that members are using the best encryption services possible, and make sure they are not just offering services via Yahoo, MSN or similar. Our OTI Ethical Framework – available free of charge at http://www.onlinetherapyinstitute.com/id50.html – also offers more information on the levels of security needed to ensure clients are protected.

The question of identity may arise with internet counselling. Some people may go to lengths to conceal not only their name, their age, and even their gender. What issues does this present for Internet counselling?

It's difficult to know how often this actually happens. Clients play with identities in Virtual Reality environments before entering therapy (and during it as well sometimes – I have a colleague in Scotland who has an e-clinic in *Second Life,* and one of his clients changes Avatar mid-session to convey to the therapist his mood). Many therapists have an

intake procedure designed to establish identity via credit cards or insurance provider information.

Personally, I take the view that I have to work with what the clients present to me. If that is part of the psyche that isn't necessarily the reality of the client's identity, it must be coming from somewhere and so I have to work with it. It can be very powerful stuff. If the underage client is presenting as an adult, is that because they are going through something that made them grow up very quickly? If the male client is posing as female, is it because they want to explore their gender identity?

Can you tell us something about online supervision, and how it works?

This works in much the same way as online therapy, a contracted professional relationship that is being offered and received using technological means. The content is much the same as face-to-face supervision, of course. The BACP *Guidelines for Online Counselling and Psychotherapy* 3rd Edition (Anthony and Goss 2009) include Guidelines for Online Supervision, and I believe they remain the only available ones worldwide.

Computer software is sometimes used in psychotherapeutic practice. The systems seem to be clients-centre, simulating the therapist-patient dialogue (often with a cognitive behavioural model). How well do these work, and have there been advances in the software since the book was published?

I have two new chapters on CCBT coming out on this in my 2010 book *Technology in Mental Health,* and the evidence for their success remains stable. The NHS trials of *Beating the Blues* consistently get good reports, and *FearFighter* is also widely used. More exciting developments are taking place with gaming software developments for mental health, particularly in enticing adolescents into therapy. Clients play a game, designed by the therapist individually using very simple point-and-click software development tools, which leads them through winning key stages of the game which focus on solution focused techniques.

Finally, there have been lots of dissenting voices from the counselling community (much as people criticised TV when it first appeared). Have things changed now that technology in counselling and psychotherapy has become more common?

It has taken ten years for the profession to recognise that technology isn't going to go away and is likely to grow as clients not only consider it but actually expect it as their first point of call for therapeutic help. Although there will always be dissenters, with training and appropriate knowledge of the issues as well as the benefits it can be a very successful and invigorating environment for client work.

Anything you'd like to add?

What the profession now needs to address is the advent of 2.0 – the next incarnation of the Internet. I already offer training on this. Web 2.0 is an attitude, rather than being about technology itself; it is the collaboration of people for the greater good of society. Applying it to our profession means that services will be designed by being client-led. For example, if the client wants to work via SMS text, we need to ask them what security we need to be able to offer them rather than saying that we need to wait 10 years for the research base to come out to be able to ethically offer these services.

Web 2.0 also applies to social and professional networking sites, blogging and commenting on blogs, tweeting resources regularly, maintaining a Wiki edited by all… the collaboration of mental health professionals for the greater good of the profession and its service users.

'Therapy Online: A Practical Guide' will be out this year.

The plethora of online services now available has led to a growing demand for practitioners to look beyond traditional face-to-face therapy and take advantage of the flexibility which email and the internet can offer them and their clients. The guide gives up-to-the minute information and research, ethical and legal advice, on the practicalities of setting up or joining a service, and the essential therapeutic skills needed to be an effective online therapist.

Writing for an international audience, the authors discuss the issues for practitioners using the internet today, as well as in the future. Basing their study on published empirical research, they address:

- text-based therapeutic interventions such as email, Internet Relay Chat, forums and mobile phone texting, from the perspective of different theoretical orientations, illustrated with case studies
- supervision and online research
- other therapeutic uses of technology including use of video therapy, telephone therapy, Virtual Reality environments, gaming and computerised CBT.

