Counselling, Psychotherapy, & Psychoanalysis

Unit 2
Counselling, Psychotherapy & Psychoanalysis
Unit 2

Contents

- Self-Development ............................................. 2 - 6
- Training & Supervision ...................................... 7 - 8
- Referral ......................................................... 9
- Ideas in Counselling .......................................... 10 - 15
- Approaches in Counselling ................................. 16
  The Humanistic Approach .................................. 17 - 20
  The Psychodynamic Approach ............................... 20 - 23
  The Behavioural Approach .................................. 23 - 25
  The Eclectic Approach ........................................ 26 - 28
- Counselling Specific Problems ............................
  Alcohol Abuse ................................................. 29 - 33
  Anxiety, Panic & Phobia ...................................... 34 - 37
  Bereavement .................................................... 38 - 39
  Trauma & Loss .................................................. 40 - 44
  Depression ....................................................... 45 - 48
  Eating Disorders ................................................ 49 - 52
  Stress .............................................................. 53 - 54
  Victim Support ................................................... 55
  Family Counselling ............................................ 56 - 64
- Counselling By Telephone ................................. 65 - 73
- Co-Counselling ................................................. 74 - 77
- Sources .......................................................... 78

Page Number

1
Self Development as a Counsellor

As important as recognising and developing counselling skills, is the willingness of the counsellor to develop as a person — to become increasingly aware of oneself.

The prospect of beginning a journey of self-exploration may seem daunting. It may seem risky, 'we may find out something we don’t like', 'better leave well alone', 'it's just self-indulgence'.

But as a counsellor how can you ask or expect a client to explore their inner world, if this is something you have not done yourself?

An essential theme of counselling is that personal change and growth is facilitated through the helping relationship. How can a counsellor form a therapeutic relationship if they do not have an awareness of themselves as a person?

Self awareness is a continuing process — a person does not reach a point in life and say 'Now I am fully developed as a person!' — but rather each person continues to move along a journey of self-knowledge.

The following diagram, known as the Johari Window (named after the originators, Joe Luff and Harry Ingham), presents a model for learning more about oneself.

<table>
<thead>
<tr>
<th>Known to Self</th>
<th>Unknown to Self</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Known to Others</strong></td>
<td><strong>Free and Open:</strong> You know and others know.</td>
</tr>
<tr>
<td></td>
<td><strong>Blind Self:</strong> You don't know but others do.</td>
</tr>
<tr>
<td><strong>Unknown to Others</strong></td>
<td><strong>Hidden Self:</strong> You know but others do not.</td>
</tr>
<tr>
<td></td>
<td><strong>Unknown Self:</strong> You don't know and others don't know.</td>
</tr>
</tbody>
</table>

Since becoming a counsellor involves increasing self-awareness, the goal should be to make the 'Free and Open' portion larger and the other three areas correspondingly smaller. The process of becoming self-aware and increasing self-understanding involves two important behaviours. First, counsellors must take risks by revealing parts of themselves to others. Secondly, a counsellor must be willing to ask for and receive feedback from others, about how she affects them and how well her behaviour matches her intentions.

Risk-taking involves trying out new behaviours, sharing thoughts and feelings with others and attempting to do those things which might be difficult. In these ways
a counsellor begins to discover more about her abilities and limitations, and how people perceive her and react to her.

As previously discussed in Unit 1, there are many personal qualities that may be helpful as a counsellor. In any interpersonal situation in which one person assumes the role of 'counsellor', that person also assumes a responsibility for her own behaviour, her knowledge of herself, and her ability to relate effectively to another. Anyone who undertakes to be a counsellor must be prepared to interact as a real person with the client and to strive for an awareness of the factors involved in the process. As it is impossible for a counsellor to be totally objective and rational, anyone who strives to be so denies herself a most valuable source of counselling information - her own feelings, perceptions, hunches, and ideas.

Counselling can be thought of as a dynamic relationship involving two people, and one in which the counsellor's knowledge of herself is as important as the knowledge of the client and of counselling principles.

The Counsellor's Needs in Counselling

Before seriously considering herself a counsellor, each person should critically and honestly examine her own motivations for taking on the responsibilities of helping another person. Very simply, she should ask herself: 'What do I expect from the relationship? What will be my satisfactions and rewards in helping others?'

A counsellor's reasons for helping are seldom entirely pure and altruistic, but every counsellor should be open to and aware of her motivations. After all, these motivations can profoundly influence her effectiveness. The counsellor who helps others in order to avoid dealing with her own problems will be limited in her effectiveness. Even if clients do not 'see through' her in a completely accurate way, they will never develop the confidence and trust in her that is essential if she is to help them effectively. Similarly, the counsellor who encourages her clients to confide in her because it gives her status and control will soon find that she will have only one type of client, as others will avoid her and her controlling behaviour.

Some counsellors may desire close contact with others but be unable to achieve these relationships in normal interpersonal situations. By becoming counsellors they are able to avoid facing up to their own deficiencies and to feel competent and fulfilled in working closely with others. There are other counsellors who firmly believe they have answers to life's problems that should be shared with others. With the best of intentions they try to convert clients to their way of thinking but end up alienating many. Others counsel out of a sincere wish to help, with no other hidden motivation. Very often they are unaware of their own rewards and satisfactions. They may be viewed with some scepticism and distrust by the more suspicious or cynical client. Whatever the reasons for helping others, the counsellor's
credibility and, hence, her effectiveness will be enhanced by her awareness and acceptance of those reasons.

The first reasons that come to mind might not always be the most honest or accurate. Self-deception in this area hinders effectiveness and, as suggested earlier, real motives will be quickly perceived by clients. Discovering her needs and motivations involves the counsellor in an ongoing examination of her beliefs about herself, her beliefs about others, and her commitment to learning more about herself. Questions she needs to answer are:

1. Who am I?
2. What are my strengths? Weaknesses?
3. What do I need from others?
4. What do I have to offer other people?
5. What do I believe is right for others?

Answering such questions is often difficult and may be painful. However, an effective counsellor should continually strive to know herself. Counsellors must be committed to continuous personal growth both in training and real life situations, and must have the courage and confidence to undertake the in-depth personal analysis they ask of clients. It must be stressed that personal development is an ongoing process, and that as a person changes, the questions above will require new answers. It will be necessary for the counsellor periodically to answer the questions, 'Should I be a counsellor? Why?' and also to recognise that her readiness or suitability to counsel will vary as her own circumstances change. There will be times when she will have to sort out her own difficulties before she can resume counselling others. The important thing to recognise is that increased awareness of herself and her motives will enable her to work more effectively with others.

The Counsellor's Personal Cultural History

A major area of the counsellor's self-knowledge is her personal cultural history and its influences on her present views of people and society. Such awareness should include a review of how a counsellor's family of origin has affected the ways she thinks and feels about herself - her values and beliefs about religion, morality, politics, race and gender issues, etc. It is helpful to focus on specific topics from one's family of origin, such as who constituted the family and what kinds of relationships existed among them, what rules operated and what sanctions and rewards supported them, how decisions were typically made and how the family dealt with tensions and crises. Personal values, however, change as a result of life's new experiences, the passage of time, etc. Although we might examine our personal values now, there's every chance that they might have changed by the time this course is finished.
How do you react to the following statements?

- Suicide and self-harm are wrong. If someone told me they were going to harm or kill themselves, I would do my utmost to stop them.

- I could not listen to someone using sexist or racist language. I would tell them that it was wrong and to stop doing it. To listen without comment is to condone it.

- I just couldn’t sit in the same room as a child abuser. I would want to kill them.

- I help people to make them happy. I would always try to end a session on a positive note.

- I believe that there is nothing wrong with being gay, but I feel uncomfortable when gay people of my sex come too close to me.

- I can’t work out what my position on abortion is. I keep changing my mind. If I have an unwanted pregnancy, I suppose I’ll work it out then.

For some of these issues, these are no ‘right or wrong’ stands to take. Counsellors as a group, don’t have a ‘position’ on suicide, or abortion. These are personal values regarding human life. However, there are some ‘counselling values’ which are generally held. e.g. counselling isn’t about making people happy or cheering them up. Also, if you have conflicts between your values and your behaviour, then the process of personal development should help you resolve these before you start offering your help to others.

How do you react to the following statements?

- People need help in understanding the hidden meanings in their life.

- People need to be offered a range of solutions to problems so that they can choose an appropriate one for themselves.

- People should have control over their own destiny.

- People have, no right to make immoral or anti-social choices in counselling.

- We should take responsibility for the consequences of our actions, praise ourselves when we do good, admonish ourselves when we do bad, not praise or seek forgiveness from God.

- All people are equal and therefore are equally deserving of my help, regardless of who they are or what they have done.
These points have been chosen to represent issues on which there is no 'party-line'. Counselling values may well conflict with your personal spiritual and political values. Will this conflict distort, or get in the way of, your helping capacity? Will being open to these conflicts through a commitment to personal development enhance your helping capacity?

'...the more I am willing to be myself in all this complexity of life and the more I am willing to understand and accept the realities in myself and in the other person, the more change seems to have been stirred up. It is a very paradoxical thing - that to the degree that each one of us is willing to be himself, then he finds not only himself changing: but he finds that other people to whom he relates are also changing.'
Carl Rogers: On Becoming a Person  p.22

'One way of putting this... is that if I can form a helping relationship to myself - if I can be sensitively aware of and acceptant toward my own feelings - then the likelihood is so great that I can form a helping relationship toward another.'
Carl Rogers: On Becoming a Person  p.51

Creating dependency
It can seem gratifying to act the 'wise all knowing person', and unwittingly you may be cast in this role by the client. However, this can create the situation in which the client feels helpless and useless without your support. So, encourage clients to take responsibility for themselves, and to appreciate their own strengths and resources.

Opening a can of worms
Active listening skills are very potent in enabling a person to talk and share difficult issues. Using these skills you are in a potentially powerful position to delve deeper than the client wishes to go. If you ensure empathy, acceptance and genuineness, then misuse of the skills is less likely, even if 'mistakes' are made. However, if the attitudes and skills are seen merely as a set of 'techniques' to get someone to talk, then this could result in a real abuse of your position.

Knowing your limitations
You may find yourself in a helping role with someone you feel very uneasy about. Perhaps there is a role conflict, or you find it hard to deal with certain behaviour or values. You may know the client too well in another context, or be sexually attracted to them. Or perhaps you are out of your depth in knowledge and experience.
It is important to recognise these situations, and give yourself permission to say that you may not be the right person for this client at that time. Supervision can help here, and the situation may resolve itself after this support. However, at other times making a referral is appropriate.
Actively listening to ourselves and to our clients will help us make this choice.

Training and Supervision

Two elements which are absolutely essential to the development of a counsellor are training and supervision.

Training and supervision share certain features:
- All professional counsellors acknowledge them as essential requirements for effective, responsible counselling practice.
- Both are ongoing processes. Neither can ever be said to be finished or complete.
- Successful counsellors are committed to ongoing personal and professional development through training and supervision.
- You should not call what you are doing ‘counselling’ unless you are properly trained and adequately supervised.
- Agencies should not offer ‘counselling’ unless the staff are properly trained and adequately supervised.

Training

What should good training consist of? A good counsellor is ‘well rounded’. That is to say that they have a good grasp of the theory of counselling, they can demonstrate good counselling skills and they have a reasonably high degree of self-awareness, gained from personal development. A further ingredient is that the first three components must be congruent. In other words, the theory, skills and personal work must be in accord, drawn from the same general approach or if drawn from many sources (eclectic), integrated in a logical, thoughtful and meaningful way.

The above four components of a counsellor must be represented in training. Training should have a good balance between theory, skills and personal work, and be congruent.

Theory

In one sense, theory is easy enough to find, since there are plenty of good books available. The theory needs to be translated into effective practice. That is where skills training comes in.

Skills

- Learning to do counselling can be compared to learning how to drive a car: You need practical experience built in to the learning process. It is not enough to know the theory of driving, you have to practice the skills of driving as well.
Knowing counselling theory is not enough. Counselling is a skills-based activity and cannot be developed just by reading books.

- You need to get practical experience in a gradual way, first in the safety of a dual control vehicle under the watchful eye of an approved instructor, moving on to practice in between lessons with the instructor by going out into the traffic with a friend or relative who has already passed their test.

*Developing counselling skills is best done in as near to a 'real' counselling setting as possible. Training courses must build in this kind of activity in. Role playing is only good enough for very simple exercises. There is no substitute for real counselling.*

- When learning to drive a car you are exposed to almost every type of traffic situation.

*If possible, training should provide varied experiences of counselling including opportunities for the development of skills appropriate for ongoing counselling. Some training courses only offer opportunities to practice the initial interview over and over again.*

**Personal Development**

Some people think that this is the most important ingredient in training, to the extent that they believe that people become good enough counsellors after an extended period of personal therapy or group work.

A counsellor:

- needs to be sufficiently emotionally stable and self aware
- should not use counselling to meet their own emotional needs;
- should know their own skill and emotional limitations;
- should be open and able to accept feedback and incorporate suggestions into new ways of being;
- should be actively committed to counselling as an acceptable agent for positive change and growth.

Anyone who will not participate in the personal development activities in a counselling skills training programme cannot be assured of meeting these criteria. In particular, they will not have demonstrated their basic faith in the counselling process (the last criterion) since the best evidence of such faith would be for them to submit to the process as a client or participant in self development. Would you go to a dentist who was afraid to visit the dentist her/himself or thought that they somehow didn’t need to go? Such a dentist would be a poor prospect indeed and I would worry about their sensitivity to my anxieties about dentists and their appreciation of the pain I might feel if they have never been in the dentist chair themselves.

When asked to participate as a client in a real counselling session in a training situation, trainees may say 'But I haven’t got any problems or anything to talk about. I’d rather make something up.' Everyone has something to talk about - a difficult
decision, something mildly upsetting that happened at home or work, something that they saw on television that got to them on an emotional level, and so on. The counselling sessions in training need not be packed with world shattering problems.

**Referral**

This is the decision made by the counsellor and/or client to look for further help with another person. The ability to make an appropriate referral is an important counselling skill. A good referral is a successful intervention, not a failure. However, if a referral is badly handled it can seem like a rejection or reinforce the client’s sense of helplessness or hopelessness.

When considering making a referral the counsellor must be sure that this decision is in the best interests of the client. It may also be in the best interest of the counsellor if she feels that she cannot provide the help that the client requires.

**Whom to refer:**
- Those who can be helped more effectively by another
- Those who do not readily respond to one’s own help
- Those whose needs surpass one’s time and/or training
- Those with problems for which effective agencies exist
- Those who need medical care and/or institutionalisation
- Those who need intensive psychotherapy
- Those towards whom the counsellor has a strong, persistent negative reaction

**When to refer:**

It may become apparent at an early stage that referral to another agency or individual is likely. This may arise because the counsellor recognises that the client requires the kind of specialist skills they do not have. Sharing these thoughts at an early stage makes the referral easier for the client to accept. However, it is important that the counsellor doesn’t immediately jump to this conclusion and suggest referral before the client has had an opportunity to explain his needs.

**Burnout and supervision**

Feeling responsible for the client and taking home all their concerns is a certain recipe for stress and burnout. The more active you are in ‘rescuing’ clients, the less likely are they to take responsibility for their own life. You can then become the victim.

If you are in a position of helping regularly, arrange to have some form of confidential supervision and support. Supervision is considered essential for all practising counsellors, however experienced they might be. Most counsellors will also have had their own counselling or therapy, a most valuable form of ‘self-supervision’. As helpers it is important to know the more vulnerable parts of ourselves too, and have a safe and supportive place to talk.
Why is theory important?

Helping is a skilled and responsible activity. Anyone wanting to improve their helping capacity needs to look at three aspects which contribute to their final performance as a helper:

• Theories
• Skills
• The personality and self-development of the helper

Theories about how and why humans behave as we do are all around us in our culture. From the small, micro culture of our family and its myths to the large, macro culture of white anglo-America we get ideas about the way humans are.

Ideas in counselling come firstly from our own personal theories and secondly from books on counselling. The aim of this section is twofold. Firstly to help you think about your personal ideas about human behaviour. Secondly to help you identify the possible origins of these ideas. You can then find and understand your starting point on theory in terms of ideas in contemporary psychology.

