Counselling in Scotland

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COSCA
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in Scotland

Contents

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Editorial

John Dodds

On the eve of starting work on this issue of the journal, Scotland's referendum was in full swing. What the implications of the decision to stay in the UK will be for the counselling profession (as much as anyone, of course) remain to be seen. But with potentially even greater powers being devolved to Scotland it will surely be interesting times. In a sense the people of Scotland stepped up to the plate and exercised en masse what we as counsellors encourage our clients to do: become self empowered and embrace the responsibility for our own wellbeing.

In this issue we have several fascinating articles by therapists within an institutional context. Dr. Douglas McFadzean writes an entertaining, sometimes ironic, and strongly personal account of his experience as a counsellor within the context of primary care. Paul Wheble, formerly a cognitive behaviour therapist with the Royal Medical Corps and Maudsley Hospital, gives us an overview of his work with people with obsessive compulsive disorder.

Some of you may have worked in an organisation which employed consultants to offer things like team training and coaching in various forms. The Rowan Consultancy is now offering coaching skills to counsellors and Rachel Weiss explains the whys and hows of it all for anyone who may be interested.

Janie Keddie writes about her experiences of training in counselling skills. She opted to write it in the form of a fantasy story, at 800-words slightly more compact than the more commonplace epic fantasy trilogy.

Sean Cowan explains in his piece on addiction that it's not necessarily the case that people with addictions need to be cured, but that helping them manage their behaviour and take more control of their lives can be equally valuable.

We're all aware that counselling is still somewhat under-researched, for a variety of reasons, some of which we've touched upon in previous journals. So it's always good to see more from that arena, and I recommend you read the article by Anne Goldie and Jacqui Lindsay on the grassroots experience of doing research for our area of work.

On 25 June, COSCA issued a press release stating that, from that date clients and the public in Scotland would be better protected by being able to choose a counsellor or psychotherapist belonging to a Scottish-based register, vetted and approved by the Professional Standards Authority for Health and Social Care (the Authority). The voluntary register of COSCA has been accredited under a new scheme set up by the UK Government's Department of Health and administered by the Authority, an independent body, accountable to the UK Parliament. Counsellors and psychotherapists on COSCA's voluntary register will be able to display the Accredited Voluntary Register (AVR) quality mark - a sign that they belong to a register that meets the Professional Standards Authority's robust standards.

While I may not have said so in so many words in an editorial, I do want to give a sincere public thanks to everyone who takes the time to write for the journal (regardless of whether you voted "yes" or "no" in the referendum, naturally!)

In the few years I have been editor it's been a genuine pleasure to read such wide-ranging, thoughtful, sometimes humorous, and tonally-varied articles. We always welcome articles, and ideas for articles, even if you've written for us before – new material is always gratefully received.

I hope that you enjoy this issue, knowing that feedback or questions about anything you read here is always appreciated.

Erratum

Owing to a typographical error in the previous issue of the journal the subtitle of Benet Haughton's Arkordia article read: "a cooperative model of counselling supervision." The correct title, clear in the article itself, should have been "a cooperative model of counselling provision."

John Dodds, Editor

Addiction:

Is the Therapeutic Relationship the Key to Change?

Sean Cowan

It is a sunny day as you start your walk to work. As you walk through the town centre you catch a glimpse of a shoe sticking out of the doorway. The nearer you get, going through your mind are a number of questions: Who is it? Will I need to do anything? As you approach the doorway you see a man in his mid-forties, wearing very dirty clothes and holding a tin of beer very tightly. After a quick glimpse, you carry on walking to work. In the process of the next few steps you find yourself reflecting: how can you let yourself get into that state? I would be wasting my time trying to help! Imagine… no, I would never let myself get into that state. He is beyond help. You carry on with your day and do not give that man a second thought.

This scenario is a common view of addiction. It seems to be the perception of society that the "alcoholic or addict" has to reach a certain type of rock bottom before seeking help. As a counsellor I believe the reality of that view is vastly different. Addiction makes no distinctions between age, gender, race, class, wealth or poverty. At Addictions Counselling Inverness (ACI), we work with clients from this 360 degree spectrum of addiction. So one question I have often asked myself is: if the addiction is based on an individual, how does my way of practising as a counsellor reflect that view or even should it?

I will outline my way of practising and introduce the ethos applied within ACI. As this service is set up to deal with addiction, the agenda of my clients is set out for me as a counsellor. However, in my experience, my clients already possess a real cognitive understanding when it comes to a theoretical approach to helping themselves change their addictive behaviour. Therefore, I believe my role as a counsellor may require a connection at a deeper level to address their feelings and emotions and the unmet needs behind their behaviour.

There is a poem I hold very close to my heart and it enables me to sit alongside my client, in their experience:

The Validity of the Moment

I know not of what you will do or become at this moment or beyond;

I know not what I will do except stay with you at this moment;

And be mother, father, sister, brother, friend, child, and lover at this moment;

I exist for you and with you at this moment;

I will give you all of me at this moment;

I am with you at this moment;

Take me and use me at this moment, to be whatever you can become at this moment and beyond" [1]

Our clients have a very strong emotional attachment to their addictive behaviour. There is a common misunderstanding in society of this fact and often my clients tell me that people will say things like "just pull yourself together," "get a grip," "it's easy, my friend did it." My job as a counsellor is to listen, to try to understand their world as it is, not what it may become. I think that working in this way enables the core conditions of empathy, congruence and unconditional positive regard to be very present in session. In my experience, working with addiction clients is like standing alongside them in a very dark corner of a room, where they don't see anything else but their chosen addictive behaviour. That is a very frightening and lonely place to be for the client, whether their issue is alcohol, drugs, gambling, sex, pornography, and so on. They have this hardened exterior that masks their fears, pain, anxiety and stresses. Since working with this client group, I have discovered that often behind the hardened exterior, there can be a

1 Bozarth, 1998, p3

very strong motivation to change their behaviour, which astounds and humbles me as a counsellor and as a person. As Angyal describes, it has "the direction of increasing self-government, self-regulation, and autonomy."[2]

This client group undertakes a very fragile process. As counsellors, if we have the conviction and awareness to stay in the moment, at this early stage in the client's process, it may well enable our client to self-govern their direction of progress. The use of addictive behaviour may have been used to bury issues such as trauma, abandonment, bereavement, to name just a few. It may be very tempting to try and rescue our clients from such despair and trauma.

As they begin to reduce their addictive behaviour, it is fundamental to stay alongside the client. The direction of the session is governed by the client and our ability as skilled counsellors/therapists is not just to listen but to actively engage our client's autonomy. As our sessions progress that hard edge may begin to soften or perhaps start to break up and come to the surface. These may become very apparent either singularly or collectively. We are all aware that lapse relapse is part of the process when working in the addiction field. I do acknowledge some clients' motivation is very active and lapsing does not occur. This is when our foundation work comes to the fore. The client has a safe environment, free from judgement and full of unconditional positive regard. This enables me to work with my client, to help them build a strong, active foundation of understanding and self-awareness and in the process, the client will begin to recognise and understand their former way of being. This may act as a reliable touch-stone for them to self-govern a life path, of their own choosing.

As I complete my diploma and continue my training, I become more skilled in my approach to working with clients with varying issues or degrees of trauma. In the field of addiction I believe clients and their needs have to be paramount in my counselling practise. It is essential that I have a deep embedded theory base to my practise but in session the autonomy of the client is my only concern. It could become an issue if I began to think that my knowledge and experience of a theoretical approach or technique overrode the best interest of my client. In my experience, this client group is very sensitive to direction and can become susceptible to it.

Therein lies my challenge as a counsellor: how do I balance knowledge and theory and remain person-centred? Do I set out a pattern of change or have an agenda of change predetermined in my thinking before each session? If I process my own thinking then I can be free to totally engage with the client. For example, a new client came to see me at ACI. His partner had instructed him to stop drinking; she thought it was taking control of him and that he was an alcoholic. His agenda was to stop drinking and everything would be ok. If I went into strategy/technique mode, I would have missed the reason for his drinking to excess. After several sessions, it became very clear that the lack of control in his daily life was the cause for his alcohol misuse. He began to recognise parts of himself and start a process of change. After several more sessions he decided he didn't need to stop drinking. He had taken several steps back from that dark corner and was beginning to experience a life that was full of self-acceptance. He was able to take control of his drinking patterns, not the other way around.

The addiction field is wide ranging and for my practice it raises an intriguing question: do I need to be an expert on every drug (illegal or legal) or causes/outcomes of addictive substances? In working with this client group, there is an ethical responsibility to become knowledgeable of side effects of withdrawal from drugs or alcohol. However it would be a 24/7 job to keep updated regarding all the latest trends. Novel psycho-active substances ("legal highs") for example are constantly changing and the chemical constituents are very diverse.

In my experience of working with drug addiction and misuse, the client will often know much more about their substance of choice than me. However, it may be necessary for me to understand the chemical effects on the brain, as this will often have an impact on the client's level of engagement in the counselling process.

Different groups of drugs affect the ability of the client to engage in the counselling process. The question of whether a client is able to engage in counselling while still practising their addictive behaviour often provokes debate and discussion. The key to the way in which I practise is to remain fully based and immersed in the ethical codes and guidelines of COSCA.

