Counselling Psychology Review

Special issue on Case Studies

Counselling Psychology Review

Subscriptions

Advertising

Advertising space is subject to availability, and is accepted at the discretion of the Editor. The cost is:

	Division Members	Others
Full Page	£50	£100
Half Page	£30	£60

High-quality camera-ready artwork and the remittance must be sent together to the Editor:
Dr Alan Bellamy, Brynmair Clinic, Goring Road, Llanelli, Carmarthenshire SA15 3HF.
Tel: 01554 772768. Fax: 01554 770489. Cheques should be made payable to: Division of Counselling Psychology.

Disclaimer

Copyright

The British Psychological Society
Counselling Psychology Review
Volume 19 ● *Number 1* ● *February 2004*

Editorial

Alan Bellamy

WELCOME TO THE first *CPR* of 2004. This special issue is on case studies, and has been guest edited by Malcolm Cross, John Davy and Rachel Tribe. The guest editors introduce the papers, and we hope that you will find them stimulating and thought-provoking. The case study as a form really begins with Freud and Breuer's *Studies on Hysteria*, published in 1895, and remains a fascinating and essential tool for teaching and learning and reflection. But part of the value of case studies lies in what the author leaves out: what is not noticed, what is not reported. There is perhaps no better example of this than the *Fragment of an Analysis of a Case of Hysteria*, Freud's account of his attempted therapy with Ida Bauer, better known to us as Dora. John Davy, in his paper 'The functions of case studies: Representation or persuasive construction?' explores this and other themes with reference to a case study of his own. This is preceded by papers by Angela Harris and Joanna Wood in which they present their own case studies, one illustrating a person-centred approach and the other a cognitive-behavioural model.

In the *Newsletter Section* you will find an article by Diane Hammersley in which she describes and explains the significant changes that have been made to what is now known as the BPS Qualification in Counselling Psychology. A great amount of work has been done by Diane and her colleagues to bring about these changes, resulting in a qualification that is simpler to understand, is more accessible, has wider appeal and is bang up-to-date.

Finally, let me take this opportunity to remind you that the Division's Annual Conference will be taking place in York in May. You might like to think about submitting a paper, poster or workshop idea; or you might like to just come along, to hear about what is going on in the profession, to network, and to meet old and new friends.

Guest Editorial:
An introduction to the Special Issue on Case Studies

Malcolm Cross, City University,
John Davy, Brookside Family Consultation Clinic
Rachel Tribe, University of East London

ONE PRINCIPLE AIM of client case studies is to allow the therapist to exhibit their capacity to link theory to practice (Papadopopoulos, Cross & Bor, 2003). This is, however, just one aim. Client case studies can be used as vehicles though which to instruct the reader (Yalom, 2002) to highlight ethical tensions imbued in the execution of professional practice (Cottone & Tarvydos, 1998), or a means of evaluating and reporting upon efficacy, as in single case design (Morley, Turpin & Adams, 2003). Client case studies may also be used as a vehicle for learning about one's self (Cross & Papadopoulos, 2001) and as is emerging more recently, as a context for critically evaluating the impact of social discourses on conceptualisation of the client, their difficulties, and the practice of counselling and therapy in its broadest sense (Davy, 2000).

The work presented in this special issue brushes against all of the aims outlined above. Rather than seek to identify exemplary accounts of practice, as if there was only one right way to conduct the business of therapy, we have chosen to present material that highlight some of the challenges and opportunities involved in writing and reading accounts of therapeutic practice. The work of Harris and of Wood were originally written in order to satisfy course requirements and are, therefore, somewhat familiar in the style of presentation. Their voice is sometimes passive and rightly assumes a willing audience that is interested in them as developing practitioners, as much as

the development of therapy and its impact on the client. These papers reflect the openness of the authors, discussing moments of confusion and uncertainty as they experience the push of professional training requirements with the pull of supervision, combined with the unique opportunities and limitations afforded by the client and therapist in their particular therapeutic settings (Papadopopoulos, Cross & Bor, 2003). Although the client, contexts and reporting style of Harris and Wood vary significantly they share a capacity to stay with uncertainty and to engage in the iterative formulation and reformulation that is so fundamental to genuine engagement with the client and self-as-therapist.

The final paper within the issue by Davy, however, stands in stark contrast to conventional presentations of client studies. It is unique as it is in fact two accounts. Davy's paper presents a deconstructive analysis of a narrative therapy case study, which was originally written in order to satisfy a course requirement as part of an accredited training as a counselling psychologist. In the work Davy engages in a critical re-reading of his original text in an attempt to illustrate how writing about clients can be seen as a constructive and constitutive activity, with potentially oppressive or progressive consequences. Davy makes the point plainly through his work that writing about our work with clients is much more than a merely representational process. His paper concludes by suggesting that therapists' training and professional development could

fruitfully include an emphasis on critical and creative reading and writing skills.

We sincerely hope that you enjoy and find rewarding the work that we have brought together in this special issue.

NB: Please note that the names and distinguishing details in each of the following papers have been changed in order to protect the anonymity of clients.

References

Cross, M.C. & Papadopoulos, L. (2001). *Becoming a therapist: A manual for personal and professional development.* London: Routledge.

Cottone, R.R. & Tarvydas, V.M. (1998). *Ethical and professional issues in counseling.* London: Prentice-Hall International.

Davy, J. (2000). *Text and context in counselling psychology.* Doctor of Psychology Thesis. City University, London.

Morley, S.J., Turpin, G. & Adams, M. (2003). *Single case studies: A practioner's guide to design, analysis and interpretation.* London: Sage.

Papadopoulos, L., Cross, M.C. & Bor, R. (2003). *Reporting in counselling and psychotherapy: A trainee's guide to preparing case studies and reports.* London: Routledge.

Yalom, I.D. (2002). *The gift of therapy: Reflections on being a therapist.* London: Piatkus.

The experience of silence: A client case study

Angela Harris, *City University*

This case study was written as a personal way to bridge the gap between written accounts of person-centred therapy and my experience of working with one client. The literature that I have studied uses illustrations of dialogue between therapist and client to demonstrate empathic understanding and I am sometimes left with the impression that the therapist is constantly chattering. This could be one of the limitations of written media as opposed to video or audiotape. It occurred to me that the nature of case studies means that silence – particularly long silences – could be excluded. I think I would have to be very brave to submit a transcript where I, as therapist, said almost nothing for a 10 minutes section analysed in depth, even though the inter- vention was pivotal to the therapeutic process. This insight led me to read some of the literature on silence and I was very surprised to find so little written by person-centred practitioners. Reflective responses seem to be the dominant discourse within person-centred therapy publications. It is possible that this discourse is distorting person-centred therapy away from non-verbal interventions and silence. This made me think about whether I talk too much with my clients and has altered my practice. Using silence as the core topic helped me get an edge or perspective when writing the case study and this made it more interesting to write.

The acts of reviewing the case and writing the case study helped me to revisit person-centred counselling. I think I had rather taken the core conditions for granted. Writing the case study was a good discipline to help me understand when I veered from them to pursue my own track rather than follow the client's. It was such hard work to do and demanded a very high level of concentration and listening skills.

I enjoyed thinking about the case, because I felt warm feelings towards my client, 'Sam'. I judged my work to be successful and this helped me be less defensive about mistakes I had made. It was hard to sieve out the less important information to fit the word count requirements, such as why his wife was angry. However, this was a helpful process in itself because it forced me to distil all the thoughts and memories into a coherent form and to look at themes rather than data.

Introduction

THIS CASE CONCERNS a 49-year-old client who came for 19 sessions spread across 11 months. I have chosen to write about this case because the fourth coun- selling session was spent predominantly in silence and this proved to be both uncomfort- able for me, and therapeutically significant, for him. This tension between discomfort and progress has led me to search for literature on the use of silence with person-centred therapy only to find it is more commonly mentioned in psychodynamic and psychoanalytical literature.

Choice of theoretical orientation
Person-centred therapy

The person-centred approach takes as a central truth that the client knows best what is hurting and knows how to move forward. The role of the psychologist is to enable clients to get in touch with their resources so that they can heal themselves. The therapeutic relation- ship is central to the work and the psychologist will be monitoring the client's experience, the psychologist's experience and the experience of the relationship between them (Mearns & Thorne, 1999).

A counselling psychologist practising the person-centred approach will endeavour to create a healing climate based on the six conditions that Carl Rogers (Rogers, 1990) argued were necessary and sufficient for therapeutic change:

1. There is psychological contact between the client and therapist.
2. The client is vulnerable and experiencing incongruity or is anxious.

3. The therapist is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard towards the client.
5. The therapist experiences an empathic understanding of the client's frame of reference and aims to communicate this understanding to the client.
6. The communication to the client of the empathic understanding and prizing is achieved at least to a minimal degree.

Silence

Carl Rogers (Rogers, 1951) gave two reasons for a therapist to interrupt an adult client's silence with a reflection: to confirm the meaning of understanding and to prevent projection and transference. Later in the book, however, he described silent cases with children in play therapy where the sessions led to improvement and he argued that one of the more important qualities of a client-centred play therapist was an ability to tolerate silence without embarrassment. He also described sitting in silence for a number of sessions with a young schizophrenic not knowing whether the relationship had any meaning (Rogers, 1962). Active listening includes silence but more attention is given in the person-centred listening literature to responses and reflections. Silence in sessions is only fleetingly mentioned as something that happens in later sessions (Mearns & Thorne, 2000) or in difficult sessions (Frankland & Sanders, 1995) or as an example of congruence (Mearns & Thorne, 1999).

Psychodynamic and psychoanalytic literature has traditionally had a great deal to say about silence (Sabbadini, 1991; Elson, 2001; Lane, Koetting & Bishop, 2002). One frequently offered interpretation of silence was its role in maintaining defence. This particular interpretation is somewhat problematic from a person-centred approach. However, the possibility that silence can facilitate the therapeutic alliance, with the client communicating emotional and relational issues of need and meaning, and the psychologist communicating safety, understanding and containment (Lane, *et al.*, 2002) would be compatible with the person-centred approach. The client can use silence in different ways and the task of a psychologist is to choose whether to respect the silence or to break it (Molnos, 1998).

The context for the work

Sam[1] was referred by his GP to the in-house counselling service that offers brief therapy in an NHS Primary Care setting. I was one of two counsellors and worked on Saturday mornings using a doctor's office. This meant that contact with other professionals was limited to those on weekend duty.