Ideas in Counselling

Imagine you are in the hypothetical situation of helping someone whose father has just died suddenly. Look down the following list of words: They are all ones we may associate with counselling, listening to and helping this person. Which ones are most likely to come to mind when you think about helping?

• Empathy
• Manipulative
• Positive Thinking
• Genuine
• Hidden Meaning
• Client-Centred
• Unconscious
• Making Plans
• Non-interpretative
• Symbols
• Behaviour
• Defences
• Active Listening
• Goals
• Non-directive
• Dreams
• Irrational Beliefs
• Step-by-step
• Avoidance
• Non-judgemental

All of these words can be traced back to three fundamental and very influential approaches to the psychology of human mental distress. We have assimilated many of the ideas which had their beginnings in these approaches into our modern culture and we make assumptions about effective helping which are directly attributable to these approaches to human psychology. Each approach has its founders and many more recent approaches to helping have been directly or indirectly influenced by these three schools of thought.

The founders of the approaches didn’t invent these ideas out of thin air. Each is a product of a person in a social context at a moment in history. Each had their own influences from which they borrowed, sometimes acknowledged, sometimes not.

Psychodynamic Approaches
Several contemporary approaches can all be traced back to the original work of Sigmund Freud, (1856 - 1939) founder of psychoanalysis
No contemporary psychologist or psychotherapist could claim not to be influenced by the work of Freud. Many schools of therapy grew more directly out of his work. Sometimes founded by Freud’s ex-students or associates, including: C.G. Jung, Wilhelm Reich, Melanie Klein, D.W. Winnicott.

Modern counselling approaches influenced by Freud include Transactional Analysis developed by Eric Berne and Gestalt Therapy, developed by Fritz Perls.

Humanistic Approaches
Approaches developed by a group of American psychologists in the 1950s. In counselling terms, the most influential was Carl Rogers, (1902 - 1987) founder of the Person-Centred Approach
Other influential humanistic psychologists, contemporaries of Rogers, include Abraham Maslow and Rollo May. Rogers ideas have had a wide influence in counselling, e.g. Gerard Egan incorporated Rogers ideas into his highly successful systematic eclectic approach popularised by his book The Skilled Helper, (1975).

Many modern approaches to helping and education now claim to be person or student ‘centred’.

Behavioural Approaches
Skinner (more so than Watson) is another highly influential psychologist whose work has touched many modern ideas. ‘Behaviour Therapy’ became popular in the 1970s after Wolpe refined the work of the early Behaviourists.

Elements of learning theories can be found in most modern counselling approaches since all psychologists would acknowledge the role of learning processes of some sort in human development.

Below is a series of scales, which may act as a framework for our opinions about human personality and behaviour.

*Do you think, for example that we learn to be ‘who we are’ or that our personality is largely inborn, the result of hereditary factors?*

*Do you think that we have conscious free will and can make emancipated decisions about how we act, or is our behaviour determined by unconscious motives beyond our knowledge and control?*

As you go through the scales note your position on each. This can then be compared to each of the major approaches on the scales. Rather than totally agreeing or disagreeing with an approach, it is common for people to find that their personal views are reflected by a mixture of ideas from each approach.

---

| I am free to consciously determine my own behaviour. | My behaviour is determined by factors or internal events beyond my conscious control. |
| Humans are basically rational, directing their behaviour through reason. | Human beings are basically irrational, with no logic or reason directing behaviour. |
| Human behaviour is best understood by looking at the whole person. | Human behaviour is best understood by looking at each aspect as a separate element. |
| An individual’s behaviour is best understood by looking objectively at it from an external point of view. | An individual’s behaviour is best understood by trying to understand their world from their point of view. |
| Human personality is learned | Human personality is inborn |
| People generate their own behaviour internally. | People’s behaviour is a set of responses to external stimuli. |
| The basic motivation for human behaviour is positive, growth-enhancing, (moving towards self-fulfillment). | The basic motivation for human behaviour is to maintain internal balance by meeting basic needs (e.g. comfort, food). |
Psychodynamic Approaches (Freud)

Where they come on the scales:
1. Freud believed that behaviour was determined largely by our unknowable and uncontrollable unconscious. Through analysis one might understand one’s unconscious, but rarely control it.
2. The fundamental unconscious id energies are chaotic and without reason. Even if we learn to be rational, our behaviour is still under irrational control.
3. Freud thought that all behaviour was important and the person should be seen as a unified whole, acting together (sometimes in conflict) towards a goal.
4. After listening to the patient’s subjective experiences, Freud would subject them to external interpretation according to his theories.
5. The id is inborn and fixed at birth, the super-ego is learned. The ego develops through genetically pre-determined stages.
6. All impulses come from the id, but the ego forces the id to react to the realities of the world.
7. Behaviour is motivated by trying to balance the basic needs of the id (pleasure, comfort, food etc).

In practice:
- Inborn instincts are the foundations upon which childhood experiences build our personality.
- Our true motives are unconscious and hidden from us because the instincts and urges are taboo.
- Our unconscious only lets itself be known to us indirectly through symbolic events like dreams or behaviour.

Using their knowledge and skill, the therapist interprets our experiences and behaviour (e.g. dreams) to unveil our unconscious motives, giving us an opportunity to be free of these unconscious controls.

Humanistic Approaches (Rogers)

Where they come on the scales:
1. Rogers believed that behaviour is determined by conscious processes that are controllable and in awareness. There are no unknowable causes of behaviour.
2. The fundamental self is neither rational nor irrational in a superficial sense, but has a deep wisdom based on underlying rationality.

3. Rogers believed that humans acted as organised, integrated organisms.

4. One of Rogers' fundamental propositions is that the best vantage point from which to understand someone's behaviour is from their point of view.

5. The fundamental self, with the positive, growing tendency of the human organism is inborn. Almost everything else is learned.

6. Impulses come from the self, and are acted upon. The organism reacts to a limited extent to the outside world.

7. A fundamental humanistic proposition is that behaviour is motivated by the tendency to seek self-fulfilment. Even if human needs are arranged in an ascending order, the energy moves us to ascend to the highest level.

In practice:

- All human beings have an inbuilt capacity to grow and achieve their full potential.

- This is called self-actualisation.

- If the self-actualising tendency can be harnessed, human beings can solve their own problems and heal their own psychological hurts.

- Self-actualisation will happen quite naturally if we have the right conditions for it.

- The therapist provides these conditions in which we can explore our own experiences. This will help strengthen our self concept and our tendency towards self-actualisation.

Behavioural Approaches (Skinner)

Where they come on the scales:

1. Skinner believed that behaviour is determined by stimulus-response associations beyond our control. Humans respond in a largely mechanistic way.

2. Skinner placed no value on rationality as an explanation of human behaviour. The principles of behaviour apply equally to all animals, so rationality is not applicable.

3. Skinner attempted to understand human beings by breaking behaviour down into separate elements or behavioural building-blocks.

4. External, objective measures of behaviour were the backbone of behavioural science. There is now some small room for subjective experience.

5. The idea is that we are born as a blank slate upon which our experiences in life leave marks. Learning is the basis of all personality.
6. Humans are seen as almost entirely reactive. Behaviour is a reaction to the stimuli in the environment. Recent approaches acknowledge that internal stimuli, including thoughts, might also be the cause of behaviour.

7. Learning takes place in response to a need, for comfort, food etc. Some recent theories acknowledge that some human needs might be quite sophisticated, eg need for approval.

In practice:
- We are born as ‘blank slates’. Human personality, in fact everything we are, is learned.
- Behaviour is the objectively observeable manifestation of our personality, although thoughts and feelings are important.
- Learning leads to only a relatively permanent change, so what can be learned can be unlearned.
- We can unlearn behaviour; thoughts and feelings which cause us distress and replace them by learning ‘good’ ways of thinking, feeling and behaving.
- The therapist helps us identify our aims and goals then designs learning programmes that will achieve the desired goal if we follow them.
The three approaches just described form the basis for the vast majority of counselling. However, if you look through any text book or counselling directory, you will find a bewildering array of counselling approaches. The list below from one such list illustrates this:

The 23 Approaches
- Adlerian Counselling
- Behaviour Counselling
- Cognitive Analytic Counselling
- Cognitive Counselling
- Existential Counselling
- Gestalt Counselling
- Hypnosis in Counselling
- Integrative Counselling
- Lifeskills Counselling
- Multimodal Counselling
- Neuro-linguistic Programming
- Person-centred Counselling
- Personal Construct Counselling
- Primal Integration Counselling
- Problem-focused Counselling
- Psychosynthesis
- Psychodynamic (Freudian) Counselling
- Psychodynamic (Jungian) Counselling
- Psychodynamic (Kleinian) Counselling
- Rational Emotive Behaviour Therapy
- Reality Therapy
- Solution Focused Therapy
- Transactional Analysis

For the purpose of this Unit, the three basic approaches, i.e., humanistic, psychodynamic and behavioural, will be described in more detail, to give a picture of how theories may be integrated in practice. (Following units will include techniques used in some of the other approaches from the above list.)
Different Styles of Counselling

Counselling has grown out of a number of different schools of psychoanalysis and psychotherapy, and the counselling movement has developed to include a number of styles. Most counsellors adhere, at least to some extent, to one of these styles, which will affect the way they work.

All counsellors, whatever their training and individual approach, aim to help clients lead a more fulfilled life and are there to provide emotional support, clarification of difficult issues and a non-judgemental, accepting environment. But differences of counselling style may mean that one appeals to a client more than another.

This next section aims to give a brief guide to the main styles of counselling in current use. It is important to remember that there are no hard and fast divisions. Styles overlap and in practice, counsellors are likely to make use of theories and methods from a wide variety of sources.

The Humanistic Approach
Person-centred or Rogerian Counselling

Person- or client-centred counselling was developed by the American psychologist Carl Rogers and grew out of the humanistic approach of the 1950s, which basically sees humans as perfectible. It was also, to some extent, a rebellion against what was seen as the patriarchal, hierarchical, Central-European basis of traditional psychoanalysis. The aim was to remove the label of 'expert' from the therapist and put the client (never called a patient) firmly in charge; the relationship between the client and the counsellor should be equal and clients are considered to know as much as, if not more than, counsellors about their own problems. The humanistic approach is not so much concerned with pathological states such as neurosis and psychosis as the ordinary unhappiness and sense of alienation experienced at times by everybody.

Carl Rogers, who was originally a Christian evangelist training for the ministry, considered that traditional lengthy analysis was often not necessary to get to the heart of people's problems, and that verbal exchanges could work just as well, if not better. He believed that our basic human nature is positive, loving and peaceful but that early and later experiences may have clouded this. The client-centred approach, he believed, can help us to be aware of our true selves, when we will be able to move forward with confidence and love and a sense of connectedness with the world around us.

In order to facilitate the process of helping us to understand our true natures, the character of the counsellor is extremely important. It is not enough just to be accepting; the counsellor must also have empathy and what Rogers called
'unconditional positive regard' for the client, combined with congruence or genuineness on the part of the counsellor.

It all sounds very nice, but Jeffrey Masson, a former Sanskrit scholar who later trained as a psychotherapist and still later, having researched the subject, decided that nobody outside oneself could genuinely be relied on to give useful help, wonders whether it is as altruistic and egalitarian as it is claimed. Masson, whose disillusion set in when he was allowed access to the Freud archives and decided that the father of psychoanalysis had hidden his findings on child abuse and led people to believe his patients were all fantasising, gave up his analytical practice to become a writer and lecturer against therapy.

In his book Against Therapy, where he argues that all modern forms of therapy are flawed, he has this to say about Carl Rogers:

'It is unarguable that Rogers did away with some of the 'trappings' of the imbalance in the power relationship. He insisted on changing the designation 'patient' to 'client' which, being more mercenary, is closer to the truth. He called his method 'client-centred' (or person-centred), eschewing the labels of expert or specialist. He rejected the 'medical model of illness'. He was against all forms of manipulation of therapy.'

His summing up of Rogers has a cynical tone and indeed Masson, who remains terminally angry about all therapists and therapies, wonders whether the 'unconditional positive regard' which Rogers says must be present in the good client-centred counsellor is actually possible. He feels that this kind of regard cannot be legislated or taught, any more than any other kind of love can, and that there is as much (or almost as much) scope for client abuse as with other types of therapy. Masson feels that empathy, on which Rogers places such emphasis, is singularly lacking in most kinds of therapy and that, at heart, therapists want to have power over their patients and bend them to their theories of human nature.

However, Masson reckons that the client-centred approach can do less harm than Freudian, Jungian or Kleinian approaches, all of which he believes have perpetrated more harm than good, because they put the therapist firmly in charge and encourage patients to believe that they are sick and need 'therapy', whereas it is more likely that society and current values are sick.

All therapies proceed on theories of human behaviour which may or may not be true. Indeed, whole edifices have been constructed on theories which, with hindsight, seem extremely questionable. Now that so much of traditional psychiatry has been discredited, how can we be sure that newer schools of thought, such as the human potential movement, of which client-centred counselling is a central part, are more accurate?

We can't be sure - we can only believe that the proof of the pudding is in the eating. Rogers' view of humanity as essentially good, loving and peaceful accords
directly with the teachings of all major religions and very many people who have come to client-based counselling have felt that it worked for them. This, objects Masson, may be quite meaningless, as all patients have a desire to believe that the medicine does them good, and the more painful, the better it must be doing them. Whatever the arguments, client-centred counselling is increasingly popular with people who are feeling unable to cope with everyday life and the challenges that ordinary events throw up.

In order to facilitate the client-centred approach, Rogers developed a technique known as 'mirroring' where the counsellor repeats back what the client has said. If, for example, the client says: 'So I went and thumped him one,' the counsellor may say: 'So you went and thumped him one.' The point of mirroring is to facilitate the clients' thought processes and make them aware of just what they have said. But clearly there is more to this kind of counselling than endless repetition by the counsellor.

The underlying idea is that, through the counsellor's acceptance, empathy, unconditional positive regard for the client, the client can gradually scour away at the layers of negativity which have been preventing them from being the kind of person they ought to be, which, according to Rogerian theory, is happy, successful, positive and at peace. The counsellor and the client both come to see how the client could be - and gradually, together, they work towards that goal. The emphasis will be on the present, the conscious thoughts of the client, rather than on unconscious processes or reconstructions of the past.

At the heart of the client-centred approach is the understanding that people act out of the way that they feel about themselves. People who are always having accidents, getting into work difficulties or failing in relationships would be seen as not valuing themselves very highly. Such people are basically co-dependent, which means they have an overwhelming desire for the love and regard of others, without ever knowing how to achieve this. They do not love themselves but want others to love them. There is progressive alienation from the true self, or the soul, and this can lead people to act in all kinds of self-destructive ways. They are the people who don’t really know who they are. This does not mean that such people are necessarily shy or timid. They may be arrogant, bombastic, aggressive, outwardly self-assured.

The aim of the client-centred approach is to enable people to get back in touch with themselves again, to become 'fully functioning' and in touch with their own deepest feelings and responses. Rogerian counsellors believe that humans are basically unique, beautiful, positive, peaceful and that the counselling merely works to uncover this, to strip away the layers of doubt and denial. The main task of the counsellor is to create a climate of love and regard whereby people can start to flourish, possibly for the first time. The counsellor attempts to provide a different kind of soil than they have known before, whereby the plant can flourish instead of withering.
The main criticism of client-centred counselling is that it can be naive and optimistic, falsely idealistic and not making allowance for the negative side of human nature. Rogerian counsellors are said to see only the loving aspect of their clients, however the latter may seem to the outside world.

<table>
<thead>
<tr>
<th>The humanistic approach in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The counsellor who adopts the humanistic approach to counselling will tend to:</td>
</tr>
<tr>
<td>• avoid ‘interpreting’ the client’s behaviour;</td>
</tr>
<tr>
<td>• seek to encourage the client to identify their own solutions to their problems;</td>
</tr>
<tr>
<td>• acknowledge that every individual is to some degree responsible for his or her own behaviour.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples of applications of this approach include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• dealing with spiritual distress and problems of meaning;</td>
</tr>
<tr>
<td>• helping with problems of self-image;</td>
</tr>
<tr>
<td>• helping to free the client who believes that they are somehow controlled by their circumstances.</td>
</tr>
</tbody>
</table>

Psychodynamic Counselling

This form of counselling grew mainly out of Freudian thought, although it has developed greatly from its early roots. Basically, psychodynamic counselling goes deeper than client-centred counselling and helps clients to understand unconscious motives for their actions and to bring these into conscious awareness.