2 Rogers, 1951, p448

The respect for the autonomy of the client is fundamental, and applying this respect in my work with clients often leads to a very close and professional intimacy. It can act as a catalyst to building a strong foundation and enables me to have an intimate understanding of the addictive world of my client. It will act as a solid touchstone for both me and my client in their process of change. Counsellors apply different approaches and work in diverse ways but as long as we have the client's interest at the centre of our practice then our approach may be secondary.

Addiction is a complex issue and counselling the affected individuals is very challenging work. Our service at Addictions Counselling Inverness has adopted a broader, more holistic attitude to working with this client group, in which the focus is not necessarily directed on the behaviour but rather on any underlying issues which may be at the root of their addictive behaviour. The counselling is client-led and the opportunity and time is available for the client to address these deeper issues. The phrase "person-centred" is a broad term used by many forms of counselling practice. If we have the individual at our core and use our theoretical approaches in this manner then the words of Merry[3] will ring true: "The person-centred relationship is not 'instrumental' in that it does not constitute the context of therapy, nor is it a preparation for techniques or strategies. The person-centred relationship is the key."

Sean Cowan, Dip Coun. has been a counsellor with the Third Sector organisation, Addictions Counselling Inverness, for over three years and was recently awarded his addictions counselling accreditation with Alcohol Focus Scotland. He has completed a Post-Graduate Diploma in Person-Centred Counselling at Strathclyde University, Glasgow and has recently been accepted for a Masters in Counselling. He is also currently building his own private practice, Counselling Oasis Inverness.

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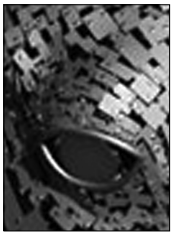
3 Merry, 2012. p42



Cognitive Behaviour Therapy

for OCD

Paul Wheble

Obsessive Compulsive Disorder (OCD) is a psychological disorder* characterised by unwanted and distressing intrusive thoughts or images (obsessions) which then produce an urge or compulsion to carry out a mental or physical act. These acts, or rituals, are carried out in an attempt to reduce the distress and anxiety caused by the obsessions in the first place. They are usually extremely time consuming and tend to be repeated throughout the day. This is not the same as having an obsessional type of character. Such 'obsessions,' like being exceptionally neat and tidy, tend not to cause significant amounts of distress or anxiety, and they seldom have an impact on a person's ability to work, study, or maintain important relationships.

Successful treatments for OCD were slow in being developed; it was held that rituals were a form of mental defence mechanism and that trying to interfere with or disrupt them would lead to total mental collapse and the onset of psychosis. By the 1960's this psychiatric orthodoxy was being challenged. Useful treatments for phobias had been developed in the 1940's and 50's, and the similarities between phobias and aspects of OCD had been noted. This early form of treatment was known as Exposure and Response Prevention (ERP). It was, and is, a very powerful tool in the treatment of OCD. The basic premise was that a gradual reduction of anxiety, a process called habituation, would occur if contact with the feared stimulus (the intrusive thought) was maintained. For this to happen, it would be necessary to prevent the use of mental or physical rituals, otherwise habituation could not take place. For example, a client with fears of contamination might be asked to touch a 'dirty' object and then be encouraged not to carry out washing or other rituals until the anxiety subsided.

Cognitive Therapy (CT) approached the treatment of OCD and other anxiety disorders from a different perspective. Originally developed for the treatment of depression, CT focuses on the meaning that thoughts have for that particular individual; it's not what happens that matters, it's what that person makes of it, their appraisal. In OCD the typical thoughts that trigger the distress are no different to those found in most people. However, people without OCD are readily able to dismiss such thoughts or images as they are regarded as 'junk' or meaningless. A common example, experienced by many railway and subway passengers, is jumping under the oncoming train, or pushing someone else under it. For people with OCD such thoughts carry a very different set of meanings. It may be believed that this is evidence that they may lose control, want to kill themselves, or are potential homicidal maniacs. These types of beliefs lead to behavioural changes such as avoiding rail travel, or if that isn't possible, to carry out other behaviours, like standing well back from the platform edge, in an attempt to feel a bit safer.

Cognitive Behaviour Therapy (CBT) combines the behavioural techniques such as ERP and the ideas of CT about the central role played by people's appraisals of their own thoughts. This synthesis has resulted in a treatment known as behavioural experiments in which firstly the meanings of particular thoughts are established. In OCD, the presence of intrusive thoughts and images of having sex with your own children, for example, is usually taken by the client as evidence that they are a paedophile and they are a bad, dangerous and wicked person. Unsurprisingly, massive attempts are made to reduce the frequency and intensity of the thoughts, by trying

*some argue for a biological or genetic cause for OCD. The evidence remains weak. Even if the biological theories turn out to be true, the psychological model produces effective therapy.

to suppress them or perhaps to try and neutralise them by replacing 'bad' thoughts or images with safe or pleasant ones. Other changes might involve total avoidance of childcare, or parts of it like bathing or nappy changing.

This appraisal, that the problem is they are a paedophile, and that they are bad and dangerous, is labelled, 'Theory A.' An alternative theory, not very imaginatively called 'Theory B,' is worked on in session by both client and therapist, and is usually along the lines (in this example) that the true nature of the problem is that they are extremely *worried and fearful* that they are a paedophile and bad and dangerous. Behavioural experiments are simply a way to find out the truth, to confirm or dis-confirm that they are a paedophile, or to confirm or dis-confirm that the true nature of the problem is severe anxiety or worry.

This basic template can be used to design behavioural experiments for other types of thoughts and appraisals commonly seen in OCD. Some people experience what is sometimes called 'Thought-Action Fusion' or, a bit unkindly, as 'Magical Thinking.' This is a belief that merely having a 'bad' thought can produce a bad outcome, and so therefore there is a need to carry out an action such as a ritual to prevent any such consequence. There can be additional meanings attached, that having a bad thought is morally equivalent to carrying out a bad action.

Many people with OCD have an exaggerated belief that they have the responsibility to prevent any negative outcome; this causes the individual to take every conceivable step to eliminate the risk of such outcomes. Others have a belief that it is possible and even desirable to control thoughts and mental images. Another common belief involves an increased perception of threat. There is an exaggerated estimation of the likelihood or extent of harm, so there is a drive to constantly act to prevent harm. Perfectionism on its own is not a symptom of OCD, but some people with OCD present with excessive perfectionism being a part of their problem. Across the whole spectrum of OCD, whether the individual has fears of contamination, or excessive checking behaviours, or worries about causing harm, exists an intolerance of doubt or uncertainty. They feel that it is essential to be certain and that it would be impossible to cope or to function unless certainty can be achieved. All these ideas and beliefs play a part in maintaining the cycle of intrusive thoughts and compulsive behaviours.

Whilst there may be a very strong belief in these types of ideas, and the fears around them are very real to the individual, they may not be very accurate.

That is where behavioural experiments play their part, in helping the person to find out what is true and real, and what isn't, thereby providing an opportunity to develop new, more accurate, more truthful and more helpful appraisals about the nature of unwanted intrusive thoughts and the beliefs that go with them. The two main categories of behavioural experiments are designed to either test out the reality concerning the predicted harm, or to demonstrate that the rituals do nothing more than maintain their fears. ERP is really a specialised form of behavioural experiment designed to demonstrate that exposure without rituals results in habituation, rather than mental collapse or an increased likelihood of bad or unwanted events happening.

When designing behavioural experiments it is important that 'Theory A' and 'Theory B' be mutually exclusive. To take a non-clinical example, one person might believe that when you drop different weights from the same height, the heavier hits the ground first (Theory A). Another person might believe they hit the ground at the same time (Theory B). These two theories are mutually exclusive, they cannot both be true. Importantly, both theories include beliefs about the behaviour of weights when dropped, and a prediction as to what would happen if you actually did so. The experiment, to take the weights to a high place, drop them and time their descents, is simply a way to confirm one theory and dis-confirm the other.

The following examples are all taken from the treatment of clients with OCD at an NHS hospital in London. Names and other details have been changed to preserve anonymity and consent for anonymised accounts of therapy has been given by the clients.

R avoided sharp knives and scissors because she had intrusive thoughts about stabbing herself or overnight visitors as she slept. Her appraisal of these thoughts was, "Because I have these thoughts it means I must want to do it (i.e. stab them) and because I have these thoughts I am more likely to do it." An alternative perspective was, "I am only having such thoughts because they are so repugnant to me; thoughts cannot make things happen." Her negative prediction based on her OCD driven appraisal was, "If I stay

close to sharp objects I won't be able to resist the urge to stab someone with them."

She was then given a large and sharp kitchen knife to handle during a treatment session. Both her thoughts and levels of anxiety were monitored during the experiment.