The referral

The referral form stated that Sam was a 49-year-old man whose wife had died five years ago and since then had suffered from persistent depression despite taking a number of different anti-depressant medications. He was on 30mg Paroxetene a day and the GP had noticed that there was some improvement. The GP had attempted to persuade Sam to see a counsellor for a number of years but Sam had remained resistant to the idea until now.

The client's view of the problem

Sam told me that he had been depressed for a long time. He did not believe that counselling would do any good but he was desperate and was now prepared to try anything. When I asked him if anything had happened that might have caused the depression, he said that there was nothing wrong apart from the depression. The depression came upon him 'like a thick cloud rolling over him' and lasted for three to four days until it lifted.

Therapist's view of the problem

The depression Sam described was reflected in other accounts of depression (Styron, 1991; Wolpert, 1999). The periods lasted less than the two weeks that would be required for a diagnosis of depression (American Psychiatric Association, 1994); however, it is conceivable that the medication may have accounted for this discrepancy. As Sam recounted some of his life history, he said that he had recovered from the death of his wife. One possible cause of

---

[1] All names and identifying information have been changed to ensure anonymity.

depression was unresolved loss caused by inhibited grief (Cook & Oltjenbruns, 1998). Also he described himself as someone who liked to have everything in order and who coped. I wondered if the death of his wife and the subsequent rearing of three teenage boys on his own had threatened this self-image and caused him anxiety (Mearns & Thorne, 1999). Person-centred therapy encourages the therapist to follow the track of the client and so I put these hypotheses on hold for the moment as possibly useful and to work with Sam on his track to awareness (Rennie, 1998).

Negotiating a contract and therapeutic aims

In the first session I explained that the first session was an opportunity for us to agree how we would work together. I explained that we could work in a number of ways including problem-solving, task-oriented way or we could work together where he could use the time to talk through his concerns and I would try to help him see things more clearly. He preferred the second way of working and said that his aim was to understand why he was depressed as he felt knowing why would help him. Since he worked shifts, we agreed that we would meet at the same time 8.00 a.m. every other week. We agreed that we would meet for six times and then review it. We agreed to extend the therapy at first to 12 sessions and then to 19. The person-centred approach allows such flexibility (Mearns & Thorne, 1999).

Summary biographical details of client and genogram

Sam is 49. He had a distant relationship with his father who worked long hours until a few years ago when his father became terminally ill. During the illness until his death they built a warm relationship. Sam had three brothers and they are all unemployed. At an early age Sam decided that he wanted to achieve something with his life and he worked hard and became apprenticed as a plumber. He was ambitious and successful and was promoted to management and enjoyed the responsibility. He married and had three sons. His wife died of Lupus when the boys were 16, 14 and 12 years old. He had a good relationship with his in-laws and maintains contact with them. He has a fiancée but their wedding has been put on hold because her father died recently. She was a 'daddy's girl' and an only child and has never been married before. Sam felt that he could not take her away from her mother so soon after her father's death and he was concerned about thrusting his three boys on her (see Figure 1 overleaf).

The content and process of the therapy

The beginning

The GP Practice secretary made an appointment for Sam to come to meet me at 8.00 a.m. on Saturday. I have found that these early appointments can be a problem for clients who are depressed but Sam was punctual and was sitting in the waiting room. The surgery is not conducive to person-centred work as it was furnished to reflect the power of the medical profession. I felt it was important to give signals of warmth and equality described by Mearns and Thorne (1999). Rather than announcing his name over the tannoy, I went to the waiting room and showed him the way to the room. As an introduction, I introduced myself by first name and said, 'Well, we have 50 minutes together. What's brought you to see me?' Although many person-centred counsellors do not carry out a formal assessment, Rennie (1998) argues that there is a case for it. I used a mental checklist to prompt me to cover a couple of items that Sam did not raise himself. I asked him if he had suicidal thoughts and asked if there were any significant recent events that might have led to his depression. He said that he was not considering suicide but he was desperate and only this desperation had made him decide to see a counsellor. This was his last hope. He could not think of anything in his life that might have led to the depression. He used the first three sessions to tell his story. I used basic attending skills (Rennie, 1998) of eye contact, forward leaning pose, minimal encouragements, open questions, repetitions and paraphrases to encourage him to continue speaking and as a way to follow his train of thought. He spoke about the difficulty he was having with his sons who were wrecking his house. They were destruc-

Figure 1: Genogram of family members discussed by Sam.
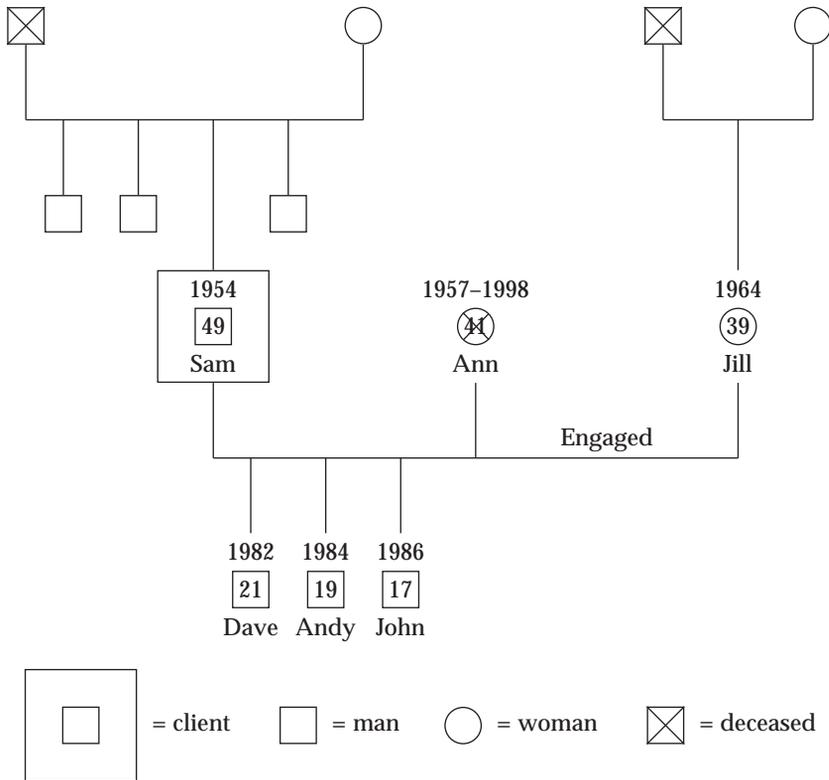
tive with his possessions and just did not seem to care about anything. He spoke about the death of his wife briefly and said that he was over that. He said that he had good days and bad days but he had not noted anything that might have led to a difference. When he was telling his story an image came to my mind of someone sorting the mail into pigeon-holes. Rennie (1998) recommends the sensitive use of imagery as away of liberating a secondary stream of consciousness. When I shared my image with Sam, he seemed pleased and confirmed that he liked to keep things orderly and this was one reason that he was so upset that he had lost control of himself. Mearns and Thorne (1999) refer to the loss of self-concept that can occur following a traumatic episode and the resulting fear and confusion brings a client to therapy. I wondered whether the death of his wife and the behaviour of his sons had been events that he could not fit into a neat box. However, these were my thoughts and not Sam's, and so I did not voice them. This could

have been a conflict between showing empathic understanding and being congruent. However, I decided that these thoughts were not relevant to the immediate concern of Sam and, therefore, did not fit the general guidelines governing the therapeutic use of congruence (Mearns & Thorne, 1999).

The middle
On the fourth session, Sam said that he was very low and lived day by day. He had an argument with his eldest son and had threatened to throw him out of the house. He fell silent and kept clenching his hands so that the nails bit into the flesh. As I waited for him to speak a weight of hopelessness came upon me and stilled my tongue. Psychoanalysts might explain this as transference, as a person-centred therapist I understood it as an expression of empathic understanding. After 15 minutes, Sam apologised for his behaviour and I said that it was okay for him not to talk and we resumed the silence. Silence can have

many qualities (Molnos, 1998), and this silence felt to me as if Sam was choking with emotion, fighting back tears, and getting in touch with the felt sense that Gendlin (1996) describes as the leading edge of the client's experience. I was frightened that by breaking the silence with a misjudged reflection, I might break his attention and throw him off track (Rennie, 1998). We sat together in silence until the end of the session when I drew the session to a close.

The next session took place three weeks later where Sam came in 'a changed man'. He told me that he now understood that the depression he felt was about the anxiety he experienced regarding his relationship with his sons. He did not feel that therapy had 'solved' the relationship problems but the insight gained in those long moments of silence helped him come to terms with his depression. So how did I make sense of what had happened? I believe that my sitting with him in silence or presence in absence helped communicate my willingness to remain with, rather than reject the depression and in turn him. This had given permission to engage in an experiential sharing of the felt sense of the problem and in turn this had led to our shared acceptance and paradoxically a readiness to move on.

After this, the sessions became characterised by starts and stops of action and problem solving. Sam decided that there was no need to delay his wedding on account of protecting his fiancée and so they duly set a date. However, this meant that he would need to confront his sons regarding their destructive behaviour and he procrastinated on this. It was like a car jerking in the wrong gear. For a number of sessions he seemed to be stuck, going round the issues. I used reflections to convey empathic understanding and clarifying questions when I was not clear. I realised that he had not mentioned his wife's death and this began increasingly to occupy my thoughts as he spoke about his sons. On the 11th session, I felt that I should raise this in order to be congruent but I raised it tentatively as a process identification and process direction (Rennie, 1998): 'I've noticed that you have not spoken about your wife's death in our time together and I wonder whether it would be helpful to talk about it?' This was very risky, but I felt that

we had built up sufficient trust that if Sam did not want to do this, the relationship would be strong enough and he would tell me. Rennie (1998), however, does advise that clients tend to defer to their therapist even when they disagree. In fact this intervention was another critical turning point. Sam's wife had died distressingly of Lupus and he experienced complicated grief because he felt guilty that he had not been able to protect her from the knowledge that she was dying and frightened that her anger towards him had not been healed before her death. As he described her dying, a tear rolled down my cheek and we shared a look and then his eyes welled with tears (Mearns & Thorne, 1999). The retelling of this story helped him reach an insight that he had set a rule that he should never leave his sons after an angry word and it was this rule that was preventing him from action. This realisation helped him to confront his sons.

The ending

After the 13th session, our relationship began to change as Sam began to take more action both in our sessions and at home. In these sessions I became more active by offering suggestions and comments as mutuality developed between us. This stage is described in Mearns and Thorne (1999). I raised the question of ending the therapy and Sam said he would like to wait until he was married and have a termination session then. At the final session we reviewed the therapy together and discussed what I should write to the doctor. Sam said that he had found our sessions much more helpful than he had hoped. He was now experiencing many 'sparkling moments'. I shared with him my admiration for his courage. We shook hands and said goodbye.