Central to Freudian analysis is the idea that many of our conflicts and problems are a result of our unconscious motives and feelings, and that there is great resistance in bringing them to the surface. Psychodynamic counselling uses psychoanalytic techniques to enable clients to be aware of underlying motives and to bring repressed feelings and fears to the surface. Because it is related to psychoanalysis, some people may feel this type of counselling is more hierarchical than other kinds. Certainly, the counsellor here is seen as some kind of expert, although the old trappings of big important therapist and nervous little client have virtually disappeared from the psychodynamic approach.

The word ‘psychodynamic’ refers to the psyche - usually meaning the mind, emotions and spirit combined - which is seen as an active force, and not static.
Activity, according to counsellors working in this way, can take place within the psyche, whether or not this bears any relation at all to what is going on in the outside world. The psyche seems to consist of a number of different selves, as in the saying: ‘I’m not feeling myself today’. But, what is myself?

When people say they are not feeling ‘themselves’, this must mean that they believe there is another ‘self’ somewhere which is more true to how they really are. The purpose of psychodynamic counselling is to help people uncover their true self - and be aware of the false ones. This means bringing unconscious material up to conscious levels and examining it closely. Counsellors will draw on analytical theories - for example, Freud’s id, ego and superego, Jung’s concepts of the anima, animus, shadow, Winnicott’s true and false self (all discussed in greater detail in Unites 5 & 6) - and will very much work on uncovering experiences and feelings in the past. Serious attention will also be paid to fantasies (or apparent fantasies), dreams and all the internal factors which contribute to dynamic forces or activities within the psyche.

The psychodynamically trained counsellor will be interested in understanding, or getting the client to understand, all the relationships involved in the psyche, and sorting them out. Because the unconscious is considered so important counsellors who work in this way will be trying to understand how the unconscious motives of the client have affected their lives up to the present. Once unconscious motives can be brought out into the open, the idea is that clients will be able to act with more conscious control and awareness. The unconscious is unknowable, therefore it is likely to act in ways which are not helpful to us. The psyche is seen as a kind of prison which craves release and the object of psychodynamic counselling is to enable it to be released.

When counselling of this kind is successful, it helps the client to balance his or her own basic psychological needs, the demands of conscience, and the demands and external reality of particular situations. Repression leads to thoughts and feelings being denied and this means that life is not being lived fully in the present. Aspects of oneself are shut off, inaccessible to feeling and emotion because of what is going on in the unconscious. So the most important aspect of psychodynamic counselling is to help clients make sense of their current situations, to understand why they have got themselves in this particular state and to help them see that they can get themselves out of it.

Because psychodynamic counselling is complicated, and because it demands knowledge of Freudian, Jungian and other theories of the mind, such counsellors have to be very thoroughly trained. They also have to understand such concepts as transference, resistance and counter-transference, as all these are likely to crop up within the counselling relationship. If a client has a history of relating to important people in, say, submissive or aggressive ways, then this will be transferred to the counsellor - and the counsellor has to be ready to deal with it. The counsellor can...
never make up to the client what he or she may have suffered in the past and there may be great disappointment when the client realizes that the counsellor cannot always provide the kind of guidance and advice that may be expected. Clients may feel rejected; especially if the counsellor has come to be seen as a kind of wise, ideal parent, and again counsellors have to be prepared for this and how to handle it.

Resistance is when the client resists attempts to bring repressed material to the surface, and counter-transference happens when the therapist unconsciously transfers her thoughts and feelings to the client. Clearly counsellors are working with deep emotional material here. Clients may express anger, rage, despair and depression during the sessions and counsellors have to know how to handle strong feelings, both their own and those of their clients.

The counsellor has to be able to listen carefully to what the client is saying and during the first session will make an assessment as to whether they can properly work together. A responsible counsellor will draw attention to the unpredictability of the outcome of counselling and will not make any false promises or give any expectation of a miraculous cure.

The counsellor needs to assess very carefully what counselling means to the client, why the client has come, what is hoped to be gained from the sessions. Because this approach may touch on fundamental disturbances in the psyche, particular attention will be paid to the client's past history, whether help has been sought elsewhere, whether the client is on any prescription or other drugs, ever been in hospital or treated by a psychiatrist, attempted suicide or other destructive behaviour.

As with other types of counselling, the most important quality the counsellor brings to the sessions is listening ability. Clients are encouraged to talk about everything that is bothering them and the counsellor will usually remain relatively quiet. As with client-centred counselling, the client is considered to be in charge and the counsellor's aim is to provide clarification, to try to put into words what the client might be trying to express, but not to impose her or his own views or interpretations. Psychodynamic counsellors are, however, likely to take increasing account of how clients respond to the actual counselling relationship as the sessions continue, and look at the feelings aroused in the client by it.

It tends to be long-term and can be particularly emotionally demanding of the client. As with other modern forms of counselling, the relationship has to be one of partnership, where the client collaborates in his own healing and growth. This can be a slow process, with many frustrations, where deep-seated problems are encountered.

Psychodynamic counsellors, unlike those working in the client-centred approach, believe that it is not enough just to provide a safe and loving environment, because it is considered that this will not necessarily help all the difficult negative feelings to come to the surface. Whereas the client-centred therapist puts the
emphasis firmly on unconditional love and positive regard, the psychodynamic counsellor allows hate, anger and other negative feelings arising from loss and disappointment to come out, be expressed, acknowledged and validated. Through the counselling relationship, clients can relive and release their negative feelings and discover that they are allowed to have them.

Most modern training courses for counsellors rely on either client-centred or psychodynamic counselling, or a mixture of both.

<table>
<thead>
<tr>
<th>The psychodynamic approach in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The counsellor who adopts the psychodynamic approach to counselling will tend to:</td>
</tr>
<tr>
<td>• highlight the relationship between past and present life events;</td>
</tr>
<tr>
<td>• acknowledge that unconscious forces are at work that affect the client’s behaviour;</td>
</tr>
<tr>
<td>• encourage the expression of pent-up emotion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples of applications of this approach include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• helping with long-term emotional problems;</td>
</tr>
<tr>
<td>• coping with anxiety;</td>
</tr>
<tr>
<td>• helping the client who talks of having had an unhappy childhood.</td>
</tr>
</tbody>
</table>

**Behaviourist Counselling**

The behaviourist method grew out of dissatisfaction with standard psychotherapy and has been developed mainly by Hans Eysenck. Eysenck questioned whether psychoanalysis could ever, or had ever, done any good. Even Freud, said Eysenck, admitted that analysis merely turned neurotic people into mildly unhappy people.

The behaviourist approach concentrates solely on symptoms, on what can actually be seen, rather than considering underlying causes which, it stresses, can only be guesswork - and we might have got it completely wrong. What we can know, however, is that, for whatever reason, people are afraid of flying, nervous of going out of the house, have a compulsion to collect and tidy things, or are terrified of spiders.
As, according to behavioural theory, we can only guess at how these problems arose in the first place, then working on the unconscious or childhood traumas may or may not hold the key to the solution. And certainly, any therapist or counsellor who has worked with serious phobias will know that, mostly, the reasons for the great fear are not uncovered during therapy sessions - they remain mysterious.

The behavioural approach, therefore, works only in the present and concentrates on helping clients to overcome and modify unhelpful behaviour by replacing it with more functional and less fearful ways of coping. The particular ritual or phobia will first be closely studied by the counsellor, then together, counsellor and client will try to work out ways of overcoming that behaviour. Behavioural counselling is very much goal-orientated, in that it will work solely towards the client being able to face that threatening situation and cope with it.

There are two specific strategies commonly used. One is 'laddering', where the client is taken step by step through the fearful situation. With a fear of flying, this may involve going to the airport, watching planes take off and land, stepping onto the runway, stepping on to a plane and, eventually, going on an actual flight. The other method often used is 'flooding', where the client is put in the frightening situation at once, thrown in at the deep end, and is surprised to survive it without mishap. Of course, behavioural counsellors should never put clients in any genuinely dangerous situations, such as literally throwing them in at the deep end, if they have a fear of water, when they can’t swim.

Although behavioural counselling does not look at root causes of dysfunctional behaviour, it can be extremely useful when the phobia or ritualistic behaviour, such as compulsive hand-washing or checking, is preventing people from living a full and active life. Since its introduction during the 1950s as part of the treatment given to patients in psychiatric hospitals, it has been very influential in the counselling movement and elsewhere.

Behavioural-type counselling can be considered by people who suffer from panic attacks, fear of public speaking, fear of making fools of themselves in public, paralysing shyness, persistent lateness, fear of flying, nervousness about getting on a bus or going to a party, fears about the outside world being contaminated or unhygienic - and who wish to overcome these problems. It has also had success with people wanting to give up smoking.

If not treated, phobias tend to get worse as the years go by, until people may be so completely hemmed in by their fears they can no longer do anything at all. Behavioural counselling works on the understanding that people get rewards of some kind for their behaviour. For instance, those who daren’t go out of the house never have to take responsibility for their lives; those who have to enact complicated rituals and checking routines do this to make them feel safer and more secure.
The eventual aim of behavioural counselling is to enable people to become aware that there can be greater rewards for letting go of the phobic behaviour. Their behaviour will be modified in the right direction, according to the theory, when the rewards for functional behaviour are seen to be greater than those for the phobic attitudes.

### The behavioural approach in practice

The counsellor who adopts the behavioural approach to counselling will tend to:

- set practical aims and objectives in counselling;
- discuss behaviour rather than reasons for patterns of behaviour;
- identify a practical programme of small changes that the client will be able to achieve in order to cope with problems of living.

#### Examples of applications of this approach include:

- dealing with long-term behaviour problems;
- helping with behaviour problems in children;
- enabling clients to cope with bereavement.

### The cognitive approach in practice

The counsellor who adopts the cognitive approach to counselling will tend to:

- rely less on personal warmth and more on confrontation in the counselling relationship;
- use a logical and rational approach to problem solving;
- encourage the client to develop a realistic and pragmatic outlook on life.

#### Examples of applications of this approach include:

- helping the person who is depressed;
- helping the person who has multiple problems;
- encouraging rational thinking in someone who is highly emotional.

(The above table is included in this section at is very often linked with, and bears many similarities to the behavioural approach.)
The Eclectic Approach

In the end, what we do in counselling depends upon a number of issues: our skill levels, what we feel comfortable with doing in the counselling relationship, our belief and value systems as they relate to how we view what people are 'about', our level of self-awareness, our mood at the time, our present life situation, our perception of what (if anything) is wrong with the client, current workload and time available and many other factors. Thus it is reasonable to argue that no one set of counselling tools or no one particular approach can be appropriate in every counselling situation.

What is perhaps more useful is that the counsellor considers a wide range of possibilities, tries out some of the approaches and slowly incorporates the approaches that most suit that person into a personal repertoire. This personal repertoire or personal style offers the most flexible approach to counselling - the eclectic approach.

After all, counsellors meet a wide range of clients varying considerably in their cultural back-grounds, their personal experiences, belief systems, needs, wants and wishes, political persuasions and personal psychologies. It is important that we offer clients what they want and not necessarily what we perceive that they want. The counselling relationship belongs to the client and not to the counsellor: we should not be dazzling them with a range of counselling interventions but finding out what they really want.

<table>
<thead>
<tr>
<th>The eclectic approach in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health professional who adopts the eclectic approach to counselling will tend to:</td>
</tr>
<tr>
<td>• believe that no one approach to counselling suits each situation;</td>
</tr>
<tr>
<td>• read widely and learn a variety of different sorts of counselling skills;</td>
</tr>
<tr>
<td>• run the risk of being 'jack of all counselling skills and master of none'!</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples of applications of this approach include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• everyday counselling practice;</td>
</tr>
<tr>
<td>• working with the client who does not respond to a particular counselling approach;</td>
</tr>
<tr>
<td>• helping the person who has very varied problems in living.</td>
</tr>
</tbody>
</table>
Psychological approaches to counselling

No one school of psychology or theoretical approach to counselling offers the way of viewing the person. The approaches offer different ways of looking at the person and those ways of looking are not necessarily mutually exclusive. Which of the approaches the counsellor chooses to use as a guide to understanding the process of counselling will depend on a number of factors, including, at least: their original psychological training, the influences of any workshops, study days or further training, exposure to colleagues and friends who offer different points of view, further reading around the topic and so forth.

Another deciding factor may be the type of relationship that the counsellor has with their client and the amount of time they spend together. It may be that the shorter relationships require a pragmatic psychology that allows for goals to be set and to be achieved: in this sense, the behavioural approach offers usable concepts that can help to structure the relationship. Or, if a longer-term relationship is being developed, a ‘process’ model may be more applicable. Here, the psychodynamic and humanistic approaches may help. In the end, too, what will determine what any counsellor adopts as a psychological model for understanding the counselling relationship will depend on their own beliefs about the nature of people. In order to clarify what our beliefs are, we need to develop a degree of self-awareness.

Summary of aspects of knowledge required for counselling.

Propositional Knowledge
- Types of counselling
- Maps of the counselling process
- Psychological approaches to counselling
- Psychology, sociology, philosophy, politics, theology, anthropology

Practical Knowledge
- Listening and attending skills
- Counselling interventions, including:
  - being prescriptive
  - being informative being confronting
  - being cathartic
  - being client centred
  - being supportive starting and finishing the session
  - coping with transference and counter-transference
  - coping with silence
  - avoiding burnout

Experiential Knowledge
- Experience of a wide range of different types of people
• Experience of a wide range of human problems
• Self-awareness
• Spiritual awareness
• Cultural awareness
• Life experience
This next section looks at how counselling specific problems integrate the approaches and skills previously described.

Case Study

Alcohol Abuse

My name is Mary. I am in my late fifties. I lived in the country for the earliest part of my life with both parents, one older sister and two younger brothers. My memories of childhood are vague but I would have thought mine was a ‘normal’ existence. I didn’t know my Mother had a drink problem. She was ill at times and spent time in her room when there would be all sorts of ‘coming and going’ with relatives etc. She had a temper and would and could be very angry. I was aware of tension and it was very important to keep on her right side. Deep inside me I felt she was very unhappy. As a child I thought this was because she was ill or maybe not happy with my Dad. What I didn’t recognise then was the feeling that lived with me always. It was FEAR. It was normal. You never knew when you came in the front door what to expect and consequently you felt that you were the one responsible for the mood swings. Because I had no awareness of how things should or might be, my feelings were only concerned with how to get through what is happening within the family circle. There was a lot of anxiety and fear - but I never lived in the day, tomorrow was always going to be different - something wonderful was going to happen tomorrow.

My Dad died when I was 16. After that my Mum no longer had to drink in secret. We were sent to boarding school. I often wondered why it was I never wanted to go home - fear, fear, fear was the underlying emotion on which our lives ran - but I didn’t recognise it as fear - it was normal - it paralysed me. It stopped me from growing up. I literally moved from one situation to another without any consciousness of what was happening. I was unable to make any decisions for myself. I depended on others to tell me what to do or how to live. There were no family relationships - no sharing or communications - you just got told what to do and not to question it and that was O.K.

When I met my husband it was wonderful. He was fun. He knew how to enjoy himself. He was older, more sophisticated and I was enthralled. There was none of the doom and gloom that was part of our house - none of the underlying fear and tension. I couldn’t believe that this man could actually want to marry me. I thought I was happy but looking back now the fear was there all the time. Within 2 years of getting married we were in trouble. The pain and loneliness I thought would leave me when I got married got worse. There was no love - no intimacy - just fear and worry. I had 3 children in a few years and I had no husband. He lived in the pub. The job went, the house went and I went home to Mother. That was worse. I had forgotten in the years in between what was happening at home. My Mother was
drinking, my brother was drinking and was shortly afterwards killed in a motor accident leaving 3 small children and in the middle of that I thought - what have I done - deprived my children of a father. At least he was alive, even if he was drinking. I went back and this time I thought with love I could overcome all obstacles. After all I loved my family and with that motivation nothing could go against me. We rented a house and I became involved in getting a business started up so that we could support a family. I honestly thought I could and would beat this disease.