R became initially very anxious but became calmer later on. Her belief in the key cognition, "Because I have these thoughts it means I must want to do it (i.e. stab them) and because I have these thoughts I am more likely to do it," dropped from 100% to 20%, and her anxiety ratings followed the same pattern. Whilst more sessions were required to further reduce her levels of belief in her fears, this experiment laid the groundwork for her belief in the alternative perspective. She learned that even when having the thought, and even when holding a knife, that she did not carry out the feared outcome of stabbing someone. Her ability to tolerate the knife in session was eventually extended so she could then tolerate the knife at home.

T presented with a wide range of checking behaviours relating to windows, doors, water taps and electrical appliances. These checks could take up to ten hours a day, during which time she was highly anxious and unable to carry out any other useful or necessary activity such as working or shopping or cooking. Her key belief was, "I can't risk leaving without checking these things; if there was a fire or flood or burglary it would be my fault." Despite this she did not feel that she was being excessively responsible. An alternative view was, "Although the risk of fire or flood or burglary is not high, my sensitivity to responsibility is making me unable to resist the urge to check." She felt that she would not be able to resist checking even if someone else took over the responsibility. And even if she did manage to not check, her anxiety would be so overwhelming she would have to return to the house if she left it unchecked.

During therapy a range of different experiments was carried out to deal with her overestimation of threat and to find out the part excessive responsibility played in maintaining her problems. The first experiment was carried out in the hospital. At home T would spend hours looking at a tap in the kitchen, checking for drips. She believed that if she did not do so then a flood would ensue. In the clinic, a hand basin was filled to the level of the overflow and the tap left running. The therapist and T then returned to the therapy room; T predicted that the wash-room would be flooded. After 45 minutes both returned to the wash-room to find that no flood had occurred. Whilst T had been anxious and worried (thereby confirming Theory B, that her problems were severe worry problems), the absence of flooding also allowed her to recognise that at home she had greatly overestimated the likelihood of floods occurring.

Later on in treatment T was given a formal letter by her therapist, stating that for one week the therapist would be responsible for any consequences of T not checking taps, appliances, windows and doors. This 'guarantee' was taken home with her. She predicted that the letter would not make any difference to her problems as she was not excessively responsible. After the week T reported that her checking had reduced considerably and that she had not suffered overwhelming anxiety. She could see that responsibility issues played a part in her problems. The experiment also encouraged her to further reduce her checking without the guarantee from her therapist.

B had intrusive thoughts about harm (accidents, illness) coming to his family. Any such thought had to be cancelled out by performing a mental or behavioural ritual. A key belief which lead him to neutralise his thoughts was, "If I think something bad, it will happen. If I have not tried to prevent it then it will be my fault." This formed the basis of Theory A. Theory B was that he was extremely worried his thoughts would cause harm. The experiments were designed to foster an alternative perspective that, "A thought is just a thought and cannot make things happen."

The experiments were designed to see what happens as a result of gradually increasing 'bad' thoughts, at first about the therapist (being less important to B than his family) and later on about the family. Would this lead to harm or just an increase in anxiety? B predicted that, "If I think a bad thought it will happen. My anxiety will get so high I will not be able to resist neutralising."

At the first phase of the experiment B was asked to think that his therapist would have a heart attack within the next ten minutes. Then he was asked to think about the therapist having an accident within the next 24 hours. During the session both belief ratings and anxiety levels fell from 80% and 90% respectively, to 20% and 20%. Both B and the therapist monitored for

the presence of covert neutralisers (replacing intrusive thoughts with more pleasant ones) which had undermined previous experiments. Between-session homework comprised thinking of increasingly worse 'bad' thoughts relating to the therapist, then wife and children. Over time his anxiety about such thoughts reduced, and with this a decreased urge to carry out rituals.

These brief accounts of behavioural experiments illustrate the central role that people's unhelpful appraisals of their own thoughts have in maintaining their obsessional problems. The aim of any treatment is to reduce the distress and handicap the disorder produces. In giving people new perspectives on the true nature and meaning of thoughts, and the accuracy of associated beliefs, such reductions can occur. The use of behavioural experiments to find out helpful truths has been a milestone in the development of effective and timely therapies.

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Paul Wheble was a cognitive behaviour therapist with the Royal Army Medical Corps and the Maudsley Hospital 1989 – 2012.

Coaching Skills

for Counsellors?

Rachel Weiss

Why might counsellors be interested in acquiring coaching skills?

It's a separate profession, after all, tainted by lucre and commerce, whilst counsellors are often more comfortable distancing themselves from business, preferring to operate in the third sector.

I exaggerate of course. But a few years ago, I viewed coaching as a diluted version of counselling, which attracted less stigma and commanded higher fees and more robust clients. I was not enthusiastic.

At Rowan Consultancy we provided employee counselling services to several organisations. Some of these started asking if Rowan could provide coaching. I became more interested – what was coaching? How did it overlap with counselling? Could I become a coach? Did I want to? Should we hire coaches with no background in counselling?

Six years later, I am now an accredited coach with the International Coach Federation (ICF), whilst still practising as an accredited counsellor. I'd like to share some of my thoughts with you on the similarities and differences between counselling and coaching, on the usefulness of coaching skills for counsellors.

I'll describe two approaches: the first sees coaching as a separate profession from counselling, the second proposed a model called "personal consultancy" which integrates counselling and coaching.

Coaching as a separate profession from Counselling

The ICF defines coaching as: "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential…Coaches honour the client as the expert in his or her life and work and believe every client is creative, resourceful and whole." Standing on this foundation, the coach's responsibility is to:

- Discover, clarify, and align with what the client wants to achieve
- Encourage client self-discovery
- Elicit client-generated solutions and strategies
- Hold the client responsible and accountable (ICFa)

How well does that description of coaching match your practice as a counsellor?

Much of it seemed familiar to me: my humanistic training encouraged client self-discovery; my subsequent cognitive behavioural therapy training emphasised agreeing and clarifying client goals and eliciting client-generated solutions and strategies.

ICF Core Coaching Competencies
A. Setting the Foundation
1. Meeting Ethical Guidelines and Professional Standards
2. Establishing the Coaching Agreement
B. Co-creating the Relationship
3. Establishing Trust and Intimacy with the Client
4. Coaching Presence
C. Communicating Effectively
5. Active Listening
6. Powerful Questioning
7. Direct Communication
D. Facilitating Learning and Results
8. Creating Awareness
9. Designing Actions
10. Planning and Goal Setting
11. Managing Progress and Accountability

Table 1: ICF Core Coaching Competencies (ICFb)

What was new to me was holding the client responsible and accountable. I looked at the ICF Core Coaching Competencies (see Table 1). Again there were many similarities and overlaps – between counselling and coaching: fewer with person-centred counselling and more with CBT. I felt that counselling included most of the competencies, but not the final three which were more focussed on results and planning actions.

My experience of Gestalt Therapy and Person Centred Therapy had little focus on planning actions and accountability, although Gestalt included client-planned experiments. I believed in Beisser's (1970) Paradoxical Theory of Change, which says that increasing awareness (ICF competency 8) will inevitably lead to change, without the need for any explicit goal-setting or action planning. My Cognitive Behavioural Coaching training certainly had a clear emphasis on the client setting themselves "homework" at the end of each coaching session, often involving practising new behaviours or thought patterns.

So I saw counselling and coaching on a linear spectrum, as shown in Figure 1, with clients being more robust and resilient towards the coaching end of the spectrum. I found coaching skills useful when working with my counselling clients towards the end of our work together, as they became more robust, had healed some old wounds and wanted to look forward to planning for the future. As clients become more robust they can "graduate" from counselling to coaching. "Psychotherapeutic 'pulling weeds' needs attention before coaching 'sowing seeds'"(Masters 2014).

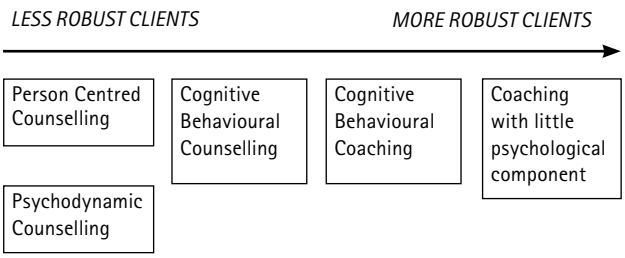

Figure 1: Counselling and Coaching as separate professions on a linear spectrum, with client robustness and resilience increasing at coaching end of spectrum.

At Rowan, our Head of Coaching is not trained as a counsellor. When he identifies a counselling need, he will refer the client to one of the Rowan counsellors. The client may return for coaching later, once the weeding is done. Similarly clients ring us wanting help in changing and may not be sure whether they would benefit from coaching or counselling. They can start with a counsellor and then move on to a coach. But the trouble with this model, as all counsellors know, is that clients attach to their therapist – the relationship is key, so they are reluctant to move to another practitioner. Hence the growing need for professionals who can offer both counselling and coaching. Also humans do not move in a linear fashion from attending to underlying emotional issues rooted in the past, to attending to more future-focussed planning. I often find myself dipping in and out of counselling and coaching skills in my client work. Should I flag up the change each time? This depends on our initial contract. The view of counselling and coaching as separate professions says that whenever I start work with a client they and I need to be clear whether it is a coaching contract or a counselling contract.