Evaluation of the work and learning

This was my longest piece of work with a client and I learned a great deal from it. Working with silence was the most striking feature of this therapeutic episode for me. After our silent session, I recall feeling markedly concerned that I had misread the signs and that his experience of the session was that of abandonment or futility. I felt it possible that he may have

experienced me as a failure. Silence did indeed cause me to experience anxiety but I was aware that many champion it as a very useful intervention when working with emotions (Martyes, 1995; Scott & Lester, 1998). My learning was experiencing the power of silence within the therapeutic relationship. Fortunately, my supervisor was very helpful in supporting me through this anxiety and later on the feedback form my client confirmed that silence had indeed been useful, however uncomfortable.

One of the unique opportunities and challenges that I experienced was working with a supervisor who practiced from a predominantly psychodynamic perspective. During our supervision sessions we talked about Sam from different viewpoints and discussed different hypotheses such as: perhaps the presenting problem of depression might be an obsessive-compulsive anxiety; metaphor of young males challenging older males could be a natural development stage or a defence against anxiety; and whether Sam's progress was a flight to health. Mearns and Thorne (1999) state that a person-centred therapist will use their unique selves in therapy and be transparent. On the other hand, they warn against a therapist taking an 'expert' stance. It seems that a Counselling Psychologist working in the person-centred approach has to hold back a large part of the academic part of themselves in order to stay in the client's field of awareness until that point when they feel they are being incongruent (Rennie, 1998) and the therapeutic relationship is suffering. When they offer information it should be in a very tentative way. I did not know how to stop these psychological theories intruding into my responses to Sam and sometimes my responses were more directive than person-centred. On some occasions they were blocks to empathy (Mearns & Thorne, 1999). Once, I brought in some information from Personal Construct therapy and although Sam deferred to it (Rennie, 1998), in discussion with my supervisor I realised that my intervention was a denial of my emotions and was a mis-match. It would have been more helpful to stay with Sam's feelings.

In many ways being empathic and maintaining unconditional positive regard for Sam was easy because he was being authentic and I felt very warm towards him. I think there were glimpses of real empathic understanding that showed itself in non-verbal ways (Mearns & Thorne, 1999). I was struck by his courage in tackling his fears and felt real pleasure in his 'sparkling moments'.

References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Cook, A.S. & Oltjenbruns, K.A. (1998/1989). *Dying and grieving: Life span and family perspectives* (2nd ed.). Orlando, FL: Harcourt Brace & Company.

Elson, M. (2001). Silence, its use and abuse: A view from self psychology. *Clinical Social Work Journal, 29*(4), 351–360.

Frankland, A. & Sanders, P. (1995). *Next steps in counselling: A students' companion for certificate and counselling skills courses.* Trowbridge: Redwood Books.

Gendlin, E.T. (1996). *Focusing-oriented psychotherapy.* New York: The Guilford Press.

Lane, R.C., Koetting, M.G. & Bishop, J. (2002). Silence as communication in psychodynamic psychotherapy. *Clinical Psychology Review, 22*(7), 1091–1104.

Martyes, G. (1995). On silence: A language of emotional experience. *Australian & New Zealand Journal of Psychiatry, 29*(1), 118–123.

Mearns, D. & Thorne, B. (1999/1988). *Person-centred counselling in action* (2nd ed.). London: Sage Publications.

Mearns, D. & Thorne, B. (2000). *Person-centred therapy today.* London: Sage Publications.

Molnos, A. (1998). *A psychotherapist's harvest: A to Z of clinical practice with special reference to brief forms of psychoanalytically-based treatment.* Retrieved 29 September 2003, from http://fox.klte.hu/~keresofi/psyth/psyhthr.html.

Rennie, D.L. (1998). *Person-centred counselling: An experiential approach.* London: Sage Publications.

Rogers, C.R. (1951). *Client-centred therapy.* London: Constable & Robinson.

Rogers, C.R. (1962). Some learnings from a study of psychotherapy with schizophrenics. *Pennsylvania Psychiatric Quarterly,* Summer, 3–15.

Rogers, C.R. (1990). The necessary and sufficient conditions of therapeutic personality change. In H. Kirschenbaum & V.L. Henderson (Eds.), *Carl Rogers: Dialogues: Conversations with Martin Buber, Paul Tillich, B.F. Skinner, Gregory Bateson, Michael Polanyi, Rollo May, and others* (pp.219–235). London: Constable.

Sabbadini, A. (1991). Listening to silence. *British Journal of Psychotherapy, 7*(4), 406–415.

Scott, V. & Lester, D. (1998). Listening to silence. *Crisis: Journal of Crisis Intervention & Suicide, 19*(3), 105–108.

Styron, W. (1991). *Darkness visible.* London: Jonathan Cape.

Wolpert, L. (1999). *Malignant sadness.* London: Faber & Faber.

Correspondence

Angela Harris is currently completing her final year of training as a Counselling Psychologist at City University, London.

BPS ANNUAL CONFERENCE 2004

The next **BPS Annual Conference** will be held at **Imperial College, London** from **15–17 April 2004**. Invited speakers have been asked to present material relating to the themes of the event which are: Positive Psychology – Prof. Barbara Fredrickson, University of Michigan and Dr Felicia Huppert, University of Cambridge; Creativity and Innovation – Prof. Margaret Boden, University of Sussex and Prof. Steve Smith, Texas A & M University; Perception – Prof. Nikos Logothetis, Max Planck Institute for Biological Cybernetics and Prof. Tom Troscianko, University of Bristol.

For further information regarding the Conference please contact the Conference Office on 0116 252 9555 or visit the Society's website at www.bps.org.uk.

in association with Centre for Stress Management

CERTIFICATE IN COACHING
19–24 April, 26–31 July,
27 September – 2 October,
29 November – 4 December

CERTIFICATE IN COACHING
Conversion course specifically for qualified
counsellors and psychotherapists
21–26 June

AIM

These six-day Programmes provide delegates with an underlying philosophy of Coaching together with a range of practical skills required to be able to undertake Coaching with individuals.

KEY OBJECTIVES

During the six-day Programme delegates will:
• Be able to define coaching
• Understand the difference between coaching and counselling
• Become knowledgeable about types of clients and their problems
• Understand the concept of the life audit and how to structure initial meetings
• Develop and have an opportunity to practise a range of relevant skills
• Become proficient in using a coaching assessment form
• Explore four learning styles and relate these to the learning cycle
• Explore and resolve difficulties impeding goal-attainment
• Understand the importance of keeping a time log to improve time keeping
• Troubleshoot obstacles to action plan implementation

COURSE CO-DIRECTORS

Gladeana McMahon, author of *Confidence Works – Learn how to be your own life coach*
Michael Neenan, co-author of *Life Coaching – A Cognitive-Behavioural Approach*
Professor Stephen Palmer, co-author of *Dealing with People Problems at Work*

PRIMARY CERTIFICATE IN PERFORMANCE COACHING: 7–8 April, 6–7 July,
17–18 November
PRIMARY CERTIFICATE IN DEVELOPING PSYCHOLOGICAL RESILIENCE:
a coaching perspective: 14–15 July
CERTIFICATE IN PSYCHOLOGICAL COACHING: 6–10 September
PRIMARY CERTIFICATE IN HEALTH COACHING: 24–25 March, 27–28 October

OTHER COURSES

Certificate in Stress Management and Performance Coaching (modular)
Certificated Correspondence Course in Life Coaching: A Cognitive-Behavioural Approach

DIPLOMA COURSES (modular programmes)

Coaching; Psychological Coaching; Coaching Psychology

COURSES HELD IN LONDON

Prof. Stephen Palmer, PhD, C Psychol, Centre for Coaching, 156 Westcombe Hill, London SE3 7DH
Course Details and Application Form: Tel 020 8293 4114 leaving name and address on 24hr
answerphone **Course Admin:** Tel 020 8293 4334; Fax 020 8293 4114
Website: www.centreforcoaching.com **Email:** admin@centreforcoaching.com

Courses recognised by Association for Coaching (visit their website at www.associationforcoaching.com)

A question of dependency: A study of a client suffering from panic disorder with agoraphobia

Joanna Wood, City University

1.0 Section A – Introduction and the start of therapy

1.1 Introduction

I HAVE CHOSEN TO write about one of the first clients I saw for individual counselling at my placement in a Community Mental Health Team (CMHT). This choice is partly pragmatic. My client, Rita, was kind enough to give her consent to use all her therapeutic material. I found that the 13 sessions of therapy so far undertaken have posed a number of questions and issues around the concept of 'dependency', which I feel may be of interest to other counselling psychologists in training. Whilst attempting to manage the therapeutic relationship and process with a dependent and needy client, paradoxically I have also been forced to consider these types of issues in relation to myself within the supervisory relationship. I will discuss how these factors affected my work in the later sections of this report.

1.2 Summary of the theoretical orientation

Viewing clients as faulty processors of information, Beck's Cognitive Behavioural Therapy or CBT argues that how people interpret or perceive experiences will determine how they feel and behave (Beck, 1976). In terms of psychopathology, it is primarily from poor childhood experiences that clients learn incorrect habits of processing information, resulting in core beliefs, dysfunctional assumptions and the accumulation of negative automatic thoughts. It is the latter, which when triggered, results in a series of emotional, motivational, somatic and behavioural effects (Nelson-Jones, 1997). In order to counter these and to re-activate the individual's 'reality-testing systems' (Beck, 1976), CBT provides a structured short-term and present-oriented therapy, enabling the client to rationally evaluate and modify dysfunctional thoughts and behaviours. To facilitate this, the CBT practitioner concentrates on developing a good collaborative working relationship and focuses on current problems aided by a number of techniques including Socratic questioning and homework. Viewing the client as a scientist, an over-arching aim is to educate and socialise clients into the CBT model and to openly discuss their conditions in order to attempt to encourage them to become their own therapists (Beck, 1995).

1.3 Context of the work and the referral

After a consultation with one of the community Psychiatrists, Rita was referred to the psychology department for therapy and was placed on my caseload. The psychiatrist provided a very detailed psychiatric report, which discussed a number of earlier depressive episodes and suicide attempts together with her current symptoms of depression, agoraphobia, panic and some obsessive-compulsive

In the interest of confidentiality, all names and identifiers have been changed.

behaviour. He further queried whether CBT would be an appropriate therapy in light of her presenting symptomatology.