That was 25 years ago and it has taken that length of time for me to accept that I am powerless. I have no control. In those years I have watched my husband continue drinking, have a heart attack and deteriorate from being a fine handsome man to a shell of what he once was. I have watched my sister and brother slowly become addicts. I have also watched my children become involved with drink and in those years I have watched myself become more angry and full of hatred and resentment. I don't know which I hated more - the drink or the drinkers, or myself. I was addicted to looking after everyone else except myself.

There was no-one in my life with whom I could be close. I had to put on a front and pretend and I do it very well. I smile. The people I meet don't know the pain that is inside, the pain of loss of having not had a full and happy life - I was always waiting - waiting for something wonderful to happen and then the pain would go.

I have been lucky. With the help of a kind and gentle counsellor I am beginning to look inside and find out who I really am. I am not my mother's daughter, my sister's twin, my husband's wife, my children's mother. I am me. I am waking up. I am starting to accept responsibility for my own life. Up to now I have taken responsibility for my husband's life and children's behaviour. It has been people like me who have kept this merry-go-round moving. Fear paralysed us. Fear of ourselves, fear of parents, fear of partners, fear of children, fear of neighbours, fear of the boss, fear that someone would turn around and point the finger at ME.

Because I do not want to end up a lonely, embittered disillusioned old woman. I will take responsibility for the part I have played in this family. I have enabled my family to carry on drinking. I offered disdain, contempt and disgust when inside I was crying. I cried when my Mother died without either of us ever being able to say 'I love you'. My husband has now stopped drinking and our relationship instead of getting better is worse. Today I am trying to develop a positive attitude first and foremost toward myself and in the process learn what solution is best for each individual situation without apportioning any blame. I thank God that I have been able to live through and come out the other end of a lifetime of being enmeshed in addiction to alcohol. I still believe that there can be a happy ending - the happy
ending for me - being able to look in the mirror and like what I see - me. I want to experience joy, to live without fear, to know that I am not responsible for anyone else’s life only my own.

Treatments of Alcohol Abuse

• Medical Treatment of Alcoholism

Alcohol dependence has serious medical consequences, and so a full medical examination is required. A detailed history will be taken. Some people may be embarrassed to talk about their drinking pattern, but it is vital that a truthful account of their consumption is given. A friend or family member’s encouragement may be helpful.

Most uncomplicated detox programmes can now take place in the community with medical supervision. In cases of severe problem drinking, or where other complicating factors exist, hospital admission may be necessary.

A reducing dose of a powerful anti anxiety medication may be prescribed and the person’s physical health is closely monitored. The physical detox (alcohol is a toxic substance) will take a number of days.

Remaining dry is difficult as alcohol is continuously pushed through advertising, and is readily available. Some Doctors may prescribe a drug which prevents alcohol from being fully metabolised in the body. This causes a severe reaction, symptoms include nausea, vomiting, dizziness, and headache. Any physical conditions caused by the toxic effects of alcohol must also be treated. Unfortunately some individuals, leave it too late to give up. Korsakoffs Psychosis is a form of brain damage associated with prolonged alcohol abuse, there is no repair for damaged brain cells.

• Psychological Treatments

The psychological damage caused by alcohol is immense. Structural damage to the nervous system may include organic brain damage. Many people who drink excessively do so to avoid addressing problems in their lives, poor self esteem, marital problems, depression. When the alcohol is removed from the system the original problem is uncovered and can now be successfully explored and treated.

Alcohol clouds consciousness, especially an unpleasant reality that the person would prefer not face. Coming to terms with difficult issues is an essential part of the psychological growth and maturity. When people abuse alcohol early in life, they
effectively put the maturation process on hold. Some become ‘stuck’ in an adolescent phase, and find the adult world daunting.

Regaining a sense of control and personal responsibility, one to one counselling helps to put thing back into perspective. Group therapies allow the person to explore their experiences in a safe and supportive setting. Groups may be lead by a trained facilitator or be a recovered group member.

- **Behavioural Approaches to Alcoholism**

  Any repeating behaviour is difficult to cease. A number of factors in relation to the human condition must be understood.

  Behaviourists recognise that any two events that occur together are likely to form an association. The shorter the time interval the greater the association made. The speed at which alcohol is absorbed into the system (about 20 minutes) forms a strong association between drinking and it’s relaxing effects. If it took longer our mind would not necessarily link the two as being related. This strong association makes the alcohol habit hard to break (Smoking has an even shorter time lag -making giving up even more difficult).

  Also most people (even problem drinkers) will have a lot of pleasant memories associated with drinking, further reinforcing its appeal.

  These two factors are further exacerbated by the forceful positive image of alcohol presented in advertising.

  The behavioural approach is to dismantle these associations by presenting the reality of alcohol abuse. It’s impact on the individual and their family must be presented clearly and a new association formed...

  Alcohol = Problems

  The use of medications which limit the metabolism of alcohol causing a violent nausea and vomiting, is another behavioural technique. This medication must be prescribed and properly monitored and may not be suitable for all alcohol abusers.

  Assertiveness training and role playing social situations where a problem drinker rehearses tempting scenarios are very useful. They also help to address any underlying social fears or shyness which may have lead to alcohol in the first instance.
• Social Approaches to Alcohol Abuse

Alcohol abuse is perhaps the biggest preventable social problem in Ireland. Fractured family relationships and domestic violence are not uncommon. Road deaths, crime, and suicide are all associated with excessive drinking and alcohol abuse. A recent European wide survey found that 4.5 million children in Europe, live in homes where the abuse of alcohol is a major problem. In the past, one half of all psychiatric hospital admissions were for alcohol abuse.

Enabling is perhaps the most damaging aspect of alcoholism within families. To avoid embarrassment and in an attempt to retain the facade of normality, may Families try to 'cover' for the problem drinker. By making excuses and allowances, the central issue is never addressed or resolved. Broken promises and disappointment lead to bitterness and a sense of betrayal. Families need to be honest with themselves and with the problem drinker. Gently confronting the situation and refusing to become involved in deceit.

It is easy to pretend that there is no problem when it is safely hidden away behind closed doors. But a solution will never be found in pretending. A number of supporting agencies provide guidance for the problem drinker (AA) and other groups (Alanon & Alateen) support family members.

Alcohol abuse occurs in all social classes with financial problems increasing the strain on family members.
Anxiety, Panic and Phobias

Many people spend part or all of their day tense and anxious, worrying about anything and everything? They are suffering from anxiety.

They begin to avoid situations which make them tense, anxious or afraid, this step further and may mean they are developing or have developed a phobia.

Their life may be dominated by the fact that they are afraid of leaving home? Or perhaps their life is shaped by fear of dogs, cats or some other animal. Maybe they can’t bear the thought of being alone, or being in a group of people makes them feel ill. Their life may be ruled by the weather forecast and whether a thunderstorm is likely? Or perhaps eating in a restaurant or at someone’s house fills them with dread. Maybe there’s something else which terrifies you? Hospitals, flying, busses, bridges, dentists, injections you can become afraid of almost anything in the world.

Such fears or phobias are often attached to objects, creatures or situations which are of no actual physical danger, and so are sometimes called irrational fears because of this. But there is nothing irrational about it - people with these fears are afraid of the extremely unpleasant feelings they experience whilst in their feared situation.

- These problems are not symptoms of serious mental illness
- They do not mean you are about to have a nervous breakdown
- You are not going mad
- These are very common difficulties - Something like one in seven of the general population will have a fairly serious problem of this kind in their lifetime

Types of Phobia

People can develop a fear or phobia about almost anything in the world - the list is endless – as is the list of the names used to describe the phobias.

There are roughly two main groups of phobias:
- Those that are linked to one particular thing e.g spiders, dogs, bridges, cats.
- Those which are a bit more complicated and involve a number of feared situations e.g agoraphobia, social phobia....

Agoraphobia is the most common of all phobias - about 7 out of 10 of all phobias. It is literally, ‘fear of the market place’. That is, it is a fear of being away from your home, especially in busy places like shops, buses, queues, visiting, or on holiday. It is not simply a fear of open spaces - in fact, many agoraphobic’s are not afraid of open spaces at all!
Social Phobia is also common, and makes meeting and talking to people a great difficulty.

Phobias can range from being a minor inconvenience to being completely life-restricting.

Symptoms

Anxiety encourages the body to produce extra adrenaline. People also start to hyperventilate when they become aroused and this can produce all sorts of very unpleasant symptoms such as:

Physical
- Nausea
- Feeling faint
- Jelly legs
- Unable to take a deep breath
- Choking sensation, unable to swallow
- Inability to walk straight
- Rooted to the spot
- Disturbed balance
- Churning stomach
- Dry mouth
- Aches and pains (muscular especially)
- Walking on cotton wool
- Palpitations
- Sweating
- Tiredness
- Over-activity
- Frequent visits to the toilet
- Unable to sleep
- Eating too much or too little

Mental / Emotional
- Panic
- Frightening thoughts
- Feeling unreal or ‘not there’
- Indecision
- Forgetfulness
- Bad-tempered
- Agitated and restless
• Catastrophising (What if...?)
• Gloomy thoughts (negativity)
• Fear

Panic, Anxiety & Avoidance

A person may experience panicky feelings, or even what could be called panic attacks - sudden attacks where the stomach chums, heart races, breathing is rapid, you may sweat and feel faint, and experience overwhelming feelings of fear, panic and the need to escape.

A panic attack is the body’s normal reaction to physical danger, and is brought into action by the automatic part of the nervous system – that’s the part that keeps you breathing without you having to even think about it! It is actually the defense mechanism of the body, because what it does is pump a chemical called adrenaline into your system to either fight what ever is endangering you, or run away from it as quickly as possible. This is why it is called the flight or fight reaction or mechanism.

It does this simply because it has learned to do so. Just as you can learn worthwhile things like reading or riding a bicycle, you can learn undesirable things like swearing or nail-biting. Reacting to situations with fear, anxiety or panic is an unwanted piece of behaviour which you have learned.

Certain experiences and situations make this more likely to happen. But often, anxiety or panic first happens:
• in response to actual physical danger e.g. a large aggressive dog,
• or in a frightening situation e.g. trapped in a lift, or
• by copying it from someone else e.g. if Mum or Dad is afraid of something, or
• because there is danger to you as a person e.g. you might make a fool of yourself. Or appear stupid, or you find yourself in a situation which you find very difficult to cope with. Because these panic feelings and anxiety are so unpleasant, it is then very easy to begin to avoid situations when you think they might happen to you.

It is avoidance of such situations which can build up to a phobia. The particular phobia depends on which situations you have been able to avoid. Your life can become very seriously restricted. Every avoidance makes the next attempt to deal with the situation even more difficult. Some people find they become continually anxious or panicky.

Anxiety and phobias can be triggered off by:
• A long or short period of stress
• A very emotional experience (‘good’ or ‘bad’) such as a bereavement, divorce, separation, marriage, birth, illness, new job or moving house.
• A number of minor stresses over a period of time.
Counselling can often be very effective in helping a person learn more appropriate responses to the trigger situations. The behavioural approach is used most frequently, and involves:

- Learning to relax again. Teaching relaxation techniques.
- Learning how to catch panic early and stop it there.
- Working slowly through the clients problem situations.
- Learning how to think positively and healthily.
- Exploring possible causes of the anxiety by looking back
Bereavement

‘People in mourning have to come to grips with death before they can live again. Mourning can go on years. It doesn’t end after a year: that’s a false fantasy. It usually ends when people realise that they can concentrate their energies on their lives as a whole, and not on their hurt, and guilt, and pain’.

*Elisabeth Kubler-Ross, On Death and Dying.*

Bereavement and loss are things which we all experience at some time in our lives. However, grief expresses itself in many different ways, often with powerful, frightening and confusing feelings. It is common for these feelings to ebb and flow over a very long period of time, whilst those around us may say ‘you should be over this by now’. Although no two people’s experience will be the same, below are listed some of the common feelings which may be experienced at different times in grief.

- **Shocked Disbelief**
  You may find yourself being very calm and rather detached. Conversely you may feel completely at sea. Both are perfectly usual reactions.

- **Being unable to accept the loss**
  This often involves what has been called searching behaviour, which means that at some level you are trying to deny that the death has occurred, and in so doing you might find yourself making mistakes, which can be worrying. For example thinking that you have seen or heard the dead person, or laying his/her place at the table. You may even find yourself at odd moments of the day actually looking for him or her. Again this is perfectly usual.

- **Anger and guilt**
  You may be wanting to ask the question, Why has this happened? and why has this happened to me? It is common to wish to find blame for it, either in yourself, in others, or even with the person who has died, and this can lead to powerful feelings of anger and guilt (or sometimes both).

- **Despair and depression**
  There may be times when you lose all interest in living and feel that there is no point going on. You may even question your own sanity and think that you are going mad. This, though painful, is a common experience.

- **Re-organisation**
  Usually this occurs with the passage of time and, when the pain has eased somewhat, you may find yourself being able to remember without feeling so overwhelmed. This can be a time for you to begin life again, maybe to renew old interests and take up new pursuits. This might seem disloyal to the person who has died, but what has
happened in the past is always a part of you and is not affected by your enjoying the present, or planning for the future.

It is sometimes very tempting to feel that life would be more bearable if you moved house or quickly disposed of possessions or refused to see people. There is a very common urge to avoid painful things. However, this can make things worse and such decisions must be given great thought. Bereavement is a time of very painful emotions, but it is important to experience these to the full in order to build your life again.

It is not uncommon, as well as feeling mentally taxed, to feel physically run down: to find it difficult to eat, sleep and so on, but eventually these symptoms should fade and disappear.

As well as going through many of the reactions outlined above, a person may also experience many other feelings (e.g. panic, relief, fear, self-pity). They may feel they ought to hide them, but they are an important part of bereavement and it can be valuable to share them with a sympathetic listener.

People may find themselves feeling hurt and convinced that some of their friends are avoiding them. Unfortunately, this often happens and can be due to embarrassment – ‘not knowing what to say’. Many people feel, following a close bereavement, that they would like someone outside their immediate circle of family or close friends, to talk with and confide in. For many different reasons they will turn to one of the numerous Bereavement Counselling and Support organisations that exist. It can be a very isolating process when people may feel as if no one else could possibly experience what they are going through.
Trauma, Loss, & Bereavement

Loss disappointment, failure and grief are normal and natural accompaniments of the human experience. Bereavement, the response we have to grief and loss is also familiar to most of us. Little has changed in terms of the emotional response to the pain of loss across the centuries. There are many kinds of loss, death is but an extreme example. There is still the agonizing experience of separation and the subsequent wrestling with the aftermath of unfinished business and unanswered questions related to ‘Why? and ‘why me?’

Having one’s comfortable and stable world rocked by uncertainty, chaos and anguish ushered in by death leaves one feeling helpless. There continues to be the struggle to deal with the uncomfortable reactions of anxiety, anger, despair and the impact on one’s self-esteem. Confusion, disorganization, and depression are the natural results of having one’s world shattered by the death of a loved one. It is normal to resist the onslaught of unexpected feelings and the fear of facing an uncertain future without the loved one. Everyone is touched by the experience of feeling mortal and vulnerable which occurs in an encounter with the finality of death. Most, despite all of this, submit to the necessary process of loss, grief and bereavement and work to rebuild the old world into a new, post-loss world.

However, while the actual experiences of mourning and its inherent demands have not changed over time what has changed is the climate in which they now occur. This changed environment is charged with potentials for complicated grief and mourning. The reason for this is quite simple. Death has become more frequent, unnatural and violent with less of a social context in which it can be integrated. The social conditions under which we exist are characterised by increased violence, accidents, terrorism, disasters, holocausts, plane crashes and seemingly random shootings.

Today, deaths are more frequently of the type known to complicate mourning. In particular, these include sudden, unexpected deaths, especially when traumatic, violent, mutilating, or random; death resulting from an overly lengthy illness, death of a child, and death the mourner believes preventable.

Loss and bereavement, then, become even more problematic, when it occurs under traumatising circumstances. Recent studies have shown that when death occurs from sudden, unexpected circumstances such as accidents, suicide, or murder, bereavement reactions are more severe, exaggerated and complicated. The individual mourner’s capacity to cope and adapt are overwhelmed.

The American Psychiatric Association has defined trauma as follows:
The person has experienced an event that is outside the range of usual human experience that would be markedly distressing to almost anyone. For example: serious threat or harm to one's children, spouse or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been or is seriously wounded, or killed as a result of accident or physical violence.