The authoritative guide to all aspects of being an online therapist, this practical text is a vital addition to any therapist's library. It will also be valuable reading for anyone training to be a counsellor or psychotherapist in our increasingly 'electronic' world.

http://www.onlinetherapydirectory.net/view/Therapy_Online_A_Practical_Guide

Supply matching demand?

Mapping, Counselling and Psychotherapy resources in Tayside

Laura Falconer
MSc Research Study, Abertay University, Dundee
(completed August 2009) **Research Background**

"The government is committed to increasing the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers" (Scottish Government, 2009). In the published *Overview of mental health services in Scotland* undertaken by Audit Scotland (2008) one of the key objectives was to "assess the equity of access and availability of mental health services across Scotland". What the audit reiterated was the current lack of knowledge about supply and demand, saying that the availability of therapy is patchy in some parts of Scotland mainly due to the fact that its whereabouts and modality is not centrally recorded.

The largest percentage of the Scottish NHS budget, at 11 per cent of the total figure, is spent on mental health issues. In 2004/05 the estimated amount spent on mental health by councils/social services across Scotland was £78.2 million.(Audit Scotland, 2008). The spend per capita on mental health in Tayside is £169m (2004/05) as opposed to £108m in neighbouring Fife (NHS Scotland). In terms of counselling and psychotherapy there is an opportunity for more effective and targeted spending if knowledge is increased about the true levels of demand for 'talking therapies' and resource are made available to meet that demand.

Tayside as a region spans three Scottish council areas: Angus, Dundee City and Perth and Kinross. It has a population of just under 400,000 and covers 2909 square miles (General Register Office for Scotland,2007). Dundee and Perth may only be a 30-minute drive apart but the life expectancy for a Dundonian is 76.6 years whereas for a resident of Perth it is 79.1. The Scottish average is 77.4 (General Register Office for Scotland, 2007). Dundee's proportion of population whose lives are affected by poverty and who are classed as socially excluded is second only to Glasgow (The Scottish Government, 2008).

Counselling and psychotherapy in Tayside is available in a number of different formats through agencies, sole practitioners and the National Health Service. NHS Tayside is the second largest health board in Scotland and has its psychological services based in Dundee City. Counselling has no central linking body across Tayside and there is no formalised dialogue between the different services.

Mapping has been used extensively as a tool in many areas of public health research. Although counselling does not necessarily follow the 'medical model' the process of mapping is valuable in generating an overview of service provision. "Mapping provides an overview of existing services, describing details of services, their target groups or links. It can assist to monitor changes over time, to reconfigure services according to need and to target resources where need becomes apparent. Mapping exercises can also be useful in identifying new areas for collaboration and inter-agency work." (Luger et al. 2001).

The aims and objectives of this mapping exercise were to discover the following:

1. How much and what type of therapy was being provided across Tayside.

2. Where provision was located throughout the region and were there gaps in terms of provision? – for example, geographical areas under-provided for or client groups with insufficient services.

3. Were there waiting lists? If so what were the waiting times?

4. To review how joined up or integrated the service was to the public in terms of inter-agency collaboration and co-ordination.

Creating a database from multiple sources the required information was generated by a postal or online questionnaires.

The participants were split into two categories, agencies and sole practitioners. A small number from both categories were interviewed.

Recipients also had the opportunity to put forward suggestions for improving local service provision. No personal information regarding counsellors or clients was requested.

The total number of questionnaires sent out across Tayside was 128-49 to agencies and 79 to sole practitioners. There were 16 returns from agencies offering one to one counselling from fully trained and qualified counsellors. This number appears low but it is worth noting that an additional 21 agencies acknowledged the questionnaire but said they supplied a listening skills or advice service only. In terms of Sole Practitioners there were 23 returns. Two agencies and three Sole Practitioners were interviewed.