Coaching is often seen as goal-focussed, with the key ingredients of goal setting, awareness raising, action planning and accountability. As I've matured as a coach I have less emphasis on action-planning and goal-setting. I will always ask the client what they are taking away from the session, and how this might apply to other areas in their lives, but the action may be to reflect on the insights gained. Recently coaching has perhaps come full-circle back to some counselling roots, with authors distancing themselves from goal-setting (Clutterbuck et al 2013) and aspiring to make coaching more transformational rather than simply transactional. Transactional coaching tackles the presenting, surface issue, for example how to tackle a difficult conversation at work. Transformational coaching aims to surface the client's underlying assumptions and patterns of behaviour, so that they can choose to change these if they wish.

I now see the counselling-coaching spectrum as almost coming full circle, see Figure 2.

"There is probably a wider gulf between psychodynamic therapy and solution-focused therapy (for example) than there is between solution-focused therapy and coaching" (Jinks and Popovic 2011)

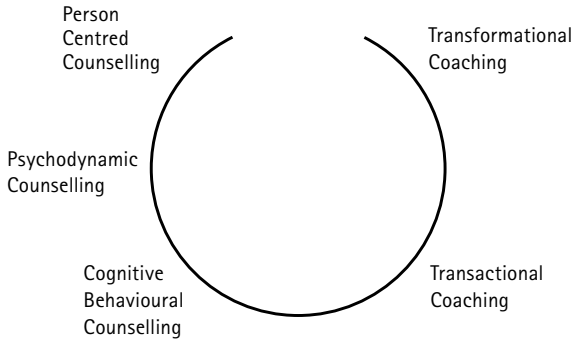

Figure 2: Counselling and Coaching coming full circle?

Personal Consultancy – the Integrative Coach-Therapist

There is an emerging professional body of consultants who encompass both counselling and coaching training in their practice. The British Association for Counselling and Psychotherapy (BACP) have a coaching division for counsellors who are also coaches or have an interest in coaching. The Association for Integrative Coach-Therapists (ACITP) is a professional body for practitioners wanting to combine coaching and counselling – instead of belonging to separate professional bodies, with no discussion of integration. Personally I have found both organisations helpful in clarifying where I stand as a joint practitioner.

James Henman recently wrote, "I present myself as a therapeutic coach/personal trainer in the process of change." He works as an integrative practitioner. An integrative practitioner will market themselves as such; they will contract with you in the first session to use both counselling and coaching approaches, usually seamlessly.

Jinks and Popovic's (2011) model of personal consultancy provides a useful map (Figure 3) where you can position your practice. I tend to move around the map, sometimes focussing on behavioural change, other times delving into deeper issues from the past which affect the present. Where do you see your practice on this map?

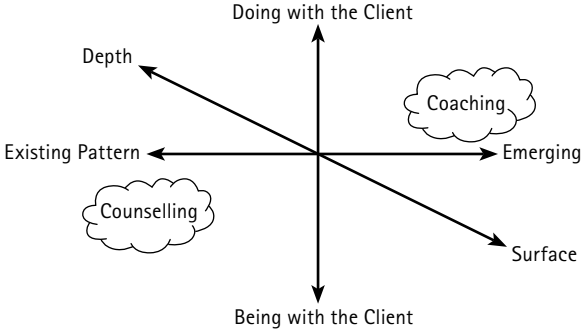

Figure 3: *Personal Consultancy Model* : adapted from Jinks and Popovic (2011)

It is a three-dimensional model:

- the vertical axis ranges from the consultant Being with the client non-directive and reactive) to Doing with the Client (more directive, pro-active and focussed).

- the horizontal axis ranges from the client's Existing Pattern (emotional, cognitive or behavioural in the past and present) to the client's Emerging Pattern (desired, strived-for patterns in present and future).

- the depth axis ranges from the "depths" of the intra-psychic, inner world of the client to the "surface" of the client's external manifestations, events and behaviours.

Popovic and Jinks (2013) postulate that Integrative Coach-Therapists navigate this personal consultancy space in partnership with the client and that this wider approach can be a more comprehensive way of helping clients than coaching or counselling on its own. I have added two clouds indicating where I see stereotypical coaching and counselling being located. Stereotypical coaching involves the consultant Doing with the client, at surface level, focussing on emerging patterns, whilst stereotypical counselling involves the consultant Being with the Client, at depth, focussing on existing patterns, in the trust that this will result in change.

I have found coaching skills, competencies and models a useful addition to my counselling practice, enriching and expanding it, to fill more of the personal consultancy map in Figure 3.

Coaching Training for Counsellors

If this has whetted your appetite to gain some coaching skills, you may wonder what coaching training is available. There are plenty, ranging from courses which focus on workplace coaching to life coaching training, or coaching courses associated with particular orientations such as the Kinharvie Institute's Gestalt Coaching course in Glasgow. However I have yet to find any coaching training in Scotland aimed specifically at counsellors. Other courses assume no prior counselling skills and so start by teaching basic listening skills. It's always useful to have some revision, but I think there's a place for counsellor-specific coaching training, which builds on our existing skills – given the extent of the overlap.

To this end Rowan Consultancy is providing a two-day "Coaching Skills for Counsellors" course, launching in Perth in February 2015, focussing on coaching competencies, introducing two coaching models and including debate on how counsellors can integrate coaching skills into their existing practice.

There are some coaching courses for counsellors in England, for example, a 5-day course on Life and Business Coaching for Counsellors and Psychotherapists from CSP Coaching in Plymouth and a Postgraduate Certificate in Integrative Counselling and Coaching from the University of East London.

We hope that Rowan's "Coaching Skills for Counsellors" course will contribute to a Scottish debate about the interaction between the counselling and coaching professions. There is room for counsellors who don't coach, and coaches who don't counsel, but is there space in the middle for people who do both – whether integrated or separately?

I leave you with some questions:

- Is there a need for a Coaching interest group within COSCA or space for discussion on this topic?
- How many COSCA members also practice as coaches? If so do they do so separately, or as part of an integrative practice?
- Is there interest in COSCA holding a joint meeting with one of the professional Coaching bodies?

I look forward to your responses and thoughts on this emerging area – either by letters to the COSCA Journal, or you can contact me directly on rachel.weiss@Rowan-consultancy.co.uk

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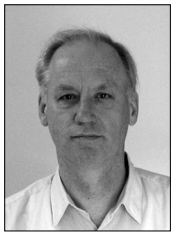

Confessions of a (Former) Counsellor

in Primary Care

Dr. Douglas McFadzean

Okay, now that I've got your attention, if you're looking for something salacious or scandalous then please move along - there's nothing to see here. If you're hoping for answers, there might just be a few to find amid a great heap of outstanding questions and residual ignorance. This article does not aspire to be a formal retrospective of a counsellor's practice (mine), but it does aim to sniff the essence of primary care work in Scotland and fan the debate about where it's heading now.

I won't bore you with the details of my CV; my main legitimacy to comment comes from working almost full-time for 17 years in the Scottish NHS, counselling almost 5,000 cases over more than 15,000 sessions in nine general practices and health centres. (Some other incarnations are listed in the footnote[1] and confirm my irradiation by the practice and politics of therapy in the statutory, voluntary and private sectors.)

What were the key factors which attracted me to primary care work in the first place? Do I still think these factors are as important? I'll immediately and emphatically reply "yes" to the latter question and expand a bit on my answers to the former. What clinched the role for me:

- patients[2] attending counselling in their own general practice, normalising the experience, reducing the stigma of "having to be sent somewhere," and having trust in local practice staff;
- being properly regarded as a permanent, albeit part-time, member of each practice's team rather than being perceived as a practitioner parachuted in occasionally from a monolithic 'department' located elsewhere;
- working essentially autonomously, but with direct accountability to, and regular liaison with, the referrers within practices (mainly GPs, but any member of the primary care team could refer);
- local GPs owning the service, both financially and clinically - no middle-man;
- having minimal administrative and management overheads, maximising the time available for counselling patients;
- being a member of a small counselling team and peer supervision group, but also having access to a very wide net of professional and consultative support;
- and last, but certainly not least, encountering the widest possible diversity of cases across the whole population.

Remarkably, and until recently, all these factors bar one were maintained over the years. However, the funding and ownership of the counselling service moved from a GP Locality within a Community Health Partnership to an NHS Trust, then to an NHS Board, then to a Psychology Service within the Board. More on corporate matters later.

Even with a good bit of counselling experience under my belt, the range of problems referred was astonishing, and steadily increased as GPs gained trust in our manner of practice and its effectiveness. Relationship, family and social issues consistently topped the bill, seconded by disorders across the anxiety spectrum (though this ordering was swapped when only the primary presenting issue reported by referrers was considered). I think I can safely say: "you name it, and it's been referred to me at some time."

1 Chairman of the Psychologists Protection Society Trust (2010-2011), Executive Director of COSCA (1995-1997), independent practitioner (1997-2011), COSCA Fellowship (2000), also a counsellor, supervisor and trainer (1991-2001) with local government and a Cruse branch, etc.