The result of these kinds of experiences results in a condition known as Post Traumatic Stress Disorder. PTSD is a normal response to abnormal circumstances. Failure to recover or adequately deal with traumatic loss and restore one's life to normal functioning is often referred to as Complicated Grief Response.

There are a whole host of factors which lead to complicated grief subsequent to trauma.

• The first is that the suddenness of the trauma overwhelms the person's coping abilities and leaves him or her in shock.

• The second is that our commonly held belief; about the justice, orderliness, safety, meaningfulness, stability, predictability, and our ability to control our destinies, is violently shattered.

• Thirdly, because of the type of loss we experience intense reactions of fear, vulnerability, helplessness, and loss of control.

• A fourth factor is that the mourner experiences a profound loss of security and confidence in the world which affects all areas of life. This is likely to increase many kinds of anxiety.

• Fifth, traumatic death leaves mourners with relatively more intense emotional reactions, such as greater anger, ambivalence, guilt, helplessness, death anxiety, vulnerability, confusion, disorientation, and obsession with the deceased along with strong needs to afix blame or make the death meaningful.

• Sixth, the traumatic death leaves the mourner with many secondary losses and problems to deal with as a result. Unfinished business, and not able to say goodbye make it difficult to complete the mourning.

• Seventh, traumatic death leaves the victims with profound feelings of mistrust. shattered belief, and inability to reattach to a future with hope and meaning A sense of foreshortened future and recurrence are common.

• Eighth, traumatic death compounds and exaggerates all of the other normal ongoing stressors of life.

• Ninth, traumatic death often creates many post traumatic reactions of a physical or psychological kind. Shock, numbing, headaches, sleep disorders, digestive
disorders, inability to feel loving feelings, depression, anxiety, and intrusive thoughts, flashbacks, fatigue, tension, weakness, sweating, hyper-vigilance, irritability, amnesia, and difficulty in concentration are all common.

- And finally, the tenth factor has to do with the mourner's attempts to cope and restore order which may turn out to be ineffective. Quite often failed attempts to cope lead to addiction, avoidance, phobias, chronic depression, compulsive-destructive behaviours, and failed relationships. Failed attempts to cope may lead to the mourner getting stuck, or suffering from a complicated grief reaction.

Trauma, loss and bereavement reactions are a complicated interaction of numerous factors; the individual mourner, the type of death, and the social context in which the death occurs. Recent events provide numerous examples of how all of these previously discussed fact interact.

Case Study

Littleton, Colorado

Millions of people watched the unfolding horrors of the massacre at Columbine High School. An entire community was simultaneously traumatised. The concentric circles of victimisation extended out from those immediately under fire to their fellow students, the families frantically searching for their children, emergency responders trying to save lives, protect themselves, and evacuate a booby trapped building. All the while the entire scene was being documented by live television reportage. Death, terror, chaos, shock, disbelief, and horror mounted as the body count went up.

How could this happen?
*We're supposed to be safe in school*

How could the police not know about this ahead of time?
*I knew they were angry and a little weird, but I couldn't believe they were capable of this.*

Tearful reunions, crying, stunned survivors telling of pandemonium and fear behind barricaded doors.

There were more than lives lost that day. Students reported that they could never go to that school again. Their beliefs in a safe, just, serene, stable, orderly, meaningful universe were shattered. Their trust in the ability of adults to protect them was shattered, their beliefs in a future in which they could control their destinies was lost. Random, sudden, intentional murder on a mass scale was committed by students who were known to them. These acts of savagery are incomprehensible yet we try to make sense of them. Shortly after the event began to wind down people were already busily engaged in trying to find answers to how this could have happened, the why and why here and why now questions were asked incessantly. One school, the next day banned trench coats. Everyone in their way
was trying to make sense of what happened and regain control of a world which went upside down and inside out.

Children were exposed to horror, blood, death, and were in fear of their own lives. They were rendered helpless, while simultaneously experiencing the most primitive feelings of terror, shock, confusion, and bewilderment. One of their own wanted to kill as many as possible. This kind of a loss cannot be understood, absorbed or made sensible. There is no way to get closure, say goodbye, or deal with unfinished issues. The sustaining context of hope, the envelope of security, trust and mutuality, the shared experiences, values and beliefs which bind a community and its citizens together was shredded by two young men who for reasons unknown felt isolated, alienated and uncared for enough to plan and carry out a vendetta of rage and revenge.

Shattered beliefs, shattered emotions, shattered relationships, shattered innocence, shattered lives: all who were even marginally involved were rendered helpless and subjected to unspeakable, unimaginable horrors and death. Trauma of this magnitude will not heal by itself. The presence of the press and national attention has already traumatised vulnerable children by subjecting their most intense and personal reactions to scrutiny. It is not possible to heal or even mourn with microphones and cameras present. It can only be done in a safe and caring environment created by knowledgeable, compassionate professionals.

In order for the victims of the Columbine High School massacre to recover, they will need to go through the following stages of mourning: (These stages also apply, of course, to other kinds of traumatic loss).

- **Task 1. Recognise the loss**
  Acknowledge the death, understand the death.

- **Task 2 React to the separation.**
  Experience the pain, feel and express all reactions to the loss. Identify and mourn all secondary losses.

- **Task 3. Recollect and re-experience the deceased and relationship**
  *Review and remember realistically*
  Revive and re-experience the feelings

- **Task 4. Relinquish the old attachments**
  *Release and work through the attachment*
  Release and revise the old world

- **Task 5. Readjust**
  *Move adaptively into the new world without forgetting the old*
  Reconcile old beliefs with new experiences
  Resolve the incongruity, dissonance and conflict in beliefs
Develop a new relationship with deceased
Adopt new patterns and structures in your life
Form a new identity

- Task 6. Reinvest

**Form new attachments**
- Develop new relationships
- Learn to care and live a new life

In all likelihood many of the more severely traumatized individuals will experience some form of complicated bereavement. This in effect means that he or she will get stuck at one stage and be unable to move on to the next. Many will try to skip the whole process and just get on with their lives.

Mourning is not optional. It is something which won’t leave us alone until we heal the wounds. If we try to avoid it, we run the risk of having our lives stop at the very place where the trauma occurred. Counselling can provide the way in which the process of healing can be facilitated.

**Case Study:**
**Traumatic incidents**

David and Eileen were in a company vehicle returning from a meeting. As they drove down a narrow road a young child ran out in front of their car and was hit. Eileen who was driving was in shock and could not get out of the car. David dreading what he would see got out and found the girl lying unconscious and her mother beside her screaming.

People came out of a nearby park and some were angry, claiming that cars always drove too fast and someone was bound to be killed. The police were on the scene first and took David and Eileen into a police car where Eileen was breathalyzed. As this was happening the ambulance took the child and mother away.

A manager at their company knew about critical incident debriefing and arranged for a session for Eileen and David. This took place three days after the incident. They knew that the child was recovering and that the police were taking no further action. The session helped Eileen in particular, as she was scared that she was having a nervous breakdown. The counsellor helped her to understand and normalise her feelings. David offered to go for a drive with Eileen so that she could see how she felt driving again. Eileen had one further session with a counsellor and while it took her some weeks to recover she was able to work normally.
The Invisible Disease - Depression

Depression is a serious medical illness. In contrast to the normal emotional experiences of sadness, loss, or passing mood states, clinical depression is persistent and can interfere significantly with an individual's ability to function.

Symptoms of depression include:
- sad mood,
- loss of interest or pleasure in activities that were once enjoyed,
- change in appetite or weight,
- difficulty sleeping or oversleeping,
- physical slowing or agitation,
- energy loss,
- feelings of worthlessness or inappropriate guilt,
- difficulty thinking or concentrating, and
- recurrent thoughts of death or suicide.

A diagnosis of unipolar major depression (or major depressive disorder) is made if a person has five or more of these symptoms and impairment in usual functioning nearly every day during the same two-week period. Major depression often begins between ages 15-30 or even earlier. Episodes typically recur.

Some people have a chronic but less severe form of depression, called dysthymia (or dysthyemic disorder), that is diagnosed when depressed mood persists for at least two years and is accompanied by at least two other symptoms of depression. Many people with dysthymia also have major depressive episodes. While unipolar major depression and dysthymia are the primary forms of depression, a variety of other subtypes exist.

Depression can be devastating to all areas of a person's everyday life, including family relationships, friendships, and the ability to work or go to school. Many people still believe that the emotional symptoms caused by depression are 'not real,' and that a person should be able to shake off the symptoms if only he or she were trying hard enough. Because of these inaccurate beliefs, people with depression either may not recognize that they have a treatable disorder or may be discouraged from seeking or staying on treatment because of feelings of shame and stigma. Too often, untreated or inadequately treated depression leads to suicide.

- Depression affects nearly 10 percent of adult Americans ages 18 and over in a given year, or more than 19 million people in 1998.
- Unipolar major depression is the leading cause of disability in the United States and worldwide.
• Nearly twice as many women (12 percent) as men (7 percent) are affected by a depressive illness each year.
• Evidence from studies of twins supports the existence of a genetic component to risk of depression.
• Research has shown that stress in the form of loss, especially death of close family members or friends, may trigger major depression in vulnerable individuals.

Treatment

Antidepressant medications are widely used, effective treatments for depression. Existing antidepressant drugs are known to influence the functioning of certain neurotransmitters (chemicals used by brain cells to communicate), primarily serotonin, norepinephrine, and dopamine, known as monoamines. Older medications tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAO is) - affect the activity of both of these neurotransmitters simultaneously. Their disadvantage is that they can be difficult to tolerate due to side effects or, in the case of MAO’s, dietary and medication restrictions. Newer medications, such as the selective serotonin reuptake inhibitors (SSRIs), have fewer side effects than the older drugs, making it easier for patients to adhere to treatment. Both generations of medications are effective in relieving depression, although some people will respond to one type of drug, but not another. Medications that take entirely different approaches to treating depression are now in development.

Psychotherapy is also effective for treating depression. Certain types of counselling and psychotherapy, cognitive-behavioral therapy (CBT) and interpersonal therapy, have been shown to be particularly useful. More than 80 percent of people with depression improve when they receive appropriate treatment with medication, counselling, psychotherapy, or the combination.

Depression: What to do about it.

Be angry or be depressed

Depressed people are angry people who won’t / don’t admit it. They tend to say nothing when they should be saying: ‘Get out of my way!’
Anger is a natural emotion which occurs whenever there is something in your way. We probably get at least a little angry about 20 times each day.
When we act on our anger we are saying: ‘I count and what I want matters.’
When we don’t take action we are saying: ‘You count. I don’t.’

Ignoring our anger can make us believe that nobody counts and nothing matters.
Professionals debate whether major depression is biological, psychological, or both. But everyone agrees that all depression, mild to severe, shows the need for better self-care.

You have probably heard: 'We all get depressed sometimes.' To the extent that this is true, it is a sad reflection of our guilt-ridden culture. It is not a reflection of some biological predisposition toward being depressed.

Any depression is a problem, and regularly occurring depression is a serious problem. Counselling (either with or without medication) can help considerably. A behavioral counselling approach is outlined below.

1. Notice how prevalent anger is. Just go about your normal day and notice every time you see even the slightest sign or anger in the people around you.

2. Notice how safe anger can be. Notice how people use their anger to get what they want, and how seldom they 'get in trouble' for it. You'll notice that some people almost always get angry responses from others when they express their anger, but most people do not. Decide to learn from those who do not.

3. Make a list, on paper, of the best examples you can find of how people around you use their anger effectively. Put an asterisk on the examples you like most. Notice how often these people get what they want when they express their anger. You'll show yourself how safe anger can be. You'll see that everyone has their own unique style of expressing anger, and that one or more of these styles 'feels right' for you to use. You'll learn that people who express their anger get what they want much more often than people who do not.

4. Learn the physical sensation you feel whenever you get angry ('tight shoulder,' 'tense stomach,' 'pain in my chest' etc.). Notice that you get this same sensation every time you are angry - and that it varies from very slight to very strong depending on how angry you are. Get good at noticing even the slightest sensations of anger. After accomplishing this task you will always know when you are angry, how strong your anger is and how much energy you have to deal with each anger-inducing situation.

5. Begin to express your anger more and more, based on what you've learned about how others express their anger. Notice what happens to your depression. The more anger you use, the less depressed you will feel.

6. Continue to experiment with expressing your anger. Focus on the results you get. Compare what actually happens with what you thought would happen. (In other
words. compare reality to your scary fantasies.) Everyone will know that their scary fantasies are far worse than what happens in real life. Most people will learn that their scary fantasies were based on childhood realities, not on, on adult realities.

When you are no longer depressed you will feel stronger, more energetic, and more enthused. You will have a renewed interest in all kinds of pleasure. Daily problems will still be there, but they will bother you much less.
Eating Disorders
Case Study

A Mothers Story

We were a normal, average family with no particular problems. Happily married we had four children, two girls first and then two boys. Financially secure, we lived in a good house in a good area. Our children were our priority and we gave them what we considered a very secure upbringing with plenty of love, attention, encouragement and tolerance. I was at home full time during the early years, and while having many outside interests my family was always my first priority. The children were doing well and caused relatively few problems. Like everyone else we had our disagreements and clashes but these were minor and of little significance in our daily lives. If the truth be told, at that time I did realise that we were very fortunate and was slightly smug when I came across people who for one reason or another, were struggling with their lives.

Then the nightmare started. One evening we were out to dinner with friends when my eldest daughter, Ruth phoned and told me that I should come home immediately. I then discovered that Susan, my younger daughter then 16, had broken down and told her that for about a year and a half, she had been caught in a vicious cycle of constant dieting and semi-starvation. Breaking down and bingeing followed by a large dose of laxatives.

My reaction was one of complete shock. I knew a little about bulimia and knew it was serious. How had we not noticed what was going on, how could we have allowed this to happen, how could we have failed her so abysmally? Feelings of guilt rose to the surface and were coupled with confusion, anxiety and ignorance. Susan had seemed such a good girl, happy, thoughtful, sensitive, kind and intelligent. You couldn’t ask for a better daughter.

In retrospect, we were fortunate that Susan, herself had recognised her problem and at this stage was willing to do something about it. However that was only the start of a long, long road. We immediately brought her to our GP who fortunately was both sympathetic and knowledgeable and were referred on from there to a specialist psychiatrist. At that stage, I firmly believed that if I could access the right treatment and was loving, accepting and supportive I could make her better. The following years were a succession of hospitalisations, long periods of depression, repeated suicide attempts interspersed with enough good periods to allow her pass her leaving certificate and to embark on a university degree course.

She was impossible to live with; the strain on family life was enormous. There were terrible mood swings, screaming at her brothers and sister, abusing and blaming us. During her periods of depression she would literally live on a couch in front of
the television set and could not even get dressed until the evening time, all the time bingeing and sinking lower and lower.

We were powerless to help her. The breakthrough came when on collecting her from hospital after yet another suicide attempt and I realised that without her taking responsibility for her own illness, there was nothing anyone could do and I broke down and cried all day. It was the first time that she realised the strain she was putting on her family and it gave her just enough motivation to start on the road to recovery. There were many future relapses but each time now she is getting slightly better.

At the same time we were also learning to cope - accepting finally that it wasn't our fault, learning about bulimia, and firmly putting responsibility on to her and all the time assuring her of our absolute love and support. It was not easy and we all had to develop coping mechanisms for ourselves when things got too much.

With the help of an excellent counsellor she is now 95% recovered and will graduate with honours from her university course tomorrow. The future looks bright but I am not quite ready to say that it is all over.

Treatments of Eating Disorders

Eating disorders have many facets and treatment needs to work on different levels. The medical complications are serious and can even be life threatening, so early professional intervention is important. As discussed earlier the psychological basis that underlies the eating disorder must be properly addressed if the weight restored is to be maintained.

The altered behaviour associated with disturbed eating patterns must be examined and healthier coping mechanisms learned. Repairing fraught family relationships can take time, but with the guidance and skill of a counsellor the hurts can be healed and harmonious communication re-established.

- Medical Treatment in Eating Disorders

A detailed medical assessment is essential, as untreated eating disorders can be extremely dangerous. Electrolyte (chemical essential to the body's function) imbalance can cause cardiac abnormalities in extreme starvation and vomiting cycles.

Medical staff will aim to stabilise the person's weight at a safe level, but this can really only be achieved with their co-operation.