1.4 The assessment session

On meeting Rita for the first time, I noted that she was a very nervous, petit and casually dressed 57-year-old woman. With wide eyes and a very serious expression on her face, she appeared scared when I introduced myself to her. She spoke quietly and gave some eye contact.

During the actual session, Rita was very anxious and nervous, sometimes not giving very good eye contact and swallowing air many times as she talked. With her quiet voice and imploring facial expression, she came across to me as very 'vulnerable' and needy. This led me to believe that she wanted me to take on some sort of nurturing role, highlighting potential dependency issues. I felt at the time that these behaviours evoked in me overwhelming feelings of sympathy and a desire to 'sort out' her problems and issues, which again I noted as a possible difficulty during the therapeutic process (Watkins Jr., 1988). In order to encourage the idea of a collaborative process, at the end of the session I asked Rita how she felt about working with me and she replied that she felt comfortable although a little bit nervous about what to expect. As I had not completed the assessment and was not totally clear about how to proceed, I explained to her that I would like to continue the assessment in the following week and would then be in a position to discuss the therapeutic plan, which seemed to allay her fears.

1.5 The client's definition of the problem

Following a panic attack during a visit to Heathrow airport in June of last year, Rita became increasingly low in mood resulting in another depressive episode, of which she has suffered periodically since her early 20s. In September of the same year, this led to her being taken to the local hospital by a friend and a consultation with the Accident and Emergency Duty Psychiatrist. At this time she reported feeling totally overwhelmed and 'down' and she was concerned that these feelings might lead to another suicide attempt.

After refusing to be admitted to hospital as an inpatient, Rita accepted an outpatient appointment at the CMHT and was subsequently given anti-depressant medication and beta-blockers. Although the medication appeared to counteract her depressive symptomatology, Rita stated that she was still left with feelings of panic and had a strong desire to stay at home where people could not witness her 'going mad' or losing control and where she could remain 'safe'. This had begun to make her life intolerable, as she now felt too frightened to go outside on her own, and although she managed to make some very short local trips if she ran and left the house by 9.00 a.m., she spent most of her time at home.

1.6 Initial assessment/formulation of the problem

My initial hypothesis was that Rita was suffering from Panic Disorder with Agoraphobia (*DSM-IV*). The agoraphobic symptoms had begun after the panic attack in the airport, in which she suffered from breathing problems, palpitations and shakiness in her legs, whilst feeling that she might 'lose control' or collapse. Rita described a number of other attacks after this incident, which occurred without warning in public places. As is sometimes the case with the onset of this disorder, the initial panic attack precipitated the agoraphobic symptoms, which led Rita to restrict her movements in order to avoid crowds of people, public transport and going out alone (Klein, 1981). Like most agoraphobics Rita then became frightened to leave her home in case she had a panic attack and people would harm her either verbally or physically, or would fail to offer her assistance (Beck, 1985).

As discussed by Beck (1985), in the cognitive model of agoraphobia, it seems apparent that the agoraphobic person develops beliefs concerning external danger, vulnerability and the possibility of a sudden and uncontrollable internal disturbance or panic attack. When alone, the individual believes that he or she may become the victim of a sudden medical, mental or emotional disorder, which can only be remedied by unobstructed access to a place of safety such as a hospital or the home. If the access to safety is blocked, then the symptoms

may be interpreted as an impending disaster, increasing fear and anxiety, which in turn results in increased somatic symptoms and with the vicious circle in place, then a panic attack is likely to occur (Clark, 1986). As paralleled in Rita's case, the specific situations which appear to trigger these attacks seem to revolve around the perception of being 'trapped' in environments which either impede escape to a safe haven or access to help. Paradoxically, despite this need for free movement and the urge to escape, the characteristic behavioural reaction to an agoraphobic's fear and anxiety is one of immobility, both during a panic attack and also in the avoidance of all situations in which an attack may occur, by remaining at home.

Therefore, with the client suffering from panic with agoraphobia, there appears to be a conflict between dependency, autonomy and control. This conflict is reflected in one of their main coping mechanisms. In believing that they cannot deal with dangers and problems by themselves, sufferers often seek to obtain help from a 'caretaker'. However, as this may lead to someone else taking control and the potential compromise of autonomy, then this can result in the individual client becoming very anxious and even leading to an impulse to break free to gain control (Beck, 1985). Rita had shown this in all of her relationships, whilst actively seeking relationships where she could be totally dependent, over time she often resented the control that was being exerted over her, which would lead to her breaking free of the relationship.

As dysfunctional beliefs are seen to develop from childhood (Clark & Beck, 1988), I also hypothesised that Rita's early life had encouraged her beliefs. Although there is no firm agreement as to why some people seem more predisposed to agoraphobic symptoms, a number of studies point to inappropriate or over-protective mothering (Chambless and Goldstein 1982). In terms of her family background, Rita's parents had divorced when she was 14 and she had lived with her mother until her late 40s. She described her mother as cold, domineering and controlling. Her mother appeared to run her life and that of her child and Rita was not allowed to do anything unless her mother permitted it and as a consequence rarely ventured out. For instance, although she wanted to go to art college her mother forced her to leave school and go straight out to work. When her mother moved into a home, Rita replaced her with a domineering male partner, who again told her what to do and made her feel that she could not cope on her own. Therefore, the tension between dependency, autonomy and control appeared to be a recurrent theme in Rita's life.

1.7 Decision to use CBT

My decision to use CBT took account of both current treatment research and the client's previous experience of counselling. In reviewing the literature, it appears that CBT for panic with agoraphobia has generally shown to be effective (Chambless & Gillis, 1983). I was also influenced by the fact that Rita had clearly articulated a number of dysfunctional beliefs around vulnerability and safety that seemed to fit within a cognitive model of the disorder.

In addition to this, Rita disclosed information regarding a poor counselling experience during a previous depressive episode. This counselling apparently took a non-directive approach, which Rita found to be unhelpful. Therefore, I felt that a more directive orientation might be more effective.

1.8 The contract and therapeutic aims

We both agreed that we would meet weekly and would continually review progress. Despite my concerns regarding potential dependency, I did not contract for a set number of hours, as all therapy in my placement is open-ended. However, with hindsight, this would have been a more sensible approach (although I managed to do this later on in therapy during a review of progress).

In terms of therapeutic goals, we agreed that we would work towards Rita being able to leave her home without feeling anxious or frightened of having a panic attack.

1.9 Summary biographical details of the client

Rita is white and single and lives in a local housing association development. Since her

illness last year she has been unemployed and previous to this she had spent around 30 years working in local factories. In terms of her immediate family, her parents and her two brothers are deceased. She talked of being very close to her father, who was asked to leave the family home when she was 14, and having distant relationships with the rest of her family. Rita has a son from a relationship she had in her 20s with a black American serviceman, and a young granddaughter. She reported being very close to her son and granddaughter and having a few close friends.

2.0 Section B – Development of therapy

2.1 The therapeutic plan and main techniques used

During the early stages of therapy, my initial concern was to develop a good working relationship. With Rita's previous history of poor relationships, this seemed to be particularly important. Beck (1976) stresses the importance of developing rapport with the client by utilising Roger's (1951) core conditions of empathy, unconditional positive regard and congruence and without these he argues that therapy is unlikely to be effective. Therefore, to encourage this, I spent the first couple of sessions actively listening to Rita using summarising and other reflective techniques (Egan, 1986) and took time to explain the process of therapy and asking for feedback. Also being aware of potential dependency issues, I was careful when socialising Rita into the CBT model (Beck, 1985), to emphasise the collaborative nature of CBT. Further to this, as part of the didactic process, we talked about her condition and I was able to give her some literature to read at home. This brought a great deal of relief to Rita that she 'was not the only one' and that she was 'not going mad'. Once again, this highlighted for me the idea that explanations are in themselves therapeutic (Emery, 1985).

When treating panic with agoraphobia it is suggested that therapy should focus first on the panic symptoms using cognitive techniques (Salkovskis & Clark, 1991). Therefore, I spent the first four or five sessions focusing on Rita's panic and the thoughts and beliefs

around this. After explaining the cognitive model of panic (Clark, 1986), Rita attempted to complete thought records to highlight the recent situations, which had provoked anxiety and panic. However, on finding these too complicated, we decided that it would be easier for her to collect data in her personal diary. We then used this to uncover and challenge her negative automatic thoughts and assumptions, which appeared to revolve around thoughts of fear and vulnerability, by using Socratic questioning techniques. After considerable practice, Rita developed what she described as her 'self talk', where she discussed being able to step back and consider the evidence for her thoughts.

With the cognitive techniques providing the foundations for the next phase of therapy, we then began to concentrate on systematic desensitisation (Wolpe, 1961), using graded exposure to extinguish Rita's fears and anxiety (Butler, 1989). Working together we produced a graded hierarchy, which included all the situations which Rita had been avoiding and used these as homework experiments to be practised between sessions (see Appendix). This fits with the generally accepted view that exposure to crowds, public transport and other feared situations is vital in the treatment of agoraphobia (Chambless & Goldstein, 1982; Mathew, Gelder & Johnston, 1981, etc.). Before Rita embarked on these experiments we discussed relaxation and distraction techniques to provide some initial relief from her fearful thoughts and anxious feelings (Clark, 1989). After these discussions Rita decided that she would prefer to use distraction and an image of her granddaughter on holiday.

2.2 Emerging recurrent themes
2.2.1. Dependency
I became aware after a number of sessions that our relationship had begun to mirror Rita's previous and current relationships, with Rita becoming reliant and dependent and fearful of being able to cope on her own. If she failed to complete a task she became concerned that she had let me down and made numerous attempts to flatter me by making comments such as 'If I had only met you years ago' and 'I can't believe that you are a trainee'. It was as if her need for

maternal love and approval, which she had not received in childhood had manifested itself in her relationship with me. Also over the Christmas period she felt that she had regressed, after a two-week break in therapy. I increasingly felt that she appeared to be placing a great deal of responsibility on me as the therapist, which later on in the therapy made me feel uncomfortable and even rather irritated at times (Watkins Jr., 1988). (On reflection I also wonder whether this irritation was heightened by my personal circumstances at the time. I began to see Rita at the beginning of my training when I felt as if I was being pulled in a number of directions, by the course, my placements and my family.) Although I accept that an element of dependency is to be expected and perhaps even welcomed to develop the therapeutic relationship (Decker, 1988), I felt that by the seventh or eighth session I needed to intervene. Therefore, I decided to hold a review session where we were able to talk about the progress that she had made by herself and my facilitative role in this, as well as stressing the rationale of carrying out the experiments regularly and on her own. As part of this intervention and in my attempt to maintain firm boundaries I also discussed my proposed plan to end therapy after 20 sessions, which Rita seemed to find acceptable. It was interesting that after this discussion Rita seemed more focused on 'getting better', she experimented more between sessions and began to move through her graded hierarchy. I have considered that this may have partly been down to the time limit! However, I feel that at this point she began to take more responsibility and started to articulate more about the success that she was making.