2 If the term offends as being too medical, please substitute with 'clients' throughout.

A good majority of cases exhibited a complexity and co-morbidity (horrible term) of conditions and problems. Patients were referred at all stages of change[3] and a goodly number had previously received or been recommended for psychological or psychiatric treatments. As you would expect in general practice, medication, past or present, was a common adjunct, although compliance with GPs' instructions and the benefits perceived by patients varied enormously. We served a population of around 56,000 souls per full-time counselling post, and each case lasted an average of just over three counselling sessions. The mean waiting time was usually in the range of three to four months, but there was quite a wide variation over practices for assorted reasons. Placing trainee counsellors occasionally managed to improve waiting times a little, but with an ever-increasing demand for counselling and our limited resources, we never achieved a permanent reduction. However, urgent cases were always accommodated somehow. Our combined cancellation and DNA ("did not attend") rate of around a quarter of appointments was not at all unusual. Contingency arrangements with practices ensured that other patients waiting could be offered these appointments if they were willing to attend at short notice.

How did I manage to work with the medics - aren't we from different worlds? There is no doubt that counselling in primary care demands pragmatism in dealing with the medical and allied professions. For the patient's sake, it is often better to bite one's lip, take the time to explain and educate, grow a little thicker skin, or even try to speaka da medical lingo if it aids communication. Perhaps the thing that stuck most in the craw was when a patient's improvement was blithely attributed by a GP to medication when you and the patient were well aware that counselling had actually stirred the change. To be fair though, the great majority of GPs did acknowledge and warmly appreciated the true extent of our impact. Also, we engaged in a sensible amount of evidence-based outcome measurement, and had solid data samples as well as patients' endorsements to prove our efficiency and effectiveness. Some of you may recoil, but the reality is that these measures *do* matter in the NHS where public money and equity are at stake. As long as they did not distract from our core counselling work, we saw little difficulty in accommodating outcome measures and we were experienced enough not to fear how their findings would be judged. Similarly, we were confident about our knowledge of the substantial evidence base[4] for what really matters in psychotherapy, and were called upon occasionally to share expertise by training medical staff. Conflicts between medical and counselling ethics[5], and issues regarding confidentiality, were few and far between, and of little significance. Mutual respect for professional boundaries was steadily established through open dialogue and informal education.

Any unsung heroes? My first award must go to those heroic patients who, despite inappropriate or failed previous therapies, still managed to have sufficient faith in counselling with us to finally emerge victorious from the struggles with their predicaments. Job satisfaction doesn't come higher than helping someone to turn their life around after they've needlessly endured maybe decades of misery and disillusionment. The second award goes to the receptionists and other administration staff who were delegated in each practice to contact counselling patients, whether by phone, in person, or in writing. Particularly in early contacts, these staff members were invaluable in setting the right tone, providing information, and reassuring often anxious patients. Also, their sensitivity in dealing with cancellations and assessing requests for further appointments was vital.

Any villains of the piece? Over the last decade, the new General Medical Services (GMS) contract and its Quality & Outcomes Framework (QOF) have fundamentally changed how GPs operate and make their income. A bunch of misguided politicians, and maybe some civil servants, must take the larger part of the blame for encouraging practices to adopt a greater "tick box" mentality, which has impinged on the assessment of, and criteria applied to, potential counselling referrals. A small number of blinkered GPs have made referrals mainly on the basis of scores on simplistic (and easily distorted) measures of anxiety and depression, for example, without looking at the bigger context of the patient's situation or the openness of the patient to counselling as a therapy.

More villains: An unfortunate growth in the "compensation culture" of our society was

3 Prochaska, J O, Norcross, J C, & DiClemente, C C (1994). Changing for Good. New York: Quill.

4 For example: Wampold, B E (2001). *The Great Psychotherapy Debate*. New Jersey: Lawrence Erlbaum Associates.

5 http://www.cosca.org.uk/docs/Statement%20of%20Ethics%20CURRENT%20May%201305-20-13.pdf

evident over the years. Some lawyers were pretty ruthless in the way they would encourage patients to abuse the referral system in their pursuit of compensation claims. Sadly, on more than a few occasions GPs and I were lied to and the real motivation for a desired referral only emerged once counselling had commenced. I took an increasingly robust stance on cases where there was a hint of potential motivational conflict, and would not accept such a referral until the GP had made further enquiries about the situation. Of course, many bona fide patients with legal entanglements were still accepted and counselled successfully.

It's sad to say, and maybe it brings out the Victor Meldrew in me, but society seems to have changed for the worse in other ways too, as I encountered an increasing number of cases with problems such as: family dysfunction, unrealistic expectations of relationships, self-centredness, impatience, and fecklessness; and decreasing: emotional management skills, social awareness, personal responsibility, problem-solving, and basic education. Of course, external pressures such as the financial recession, a shortage of work and poorer working conditions also have enormous effects on patients, but all too often people are lacking the basic skills, knowledge, values and attitudes which should come readily through the educational system and an upbringing within a loving and stable family environment. Once emotions were calmed, it was notable the number of times I had to "go back to basics" with adult patients to teach them baby steps towards addressing their circumstances. This doesn't sound very person-centred[6], but there again, many of the immediate problems just cried out for a pragmatic and practical approach to make any headway whatsoever. More indulgent psychological exploration could wait till later. It was also striking how powerful affiliations are throughout our lives and how much misery can result from making the wrong choices of friends, colleagues, teams, gangs, substance abusers, etc. The need to belong is indeed powerful and potentially very dangerous, especially when family ties are weak and unable to place sufficient restraint on foolish impulses.

Moving on from some of the gloomier aspects of work in primary care, I'm going to indulge in a few lighter anecdotes about cases, with the odd identifying feature changed to maintain confidentiality.

There was the young lad who came along with his mother for an initial counselling session and it immediately became clear that he'd been "brought to the doctor" under false pretences. He therefore glowered in silence throughout; any attempt to involve him in the conversation with his mother fell on the deafest of ears. At the end, although the mother requested another appointment, I had a feeling of comprehensive failure, but then again, it wasn't really of my making. Mum appeared for the second session, hardly surprisingly, *sans* sprog. I smiled weakly with a "just yourself today?" and "how are you?" To my amazement she replied that "things are so much better, and thank you for all your help." It turned out that during the first session her account of the son's behaviour and its effect on her family had eventually been absorbed by the silent party and he'd now taken responsibility to change for the better. Doubtful and querying about progress, the referring GP was baffled when I replied that counselling had been very successful even though the child and I hadn't spoken!

Waiting on a patient, the receptionist called me to say that Mr X wouldn't be attending today. His brother had come in to let us know, and thought he'd just use the counselling session himself as he didn't want to see it going to waste. Needless to say, the brother wasn't seen.

On rare occasions, I managed to help patients with a phobia of dogs (cynophobia) by trotting along to the practice with our own family pet, a large and very laid back retired racing greyhound. For a certain patient one day, I knew that the first 'in vivo' exposure would be a challenge for the patient, although we had done useful preparatory work. What I hadn't reckoned on was the effect of a different consulting room on our dog, made worse by it reeking of the powerful phenolic aroma of disinfectant. He wasn't happy at all and became most unsettled by the time the patient arrived. So, bizarrely, I ended up with an anxious, panting dog and a calmer patient who somehow rose to the occasion to comfort the distressed animal! The patient didn't look back after that.

The impact of just one session can apparently be profound. I saw an unhappy chap once only, and he concluded by saying, "So maybe I should sort out my marriage first… think I'll leave it at that." On many occasions over the next decade,

6 I've never advertised myself as a Rogerian therapist in any case, and I always referred on for debt counselling!

he passed me in his car as I walked to work and every time he gave me a huge, cheery wave. I never knew how his marriage actually worked out, but *he* was evidently glowing again.

Why did I resign as a counsellor in primary care and take premature retirement from the NHS? In a nutshell, recent changes imposed by the Scottish Government and rigid new local management badly corroded all the key factors which attracted me to the post in the first place. The HEAT[7] target, 'Deliver faster access to mental health services by delivering 18 weeks[8] referral to treatment for Psychological therapies from December 2014,' was approved by the Scottish Government in 2010, and its subsequent implementation has had an enormous impact on the ways that cases are assessed, allocated and monitored. The related treatment bible *The Matrix*[9] was published in 2011, with the inclusion of therapies dependent on the evidence base, particularly as interpreted by SIGN (Scottish Intercollegiate Guidelines Network) and NICE (National Institute for Health and Care Excellence). Now, one can readily observe that the committees which decided on approved therapies for *The Matrix* largely comprised clinical psychology and psychiatry establishment figures, steeped in the medical model[10] of psychotherapy.

Without being too cynical, it is hardly surprising that counselling and counsellors received exceedingly scant attention. Counselling only appears in *The Matrix* as a treatment with a low level of recommendation in two minor areas, along with the rather patronising comment: "It is recognised that counselling is one of a range of interventions which NHS Boards may choose to make available at lower tiers of the service." Although the Government says that "[*The Matrix*] is not intended to be prescriptive but does offer guidance in the strategic planning and delivery of psychological therapies," you would obviously ignore *The Matrix* at your service's peril and risk the displeasure of the Government's HEAT compliance teams. The resulting anxiety of NHS practitioners and managers to obey the new rules is palpable and their administration absorbs much time which would often be better spent on direct work with patients.