A structured specific programme is negotiated so that the person with the eating disorder is consulted and involved in its design.
A full medical history and blood tests are required to assess the condition before a treatment programme is agreed.

This may require hospitalisation, in a special treatment centre.

A Dietician will design a suitable diet and exercise may be curtailed in the early stages. Nutritional and vitamin supplements may be prescribed and appetite-stimulating medications may also be recommended.

While there is more to eating disorders than food, the body's basic requirements must first be addressed and stabilised before the psychological aspects can be explored.

Underlying anxiety and depression must also be treated if recovery is to be complete. Physical symptoms, such as ulcers, dental decay and menstrual regulation must also be attended to.

- **Behavioural Approaches to Eating Disorders**
  
  Behaviour therapies consider people's problems as learned responses to life's difficulties, if learned many can be *unlearned*.

  We all hold beliefs in life, most are healthy and based on life experiences, but some are formed through making associations that are not valid. Some people with eating disorders have come to associate slimness with success, popularity or control.

  *Cognitive Behavioural Therapy* examines the person's beliefs that underlie his or her behaviour. By discussing these beliefs openly their basis is questioned and over time replaced by healthier belief systems.

  When any behaviour has become established over a period of months or years, change can be difficult and slow. Behaviour Therapists are skilled in helping the individual through this transition, by building their confidence, and demonstrating alternate coping strategies. Relapse prevention and practical problem solving techniques are also taught.

  The choice of therapy depends on the individual and their readiness. This treatment approach moves the emphasis away from food fixation and on to the real underlying issues of self-image and self-esteem.

- **Psychological Approaches to Eating Disorders**
  
  Recovery from an eating disorder requires acceptance and courage. The importance of a trusting, honest and open relationship with the therapist is paramount. One to one counselling in the initial stages can help to gain a clearer
insight into the mental processes that have led to the eating disorder. While gently exploring the issues, the counsellor will help the person to develop healthy and more direct coping strategies.

Rebuilding self-worth and a realistic self-image are key elements in recovery, the person must value themselves. Group and peer support reduces that sense of isolation and offers hope.

Underlying anxiety and depression must also be addressed to prevent recurrence. Psychological approaches promote a greater understanding of the condition through educational inputs, and encourage the individual to retain responsibility for their health.

- **Social Aspects in the Treatment of Eating Disorders**

  For some, an eating disorder is an attempt to exert control in difficult environments. Many young people wrestle with the need for autonomy and challenge parental wishes. Family dynamics can become tense, with mealtimes becoming a battle zone.

  Social approaches explore the persons ability to express their needs in a more direct way, without resorting to control behaviours. Social approaches examine such topics as communication, anxiety management, interpersonal dynamics, personal responsibility and assertiveness skills.

  A true sense of self worth and value allows for healthy and satisfying relationships without dependence or approval seeking. A key element of mental health, is the relationship we have with ourselves, maintaining a positive self-image, and realistic self-awareness is essential. People with eating disorders often have low self-esteem, and feel unable to relate comfortably to others. Social therapies rebuild self-confidence and encourage assertiveness, and help the person to recognise their responsibilities to themselves and to others.

  The involvement of the whole family in the treatment programme is necessary if recovery is to be complete.
Stress

‘Life should be fun’

How many times have you said that to yourself?

Perhaps as you have crawled to work in all that traffic, stared at that unexpected bill or worried that you just can’t cope any longer at work.

For life to be enjoyable we all need challenges that we feel we can cope with. Sadly we are all, at times, faced with challenges that we feel we cannot cope with and it is then that we may experience negative stress.

Showing signs of negative stress does not mean you are a weak individual who cannot cope!

It means you are human like everyone else! People react differently to the situations they have to face because they are all unique individuals. Some may be very passive personalities whilst others may be very competitive. Their life experiences will vary enormously as will their overall conditioning. Their state of health will also vary - it is far more difficult coping with the pressures of everyday life when one is feeling unwell.

Life today is very different to that of only a few years ago. It is very time pressured and competitive. Technology is changing daily. Sadly marriage/partnership breakdowns are becoming very common and long-term job security seems, for many, to be something of the past. It is hardly surprising that at times people feel they just cannot cope.

Some of the most common signs of negative stress are:

- Mood swings
- Anxiety
- Skin problems
- Tiredness
- Muscle tension
- Poor concentration
- Changes in sleep patterns
- Changes in eating patterns
- Low self esteem
- Poor memory

It is very important to take positive action when faced with negative stress as, if experienced over a period of time, it can seriously impair your mental and physical health.
There are times when we all need the help and confidential support of other people, and counselling may be helpful for people trying to cope with stressful situations.

Case Study:
Stress at work

Jane worked for the company for many years and contributed to the reorganisation that was to make the company more efficient. She did not, however, get the position that she assumed would be her’s. She was reluctant to take the job that was offered to her as in her mind it did not acknowledge all the effort she had put in.

Before a decision was finalised she became ill. After four weeks sickness absence for stress she attended Employee Counselling Service where she was able to talk freely about her anger and sense of betrayal. She then explored her options in a calmer frame of mind. Being away from the workplace she was able to admit her fears and face her concerns without worrying that there would be consequences.

Aspects of her personal life were contributing to how she felt and after three sessions she felt she had a better perspective on her job and was able to return and discuss her future in a more positive frame of mind.

Case Study:
Harassment

Kenneth was a well respected and valued member of staff. He enjoyed his job and for many years did not apply for promotion because it would take him away from customer contact. Eventually he was persuaded to take on a new role that moved him to work under a new manager with a very different style of working. She gave him lists of tasks and deadlines, which she pinned on the section noticeboard. She sat in on some of his meetings and afterwards gave him a list of criticisms. When Kenneth challenged her she said, ‘Look, while you are here you do things my way. If you don’t like it - get out.’ Kenneth stayed out of her way as much as possible, but his work began to suffer as he lost confidence.

At home his wife began to lose patience with his constant moaning about ‘that woman’ and she persuaded him to talk to a counsellor.

With his counsellor he planned a strategy where he would make a note of the times he felt he was badly treated. He then arranged to meet with his manager and pointed these out, he also explained what he thought was an acceptable way of raising criticism about his work. At first she was defensive, but as Kenneth put his points in a reasonable and constructive way she had to respond in the same way. There are still tensions but they do now have a working relationship.
Victim Support

How Volunteers Help Victims

The first line of treatment is just getting the victim to express their feelings and let it all out – talking it through, without tranquillisers is the best solution.

It is now established that where a victim does not have a ‘listening ear’ reasonably soon after the traumatising event to encourage natural coping mechanisms, deep seated problems are more likely to occur and subsequently may require professional intervention.

We know that when a volunteer talks through the traumatic experience with the victim coping is significantly improved.

So what is this ‘listening ear’? It is the ear of a third party who is not particularly close to the victim, who is not a professional, who is not part of a state service and whose role is comparatively transitory. The person who best performs this function is a volunteer.

How victims may feel:

They have:
- the need to talk through the experience and the unusual and frightening feelings which followed it - these often include disbelief in the traumatic event, quite intense anger, and inability to cope with ordinary tasks.
- a sense of isolation, of being on one’s own, of suffering what no one else has suffered.
- a loss of trust in other people,
- a sense of insecurity,
- of having one’s privacy invaded,
- of being vulnerable,
- of losing control over one’s life,
- of fearing to leave the house.

Alongside and perhaps consequent on the above - feelings of illness, weakness, dizziness, crying, depression and sleeplessness.

There is ample evidence of victims recording the way in which the ‘trusty volunteer visitor’ can help the victim to cope with the experience of victimisation. The victims found it helpful to have someone to listen to them, to share their feelings with, to confirm that others had been through similar experience, to give them the security of a friendly telephone contact if they needed it and above all to acknowledge that they had suffered.
Family Counselling

Family counseling is an area of great expansion and emphasis in the counselling field today. School counsellors, community and agency counsellors, and private mental health practitioners are showing an increased interest in a family systems approach to problems. Counsellors are turning toward family counseling as a preferred treatment approach for the same reason that family work was initially conceptualized. When a counsellor fails to involve a counsellee’s family in the therapeutic process, the counsellor often experiences futility and frustration in making lasting progress with the individual counsellee.

The family can be viewed as a human system composed of interlocking, reciprocal relationship patterns which significantly influence the behaviour of its individual members. Family counseling is the assessment and treatment of problems of an individual member in reference to the organisation and functioning of that system. Persons within the family, be they parents, marital partners, or children, who manifest emotional problems, psycho-physiological symptoms, or problems in relating to others are viewed as ‘symptom bearers’ or ‘identified patients’ who signal disturbances in the human system in which they live. From this perspective, ailment is not within a person but between and among persons.

Historically, family counseling work began in the 1950s. Psychiatrists, psychologists, and social workers wanted better ways to treat certain patients. Professionals had discovered that some patients only made progress as long as they were separated from their families. They also had seen that after some patients improved, other members in their families clearly played some role in individual symptomatology.

Principles of Family Systems Theory

Family assessment and treatment looks at the family as a system. Any system is comprised of parts which have a relationship to one another and predictable outcomes. In families, the members in their relationships to one another produce certain behavior. The whole of the system is greater than the sum of the parts. A family system cannot be described by adding the characteristics of its members. Instead, by necessity one must understand the family organisation and interactional patterns that involve an interlocking of behavior of its members. Relationships are interlocking and reciprocal like a loop. Events involving one member of the family reverberate around the loop as they affect others and are affected by others. Because change in one part of the system affects the entire system, systems tend to perpetuate themselves in a stable manner through homeostatic mechanisms. When applied to a family, change in one member causes a reaction producing a feedback process from other members which negates the change and restores the family to its homeostatis or equilibrium. Thus, when a family or any member of it shows symptoms, regardless
of the particular form they take, those symptoms can be understood as a homeostatic mechanism which restores stability to a dysfunctional family system.

**Family Assessment**

To be aware of the existence of problems or lack of healthy characteristics in a family can be difficult. Counsellors operating out of a family systems viewpoint make assessments of families using several criteria. Barnhill (1979) identified four basic dimensions of healthy family functioning that can serve as gauges of family life:

1. information processing (communication),
2. coping with change,
3. identity formation, and
4. role structuring.

These issues will be examined here with examples of the types of problems family therapists see when family interaction is dysfunctional.

- **Information Processing - Communication**

  Because the nature of a family system is viewed as interactional, to focus on the patterns of communication that occur within that system is important. Communication is vital to the organization and functioning of a family as a whole and to the development of each family member. Every communication has two functions: a content (report) aspect which describes facts, opinions, or feelings and a relationship (command) aspect which conveys how the information is to be understood. All verbal and non-verbal behavior convey interpersonal messages. Not to communicate is impossible. In communication, family members seek to define the nature of their relationship. When this is unclear, pathological consequences can result.

  Satir (1971) has described styles of miscommunication adopted by family members when they experience threat to their self esteem. Functional family relationships are based on love or trust, so any behavior which suggests something unloving or something untrusting creates anxiety and threat. Several patterns of communication, have been identified as: *placating, blaming, distracting, and being super-reasonable.*

  These are pursued by family members to disguise their fears. *Placating* is communicating in an agreeable manner no matter what a person really thinks or wants. Placating functions to help people avoid anger and conflict but may result in a build-up of resentful feelings. *Blaming* helps a person avoid being held responsible for a problem and to appear strong and righteous. Blaming is unhelpful to negotiation of difficulties. Being *super-reasonable* is a pattern of communication demonstrating logic but no feelings. The problem is that it may interfere in needed closeness with family members. *Distracting* communication, being irrelevant about the
issues at hand, may help reduce immediate tension but ultimately does not facilitate problem resolution.

A child in counselling who is having problems in school may be a distractor for parents who are extremely blameful and hostile toward one another but who will unite in their concern for the child. An adolescent with psychosomatic complaints may reflect a family system in which a great deal of placating and little direct negotiation of differences exist. An acting-out youngster may function to draw in a distant computer-like father into the family.

• Coping with Change

Coping with stress and crises is a normal part of family life. Families have to deal with situational crises such as deaths, divorces, illnesses, separations and additions of family members; unemployment, and relocations. External events like wars, economic problems, crime, and weather catastrophes also can have much impact on families. Individuals have a greater chance of becoming ill when too much change occurs in a short amount of time. Families, too, experience a pile up of stressors and have problems in their inter-relationships. A child who is underachieving in school may be struggling with self-esteem problems, but that child also may be a symptom bearer of a family in which the father has become unemployed, the mother has gone to work, and the parents' relationship has not adapted to the new situation.

Families also experience developmental crises; These are the significant turning points that each family experiences in the life cycle from marriage, birth of children, children starting school, children beginning adolescence, first child leaving home, last child leaving home, marriage of adult children, aging and retirement, to death of a spouse. Carter and McGoldrick (1980) described the family life cycle in terms of the loss that is experienced and the renegotiation and reorganization of relationships that are required by families as they make the transition from one developmental stage to the next. Symptoms often occur when families have much difficulty in making these transitions. The kindergarten phobic child often represents a family situation in which a parent is over-involved and not able to emotionally release the child to the school.

Individual problems need to be considered in both a situational and developmental family context. They often reflect disorganized or rigid problem-solving responses by a family to situational or developmental crises. A healthy family system is one in which resources and flexibility are sufficient for individual members to adapt to changing circumstances and developmental stages.

• Identity Formation

Over time a need for the family to be a core unit of society always has existed—a group where people live together and share life’s basic day to day functions. Because
of the importance of the family, it has a need to feel a basic sense of belonging and development together; A requirement exists, however, that individuals within the system must be able to grow. As the individual and the family unit both need to develop, struggles occur between separateness and togetherness, between differentness and sameness, between protection and freedom.

Some families are too close with little latitude for independent thought, expression, and privacy among members. The families are referred to as enmeshed when boundaries are the means to provide a sense of separateness. Working with the family of a teenage anorexic girl, the counsellor discovers that the girl seldom expresses any ideas which run counter to the family opinions and that only minimal privacy exists between family members. Her control of body is the one way that she has chosen to be different and separate.

Other families are disengaged with rigid boundaries between members. When families are too distant or too disorganized, they cannot provide a sense of support and protection needed by the members. A secondary school student who was caught shoplifting was referred for counselling because the school officials could not understand such behaviour from the nice girl. When her family was interviewed, it became evident that both parents were very involved in their own directions. The girl was floundering as an isolated individual in a fragmented family unit.

Healthy families are neither extremely enmeshed nor extremely disengaged. The members are connected and supportive to one another but also independent and private.

- Role Structuring

In families, roles should be clear and reciprocal. Boundaries then distinguish distinctive parts of the family—the marital unit, the parental unit, and the children. If the subsystem boundaries are not intact, then various problems occur. One such problem is referred to as an inverted hierarchy and exists when clear generational boundaries between parents and children are lacking. A family with a very unruly child obtains counselling help and it is quickly apparent that the child repeatedly does not obey when the parents tell the child to do something. The child is not acting in an appropriate role and the parents are abdicating their parental authority.

Another form of breached generational boundaries is when a child assumes the role of a parental child who acts adult-like and takes on parental roles in the family. This may be important, even necessary at times, in single parent families or large families but can become dysfunctional when the role is too rigid and the child cannot also act in age-appropriate ways.

One or both spouses may seek emotional support outside that sub-system when stress is in the marriage. A child may be triangulated, as comfort and support, to one or both adults. Research has suggested that a very high percentage of child behavior
problems have a basis in marital problems. Triangulation of a child is especially negative when the child serves as a go-between, balancing loyalties and regulating tension in a very hostile situation between parents.

Sometimes, the intergenerational boundary in a family has become too diffuse with respect to one parent and too rigid with respect to the other. Hence, a parent-child coalition against the other parent exists. This has been referred to as a perverse triangle and obviously interferes with the ability of the parents to work together to rear their children.

Counselling Process with Families

The goal of family counselling is the alteration of dysfunctional relationship patterns existing in the family which organize and reinforce problem behavior in the individual. The focal point of assessment and intervention is thus shifted from the person who has the problem to the individual's existing human system, the family.

The specifics of assessment and intervention of the counselling process vary depending upon the theoretical model followed by the counsellor.

The initial phase of family counselling involves getting to know the family and exploring the problem. The word 'joining' is a term used particularly by structural family therapists and refers to the process of developing positive alignments and relationships with the different family members. Joining can be facilitated initially in a variety of ways, both verbal and nonverbal, such as shaking hands with everyone and conversing in small talk.