* NHS Psychological Services Tayside felt that the questionnaire was not applicable to their services.

A brief synopsis of findings

How much and what type of therapy was being provided?

The number of counselling positions in operation over the sixteen agencies was 190. Some counsellors were working in more than one agency. Positions were predominantly part time (184) against 6 full time places. Students and trainees accounted for 34 positions. The number of part time hours for sole practitioners averaged out at 10 hours per week.
Full time equivalent (FTE) for counsellors against these part time figures equates to 17-21 FTE for agencies and 1.5 FTE for sole practitioners. This is in comparison to the NHS psychotherapy services which employs 33 psychologists, 7 accredited therapists and currently has 24 trainees.

The average number of sessions provided by agencies was 7 and by sole practitioners 7.6. NHS Psychological services estimated a range of 8-12 sessions per patient.

Major counselling approaches for agencies

1. Person centred	78	per cent
2. Integrative	71	per cent
3. Psychodynamic	57	per cent
4. CBT	9	per cent
5. Family Therapy	7	per cent

Major Counselling Approaches for Sole Practitioners

1. Integrative	55	per cent
2. Person Centred	36	per cent
3. Psychodynamic	27	per cent
4. CBT	9	per cent
5. Family Therapy	0	per cent

Are there waiting lists?

There were no waiting lists for sole practitioners. Agencies had an average waiting list of 6.5 weeks but ranged from 5 days to 12 weeks. The number of people on the waiting lists for nine agencies totalled 450. NHS waiting times varied across the different services within Tayside with the wait for adult psychological services in Dundee being up to 13 weeks. Waiting times for clinical psychology are by far the longest with 44 per cent of patients waiting 26-52 weeks and 7 per cent waiting more than 52 weeks. There were 706 people waiting for

NHS Psychological services with 409 new referrals received for May 2009.

About counsellors and clients

Ninety per cent of counsellors within Tayside are women with only 19 places being held by men. In agencies the number of paid and voluntary hours was fairly equal (96 versus 75). In contrast sole practitioner hours were predominantly paid. All agencies require a minimum level of training for counsellors with 64 per cent requesting a diploma or above. All agency counsellors and sole practitioners had some form of supervision, the majority adhering to COSCA (Counselling & Psychotherapy in Scotland) and BACP guidelines. The gender split of clients seen was consistently one third male to two-thirds female both for agencies and sole practitioners.

Is the counselling evaluated?

All agencies and sole practitioners used an evaluation method to review the outcome of Counselling. 85 per cent of agencies used a customer satisfaction questionnaire with 50 per cent using the CORE system. 40 per cent of Sole practitioners used a client satisfaction questionnaire with 27 per cent using CORE.

Are there gaps in service provision?

The cartographic representation of Tayside illustrated how 90 per cent of the resources are based within the two cities. Dundee has the largest proportion with 62 per cent being based within the central city postcodes, DD1 – DD5.

Rural areas appear to have little or no access to counselling services.

Just under 20 per cent of the services are aimed at children and adolescents and there appears to be no specific agencies focussing on the ageing population, both government target areas.

How integrated or 'joined up' is the service provision in terms of inter-agency collaboration and co-ordination?

There seemed little or no structured networking. It was very dependent upon the individual agency or sole practitioner which service they knew about and whether they had any dialogue with one another. The local GP was seen to be a potential conduit of communication but feedback suggested that GPs knowledge of available counselling services in the community was limited.

Most practitioners linked into a central professional body such as BACP or COSCA plus a large number into the local counselling organisation (TAYNET). However there was little evidence of cross-referencing of available specialist support. The Scottish Government and NHS sponsor a number of support services such as telephone help lines e.g. 'breathing space' and 'living life to the full' but there was little mention of these facilities as an additional resource for counsellors and clients.