So, despite a wider, more enlightened, view of the huge evidence base, notably by Wampold (2001), firmly discrediting the relevance of the medical model to psychotherapy, NHS Scotland has re-enshrined the outdated idea that specificity is king: diagnose specific disorders, explain their specific symptoms theoretically, and apply approved treatments with specific therapeutic ingredients. Even if the designers of HEAT started with good intentions, it is something which I think will ultimately prove to be seriously regressive in the treatment of mental health here. With the research data we have, the Scottish public deserves much better than such a simplistic view of our complex lives and troubles. I could no longer subscribe to many of the values and priorities being advanced by the NHS, and had no wish to be deskilled by only being allocated a very restrictive range of "lower tier" cases at the whim of a clinical psychologist making assessments according to the ticking of boxes in *The Matrix*.

I've reminisced quite a bit, clearly ranted a bit, and maybe even informed a bit. Now I promise faithfully to ride off silently into the sunset. Counselling in primary care for so long was a wonderful experience which I will always be grateful for. But times have changed and practitioners entering the fray now will have some very different challenges and constraints to contend with. Perhaps the last word should go to the aforementioned Victor Meldrew:

"When you think about it, nothing ever exists, in fact. I was working this out in the post office as I was waiting for that woman to finish twanging her elastic bands. The future doesn't exist because it hasn't happened yet; the past doesn't exist because it's already over. But the present doesn't exist, because as soon as you start to think about it it's already in the past. Which doesn't exist any more."

7 HEAT is an acronym mangled from four Scottish Government priorities: **H**ealth Improvement; **E**fficiency and Governance Improvements; **A**ccess to Services; and **T**reatment Appropriate to Individuals.

8 Ahem, you will note our mean waiting time was significantly shorter than this.

9 http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix.aspx

10 See Wampold (2001) again for an extensive discussion about the medical model.

Doing Research

A Grassroots Experience

Jacqui Lindsay and Anne Goldie

Volunteer Researchers

Jenny Charters, Alwyn Ferguson, Stephan Helfer, Emma Keir, Margaret Kent, Jacqui Lindsay, Judith McCluskey, Sheila McDonald, Joyce Mitchell, Anne-Marie McNeil, Lesley Reid, Janis Sinclair.

Introduction

We work within the voluntary sector, managing the generic counselling services of CrossReach, the social care arm of the Church of Scotland. Based at the Tom Allan Centre in Glasgow and Crossreach Counselling Lothians, our services provide counselling to around 1300 clients per year. We both have an interest in research, particularly qualitative, and the possibilities that exist for counselling research to take place in the type of large agencies that we run.

Early in 2012 we were offered a research opportunity, assistance and an outline plan by Professor John McLeod from the Universities of Abertay and Oslo. One of us already had a Master of Science by Research (MScR) and the other was keen to pursue this. It seemed an ideal way to look at service outcomes and how we could improve them while honing our research skills. John's interest was twofold. He was keen to understand more about the effectiveness of frontline counselling services, particularly in relation to the ways that clients evaluated the helpfulness of the therapy they received. He was also interested in developing the idea of "grassroots" research which would be carried out in the agency setting by counsellors.

Setting it up

The first stage was to help the agencies become "research ready." For us this meant we would have clients who would be willing to be participants and counsellors keen to be researchers. It also involved creating an atmosphere in the workplace where research was seen as an exciting opportunity rather than something to be tolerated at best and dismissed at worst. We needed to get our administrative staff onside and be enthusiastic when our colleagues asked questions.

We began by developing an ethical framework for the research, in which all participants could feel safe and be fully informed about what was happening. This involved asking all clients at assessment if they would be willing to be contacted at some point after their counselling had finished, with the possibility of taking part in a research project. This information was recorded and we have built up a significant number of clients who have consented to contact.

We invited all volunteer counsellors, of whom there are around 130 at any given time, if they would be interested in taking part. From an initial response of 16 counsellors we ended up with a pool of 13 who have been involved at all stages of the research. For most, this was their first venture into research, for all of us it was our first experience of conducting counselling research.

John held an initial training day where he briefly introduced the main concepts of qualitative research, and provided some initial training on how the research interviews would be undertaken. We were encouraged to read key examples of research that were similar to our own project. Many of us were particularly inspired by a study by Brigid Morris (2005) and her colleagues, based at a women's therapy centre in London. After all this, we were then ready to begin the process of collecting data.

Method

We recruited 20 clients who were willing to take part. The age range was 21-70, with 15 women and 5 men. The number of sessions they had received ranged from 5-72. Clients were contacted 6-12 months post-therapy. Those who were willing to take part had the study explained to them and completed an ethical consent form. The research interviews lasted for 1-2 hours, were semi-structured and included an adapted form of the post-therapy Change Interview devised by Prof. Robert Elliott at Strathclyde University. This interview schedule is built around a carefully structured set of questions that explore all aspects of client change. Further information on the Change Interview can be found at the website of the Network for Research on Experiential Therapies; a good example of how it works in practice is available in Elliott et al. (2009). As a means of helping clients to recall how they had felt at the outset of counselling, we also used a visual timeline with each client where significant moments before, during and after therapy were plotted. We were interested in capturing information about any other events or interventions that the client may have been involved in, or were using, so that we could see where counselling fitted in as a resource during this period of time.

Results

Prior to analysis of the interview transcripts, each client was given a title: 'young mother,' 'artist,' 'nanny,' etc. This seemed to us more respectful than giving them a number and helped us in our discussions to understand to which client we were referring.

Members of the research team worked together to transcribe their interviews and coded them for themes. These themes were then organised into a narrative summary for each case. Each coding and summary was audited by at least one other member of the group and consensus reached. Narrative summaries were compared by John, to develop a preliminary set of cross-case themes, which were then discussed and refined through dialogue in the group.

What did we find? All of the participants were satisfied with the services and appreciative of counselling. Sixteen clients could be classified as having had a good outcome and four had a mixed outcome.

Comments from clients included:

Artist: "Often in my prayers you know if she came into my mind, I would say 'thank you for the help and I hope you're ok'."

Young Business Woman: "I suppose I think it's quite nice really to think about the progress that I have made, compared to when I came in. I did find the whole process very helpful and supportive and am very grateful for it."

Although each participant had their own unique story, looking at the experiences of all twenty clients, we were able to identify three basic trajectories through therapy.

First, there was a group of clients who reported transformational change of a lifelong problem such as childhood sexual abuse. One example of this pattern was a client, who at the age of seventy was able to finally move on with her life, to the extent that, from living a very limited life that had always been shadowed by severe depression, was able to travel to the developing world and work with children in an orphanage.

Second, there was a group of clients who came after a life crisis such as bereavement who, until the crisis event, would have described themselves as generally content. One client talked about her very close and loving relationship with her husband, as a result of which they hadn't needed other relationships to satisfy their emotional needs. Five months after he died she found herself "in a bubble," "numb," "depressed," "anxious" and "panicky." Post therapy she felt that she could approach others and ask for help, had a positive attitude, coping strategies and was functioning more effectively at work.

There was a third group who could be described as mixed outcome cases. These were clients who, after therapy, although partially helped and enabled to explore issues, did not feel "cured." An example would be the client who presented with post viral fatigue syndrome and had only some relief of symptoms but had improved relationships within her family and was able to take better care of herself.

Some powerful themes also emerged from analysis of the interviews. First, the counselling agency was recognised as a stable and known presence within a local network of care.

Most clients contacted the agency following recommendations from trusted others such as a friend, their GP or a family member. Clients described the counselling centre as a safe place to be, where they felt taken care of, and trusted their counsellor. A further key theme referred to the views of clients regarding how and why counselling helped. On this issue there was a high degree of consistency across participants. They talked about their counsellor as "someone who genuinely cares about me," who made it possible to "talk and express my feelings." Clients valued the flexibility and responsiveness of the service, for instance describing their counsellors as "going the extra mile."

Clients also valued creative interventions such as two-chair work or art therapy, and having enough time to go at their own pace.

They also told us about how they had changed as a result of the counselling they had received. Some of the recurring sub-themes within this part of the data analysis included "bursting the bubble" (the experience of moving from a feeling of being cut off, toward making or remaking contact with the world, getting in touch with feelings; reconnecting) and "the jigsaw effect" (making sense and making links, both in the past and the present; putting the pieces together; beginning to see the bigger picture).

Within the limits of this article we can only offer a flavour of what we found in the interviews. A more complete account of our results will be available in an extended report which will be published by Crossreach, and in journal articles.

Overall, what we found was that clients described a shift in their emotional landscape, commenting that they saw their lives differently as a result of counselling, were able to re-organise their lives, make decisions and use new coping skills and strategies. They described themselves as having "found a voice."

Doing research – is it worth the effort?

For us as managers both the process and outcomes of this research project have been very rewarding. We have gained an insight into not only the journey and progress of a group of clients but have also been able to hear how the services are viewed and appreciated by them. It was reassuring to hear that the agencies are seen as "safe" and "trustworthy" by the clients who took part in the research.