2.2.2. Autonomy and control
Being able to reduce her anxiety and achieving the goals set in the graded hierarchy led to increased confidence and an apparent shift in therapy. The theme became one of autonomy and gaining control rather than one of dependency. Rita talked of wanting to 'free' herself from her 'illness' and to be able to leave her home without fear. Further to this she discussed new future goals of wanting to be able to go to London and also to go on holiday

by plane. To some extent, this theme of autonomy and control has also been acted out in the therapy sessions, with Rita interrupting at times and being more assertive and confident in her interactions with me, challenging and occasionally disagreeing with my interpretations. This provided a very different scenario to that present in our earlier sessions when she was very timid and expected me to have all the answers. When session 12 was cancelled due to my ill health, Rita was able to cope during the break from therapy, and did not regress as she had done in the earlier stages of therapy during the Christmas break. Feeling more in control and able to cope on her own, she was even able interact confidently and assertively with her abusive controlling ex-boyfriend, whom she admitted to being frightened of in the past.

2.3 Difficulties and making use of supervision
The main difficulties I have had to deal with during therapy with Rita have centred on myself as a trainee therapist. As I had no experience of working with a panic with agoraphobia presentation, I felt quite anxious about this at the beginning of therapy and was very much pre-occupied with 'surviving' the session. In order to contain my anxiety, I constantly read and reviewed didactic material and carefully planned my sessions. Due to this, I felt that I was sometimes 'rushing' therapy with Rita in my attempt to put theory into practice, resulting in a failure on my part to stay with the client and leading to confusion through premature interventions.

This insecurity was also apparent in supervision. Like Rita, I presented as dependent and needy, wanting constant re-assurance that I was working effectively. My supervisor became uncomfortable with this, and stated that I needed to be more confident in my abilities and to stop relying on the theory. Any attempt to elicit a concrete answer was pushed back to me. At the time I felt very frustrated by this and after discussing these issues in personal therapy, I considered whether the supervisor had expected too much of me at the time and also whether I perhaps appear more competent than I actually am. As argued by Stoltenberg, McNeill and Delworth (1998), like

clients at the beginning of therapy, trainee therapists also go through a stage of dependency during their professional development, when they feel highly insecure and anxious. At this stage they have a need for their supervisor to contain these feelings, which is best achieved through taking a structured and supportive approach. Therefore, to encourage this, I began to plan and structure the supervision sessions for myself which made them more satisfactory. Although this improvement may also have been facilitated by my move into the second stage of development, which is characterised by dependency-autonomy conflicts. Where fluctuating between feeling over-confident and overwhelmed, my focus became placed very much on the client rather than on myself (Stoltenberg *et al.*, 1998).

3.0 Section C – Review

3.1 The future

Having achieved the therapeutic aims, in our last sessions we plan to consolidate the progress made so far, by focusing on Rita's core conditions or schemas, improving confidence and extending her social network. Rita has been referred on to a group for confidence building and assertiveness, which begins in a couple of months and in the meantime I plan to terminate therapy. Due to Rita's potential dependency issues our final sessions will be staggered over this period (Ward, 1984).

3.2 What you have learnt about psychotherapeutic practice and theory

My experience of working with CBT is that it is a complex and creative form of therapy, requiring the therapist to integrate a number of tasks at once including conceptualising the case and collecting data and testing hypotheses, whilst at the same time, tailoring therapy to the level of the individual client (Beck, 1995). This can be very challenging for the trainee therapist as this demands a certain amount of flexibility which at the beginning of training when the trainee lacks experience, is difficult to come by.

Despite this complexity, as in most other theoretical orientations, at the heart of effective CBT lays the therapeutic relationship, or alliance (Dryden & Feltham, 1994). Within the model, this is partly fostered by the three core conditions (Rogers, 1951) and also partly by the use of collaboration. It is through collaborative empiricism that therapy provides a transparent environment, where information is shared and the presenting problems are worked on together, helping to provide a climate of trust.

I have also changed my views about dependent clients during my work with Rita. Rather than recoil with horror at the very thought of a client being dependent, I feel that it is more realistic to accept that this is likely to occur with most clients, who come to therapy in a troubled and distressed state. Further to this, dependency can have positive as well as negative consequences. Therefore, despite being pre-occupied by Western notions of independence and self–sufficiency (Neki, 1976), perhaps it should be acknowledged that dependency is even necessary at the beginning of therapy in order to develop the therapeutic relationship or alliance which is key to effective therapy (Storr, 1990). In terms of further research on this area it would be interesting to develop a model of managing dependency from this more positive accepting standpoint.

From the therapy, I have also learnt that I would like to work more psychodynamically. Although I have learnt a great deal about CBT by working with Rita, our sessions so far have highlighted to me some of the weaknesses of the approach. A major issue appears to revolve around Rita's early relationship with her mother. However, within CBT, it would be inappropriate to explore this in any depth. Therefore, to some extent I feel constrained by the model and due to this would like to try out other more analytic approaches such as cognitive analytic therapy.

3.2 Learning from the case about yourself as a trainee therapist

My work with Rita has highlighted the different levels of trainee development and how difficult and anxiety provoking the first stage can be. The dependency or professional training stage (Skovholt & Ronnerstad, 1995) of my development has stressed both my enthusiasm and insecurities about myself as a therapist.

As a result of this understanding, I feel that I am more realistic and that therapy is less about proving myself and what techniques I can utilise and more about being focused on the needs of the client. My earlier expectations of myself were too high and I have again been reminded that I cannot expect to be totally proficient over-night. Therefore, I now find that I am concentrating more on developing myself as a therapist and finding my own style and ways of working. Although I am using supervision and personal therapy to help me in this quest, it is very much a personal journey. Also as part of this more realistic stance and fostered by a greater awareness of myself as a trainee, I feel that I have become more realistic about my supervision and do not expect my supervisor to have all the answers, leading me to take more control of the supervisory process (Loganbill, Hardy & Delworth, 1982).

To conclude, considering the progress of both myself and my client, perhaps part of the process of moving away from dependency comes with the confidence that you are 'good enough' (Winnicott, 1964).

References

American Psychological Association. (1994). *DSM-IV.* Washington DC: APA.

Beck, A.T. (1976). *Cognitive therapy and the emotional disorders.* London: Penguin.

Beck, A.T. (1985). The Agoraphobic syndrome. In A.T. Beck & G. Emery (Eds.), *Anxiety disorders and phobias.* US: Basic Books.

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford Press.

Butler, G. (1989). Phobic disorders. In K. Hawton, P.M. Salkovskis, J. Kirk & D.M. Clark, *Cognitive behaviour therapy for psychiatric problems: A practical guide.* Oxford: Oxford Medical Publications.

Chambless, D.L. & Gillis, M.M. (1983). Cognitive therapy of anxiety disorders. *Journal of Consulting and Clinical Psychology, 61,* 248–260.

Chambless, D.L. & Goldstein, A.J. (Eds.) (1982). *Agoraphobia: Multiple perspectives on theory and treatment.* New York: John Wiley.

Clark, D.M. (1989). Anxiety states. In K. Hawton, P.M. Salkovskis, J. Kirk & D.M. Clark, *Cognitive behaviour therapy for psychiatric problems: A practical guide.* Oxford: Oxford Medical Publications.

Clark, D.M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy. 24,* 461–470.

Clark, D.M. & Beck, A.T. (1988). Cognitive approaches. In C.G. Last & M. Hershen, *Handbook of anxiety disorders.* New York: Pergamon.

Decker, R.J. (1988). *Effective psychotherapy: The silent dialogue.* New York: Hemisphere.

Dryden, W. & Feltham, C. (1994). *Developing the practice of counselling.* London: Sage.

Egan, G. (1986). *The skilled helper: A systematic approach to effective helping.* California: Brooks/Cole.

Emery, G. (1985). Principles of cognitive therapy. In A.T. Beck & G. Emery (Eds.), *Anxiety disorders and phobias.* US: Basic Books.

Klein, D.F. (1981). Anxiety reconceptualised. In D.F. Klein & J.G. Rabkin, (Eds.), *Anxiety: New research and changing concepts.* New York: Raven Press.

Loganbill, C.R., Hardy, C.V. & Delworth, U. (1982). Supervision: A conceptual model. *The Counselling Psychologist, 10*(1), 3–42.

Mathew, A.M., Gelder, M.G. & Johnston, D.W. (1981). *Agoraphobia: Nature and treatment.* New York: Guilford Press.

Neki, J.S. (1976). An examination of the cultural relativism of dependence as a dynamic of social and therapeutic relationships. *British Journal of Medical Psychology, 49,* 1–10.

Nelson-Jones, R. (1997). *The theory and practice of counselling.* London: Cassell.

Rogers, C.R. (1951). *Client-centred therapy.* London: Constable & Co. Ltd.

Salkovskis, P.M. & Clark, D. (1991). Cognitive therapy for panic attacks. *Journal of Cognitive Psychotherapy, 5,* 215–226.

Skovholt, T.M. & Ronnestad, M.H. (1995). *The evolving professional self: Stages and themes in therapist and counsellor development.* Chichester: Wiley.

Stoltenberg, C.D., McNeill, B. & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counsellors and therapists.* San Francisco: Jossey-Bass.

Storr, A. (1990). *The art of psychotherapy.* New York: Menthuen.

Ward, D.E. (1984). Termination of individual counselling: Concepts and strategies. *Journal of Counselling and Development, 63*(2), 1–25.

Watkins Jr., C.E. (1988). Transference phenomena in the counselling situation. In W. Dryden (Ed.), *Key issues for counselling in action.* London: Sage.

Winnicott, D.W. (1964). *The child, the family and the outside world.* Harmondsworth: Penguin Books.

Wolpe, J. (1961). The systematic desensitisation treatment of neurosis. *Journal of Nervous and Mental Diseases, 132,* 189–203.