GP surgeries were seen as being one of the key locations for holding a register of counselling resource alongside Citizen's Advice Bureaux and Libraries. Funding was another issue close to participant's hearts. One commented "Funding from NHS Tayside- We get none!! Despite taking 80 per cent of clients via GPs and 50 per cent of clients being in the moderate, moderate-severe CORE range at assessment". Funding to meet the requirement and cost of training to meet future registration guidelines was also of concern especially to the voluntary sector.

The wider view and future opportunities

The study can only make tentative conclusions as there have been no previous mapping exercises to compare these findings to and research on

counselling demand has been limited. The research had many challenges and limitations not least the sheer size and scale of the project versus the manpower available. The small response to the questionnaire from sole practitioners (32 per cent) was disappointing but perhaps understandable. Did people feel they were being checked up on?

For me the two key issues to take from this study are as follows:

The demand for counselling is demonstrated through the length of current waiting lists. However what the research also identifies is that counselling is readily available if clients are prepared to pay, an option perhaps not always made clear by GPs and other sources of referrals exacerbated by the fact there is no central database within Tayside. With the extreme waiting times existing in clinical psychology it would be highly beneficial to identify if any of these patients are waiting for a 'talking therapy'.

Counselling outside of the NHS is shown to be operating to consistent standards. The counselling workforce is unusual and possibly almost unique in the fact that it has highly qualified, flexible, supervised staff who in an agency environment offer similarly matched voluntary and paid hours. This resource could be seen as a real creative opportunity, as yet untapped and not centrally accessed or co-ordinated. One of the biggest ongoing expenditures for any profession is staff development and training yet here is a resource fully trained with ongoing personal development. When considering the average number of hours for sole practitioners (10) it is more than likely many are underutilised.

Throughout the research there was plenty of evidence of areas of consistency of approach such as evaluation. Is there an opportunity to adopt universal methods? What is not being provided for in Tayside in terms of service provision? Acknowledgment of the sparse rural provision in Tayside suggests consideration of more creative approaches to counselling provision such as On-Line Counselling. Could rural areas with limited access to transport and services tap into this available Tayside resource via their GP or local promotion?

Counselling as a resource to the community needs to provide a clear outline as to what a client should expect, if and how much it might cost and where they can access the resource quickly. At what point does Counselling become an 'Alternative therapy'? Does a person opt for Counselling or Psychotherapy? Do they see a therapist or counsellor?

Spending on mental health in Scotland is the most significant proportion of the Scottish NHS budget. Mapping exercises across the country could provide the detailed information required to ensure supply is married with demand for counselling and psychotherapy and money is targeted and spent where it is needed the most. Mapping gives the counselling community the opportunity to start to talk with 'one voice' as opposed to presenting a fragmented picture of individual services.

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An Inspiring Story

Dr David B Lingiah

Following the publication of my article in Mauritius Today.com (29 June 06, *The Cracked Pot Experience*) I received two emails from Mauritius, each one containing an inspiring story. Both stories have an element of disability that I found inspirational. I would like to share one of these stories with you in the hope you too will appreciate what we can all learn from people with disabilities or those who rise above their own physical conditions to bring us joy of a special kind.

People with disabilities are still excluded from society in many countries of the world. Even where effective disability legislation is in place, the implementation lacks ideas and is hindered by negative attitudes towards disability. Disabled people are not yet fully considered within international development issues. Many problems are still unresolved. Here's the story:

Blind Courage

Two men, both seriously ill, occupied the same hospital room. One man was allowed to sit up in his bed for an hour each afternoon to help drain the fluid from his lungs. His bed was next to the room's only window. The other man had to spend all his time flat on his back. The men talked for hours on end about their wives and families, etc.

Every afternoon when the man in the bed by the window could sit up, he would pass the time by describing to his roommate all the things he could see outside the window. The man in the other bed began to live for those one-hour periods where his world would be broadened and enlivened by all the activity and colour of the world outside.