The counsellor then addresses one of the parents or simply presents a question in a non-directed fashion to determine why the family has come for counselling. Then to pass the problem around and hear how everyone describes the problem and his/her part in it are important. Tracking refers to this process of following the family story as it is told. Empathy and respect should be shown the family members about their view of the problem. The counsellor encourages family interaction among its members by watching what emerges between them or by calling for specific interactions, a process called enactment. Information also may be elicited through picture drawing techniques or family sculpting, a process in which each family member arranges the family in a tableau showing each one's perception of the members' relationships.

In the process of questioning and observing, the counsellor makes assessments about the family in regard to its structure, communication patterns, roles, rules, problem solving methods. Note is taken of any external changes or crises for the family, as well as internal developmental change. In several approaches to family counselling, focussing on family history is viewed as helpful to determine the level of individuation adults have made from their families of origin. A genogram, which is a three generation map of family relationships, can be used.
The goal then of this first phase of family counselling is to engage the family in a collaborative treatment effort and to reframe the presenting problem from an intrapsychic problem to a family system problem. The counsellor becomes the person in charge and can do this from an involved or more removed position.

Problem Solving Phase

From the assessment phase the counsellor develops hypotheses about newly changed forms of family structure. The goals for change may be short-term, intermediate, and/or long-term. The goals need to focus on interactions and relationships within and among systems, and are to be formulated in behavioural terms so change can be observed and understood by family members as well as the counsellor.

Appropriate interventions are many and follow from assessment of the family system. Restructuring techniques work to strengthen or create positive subsystem alignments and boundary clarifications. For example, in a case in which the children have too much voice, the counsellor may structure interaction between the parents so as to come to agreement on what they expect from the children. The parents are helped to develop executive power and therefore draw an appropriate generational boundary. Or in a case in which a mother and son are overly involved and the father is quite distant, the counsellor might first tell the mother that she needs a "vacation" from the troubled son and then facilitate the father and son talking and planning some events together. The father-son sub-system is therefore strengthened. The counsellor may reposition family members during the counselling session, may support and align with different subsystems, may facilitate more independence for a family member, and may see certain members at some sessions in the process of restructuring a family.

The counsellor may need to teach direct, effective communication skills such as listening, empathic responding, and non-destructive expression of anger. For example, in a family in which the father attacks the mother verbally, where the mother placates to try to calm him and the child distracts by being a school problem, the counsellor may block these ineffective communication patterns during a session and help all members communicate forthrightly in a direct, assertive fashion. Another example of communication intervention would be a case in which there needs to be negotiation of new family rules. If the parents in a family are continuing to treat their teenage young person as if he were in primary school, the counsellor can facilitate more effective rules and help them acknowledge a new developmental stage.

An important aspect of family counselling is for families to experience hope and recognize their strengths; therefore, interventions focused on building the positive aspects are necessary. For example, a counsellor can explore the resources used by a family in another time of crisis and emphasize that they do have many coping skills. A counsellor can direct an enactment in which a parent shows some
nurturing toward a child and then comment that the parent’s gentler side had been there all along but is now being demonstrated in an overt way.

Case Study
Assessment of the Client

Billy Brown, a 12 year-old student was exhibiting many behavioural problems in school. His teachers complained a great deal about his disruptive and impulsive behavior, and he was repeatedly sent to the office for disciplinary action. Tests did not indicate any sign of hyperactivity. Billy had a high average range of ability but was not making academic progress He also had problems with peer relationships.

The school had consulted frequently with Mrs. Brown, and she reported many home problems with Billy as well. Billy had lived with the Browns from one year of age and was legally adopted by them when he was four years old. The adoptive father had died when Billy was five years old. According to the mother, Billy’s problems began at that time.

Intervention with the Client

Billy was referred to the school counsellor. Accustomed to viewing problems from an individual perspective, the counsellor looked for the intrapsychic struggle or the individual development problems that Billy was experiencing. Self-esteem problems and problems of loss or grief were explored in individual counselling sessions. Study skills and social skills with peers were pursued in group sessions. These approaches, which are so often effective with problem students, did not change things for Billy. Eventually the case was referred to a counsellor with an orientation to family systems and training in family counselling.

Assessment of the Family Structure and Functioning

The family counsellor asked the entire family to attend the intake session. This group consisted of Billy, Mrs. Brown holding an infant, and Melinda, age 13. The counsellor learned that the baby was a foster care placement waiting for adoption and that Mrs. Brown had taken such foster placements over the years.

Mrs. Brown was in her 50s, overweight, and dressed in black. She was worried about the cost of counselling because the family did not have much money, but she agreed with the school counsellor that some kind of counselling was necessary. She talked at great length about all that was wrong with Billy. She said that he did not listen to her, talked back, and fought a lot with his sister and other kids. Mrs. Brown was perplexed because she adopted these two children when they were in her foster care at very young ages and was confident that she had given them a lot of love. Mrs. Brown presented the picture that everyone - the school, the church youth group leaders, her grown children - were all totally frustrated with Billy. The school had contacted her often about Billy’s disruptive behavior and school personnel were ready to recommend him for a class for the emotionally disturbed.
After asking Mrs. Brown more about herself, the counsellor discovered that the husband died one year after the adoption. Since that time, Mrs. Brown, who had been totally dependent on her husband, devoted herself to raising Billy and Melinda. She did not involve herself in any activities except seeing her grown daughters; and their families. An older son, age 31, still lived at home.

While the mother talked, Melinda was rather withdrawn but echoed her mother about everything that was wrong with Billy. She looked at her mother while sharing that she had some academic struggles at school. They did agree that she had no discipline problems there. Although she fought a lot with Billy, she did seem to look to him for peer companionship. She had not spent much time away from her mother and brother.

Billy responded by being very oppositional to everything that was said about him. He sat close to his mother and bothered her until she corrected him. He refused to assume responsibility for his problems until the counsellor teased him about that and then he broke out in a guilty smile. Billy claimed that he wanted to be a good student. Billy was grounded at home a lot and spent time reading or withdrawing to a cave he built for himself.

Based on this interview, the counsellor drew some tentative hypotheses about communication, coping with change, role structure, and identity formation in this family. Much of Mrs. Brown's identity seemed tied up in mothering, and she had not felt successful with Billy. Under this sense of threat to her self esteem she operated out of a blaming stance and Billy had been labelled the 'bad seed' in the family. In focusing on the children and particularly on Billy as a problem, she did not have to focus on her own issues or growth in life. The family still seemed somewhat mired in terms of adapting to life without the father. They have not expanded out to external resources. Whether or not the grief has been dealt with was unclear since the mother seemed depressed and appeared almost in mourning. The daughter colluded with the mother, acting inappropriately maternal. The family was highly enmeshed, and the counsellor theorised that Billy, who was entering adolescence, was having difficulty getting distance or feeling safe. Billy's misbehaviour clearly kept his mother over-involved with him. The family then continued in a pattern which resisted growth and change.

Intervention with the Family

The family counsellor developed the goal of helping the family achieve some separation while supporting the mother in her competency as a parent and reducing the role of Billy as the scapegoat.

Many restructuring techniques were used. To facilitate individuation, the counsellor positioned all three people apart from one another during the session.
This reduced physical contact between them as they talked. Mrs. Brown and Billy were asked to negotiate a problem while Melinda sat back with the counsellor and watched, thereby cutting into Melinda’s coalition with her mother against Billy. To strengthen the sibling subsystem, the two children were asked to plan an activity without involving the mother in their conversation. Out–of-session tasks were given to encourage individual activities on the part of each family member. The counselor prescribed that for the good of the children, the mother was to have time away from them weekly. A suggestion was made that Billy get involved in either the Boy Scouts or activities at a local science museum. Melinda was encouraged to invite a girl friend over to the house.

Interventions around the communication styles in the family began when the counsellor interrupted and blocked the negative comments of the mother about Billy. A transaction was completed between the mother and Billy in which he was able to disagree with his mother but in a respectful tone that she was able to hear. Billy was confronted by the counsellor on his pattern of always projecting blame outside of himself. The family was encouraged to be more playful and humorous with one another. Mrs. Brown was complimented on all her work as a mother so that she did not experience as much threat to her self esteem, and therefore, did not have to fall back into such a critical stance.

This process continued until separation became more comfortable for this family. Melinda spent more time with a girl friend from school. Mrs. Brown’s appearance changed as she dyed her hair and dressed in some brighter colours. She talked with more enthusiasm about her life and joined some activities at the church where she was active before her husband’s death. With time, Billy’s acting-out behaviour at school lessened, and he became more involved with a peer group. Although still in trouble sometimes, he was no longer the ‘bad’ member of the family who was blamed for everything. The family terminated counseling with a better sense of their strengths, an improved way of relating, and a family structure which allowed for individual growth of its members.
What is Counselling by Telephone?

In simple terms, counselling by telephone may be defined as a service whereby a trained counsellor works with a client, or a group of clients, by telephone, to enable the client(s) to explore personal situations, problems or crises in a one-off or in an on-going longer term therapeutic relationship.

A contract of some sort is agreed between the counsellor and client(s) and there may be a financial relationship as well, particularly for ongoing work.

Not all counsellors will find that they are able to work effectively on the phone. Of course, this does not mean that they are any less effective as face to face counsellors; simply that the telephone medium does not suit them. Similarly, not all clients have a telephone and nor will all potential clients find the telephone a comfortable medium.

There are, of course, other, more common reasons than counselling for working with people on the phone:

- advice may be offered
- advocacy may be provided
- information may be provided
- support can be offered
- befriending can take place

The continuum of the relationship between the different methods of working by telephone:

Advice ↔ Advocacy ↔ Information ↔ Counselling ↔ Support ↔ Befriending

- **Advice giving**

  This is when the caller is offered a course of action to follow. In response to a question or a situation being explained by the caller, action can be suggested. It might be phrased as ‘If I were you I’d ...‘ or ‘You must do ...’

  It is a straightforward call with the caller seeking advice from someone with more knowledge about the issue.

- **Advocacy**

  This requires the person answering the phone to support and to act on behalf of the caller, or perhaps on behalf of the person the caller is talking about in the case of a child protection helpline. To be an advocate, the person answering the call has to have knowledge of the issue being discussed and be able to interpret or assess needs as well as knowing how to progress the enquiry.
Taking the example of a child protection telephone service helpline, the person answering the phone may advocate on behalf of the caller or on behalf of the child about whom the caller is speaking. If the caller is an adult and is talking about a child whom the helpline counsellor perceives to be at risk, the counsellor is able to refer information to local social services, for example, whether or not the caller agrees, although clearly every effort is made first to try to gain the caller's co-operation in such situations. The Helpline's primary responsibility is to advocate on behalf of a child.

**Child Protection Helpline (CPH):** Hello, this is the Child Protection Helpline.

**Caller:** I don't know if I should be calling... you see I'm very concerned about a child in a particular situation. Can I speak to you in confidence?

**CPH:** Yes you can speak in confidence, but if you give us details of a child who is at risk, we have a responsibility to act to ensure the protection of the child. Would you like to give me a general idea of what your concerns are?

**Caller:** I'm a grandmother and the child lives with its mother. Its father is my son and we have concerns about how the child is being looked after....

**CPH:** Can you give me some detail of what are your actual concerns and perhaps tell me when you last saw the child...?

The CPH counsellor needs to establish how urgent the concerns might be. Using counselling skills to work with the caller, the counsellor must explore the situation in order to be able to make a judgement, there and then, of how to focus the call, on the basis of the information received. So in the above example, the counsellor would possibly move on to establish whether the grandmother's concerns are significant enough to indicate that the child might be at risk. If the counsellor perceives that this is the case, the counsellor might then try to encourage the grandmother to willingly disclose more information in the child's interests so that action to protect the child can be taken.

- **Information**

This is the delivery of facts about a situation, in answer to a question or presenting circumstances. Although requiring a friendly tone of voice, there is no engaging in any in-depth conversation except for further clarification of what has been said. The person answering the call must have, or be able to access readily, the information sought. A welfare benefits enquiry to a carer's service may offer this type of service.
Many helplines will report that calls to the service often present themselves as an initial enquiry requesting information. If the worker provides openings in case there are any other issues to be discussed, as happened above, the caller can choose to take them up or not.

- **Support**

This involves responding with empathy to a caller. Some people have this ability quite naturally but others do not. If the fundamental instinct to be able to be alongside someone without jumping in to offer sympathy, an opinion or instruction is lacking, a person is unlikely to be able to modify their attitude over the telephone. This is because the person does not have the visual clues which might otherwise warn them, if they could see the impact their remarks were having, that they were not responding appropriately.

Telephone support may be sought either from someone who has been through a similar experience to oneself, that being their primary 'qualification', or from someone who has detailed knowledge and awareness of a particular situation and an ability to empathise. Whether offering support based on professional training or on personal experience, the supporter must be clearly aware of when their professional or personal experience of the situation can become a limiting factor in the support that they can offer. In other words, there must be awareness of the boundaries or limits of the service which can be offered and knowing when it could be more helpful for the caller to also talk to other people or to consider alternative suggestions.

Self-help groups may offer a supportive type of telephone service:

**Caller:** Is that the Eastbridge breast cancer support group?

**Supporter:** Yes, I'm Maria. How can I help?

** Caller:** Well, it says in your leaflet, that I got from the hospital, that you're there to support and help people who have cancer. I've just been told that I have got breast cancer ... and I'm really scared. What will happen?

**Maria:** It is very hard to be told that you have cancer and there can be lots of things to think about....

**Caller:** Have you had cancer?

**Maria:** Yes, I had breast cancer four years ago.

**Caller:** How did you feel? Were you scared? I can't believe it is happening to me ... I'm so frightened....

**Maria:** It is a very difficult time. What have you been told?

**Caller:** (crying) I'm so scared... all you think about is that that's it, the end ... I'm sorry for crying....

**Maria:** Mmmmm, it's OK, take your time ... it is quite natural to be worried... has anyone at the hospital suggested any treatment?
Caller: Yes, they say I’ve got to have the lump taken out and then four weeks’ radiotherapy. Did you have that?

Maria: No, I had an operation and then chemotherapy. It was very scary when I first learned I had cancer, but you do get on with it, and once you start your treatment you could find, as I did, that you get used to the idea. At the group we’ve all been through the stage of being diagnosed, told you have cancer, and then having some sort of treatment. ... Many people find it helps to talk to someone else who’s had it.

Caller: Yes, I don’t know what to tell the family. I have to be so strong for them. Do you know of anyone who has had treatment exactly like mine will be? (crying)

Maria: It’s OK, take your time, we can talk for as long as you wish. There are other women in our group who have had radiotherapy and I can give you a phone number for one of them if you like.

Caller: Someone’s just come in. I’ll have to go. Can I call you later to talk a bit more?

Maria: Of course, any time up to 10 tonight or again tomorrow.

Caller: Thank you Maria. My name’s Susan.

Maria: Well, bye for now, Susan.

Susan: Goodbye and thanks.

Here the caller is unsure of what she wants, but on hearing that the supporter has identified with her situation, in this case from her own experience, and knowing that there are also others in the group with whom she could have contact, the caller is able to talk a little more and to release some emotion which does not put off the supporter. With such a safe environment and a rapport established, it is likely that the caller will ring again when she is not going to be interrupted.

- Befriending

Moving further along the spectrum and indeed at what might be considered the opposite end of the spectrum from advice giving, befriending is emotional support, given unconditionally, by one human being to another. There is no contract between the two people, no requirement to ‘qualify’ for the service, and it involves the extensive use of active listening skills and is the least directive form of telephone work. The caller is listened to, heard and encouraged to talk further if they wish. The Samaritans is the most well-known service which offers telephone befriending 24 hours a day, all year round, when the caller needs it. Strictly speaking, Samaritan befriending is the provision of emotional support without which the caller, or befriended, may go on to become actively suicidal. It might not be necessary for the befriended to be recognisably suicidal - indeed the person may be in a state such that, with the absence of emotional support it is likely they would become suicidal. The
Samaritans organisation does not judge, prescribe, analyse or advise callers and is absolutely confidential. The caller can remain anonymous.

*Samaritan Volunteer (SV):* The Samaritans, can I help you?