Appendix

Genogram
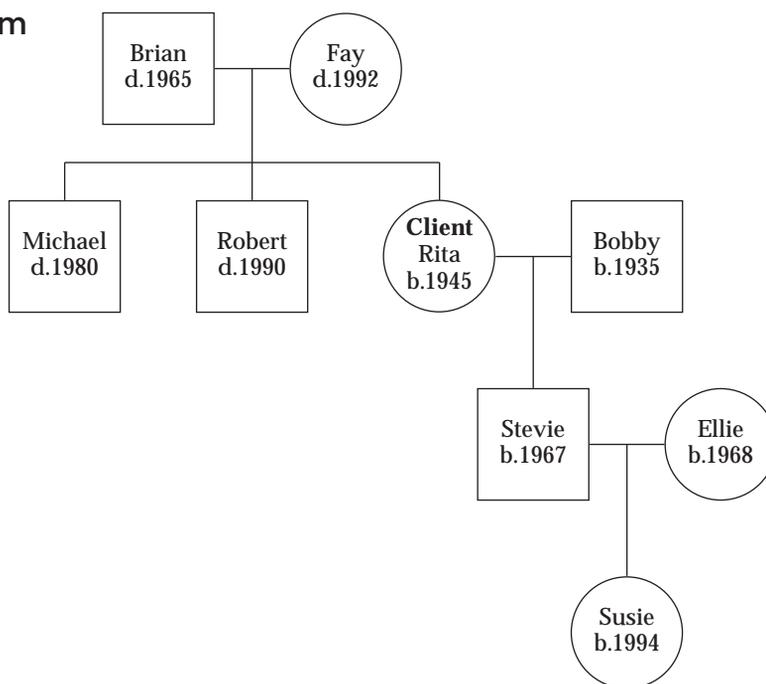
Graded hierarchy

	Anxiety Rating Scale (0–100)
Go out to local shop by 9.00 am	40
Go to local shop after 9.00 am	50
Go to shop and another destination after 9.00 am, e.g. post office	60
Go into the town centre and browse or go to library in the morning	70
Go into the town centre and browse or go to the library in the afternoon	80
Sit down in a café and have a coffee	90
Go to another town by public transport and shop in a busy department store	100

The functions of case studies: Representation or persuasive construction?

John Davy

This paper presents a deconstructive analysis of a narrative therapy case study originally written by the author while training as a counselling psychologist. This critical reading illustrates how writing about clients can be seen as a constructive and constitutive activity, with potentially oppressive or progressive consequences, rather than a merely representational process. The paper concludes by suggesting that therapists' training and professional development should include an emphasis on critical and creative reading and writing skills.

Introduction

THERAPY CASE STUDIES may be written for several purposes, such as demonstrating proficiency to an assessor (Davy, 1999), as a joint therapeutic endeavour with a client (White & Epston, 1990), or as an exercise in empathy and personal reflection (MacMillan, 1992) which can itself be understood as a form of idiographic research or inquiry (Mair, 1999). The form and content of a case study should be suited to its purpose.

While training as a counselling psychologist in the 1990s I wrote a case study describing therapy with a client I will call 'Megan', to demonstrate some basic competence in narrative therapy. That writing reflected my excitement at that time with textual metaphoricity and postmodernism in therapy. However, written case studies are not simple representations of clinical work, but are themselves constructions (Spence, 1989):

- Translating a series of interpersonal encounters into a short written form necessarily involves interpretation, selection and transformation of meaning (Kvale, 1996; Ochs, 1979).
- Case presentation is shaped by the writer's purposes and capabilities as much as the original clinical encounter (cf. Kaschak 1978;

Mintz *et al.*, 1973). When I first wrote about this case I needed to convince assessors that I was competent to practise a specific therapeutic approach as part of BPS Chartering requirements. This produced a relatively conservative style of writing emphasising a single, coherent, and academic narrative of ethical professional practice, marginalising other possible accounts. In van Maanen's ethnographic terminology (1988), my original study was written primarily in a realist genre, from a distanced position of 'interpretative omnipotence'.

- Case presentation is intimately connected with the dominant discourses within which writers and readers are constituted. Deconstruction calls into question the covert norms maintaining the objectifying and pathologising gaze expressed in a professional's account of therapy (Burman, 1999, p.166). A deconstructive reading (Lather, 1995) asks what is omitted altogether (is unspeakable), or what is only present through an implicit opposition to that which is written about (is taken for granted or beyond question)?[1] This concern with the partiality (in the sense of incompleteness) of the text can also be used

---

[1] For example, when anti-racist practice is discussed in relation to the disadvantage and oppression of black people, rather than white identity, privilege and collusion.

to develop a critical reading (Lather, *ibid*) of therapeutic partiality (in relation to preference and promotion) concerning contextual issues of power and privilege.

Using a case study to show two different uses of deconstruction

This paper presents an extended case study of therapeutic work produced through a reflexive critical reading of the original shorter study I wrote about my work with Megan. One aim of the original case study was to illustrate how deconstruction may be used as a form of therapy with a client following the narrative practices of White and Epston (1990), linked with the reconstruction of 'preferred' accounts.

However, the principal purpose of this 'second take' on my original study is to suggest how psychologists can use disciplined analysis of their own writings as a mode of reflective practice and continuing professional development. This case study is not meant as an example of qualitative case study research into Megan's life, but rather is intended as a reflection on the role of writing and re-reading in professional development. My aim is to suggest how deconstruction can be used to forestall conservative closure of interpretation in relation to clinical practice. Although I discuss this here in relation to case studies, the idea is also relevant to clinical case notes, reports and clinical letters (cf. Steinberg, 2000).

The structure and style of this case study

The structure of this case study reflects this double function:

a. The **original commentary** of the early case study, which claimed to represent a deconstruction of the client's story, is provided in plain typeface.

b. More recently, I have developed a second reflexive commentary by making the original case study the focus for further analysis through a critical reading. This second, reflexive commentary is provided in 'Gill' typeface within boxes. This analysis derives from a 'hermeneutics of suspicion' (Habermas, 1971; Ricoeur, 1971), which demands repeated return to the interpreted text for further work, on the assumption

that there is always meaning that escapes each reading, and always further meaning that can be constructed. *'Suspicion is directed towards the unconscious meaning which could occur in the conversation between the interpreter and the text. In the process of communication the interpreter should be aware of distortions that are caused by tradition or racism, for example'* (Gouws, 2000, p.21).

This stylistic disjunction between the 'client' study and the 'meta-study' is somewhat clumsy, since it hinders the smooth flow of a written account. However, the use of devices like this is one way in which to foreground the textuality and constructed/constructive nature of such accounts, such as their specificity to a particular time, context and purpose, and in so doing facilitate a critical evaluation of their functions. *'Language which flows naturally and easily must always, in a 'climate of problematisation', arouse suspicion. Its very ease and fluidity helps to beguile the reader into believing the text is merely mirroring the world 'as it really is', and obscures its ability to glamour that reality into being'* (Curt, 1994, p.14).

Original commentary

Case study – 'Megan'

Introduction

This case study describes counselling work over a six-week period between me and Megan, a 42-year-old white Irish woman, at an urban GP practice where I was employed to provide brief counselling to individual adult clients.

The referral

A male doctor at the practice referred Megan to me for 'depression', adding that Megan wanted help in managing her daughter's behaviour. The doctor wrote that the daughter might be anorexic.

Initial contact with the referrer

I felt it was unclear from the referral letter what sort of intervention might be needed and what the GP's expectations were, so I discussed the referral with the GP. He explained that he had only met the daughter, Cary (17 years old),

on one occasion when she had refused a full medical examination, but he suspected as did Megan that she might be anorexic. The GP said that Megan seemed very depressed about her own inability to change this or other aspects of Cary's behaviour, which was described as 'unco-operative', and he wanted someone (i.e. me) to help Megan 'come to terms with her helplessness'.

Requests for consultation or therapy often arise when one person in a triadic relationship is losing. It is possible that the doctor was feeling triangulated between the demands of the mother and the apparent 'resistance' of the daughter, and was seeking a way out by substituting a counsellor for their own place (the doctor declined my suggestion that he and I could offer a joint consultation to Megan or to Megan and Cary together).

Second reflexive commentary

Within the first few lines of the study, I have already introduced four subjects (Megan, her daughter Cary, myself and the GP), yet the title names only one. The title does not simply summarise or 'represent' the case in any simple way, but also suggests certain readings of the text over others. In Gadamer's hermeneutical terms (1975), the title shapes or 'fore-structures' the horizon of potential meaning in the case study, which in turn interacts with the range of interpretative biases that each reader brings to a text given their personal and professional history, attitudes and skills. For a psychologist, this concept of a 'horizon of potential meaning' is quite similar to Vygotsky's zone of proximal development (Vygotsky, 1978), especially since Gadamer suggests that the horizon is 'realised' in some way through engagement with a reader's horizons; text and reader provide mutual scaffolding for each other's development. Jerome Bruner puts this as *literary texts initiate 'performances' of meaning rather than actually formulating meaning themselves* (J. Bruner, 1986, p.25).

My decision to name the study 'Megan' could be read as a demonstration of a client-focused attitude compatible with the 'decentred practice' of narrative therapy (White, 1997) which positions the therapist's concerns as peripheral to the client's best interests. However, there is also a sense in which this 'client-centred'/'decentred therapist' stance is also a flight from context into text. The title implies that the focus for intervention is located clearly within the identified patient's belief systems and actions. Megan is constructed as the object for the critical gaze of therapist and reader, and as the necessary site for change. This is paradoxically both empowering and objectifying. The woman is positioned as an object of pathology in need of intervention by others (here, specifically male others such as me and her GP) but is accorded the responsibility for change.

By contrast, more contextually oriented cybernetic therapies would note that Megan has been offered as the 'identified patient', but foreground the wider system that has produced and responded to the referral as the unit for analysis and intervention (e.g. Bor *et al.*, 1996, Minuchin 1974). Some feminist analyses of family therapy (e.g. Bograd, 1984; Goldner, 1991; Hare-Mustin, 1986; Jones, 1990) have criticised the notion of circular causation for implicating women in provoking and maintaining their own abuse. However, the contextual emphasis of cybernetic family therapy offers therapists a lens to look beyond the individual towards social structures and processes – notably but not necessarily the family - providing analytics to connect the socio-political with the personal (Rowbotham *et al.*, 1979).