The window overlooked a park with a lovely lake. Ducks and swans played on the water while children sailed their model boats. Young lovers walked arm in arm amidst flowers of every colour and a fine view of the city skyline could be seen in the distance. As the man by the window described all this in exquisite detail, the man on the other side of the room would close his eyes and imagine the picturesque scene. One warm afternoon the man by the window described a parade passing by. The other man couldn't hear the band – he could see it in his mind's eye from the description.

Weeks passed by. One morning, the day nurse arrived to bring water for their baths only to find the lifeless body of the man by the window: he had died peacefully in his sleep. She was saddened and called the hospital attendants to take the body away.

When it was appropriate, the other man asked if he could be moved next to the window. The nurse was happy to make the switch, and after making sure he was comfortable she left him alone. Slowly, painfully, he propped himself up on one elbow to take his first look at the real world outside. He strained to look out the window beside the bed. The bed faced a blank wall. The man asked the nurse what could have compelled his deceased roommate who had described such wonderful things outside this window. The nurse responded that the man was blind and could not even see the wall. She said, "Perhaps he just wanted to encourage you."

Taboos and stigmas are the shackles of a society. The determination of governments to make a difference to the quality of life of disabled citizens is to be welcomed and supported by everyone. "Full participation of disabled persons in society" is a concept worth striving for. Can we learn any lesson from these stories?

Are You 'Listening'?

A new webcam service for those who are deaf or deafened using British Sign Language

Tony McLaren

Some time has passed since Breathing Space asked the questions: 'What do deaf people do to access a mental health service? What is available? How can we, as a phone line service, make our service accessible to the deaf community?' We were able to provide text phoning which, from all accounts, was not that popular with users and was not often used as a means of contacting Breathing Space. As a way of developing the service to meet the needs of, and give better choices to this community, we were able to work closely alongside NHS 24's New Media department and approach the Government for funding from their e-health department. This was a successful bid and it allowed us to drive this initiative forward to deliver a two-year demonstrator project, which I will outline in more depth in this article.

Breathing Space is a national phone line and web-based service that delivers a listening, advice and signposting service to people suffering through low mood or depression. As an out-of-hours service, it receives around 4,500 to 5,000 calls a month from people all over Scotland who present on the phone with issues concerning relationships, anxiety, depression, stress, sexual issues, bullying, existentialist concerns and queries around homelessness and debt. As a counselling skills organisation, recognised through the COSCA Recognition Scheme, it is staffed by a multidisciplinary group of trained mental health professionals who work a variety of shifts attending to the diverse needs of callers.

As our mission statement maintains: 'Breathing Space is a free, confidential phone and web-based service for people in Scotland. We are here in times of difficulty to provide a safe and supportive space by listening, offering advice and information.' It is our belief and hope that by empowering people, they have the resources to recover. It was very important that clear plans were made from the outset to engage meaningfully with the deaf community. To this end early communication was established with the Scottish Council on Deafness (SCoD) and Deaf Connections who were, of course, invaluable in offering guidance and support. NHS 24 were able to examine a number of web-based services on the market that would enable a deaf person to access BS through a webcam in a secure and confidential matter.

It was decided by NHS 24 that a product called 'Sign Now' would offer best value for money and best access for the clients with a further benefit of being an award-winning Scottish product. Two of the directors, Andrew Thomson and Dean Humphreys, are themselves deaf, and they developed this application to remove the barriers that the deaf community experience when accessing information and services. We needed to set up PCs with webcams, and embedded the 'Sign Now' software in our website as an iframe. This is a window that allows users to see a website within a website – this means you can plug external services into your own website. For Breathing Space this was an introduction into a new world where we were asked to question our assumptions and think in another language about how we would be able to provide a service that would be easily accessible to the deaf community.