However, as with all good research, we are left with more questions than we started with. It would be interesting to look at what happens in poor-outcome cases. Some clients described some confusion early in their engagement with the service about what counselling is and what was expected of them. We are curious about what effect giving clearer information at the beginning might have on dropout figures for the services. We know from other research that there can be a therapeutic effect in taking part in a follow-up interview, so we would like to explore this more fully in the context of our particular situation.

This has been an energising and exciting piece of work in which to be involved. We are indebted to John McLeod for his patience, hard work and, most of all, expertise as he guided us through the project. The volunteer researchers gave their time to support and work with our services on top of their commitment to their client work. Together we created a vibrant and stimulating group where the research was not only carried through successfully, to the extent that it has just been presented by us at two major conferences, but also left all of us with the knowledge that we have the requisite skills to do more of this kind of research.

For those interested in finding out more about undertaking research within the voluntary sector: The Scottish Voluntary Sector Counselling Practice Research Network: http://svscprn.abertay.ac.uk

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Network for Research on Experiential Therapies: www.experiential-researchers.org

The Quest – A Fairy Story

Or A Personal Journey through Modules 1 and 2 of the COSCA Counselling Skills Certificate

Janie Keddie

Introduction

I told the following allegorical tale as my presentation to the class at the end of Module 2 of the COSCA Counselling Skills Certificate Course. The class had been expertly tutored by Susan MacRae and run by Aberdeen University. We were asked to reflect on our experience as part of the group, and how the course had changed us.Not being fond of endings, it seemed easier to tell a story. I hope you enjoy it.

The Quest - A fairy story

Are you sitting comfortably? Then I'll begin.

Once upon a time, a woman was exiled from the Dark City of High Finance in the Land of the Doing. She'd been trapped there for much of her life, hiding behind shiny plate glass windows. As she emerged for the last time out of the Dark City of High Finance, the Gateway to the Future creaked open on its rusty hinges. Few people had ever escaped beyond the Dark City's walls before, and none had ever returned to tell their tale. Therefore, she had no map to guide her and no idea what she'd encounter. She emerged, blinking, into the Forest of Possibility, which appeared to be a dense wilderness without shelter, pathways or landmarks. She wondered which way to turn, and where she'd find the strength to survive in this strange new world in which she found herself.

Eventually she realised that there would be no return to the familiar but frightening Dark City, and she stopped longing for the false security of its walls. She found a spark of courage within her and set out on a quest to find a new Place to Be. To begin with, she was floundering in a Marsh of Painful Feelings, mired in the Mud of Confusion. She struggled to know which way to turn. Then, one day, she saw a signpost to the Land of Becoming, which you reached by journeying along the Path of Self Discovery. Looking around her, the woman found that she was no longer alone, because just when she needed companions, a group of fellow travellers appeared from the mist. But none of them had what they needed for the journey either.

And then, at just the right moment, a magical being appeared, one who owned a map and a compass. Let's call this Good Fairy – Susan.

The Good Fairy proudly waved her Wand of Helpful Listening before them, and she showed each of the travellers how they could make their own wands too. She also gave them the Gift of Knowledge, with which each traveller found for themselves, three precious jewels: the Garnet of Genuineness, Emerald of Empathy and Amethyst of Acceptance.

As they set out along the path together, the fellow travellers learned to trust each other. They found that they came in all shapes and sizes and from many lands. Yet, they discovered that when they journeyed together, their shared path became smoother to travel and the direction was clear. Each traveller had unique gifts which they shared with the others. All brought baggage with them on the journey. Some burdens were huge and heavy, others tightly packed, still more were unravelling and spilling their contents on the path. And yet, an amazing thing happened: when they exchanged their burdens for a while, each bundle returned to its original owner somewhat lighter and easier to carry.

Along the way, the travellers found that their wands and gem-stones made powerful magic. When they used them, this diverse group of travellers were turned into a band of warriors called Carl's People, able to tackle the Dragons of Self-Doubt, the Goblins of Grief, and the Demons of Despair.

After a journey of 24 weeks, with many adventures along the way, the fellow travellers finally arrived together at the Land of Becoming. Waiting there for them was buried treasure, the pure Gold of Self Actualisation. And so it came to pass, that they had reached the end of their present journey in each other's company: transformed along the way by the gifts shared and burdens eased. Each traveller held on proudly to the Gift of Knowledge and their own bright tools, especially the Wand of Helpful Listening and three gem-stones of Empathy, Genuineness and Acceptance.

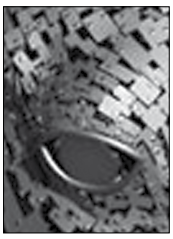
And what of our heroine, the woman who escaped the Dark City of High Finance?

She knew that in the Land of Becoming, she'd finally arrived at her own Place to Be, where she could put down roots and flourish. She felt joy that she'd never again dwell in the Dark City.

Although sad to say goodbye to her companions, she would hold the memories of the journey in her heart. She knew that each of them would continue on their own paths changed by the time they'd shared together.

And the woman was comforted to know that they'd all live happily ever after.

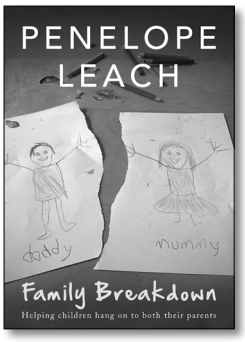
Janie Keddie is a BSc(Hons), ACA, MISPA is a student on COSCA Counselling Skills Certificate Course. She has spent most of her working life as a Chartered Accountant. In August 2013, approaching her 50th birthday, she left her job and decided to retrain as a counsellor.



Book: Family Breakdown

helping children hang on to both their parents

Penelope Leach, June 2014



This book is written for mothers and fathers who have separated or divorced or intend to do so; for their extended families and prospective new partners, and for the many professionals who support and advise them. Above all, though, the book is written to help those parents help their children.

Huge numbers of children are involved. Almost half of all teenagers experience family breakdown before they leave school and the number of babies and toddlers whose parents separate is going up. But although recent research, especially from attachment science, stresses and explains the significance of family breakdown to children, the way it is handled is as adult-centric as ever. In families, and often in lawyers' offices and family courts too, everyone's energy goes into fighting for, or trying to reconcile, the interests of father and mother. But the end of a marriage means the disintegration of the children's family and their interests may be quite different. Changes are urgently needed.

The fundamental message of this book is that parents matter to children even more and for longer than we knew. That still-growing body of research offers today's mothers and fathers a new understanding of their own and each other's importance. It is because parents — fathers as much as mothers — are so crucial to children's growth and wellbeing, from before birth, through childhood and into adulthood, that parental separation turns children's lives upside down.

The book describes many ways to minimise the impact of family breakdown on children. It sets out, often in their own words, what children and young people of different ages are likely to understand and feel about the process and something about how to address likely feelings of anxiety and guilt. There is some real research evidence to guide those dreadfully difficult decisions about access, and a lot of detailed practical suggestions - many of them from parents themselves - about everything from how best to manage handing over a toddler from one parent to the other to organising teenagers' possessions between two homes or coping with Christmas.

All these things are important but when a family disintegrates what is most important to children is not their parents' physical separation but their enmity. The more separated parents hate each other, fight over their children and try to get them to take sides, the more damaged those children will be. If parents can confine their adult issues, anger and bitterness, to their man-to-woman relationship so that their relationship as parent-to-child can remain intact, children will survive the inevitable misery of family breakdown much better. But children will survive best of all when despite being apart and burdened with adult issues, mothers and fathers remain united in their determination to carry on being, and helping each other, to be loving parents. That "mutual parenting" is not always easy to achieve but from children's point of view it is the best possible way forward from separation or divorce. No longer a wife, husband or partner, but always and forever a joint parent.

Family Breakdown: Helping Children Hang Onto Both Their Parents by Penelope Leach. Published by *Unbound*, 19 June 2014. ISBN, 978-1-78352-049-7.

COSCA Annual General Meeting 2014

Report of the Chair

Mary Hunter Toner

Today, this Annual General Meeting marks the final task for me as Chair of the COSCA Board, a post I have held for 6 years. I have been a member of COSCA and COSCA Board for much longer – approximately 15 years. Initially, I represented the specialist area of relationship counselling, followed by 3 years as Vice Chair before accepting the role of Chair.

I could not begin to say how much I have gained from COSCA during these years, suffice to say it has widened my knowledge of the counselling world here in Scotland and beyond, introduced me to the workings of a professional body and involved me in the roles and responsibilities of governance. It has been challenging, enriching and enjoyable.

Today, I thought I would share with you some of my thoughts and reflections of what I see as important recent successes for COSCA and also some challenges which remain, and need to be pursued.

I am going to start with challenges.

1. Awareness of Counselling as Social Action
I clearly see counselling as social action that involves seeing the counselling process as having a value and an outcome beyond what happens in the counselling room. I believe those of us involved in the counselling world must never let that be forgotten or in fact 'not known.' Counselling as social action is the 'added value,' the additional outcome, and we in counselling are required to educate others of its existence. I believe families, friends, communities, neighbours and work colleagues are all positively touched by the benefits of counselling. Counselling helps people to deal with the stresses and strains of life.