Some alternative titles may help clarify this. For example, I could have titled the study as 'Therapeutic responses to male violence against women', or 'Problematising masculine accountability in relation to therapy with an abused female client'. Drawing on the referring doctor's request to me, the study might be titled 'Help her come to terms with her helplessness', drawing attention to the traditional role of mental health services in pacifying women's distress and reproducing gendered power relations (see, for example, Kitzinger, 1993; Kutchins & Kirk, 1993; Masson, 1989; Ussher, 1991). Such cybernetically informed titles might have seemed incompatible with presenting the case as a narrative study. However, these titles also make sense when read as narrative 'externalisations' of problems (e.g. Title: 'Megan and John protest against male violence'). My wish to show theoretical consistency in the case study cannot

adequately account for the exclusive focus on Megan in the title. The title of the case study reproduces a patriarchal dynamic that deflects critical attention from masculinity.

These titles do not necessarily offer 'better' readings of the case. Rather, my analysis draws attention to the necessary partiality of any reading or representation of clinical practice, in the double sense that any single account (a) offers an incomplete view of therapy, which is always open to elaboration or revision (Scheflen, 1978) and (b) is partial in the sense that it supports a particular set of purposes and values.

Original commentary

Setting up the initial session

I was unsure what therapeutic work might be possible, but accepted the referral for initial assessment. I wrote to Megan offering an appointment for an 'initial discussion about counselling and the problems affecting her' (avoiding an assumption at this stage that Megan actually wanted counselling for herself as opposed to some other form of help (Street & Downey, 1996, p.14), and implying an narrative approach to problems that views them as separate from or external to persons (White, 1989)).

Initial presentation

Megan arrived promptly, dressed in clean casual clothes, looking in fair physical health but above average weight for her height of about 5'4". She made good eye contact, seemed well oriented, and was able to speak clearly with me in a conversation without apparent problems with concentration, memory, etc. She initially described herself as 'feeling down quite a bit' and often tired, and seemed worried and rather thoughtful, but not clinically depressed in terms of the combinations of signs and symptoms specified in standard diagnostic manuals such as *DSM-IV*.

Second reflexive commentary

Some of my anxiety about assessment as a 'safe practitioner' is evident here. My references to DSM-IV, clinical depression and signs such as her orientation are not consistent with the narrative frame I claimed to be using, but are perhaps a defensive manoeuvre to forestall an imagined question, 'Did you assess her properly?', mixed with some unwitting allegiance to medico-diagnostic models of distress and my inexperience in thinking about formulation or hypotheses.

Original commentary

The main problem that Megan initially presented concerned what she saw as her failure to help her daughter Cary, combined with a deep sense of responsibility for Cary's behaviour and perceived difficulties. Megan was particularly worried that Cary seemed very thin, and seemed to eat very little. The referring doctor had suggested to Megan that Cary might be anorexic, but neither of them had persuaded Cary to be medically examined or to co-operate with being weighed, monitoring food intake or even discussing the concern. Megan felt that she didn't know how to talk to her daughter, and didn't know what to do to protect her from harm. Megan described herself as failing as a mother with Cary, and feared that similar problems might arise in future with her two younger sons.

Second reflexive commentary

My analysis of the content of 'Megan's problems' and my conduct of the case was influenced by my engagement with feminist ideas concerning the problematic practice of 'mother-blaming' in many therapies. However, I tended not to include my own masculinity in the case study, and generally excluded masculinity from my understanding of the case process. It is notable that I did not include myself in the description of the 'initial presentation'. This was not something justified by my theory of therapy, since second order cybernetic and constructionist therapies insist that the therapist is a part of the 'observing system' (von Foerster, 1981) or co-constructed reality of the therapy (MacNamee & Gergen, 1992).

Writing as a feminist psychologist, Burman (1999) argues that there is a tendency for political and feminist concerns to become neutralised or deradicalised through recruitment into theoretic grand narratives or disciplinary 'bodies of knowledge', rather than remaining grounded in relation to **actual** bodies whose materiality signifies in terms of race, sex, class etc. (For instance, Burman points out that the BPS sanctioned a 'Psychology of Women' section, but not a 'Women's Psychology Section' (Burman, 1999, p.169).)

The details of the 'initial presentation' focus on the client's physical appearance and her verbal description of the problem. Other contextual dimensions potentially relevant to an understanding of 'helplessness'/empowerment are absent from the description, such as her class and ethnicity. It seems inadequate to claim that I omitted these simply because Megan did not suggest they were relevant to the problem, since neither did she tell me that her height, concentration or clothes were.

Deconstructive readings of the historical development of feminism (e.g. Amos & Parmar, 1984; Carby, 1987; McClintock, 1995) suggest that it has sometimes provided collusive support to discourses of racism, colonialism, class and heterosexism (to name but a few) through an early emphasis on a romantic grand narrative of women's common oppression by patriarchy, implying consequent common cause. This denial of potential difference and conflict between women, and disinterest in axes of ethnicity, class etc. has at times served to conceal and reproduce these forms of oppression and injustice. For example, my attempted commitment to focus on Megan's experience as a woman may have excluded a helpful focus on the treatment of working class Irish people by middle class doctors and therapists, or by the British police and judicial system. Ethically motivated attempts to focus on the significance of gender, sexuality, race, class, etc., in therapy should take into account the ways in which these subject positions intersect and co-organise (Brah, 1996).

I am not suggesting that therapists can avoid partiality and selection in writing about clients, but that we must be vigilant about the perspectival biases this reflects and reproduces, systematically reviewing how this shapes our practice.

Original commentary

The therapeutic approach

I adopted a narrative approach to this work, aiming to work collaboratively with Megan to re-author and revise an initially problem-saturated dominant narrative in order to help free *'the client from a particular kind of account or 'story', and opening the way to alternatives of greater possibility and promise'* (Bor *et al.*, 1996, p.248). This approach was chosen for two main reasons:

- the 'problem-saturated' nature of the case from the referrer's viewpoint and the client's initial presentation;
- narrative approaches stress working collaboratively with a client to form a coalition against an externalised problem, rather than against a problem internalised or located in the client or a third person. Externalising the problem seemed a useful way to try to avoid becoming frozen in a mother/daughter/therapist triangle (especially since it seemed unlikely that the daughter could be engaged at this point).

Second reflexive commentary

When I first wrote about this case, I tried to present my case conceptualisation and interventions as consistent with narrative therapy following social constructionist ideas. However, in so doing I tended to downplay other theoretical and personal experiences which shaped my response. I attempted to present myself to my assessors as influenced by a single dominant theoretical narrative, and my anxiety about assessment made me hide or ignore other influences.

Looking back on the encounter as a whole (rather than my client), it seems both inevitable and obvious that my professional practice and case theorisation was something messier and socially constructed, arising epigenetically (Bertrando, 2000) through the interaction between my prior experiences and engagement with different therapeutic models.

For example, my initial case conceptualisations actually owed something to Milan systemic and structural models of family therapy which I had tried to use in my previous career as an educa-

tional psychologist. My style of engagement with Megan probably owed much to my person-centred counsellor training, which I seldom wrote about during my initial counselling psychologist training, perhaps thinking that this was somehow a 'lower status' form of therapy.

Original commentary

(A) Identifying dominant narratives

White and Epston (1990) argue that *'in striving to make sense of life, persons face the task of arranging their experience of events across time in such a way as to arrive at a coherent account of themselves and the work around them... The success of this storying of experience provides persons with a sense of continuity and meaning in their lives…'* (White & Epston, 1990, p.10). For many clients this dominant story may seem very problem-saturated, inadequately representing their lived experience and implying a feared future, failing to offer pathways to more satisfying 'story endings' (Figure 1).

Second reflexive commentary
Although I intended to portray my therapy with Megan as grounded in a discursive and post-modern form of narrative therapy, on reflection I realise how this diagrammatic representation focuses attention on the identified patient's individual story-making and story-changing processes, rather than the social construction of experience and the co-construction of lived reality. Narrative therapy's apparent return to the individual's sense-making processes can be understood as a rapprochement between systemic therapies and humanism (Bertrando

Figure 1: Diagrammatic representation of a dominant narrative brought to therapy with a problem (P) filled past and present implying a feared future, with a relatively narrow range of future paths available for consideration and little emphasis on resources and skills used before and available now.
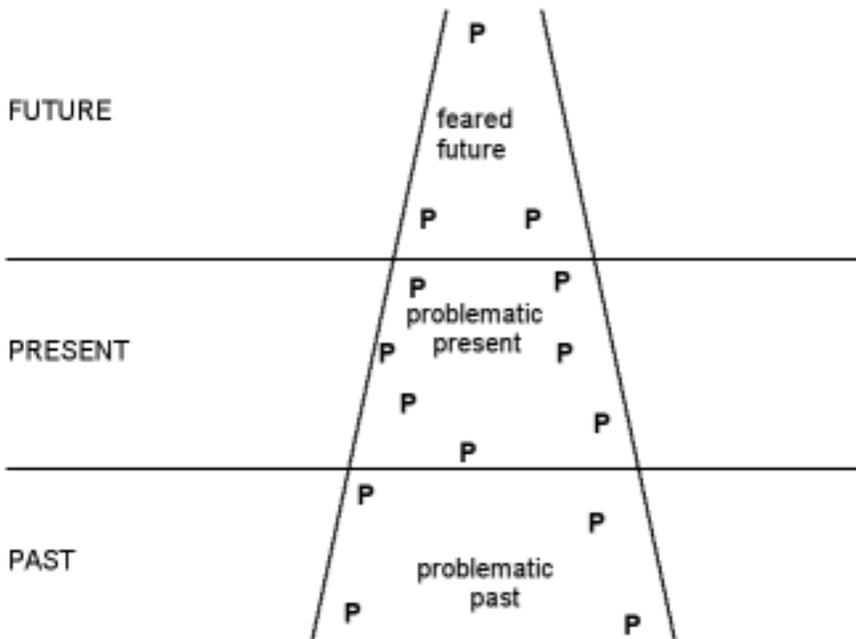
2000), replacing cybernetic epistemology with the metaphor of narrativity and a renewed interest in clients' authorial status and autonomy. However, the narrative emphasis on textuality and individuals' capacity to 're-author' their lives risks losing the contextual and inter-active sophistication of the systemic therapies it developed from (Bertrando, 2000). With minor modification, Figure 1 could equally represent the core message of cognitive therapy for clients that *'You don't have to see it that way. There could be another way of seeing things'* (Butler, 2000, p.25), or a weak form of Kellyian constructive alternativism (Kelly, 1955, p.15). It seems impor-tant to keep asking <u>whose</u> narratives should be in question, and how empowerment and protec-tion can be reconciled with just responsibility.