After many months of planning and testing, this tool is now in place and offers through the Breathing Space website (www.breathingspacescotland.co.uk) a secure method of contact for deaf people who have access to a webcam to communicate to a British Sign Language interpreter using BSL. The clients can then be 'listened to' in their own language and at a time that is suitable to them and very often from the comfort of their own home or another deaf service, which has a private space. This encounter is conducted in real time without the need for any third party to interpret.

This is not a counselling service but the core skills are very much in place fully reflecting the warmth, empathy and acceptance that a hearing client would gain over the phone and certainly mirroring those core conditions that would be available face-to-face.

We hope that for those clients who live in remote and rural areas then a first contact can be made with Breathing Space BSL as a way of exploring other support including the possibility of face-to-face counselling if appropriate (and available) in the community.

Recruitment also offered some challenges and took some time. We were able to advertise through all the usual outlets as well as throughout the deaf network. We received a favourable number of responses to the advert for a Breathing Space phone line advisor (BSL). We were then able to appoint two part time (0.2 whole time equivalents) BSL phone line advisors who would work for the duration of the pilot period, which ends in November 2010. After an exhaustive induction period on all things NHS 24, Breathing Space and BSL technology, our new staff members are now prepared to take up this mantle and deliver this innovative service. It is impossible to guess what the uptake of this service will be as the deaf community is small. There are reportedly 5000 deaf people in Scotland. Within the general hearing population, 25 per cent will at some stage develop a mental health difficulty. Within the deaf community, it is around 40 per cent. It is a community that can often be challenged by access to services.

Good advertising throughout the community will probably be effective. This is a pilot project and we hope it will demonstrate the viability of the concept as a means for BSL users to access services and thus evidence that this model can be used in other health settings. Obviously the primary role is for Breathing Space to provide the same level of service to the deaf community as we do to the wider community.

The British Sign Language advisers are Breathing Space advisers in the same way as our other staff. They have come from a mental health background and have the qualifications and training similar to their colleagues. Callers will access the service through the Breathing Space website. From 2nd December there has been BSL video messages on the website with the opening hours and instructions on how to use the service. This groundbreaking web-cam service is now live. We did have to make certain the lighting was suitable for webcam use in order to ensure that the caller and advisor could see each other and communicate properly. We made sure that there was no environmental clutter behind the advisor, and that the PCs are in an area where they will not be disturbed by general office traffic.

With regards to caller and advisor safety, we will initially launch the service with both of our advisors working to support each other on each shift, so calls will be supported by the advisor's peer, who will only be able to view what their colleague is saying in the same way that the rest of our staff can hear what their colleagues are saying without listening in to calls. It might be appropriate for us to go down the route of recording video interactions, but at the moment we have chosen not to, as we do not record our telephone calls to Breathing Space. Advisors will also be quality managed using interpreters for call review and supervision. It is important to ensure that our advisers are safe. All staff including our BSL using staff are supervised in one-to-one meetings, call reviews and in externally supported group supervision (provided by the Tom Allan Counselling Centre in Glasgow) to ensure that we provide the best support possible. However, we are aware that there is a far greater likelihood

that our staff will know the callers due to the relatively small population group compared to the population who use the telephone service.

Of course the use of web-cams makes recognition even more likely, so we have discussed with our advisors in training about how they might work to maintain appropriate professional boundaries. With regard to abusive callers, we have NHS 24/Breathing Space organisational policies in place on how to respond and support our staff. On reflection, the biggest hurdle has not been technical or procedural – the biggest hurdle has been overcoming the lack of awareness we have as a hearing community about how to work appropriately with deaf BSL using colleagues and callers. In this sense our challenge has been to learn from the community we want to work with and often to be led by those who have more knowledge through their own experience and skills.

A very basic example would be people not actually knowing what BSL is – that it's a completely different language to English. One of the further challenges for us has been to ensure that the workplace we provide is safe and appropriate for all of our staff's needs such as ensuring that there are visual cues for fire alarms and emergencies around the building. This is an exciting development as we reach out further in offering our services to the whole community. It has come about with the full support of the deaf community and is endorsed wholeheartedly.