The challenge I think is for us to promote counselling on two levels; one, the outcomes for clients which are crucial and two, the social action outcomes for others which stretch far beyond the counselling room.

2. Raising the Profile of the Voluntary Sector
Voluntary organisations in Scotland deliver a considerable level of services to the public. This is certainly true of counselling organisations and related sector services. Progress in terms of recognition and funding has improved in recent years. A number of our own specialist agencies have gained increased funding and support from the Scottish Government, which is great news and we celebrate this fact. But I think more needs to be done. The general public, Local Authorities and the business world need to know the value, the contribution and the expertise that exist in the voluntary sector. COSCA uses every opportunity to give voice to these facts.

In terms of the benefits to families and communities, I would put the voluntary sector, and certainly voluntary sector counselling services, alongside statutory health, education, and social services in terms of professional standards and expertise which stand up to the most rigorous scrutiny.

3. Reducing Financial Exclusion in Counselling and Training
The scourge of financial exclusion is real and alive today, and sadly it is alive in counselling and in training. In our dealings with Government and policy makers, COSCA often cites the need for affordable counsellor training to be made available in order to be inclusive of individuals and, indeed, some deprived geographic areas.

Some concessions are, of course, available in some agencies: such as subsidised rates, part funded training, incremental payments. These are all welcome interventions and do help, but there is no national training fund of any significance.

Today, no voluntary organisation can pay in full the high costs of professional counsellor training, but surely subsidised training/ education should be more

widely available in order to enable those who require financial assistance to be eligible to apply.

I would share with you an experience I had a number of years ago of selecting someone for counsellor training who had financial, social and educational difficulties, but they also had a natural warmth, empathy and concern for others and their wellbeing. Considerable support was needed and given; it was not easy but in the end paid huge dividends. That individual has done and continues to do great work in counselling, and has contributed greatly to working with young people in counselling and related services.

COSCA, I know, will continue to seek a reduction in financial exclusion in counselling training.

Achievements

1. COSCA Register of Counsellors and Psychotherapists

In June 2014, COSCA gained accreditation of its Register of Counsellors and Psychotherapists from the Professional Standards Authority. PSA is charged by the UK Government to hold the voluntary register for organisations and services that do not already have statutory regulation.

PSA standards are extremely high; they have a clear focus on public protection, which COSCA also subscribes to, along with support for our members.

Success came a full year after our application was lodged. The work involved in achieving this accreditation for a small organisation like COSCA was huge. The Board dealt with issues relating to the PSA application at every meeting during this period. A considerable amount of Board time and effort was invested. However the detailed work of drafting and redrafting policy documents and amendments as well as writing the initial application was the work of Brian Magee, Chief Executive, and his team, a remarkable achievement in terms of volume of work but it has to be said also in terms of Brian's ability to produce quality documents which would meet their standards but also retaining the essence and culture of COSCA.

I consider this accreditation to be a great achievement for COSCA and I want to thank the Board, Brian and his staff for their hard work and dedication which made this happen.

2. Governance of COSCA

Governance, or the overseeing of COSCA's affairs, is, I believe, in good order. Governance is not the day to day running and management of the organisation, but rather it is about policy, development, direction and to consider as objectively as possible how change and development, both internal and external, will impact on the organisation.

Attendance at Board meetings is high, and participation in discussion and debate is something I am particularly happy with - no silent members in this group - quite the opposite!

Beyond the Board there are, of course, other layers of Governance and standards which we are required to meet. These include Charity and Company Law, annual returns to OSCR and Company's House being submitted.

Returning to governance, with COSCA Board I think we are strengthened by 4 aspects of our work which we value and operate at all of our meetings:

1. Everyone on the board has a particular area of interest within counselling/ psychotherapy. That individual carries in-depth and up to date knowledge in their specific field, and which can be called on at meetings.
2. The COSCA Business Plan is a living document, reviewed and updated every year of the 3 year plan. The agenda for every Board meeting aligns to the current priorities in the Business Plan which ensures we do not stray from the agreed work plan more than is necessary
3. Finance is one of the main responsibilities of Board members, involving oversight and responsibility for the efficient and legal requirements of the company's funds. COSCA exercises this duty with great care. Brian and Alan, our bookkeeper, work with the accounts on a daily/weekly basis. Elaine, our Treasurer, oversees the accounts and presents a detailed account of finances at every Board meeting. We are fortunate to have such expertise available within COSCA, and of course our auditors carry out an annual Independent Financial Report of COSCA'S finances.
4. Finally we have the benefit of two lay members on the Board both of whom bring their own professional expertise and an ability to see issues from a more objective perspective. They have become a valuable part of the governance of COSCA in a relatively short space in time.

Mary Hunter Toner trained as a Relationship Counsellor in 1988 and practised for approximately 10 years, becoming a Supervisor and Trainer along the way. Appointed Chief Executive of a national Counselling Agency for a further 10 years, she retired in 2008. For most of that time Mary had an active involvement in the work of COSCA.

COSCA's Register of Counsellors and Psychotherapists and New Members

COSCA's REGISTER OF COUNSELLORS & PSYCHOTHERAPISTS

ACCREDITED (BACP) COUNSELLOR/PSYCHOTHERAPIST MEMBERS

CAMPBELL, WENDY HELEN
MASTERTON, JANETTE
MCBEATH, ALISTAIR GRAHAM
MULE, PALMA

PRACTITIONER MEMBERS

BAIN, ELENA
FERRY, FIONA
GUNN, LORNA
MARSH, JACQUELINE MARY
ROBERTSON, LOUISE ANNE
SAUNDERS, JEREMY CHARLES LAWLESS
SOJKA, ANGELA R T
WIGGLESWORTH, ANDREA

COUNSELLOR MEMBERS

BATES, KEFAH
BROWN, SANDRA
DOUGALL, SHELAGH ANNE
FERGUSON, ELISSA
FORBES, KATHLEEN JANET
FYFE, ELAINE SHAW
HOWARD, BEVERLEY
KEIR, EMMA
KOUTSINOU, KONSTANTINA
MACQUEEN, ELSPETH
MCCALL, FIONA
MCNALLY, NICOLA
MILLICAN, JANE
MOWAT, JANET
MULLER, REBECCA
PETRIE, JULIET
SHAW, SUSAN
SIMSON, LENORE
SMITH, JENNIFER
VALECILLOS, GABRIELA MARINE
WILLIAMSON, ALISON

NEW MEMBERS OF COSCA

CORPORATE ORGANISATIONAL MEMBERS – LOCAL AGENCIES

COUPLE COUNSELLING AYRSHIRE
RELATIONSHIPS SCOTLAND COUPLE COUNSELLING ARGYLL
RELATIONSHIPS SCOTLAND COUPLE COUNSELLING FIFE
RELATIONSHIPS SCOTLAND COUPLE COUNSELLING GLASGOW
RELATIONSHIPS SCOTLAND COUPLE COUNSELLING LANARKSHIRE
RELATIONSHIPS SCOTLAND COUPLE COUNSELLING SHETLAND

FULL ORGANISATIONAL MEMBERS

ADDICTIONS COUNSELLING INVERNESS
EDINBURGH COLLEGE

COUNSELLING SKILLS MEMBER

JONES, GILLIAN ANNE

STUDENT MEMBERS

ARMSTRONG, FIONA
BERNARD, JANE
BOYD, PATRICIA
CAMPBELL, SUSAN
CAREY, CATHERINE
CURLE, NINA
DALGETTY, ELIZABETH
FERGUSON, MARGARET ASHCROFT
HUNTER, SUSAN
LEE, MARGARET
MACMILLAN, SHIRLEY
MAYNARD, GAYLE
MCILVANEY, RAYMOND
MCKENDRY, LORNA
MOIR, SHEILA
MWAFULIRWA, ANGELINE
O'NEILL, JOSH
POWNEY, FIONA
REID, SUSAN
REYNOLDS, GILLIAN LEWIS
RICHARDSON, PAMELA
SAGE, LISA
SMITH, AMANDA
SWEENEY, SALLY
TAYLOR, OLIVIA
VAN DESSEL, JAN-PAUL
VAUGHAN, VIVIEN
WALKER, FRANCES
WOTTON, HAZEL

SUBSCRIBER TO COSCA

MONTAGUE, CAROLINE

Forthcoming Events

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.**

2014

04 December
COSCA Counsellor Accreditation Workshop
Stirling

11 December
COSCA Trainer Accreditation Workshop
Stirling

2015

February/March
COSCA Recognition Scheme Surgeries
Stirling

March
COSCA 7th Annual Ethical Seminar
'Ethics and Boundaries in a Changing World'
Stirling

June
COSCA 17th Annual Trainers Event
Stirling

June
COSCA Counsellor Accreditation Workshop
COSCA Trainer Accreditation Workshop
Stirling

June/July
COSCA Recognition Scheme Standards Event
Stirling

23 September
COSCA Annual General Meeting
Stirling

Cover Photograph by Nicola Miller

COSCA

Counselling & Psychotherapy in Scotland

VISION

A listening, caring society that values people's well being.

PURPOSE

As Scotland's professional body for counselling and psychotherapy, 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.

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