*Caller:* I'm not really sure that I should be troubling you... you see, I'm not about to kill myself... but I just need to talk to someone..

*SV:* That's OK, there's plenty of time. ... Why not try talking to me?

*Caller:* I... I... I just don't know where to start... (crying)

*SV:* (absorbing the silence, doubt and uncertainty, leaves the silence for some minutes)

Well, let's try together to explore what might be going on. Perhaps you can tell me what was in your mind immediately before you decided to pick up the phone?

And so on.

Here The Samaritan volunteer, or befriender, simply allows the befriendedee time to think and talk. The silences may be long, but there is no pressure of time on the caller. Gently, the befriender will explore with the caller whatever the situation might be. The befriender goes at the pace of the befriendedee, using empathy to support the caller and giving the caller permission to be as they are, acknowledging the feelings they have.

In all of these communications across the spectrum, a relationship will have to be established between the caller and the person answering the call if the essence of the call is to be effectively addressed. The skills needed to carry out any type of telephone work are fundamentally the same, with an emphasis being placed more strongly in some areas than in others according to the nature of the service offered and, within that, the nature of each call.

The worker must be appropriately trained in order to be able to move comfortably between the service's specific parameters for crisis intervention, support, information or advice giving as each call to the service requires.

**Before the Call**

Getting ready to start telephone counselling is rather like going on holiday or making a long car journey - careful preparation makes all the difference between a successful event and possible disaster. You would not think of making a long car journey without:

- checking the mechanical condition of the car,
- filling up with petrol,
- making sure you have enough qualified drivers,
- correct insurance and
• a map.

Having such a checklist for counselling is, in essence, no different whether we are counselling on the telephone or face-to-face, but our pre-counselling checklist will be somewhat different. For telephone work, the checklist is divided into two sections:

• The agency checklist (things an agency must do to provide an effective service and to protect its workers/volunteers and clients).
• The individual counsellor’s checklist (things counsellors must do to ensure we and our clients are safe enabling us to work to our full potential.

**Agency Checklist:**

**Agency Policy – Is there one?**
If Yes does it cover:
Training
Support and supervision
Boundaries
Advertising
Worker/volunteer personal safety
Equal opportunities for workers & clients
Legal issues
Insurance
Abusive calls
Referrals
Silent calls

Are there enough workers/volunteers?
Does the rota system work?
Are the premises adequate?
Is the telephone system adequate and appropriate?
For how long is funding secure?

**Personal Checklist:**

Do you feel properly supported on the following issues by the agency?
Sufficient training
Adequate support & supervision
Boundaries
Congruent advertising
Your personal safety
Countering discrimination
Understanding the law
Are you insured?
Do you have to listen to abuse? Are you allowed to put the phone down on abusive callers?
Who do you take referrals from and make them to?
Are you allowed end silent calls?

Do you feel personally able to take on this work today?
Have you left your personal issues behind?
Are you familiar with the agency routines?

An agency without a policy will fail to provide a safe working environment for its counsellors and clients. If counsellors do not have sound guidelines on confidentiality and referrals, adequate support and supervision, sufficient training or work in an agency that doesn’t have a clear idea about the work that it does, then they cannot give 100% of their attention to their clients.

For counselling to be successful the counsellor must give full attention to the client, confident in the knowledge that the agency is holding the safety net woven from the elements listed above. Counsellors should do the counselling and the agency should take care of the rest.

- Confidentiality and Privacy are different.

Confidentiality and Privacy are different. On the phone it’s important to distinguish between these two features of the counselling boundary. This problem would not occur in a face-to-face setting since it would be assumed that the interview was private, i.e., that no-one else is present. Confidentiality refers to the treatment of information disclosed to you by the client, including their identity. Privacy refers to the setting in which the counselling takes place. A setting can be somewhere on a sliding scale between private or public.

Clients might expect their call to be received in private and confidential surroundings. How would a client feel if after hearing assurances that the call is confidential, they could hear other voices in the background (a common experience for callers to helplines) or a voice saying ‘Hey, would you like a cup of coffee?’

Keeping information disclosed by clients confidential is a major factor in establishing an environment in which your clients can feel safe and secure. In order to avoid confusion amongst agency workers and to protect counsellors, there should be an agency policy on confidentiality.

Agency policy should be clearly written, available to all workers, not just counsellors; made known to all callers at appropriate times during their helping relationship;
fully explained in training and induction to all agency workers.

Agency policy should cover:
what categories of information are confidential;
under what circumstances and to whom confidential information would be disclosed;
lines of support in confidentiality disputes;
who has the final say in matters of disclosure of information - client, counsellor, supervisor, manager?
the legal position on confidential records.

Counsellor anonymity - in addition to protecting the identity of your callers, you may well expect your privacy to be respected too. Is there an agency policy which says that your personal details must not be given to anyone without your permission, and never to a client even with your permission?

Examples of agency statements on confidentiality:
• confidentiality is not kept just between the individual worker and client. Confidentiality is shared between past, present and future workers;
• do not speak about callers when off duty, even when you think the caller cannot be identified;
• only talk about callers to other agency workers when on duty, always protect their identity. Always have a reason to talk about a caller (eg supervision or support), never gossip;
• never break confidence without the client’s knowledge;
• always seek the client’s permission before speaking to a third party;
• only the agency manager may speak to anyone outside the agency eg police, social services, GP’s etc.

The legal position
As far as the legal situation is concerned, the law is constantly changing in two respects. Firstly, the various laws concerning confidential information are occasionally re-written. And secondly, as cases are tried in Court, certain judgements set legal precedents. Therefore, anything written here, today, may well be out of date by the time you read it.

In general, agencies and individuals do not have to disclose information to the police or anyone else for that matter (there are two exceptions - see below) even when the information concerns crimes as serious as murder. You will not commit an offence by withholding information asked for unless,
i) it relates to the Prevention of Terrorism Act, when withholding information without reasonable excuse is an offence, and
ii) you are ordered by a court to produce information and you refuse, in which case you may be in contempt of court and may be fined or imprisoned.
Personal safety

The issue of personal safety is not simply about ensuring your physical safety, but also about ensuring that you feel safe whilst working. You can hardly be expected to create a safe secure space for your clients if you do not feel safe and secure yourself. Your feelings of insecurity will be detected by clients and may well rub off on them. Make sure that your need for a safe working environment doesn’t turn your agency premises into a prison. You need to feel comfortable too!
The final type of counselling put forward for consideration here, is co-counselling. As you will see, it differs considerably from all previous examples.

Co-Counselling

Co-counselling, also known as Re-evaluation Counselling, was developed by American therapist John Heron as the ultimate in non-authoritarian counselling. The idea is that client and counsellor interchange roles and spend an equal amount of time counselling and being counselled. Before becoming a co-counsellor, people attend a course, run by a group leader, where the basic premises of co-counselling are explained.

Co-counselling partners are not always the same: most people in co-counselling find that they can work with a number of different partners. The relationship is supposed to be that of equals, loving but detached partners. This means that intimate liaisons are not encouraged through the co-counselling network. There is touch, and hugging - seen as a very important aspect of the therapeutic process - but this must remain non-sexual.

Co-counselling is intended for those who wish to be more effective in their lives, rather than people who have deep-seated problems which they cannot seem to address or solve. It is a way of relating better to other people, and also to oneself. The fundamental premise behind it is that we are all basically good, loving intelligent people and that if we cannot respond to others, if we are negative, if we have low self-esteem, this is because of some hurt we suffered in early life, which has clouded our vision and our judgement.

The idea is that, through co-counselling, we will be able gradually to strip off the layers of negativity and reveal the intelligent, loving, positive person beneath. If there is incompatibility with other people, according to the co-counselling philosophy, this is most probably because of early distress. Through pairing off, we can learn to lose our fear of others and also our inhibitions. We can learn to trust other people more and also gain the confidence to face up to the source of our early distress.

Peter Clark, a psychotherapist and former university professor, teaches Fundamentals of Co-Counselling at London University. He says: 'Basically, co-counselling is a method of self-development which can help people improve their relationships with others. 'For most of us, the greatest problems in life spring from our interpersonal relationships. Co-counselling can show people how to be assertive rather than aggressive; it can teach people both how to listen and be listened to, and it can allow a situation where you can trust others not to betray or hurt or insult you. 'Many of us have established patterns in our lives where we are always putting either ourselves or other people down, and we have also established habits which are self-sabotaging rather than helpful.'
'Co-counselling can work to change these negative patterns, and substitute them with more positive ones.'

There are three basic areas addressed in co-counselling: relationships, work and lifestyle. Most people cannot work their problems out on their own and they need some kind of help. But they may not need the sort of help that a professionally trained counsellor can give. This form of counselling is not considered suitable for people who are trying to cope with so much distress of their own that they are actually unable to listen to other people, nor is it for those who need actual psychiatric care.

It is for 'ordinary' people who wish to become more effective in their relationships with others, and also get to know themselves a bit better. As with other forms of counselling, though, painful, long-buried issues may come up which cause distress and which are difficult to discharge.

Co-counselling proceeds on the Rogerian basis that everybody, without exception, is loving, co-operative, zestful and intelligent. Through talking to a 'friend' it becomes possible to discharge early hurts and learned negative habits, to reveal the wonderful person beneath, the person who has been trapped for years in a destructive cycle of behaviour. Co-counselling provides a way of doing this without the expense and length of time that other forms of counselling may involve.

During co-counselling, emotional discharge, such as crying, trembling, raging, is encouraged on the grounds that such discharge aids healing. When adequate emotional discharge can take place, according to John Heron, the person is 'freed from the rigid behaviour and feeling left by the hurt. The basic loving, co-operative, intelligent and zestful nature is then free to operate.

'Such a person will tend to be more effective in looking out for his or her own interests and the interests of others, and will be more capable of acting successfully against injustice.'

All emotions must be discharged in a safe environment, which is why co-counselling is quite different from merely talking to a friend, who may collude with and encourage the negativity.

Often, those who have been in a co-counselling network come to find that they hit very deep or painful issues which cannot seem to be sorted out by the co-counselling methods. Therefore, this kind of counselling can lead on to more formal types of counselling or psychotherapy.

**Definition of Co-Counselling**

1. Co-counselling is usually practised in pairs with one person working, the client, one person facilitating, the counsellor, then they reverse these roles. In every session each person spends the same time in the role of both client and counsellor. A session is usually on the same occasion, although sometimes people may take turns as client and counsellor on different occasions.
2. When co-counsellors work in groups of three or more, members take an equal time as client, each client either choosing one other person as counsellor, or working in a self-directing way with the silent, supportive attention of the group. For certain purposes, the client may request co-operative interventions by two or more counsellors.

3. The client is in charge of their session in at least seven ways:
• trusting and following the living process of liberation emerging within
• choosing at the start of the session one of three contracts given in no.9 below
• choosing within the first two contracts what to work on and how
• being free to change the contract during their session
• having a right to accept or disregard interventions made by the counsellor
• being responsible for keeping a balance of attention
• being responsible for working in a way that does not harm themselves, the counsellor, other people, or the environment

4. The client's work is their own deep process. It may include, but is not restricted to:
• discharge and re-evaluation on personal distress and cultural oppression
• celebration of personal strengths
• creative thinking at the frontiers of personal belief
• visualising future personal and cultural states for goal-setting and action-planning
• extending consciousness into transpersonal states

5. The role of the counsellor is to:
  a. give full, supportive attention to the client at all times
  b. intervene in accordance with the contract chosen by the client
  c. inform the client about time at the end of the session and whenever the client requests
  d. end the session immediately if the client becomes irresponsibly harmful to themselves, the counsellor, other people, or the environment

6. The counsellor's intervention is a behaviour that facilitates the client's work. It may be verbal, and/or nonverbal through eye contact, facial expression, gesture, posture or touch.

7. A verbal intervention is a practical suggestion about what the client may say or do as a way of enhancing their working process within the session. It is not a stated interpretation or analysis and does not give advice. It is not driven by counsellor distress and is not harmful or invasive. It liberates client autonomy and self-esteem.
8. The main use of nonverbal interventions is to give sustained, supportive and
distress-free attention: being present for the client in a way that affirms and
enables full emergence. This use is the foundation of all three contracts given
below. Nonverbal interventions can also be used to elaborate verbal
interventions; or to work on their own in conveying a practical suggestion; or, in
the case of touch, to release discharge through appropriate kinds of pressure,
applied movement or massage.

9. The contract which the client chooses at the start of the session is an agreement
about time, and primarily about the range and type of intervention the counsellor
will make. The three kinds of contract are:

*Free attention*
The counsellor makes no verbal interventions and only uses nonverbal interventions
to give sustained, supportive attention. The client is entirely self-directing in
managing their own working process.

*Normal*
The counsellor is alert to what the client misses and makes some interventions of
either kind to facilitate and enhance what the client is working on. There is a co-
operative balance between client self-direction and counsellor suggestions.

*Intensive*
The counsellor makes as many interventions as seem necessary to enable the client to
deepen and sustain their process, hold a direction, interrupt a pattern and liberate
discharge. This may include leading a client in working areas being omitted or
avoided. The counsellor may take a sensitive, finely-tuned and sustained directive
role.

10. Counsellors have a right to interrupt a client's session if they are too heavily
restimulated by what the client is working on and so cannot sustain effective
attention. If; when they explain this to the client, the client continues to work in
the same way, then they have a right to withdraw completely from the session.

11. Whatever a client works on in a session is confidential. The counsellor, or others
giving attention in a group, do not refer to it in any way in any context, unless the
client has given them explicit, specific permission to do so. It is, however, to be
taken into account, where relevant, by the counsellor in future sessions with the
same client.
First Steps in Counselling
Pete Sanders
PCCS Books, Manchester, 1992

An Incomplete Guide to Using Counselling Skills on the Telephone
Pete Sanders
PCCS Books, Manchester, 1993

Depression
Tony Schirtzinger

Counselling: - Interdisciplinary Perspective
Ed. By Brian Thorne & Windy Dryden
Open University Press, Buckingham, 1993

Counselling in the Voluntary Sector
Nicholas Tyndall
Open University Press, Buckingham, 1993

National Institute of Mental Health
www.nimh.nih.gov

Employee Counselling Service
www.empcs.org.uk

Bereavement
www.bereavement.org.uk

Stress
www.web.ukonline.co.uk

Mental Health & Illness
Eating Disorders/Alcohol Abuse
www.mhai.healthyirish.com

www.counsellinginfo.bizland.com
Sources

Practical Counselling Skills
Roy Bailey
*Winslow Press, Oxon, 1994*

Counselling Skills for Health Professionals
Philip Burnard
*Chapman & Hall, London, 1995*

Theory of Therapy – Guidelines for Counselling Practice
Arthur W. Combs
*Sage, London, 1989*

Theory & Practice of Counselling & Psychotherapy
Gerard Corey
*Brooks Cole, California, 1991*

Relating to Others
Steve Duck
*O.U.P., Milton Keynes, 1988*

The Skilled Helper
Gerard Egan
*Wadsworth Publishing Company, California, 1975*

Definition of Co-Counselling
John Heron
*December, 1996*

Counselling
Liz Hodgkinson
*Simon & Schuster Ltd, London 1992*

Practical Counselling & Helping Skills
Richard Nelson Jones
*Cassell, London, 1989*

Counselling – The BAC Counselling Reader
Ed. by Stephen Palmer, Sheila Dainow & Pat Milner
*Sage, London in association with BAC, 1996*

Trauma, Loss & Bereavement
Gary W. Reece
*Counselling by Telephone
Maxine Rosenfield
*Sage, London, 1997*
First Steps in Counselling
Pete Sanders
PCCS Books, Manchester, 1992

An Incomplete Guide to Using Counselling Skills on the Telephone
Pete Sanders
PCCS Books, Manchester, 1993

Depression
Tony Schirtzinger

Counselling: Interdisciplinary Perspective
Ed. By Brian Thorne & Windy Dryden
Open University Press, Buckingham, 1993

Counselling in the Voluntary Sector
Nicholas Tyndall
Open University Press, Buckingham, 1993

National Institute of Mental Health
www.nimh.nih.gov

Employee Counselling Service
www.empcs.org.uk

Bereavement
www.bereavement.org.uk

Stress
www.web.ukonline.co.uk

Mental Health & Illness
Eating Disorders/Alcohol Abuse
www.mhai.healthyirish.com

www.counsellinginfo.bizland.com