We began to take referrals in December 2009. Lilian Lawson, Director of Scottish Council on Deafness (SCoD), said: "SCoD has always actively campaigned for fuller access to mental health services. We are delighted that Breathing Space has taken a positive step forward in recruiting BSL staff so that Deaf sign language users can access this important service."

Deaf Connections Community Services Manager John Speirs said: "Deaf Connections is delighted to see this innovative support service become a reality for deaf people. Accessing Breathing Space in BSL breaks down these barriers and will encourage people to use the service confident in the knowledge that communication will be in their own language and will acknowledge deaf cultural experience."

We will endeavour to keep COSCA up-to-date on the development of this new initiative and report on its uptake and offer some critique as regards its impact and effectiveness.

Breathing Space voice helpline is on 0800 83 85 87, 6pm-2am Mon-Thurs and 6pm on Fridays right through till 6am on Monday mornings.
The Breathing Space website is at:
www.breathingspacescotland.org.uk.

If you have any questions about the service please contact: National Co-ordinator Tony McLaren
tony@breathingspacescotland.co.uk
Operations Manager Stephen Anderson
stephen.anderson@nhs24.scot.nhs.uk

STOP PRESS:
Breathing Space's BSL webcam service achieved 1st equal at British Telecom's Sponsored Telephone Helplines Association Awards in London on 8.02.2010.

Letters

Dear Editor,

I must admit that I found the section entitled "The place of the amateur" in Benet Haughton's article in the last edition of *Counselling in Scotland* rather confusing. Particularly with a view to forthcoming statutory regulation, the issues concerning weak links between effectiveness, training and professional status deserve much more careful consideration than a bald "This is nonsense" statement and a selective reference to chaos theory. Indeed, the very future of a thriving voluntary counselling sector in Scotland may depend on a much more intelligent appraisal of the research evidence than has hitherto been exhibited by those powers shaping statutory regulation.

Your readers, and Benet, certainly don't have to take my ageing digest of the research evidence as gospel. Perhaps it might be more palatable coming from (Professor) Mick Cooper's more recent work, *Essential Research Findings in Counselling and Psychotherapy*. His key finding on the topic is summarised (page 96) thus: "Professional development through training, supervision and experience have some relationship to therapeutic outcomes, although the size of the effect tends to be small, and paraprofessionals seem to have as good outcomes as professionals."

Possibly, as Alphonse Karr said in 1849, "Plus ça change, plus c'est la même chose"?

Yours sincerely,
Dr Douglas McFadzean

New members of COSCA

FULL ORGANISATIONAL MEMBERS
CHANGES COMMUNITY HEALTH PROJECT
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Gazette

Details of all events are on the COSCA website: **www.cosca.org.uk**
Please contact Marilyn Cunningham, COSCA Administrator, for further details on any of the events below:
marilyn@cosca.org.uk
Telephone: **01786 475 140.**

2010

22 February
COSCA Ethical Seminar
Dunblane
"Counselling & Psychotherapy within Small Communities: (place and interest)"

19 March
COSCA Diploma Trainers/Providers Forum

31 March
Deadline for receipt of COSCA Trainer and Counsellor Accreditation applications
- See enclosed flyer

10 June
COSCA Annual Trainers Event
Stirling

June (tbc)
COSCA Trainer and Counsellor Accreditation Workshops

29 September
COSCA Annual General Meeting
Stirling

30 September
Deadline for receipt of COSCA Trainer and Counsellor Accreditation applications

23 November
COSCA 7th Counselling Research Dialogue

December (tbc)
COSCA Trainer and Counsellor Accreditation Workshops

Vision and Purpose

As the professional body for counselling and psychotherapy in Scotland. COSCA seeks to advance all forms of counselling and psychotherapy and use of counselling skills by promoting best practice and through the delivery of a range of sustainable services.

Contact us

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