A measure of distrust is also required in our attitude towards our own answers to these questions and to clients' answers. After all, if one believes that subjectivity is constructed, a client's formulation of, and attitudes towards, their 'own' goals are as socially constructed as the thera-pist's. On what basis then do the client's goals constitute a privileged and necessarily benign means for guiding therapy? (If Megan's daughter Cary were to tell a therapist that her goal is to become as thin as possible, should the therapist simply accept this? If not, on what authority can the therapist presume to offer a valid recon-struction of the goal, given that the therapist's subjectivity is also discursively produced?)

Original commentary

Megan lived with her partner of four years, Brian, and her three children aged 17, 11 and nine by her marriage to Peter. Megan felt she had experienced increasing difficulty in 'dealing' with Cary's behaviour (e.g. arguing and 'answering back', not eating, staying out late) since her separation from Peter six years ago, with a sharp turn for the worse (including 'worrying' changes in her appearance and diet) when Cary had spent a summer away from Megan and Brian working at a fruit farm, after which she had initially returned to stay with her father, who still lived nearby.

Megan said Cary seemed even more unhappy and uncommunicative since returning to Megan's about three months previously, and she worried that Cary might leave home for another summer job soon, when Megan feared that Cary's health might suffer if she continued not to eat.

It also became apparent that Megan was worried about Cary going to stay with Peter again. This did indeed happen midway through our sessions when Peter's sister died. Cary went to stay with Peter to organise the funeral and started cooking for Peter. By this time, Cary had turned 18 years old, but it was apparent that Megan found it hard to think of Cary as an adult making her own decisions.

A process of shame and failing words...

Megan explained that she felt that her own upbringing and early adult life had been good until about 10 years ago when her husband Peter had suffered a small stroke. She described Peter as becoming increasingly aggressive to her after this, both verbally and physically, taking drugs, and becoming extremely sexually demanding.

Second reflexive commentary

My original case study continued with a further section here describing some of the abuse which Megan had experienced from Peter, including rape. I have omitted that passage because in hindsight I now feel that some of my account verged on the voyeuristic (although this was not something which my original assessors commented on). I think perhaps I included excessive detail in the original case study because I was still struggling to relate profes-sionally to such extreme experiences and was using the study to process this secondary or vicarious traumatisation. Although I had the client's permission to write about our work together in an anonymised case study, ethically such permission does not release the therapist from a duty to write sensitively and respectfully about their clients.

A little told story…

She also explained that after one particularly brutal assault Cary had seen her in the shower with bad bruising across her thigh, and had asked 'did Daddy do that', to which Megan

answered 'yes'. Megan was worried about the injury and had gone to a male Asian GP, who had been dismissive and irritated when she tried to explain how it had happened. Megan told me that this was the only time she had thought of trying to tell someone about the sexual violence against her, although she had told Brian that Peter had been violent.

Original commentary

Megan explained that she eventually left when Peter kicked the youngest child very hard one evening, which had led to a difficult time living in hostels on low benefits, with many moves until they settled with Brian who she described 'a good man, like Peter before the stroke, very gentle'.

Second reflexive commentary

Looking back on my original commentary, I am saddened to see my own unwitting racism at work in the text. If the ethnicity of that GP was relevant, why had I not previously discussed my own and that of other subjects in this narrative, besides Megan? If instead I believed that professionals' ethnicity was not a relevant therapeutic dimension, then why did I describe this GP as 'Asian'?

A summary of a dominant narrative…

Megan saw herself as a bad mother who had not managed to protect her children from Peter's violence and aggression, and might be failing again in protecting her children from both Peter and other possible dangers in the world. She saw this failure primarily in terms of her failure to find ways of communicating with Cary, and her failure to 'stand up to' Peter. Megan felt 'dirty' and ashamed as a result of her experiences of physical and sexual abuse by Peter, and saw herself as powerless and unable to take action or speak out against male violence.

Megan recognised these themes when I offered them towards the end of the session as my understanding of our conversation to that point, and seemed relieved that this much had been heard and told.

(B) Inviting an alliance against a problem…

Narrative therapists actively seek to engage with clients in an alliance, but aiming to ally against problems seen as external to the client and significant others rather than owned by or located within them. The therapist's intention is to help the client contextualise and locate the problem in relation to meaning systems or discourses within their social context – this could include family belief systems, but also broadens the scope for exploration and change in therapy to the client's relationship with social and political forces/discourses beyond the family (White, 1989). We agreed that we would work together for five further weekly sessions to: (a) consider the effects of communication problems on her, and her influence on the communication problems; and (b) look more closely at the relationship between her experience and the notion that she was a bad mother who failed her children.

Second reflexive commentary

While I was working with Megan I was training as a counselling psychologist, and acutely aware that I needed to get a certain number of placement hours. In the original case study, I presented as unremarkable my choice to offer five further sessions. In fact, the service I worked for did not allow longer contracts, and I do not mention the possibility that I could instead have referred Megan to a secondary mental health service with less restrictions on the contracts that could be offered, and which could also have offered a choice of male or female therapist. I believe that I endeavoured to provide an ethical and appropriate service to Megan, but by omitting these contextual factors in the written account I minimised the study's transparency about my institutional power as a gatekeeper to other services.

There is an ethical requirement to link the textuality of this case study with the context of the work. I am writing as a white British middle-class male psychologist about therapy with a working-class Irish female client, where the concerns discussed in the sessions related significantly to the abuse of women by men. The way in which I conducted the therapy and

---

then wrote about this work is not separate from this. In making my own beliefs and writing part of the system which this paper examines, I am attempting to develop reflexive and accountable practice (cf. Law, 1999; Lax, 1992).

In this sense, both therapy and the original case study reproduced a patriarchal structure in which women are objectified through the pathologising gaze of men, while male actions and beliefs remain distant or unquestioned as the covert norm. I conducted the therapy to help Megan 're-author' stories about herself as a resourceful and competent mother, but in so doing retained 'motherhood' as a central discourse rather than fatherhood, male sexuality and violence, and thereby also replicated male bystanding (Clarkson, 1996).

Original commentary

(C) Reclamation of subjugated narrative and construction of alternative narratives

'Life experience is richer than discourse. Narrative structures organise and give meaning to experience, but there are always feelings and lived experience not fully encompassed by the dominant story' (E. Bruner, 1986, p.143). The narrative therapist aims to help a client construct a narrative implying more resourceful future possibilities by:

- Helping the client identify and reclaim resourceful and rewarding aspects of experience which have been disregarded or forgotten as inconsistent with the dominant narrative. This can be understood as a search for times when the 'problem didn't happen', for 'exceptions' (e.g. de Shazer *et al.*, 1986) or 'unique occurrences' (White & Epston, 1990). Similarly, problematic issues already discussed can often be reframed as evidence of the survival capacity of the client (Wilson, 1997, p.62). A few examples from the work with Megan include:
  - she had survived two years of severe abuse, remaining able to provide for three children, seek new part-time work and find a new partner;
  - she acted effectively to protect the children and herself when she left Peter and sought divorce;

- she had given up her enjoyable work as a school cook to look after her children while they were in temporary accommodation, after considering leaving them with a childminder instead;
- although Megan found Cary 'difficult', the two younger children seemed to be 'turning out well', which she agreed owed a lot to her;
- Megan had been able to 'speak the unspeakable' in telling me about Peter's assaults;
- between sessions four and five, Cary told Megan that she felt maybe she had lost too much weight, allowed Megan to watch her weigh herself, and agreed that Megan should make her an appointment with the doctor.

- Seeking to bring into awareness stories about other possibilities which were not experienced, or generate alternative visions of the future. Narrative therapists emphasise the exploration of negative explanation and restraints, asking not so much how the current pattern developed and is sustained, but wondering instead why other patterns haven't developed instead, or why clients envisage one form of likely future rather than other possibilities (Bateson 1972, p.399).

Why didn't Megan leave Peter sooner? Megan felt that this would have been financially very difficult; instead, she had started putting money aside 'just in case'. Also, she felt that a transient life in hostels would have been very hard with a toddler; when she did leave, Cary had started at her new secondary school, Edwin at a primary school, and a nursery place was due shortly for Darren. Megan began to feel that: (a) her timing reflected some very caring motherly planning; (b) her dilemma was one shared by many women in a society where financial circumstances and childcare arrangements help keep women entangled in abusive relationships, and where women trying to disclose abuse within a marriage may be seen as 'disloyal' or at fault themselves, as when Megan had tried disclosing to her previous doctor; and (c) she was frightened about Peter's

reaction if she tried to leave, which she decided was not so much due to her being a bad mother as a well founded fear of abusive treatment.

Asking Megan why she thought Cary didn't allow herself to be closely 'protected' by staying in each evening and having her diet monitored led Megan to think about Cary's age and place in the family and increasingly decide that it might be appropriate for rules to be different for an 18-year-old on the verge of leaving home, compared to the younger children. Previously there had been significant conflict between her and Cary as Megan had demanded that what was 'a rule for one should be a rule for all'.

● Helping the client to voice or 'perform' existing alternative narratives which may be already be in awareness but hard to 'perform' and lacking power in relation to the dominant story. (*'Some experiences are inchoate, in that we simply do not understand what we are experiencing, either because the experiences are not storyable, or because we lack the performance and narrative resources, or because vocabulary is lacking'* (E. Bruner, 1986, pp.6–7)).

In our last session Megan told me that she had recently been to see the referring doctor about a minor problem, and while he was examining her she had told him that she was violently raped by her ex-husband. The GP was rather taken aback and made little response. This did not concern Megan, who felt elated that she had been able to disclose this information to the GP, in contrast to her years of silence after a previous GP had angrily dismissed her attempts to speak of Peter's abuse. To her, this represented another step in overcoming a powerful story of shame and silence taken independently, after our work together 'rehearsing' lines for a new narrative.

Megan told me that she had recently told Cary she had been coming for counselling, which we agreed was one step in working out how to talk with Cary about the family's experience and perhaps help Cary avoid some pitfalls in her own adult life. This reminded me of the feminist psychologist Jean Baker Miller arguing in 1976 that *'Women start…from a position in which they have been dominated. To move out of that position requires a power base from which to make even the first step, that is to resist attempts to control and limit them. And women need to move on from this first step to more power – the power to make full development possible.'* Reclaiming or reconstructing a self-narrative as an abused but resilient woman with the power to speak in therapy had been a first step, but Megan was also taking second and third steps outside the therapy sessions.

The use of supervision

In addition to her concerns about her daughter Cary (legally an adult during the latter half of the therapy) Megan worried about her two younger children's safety with their father Peter. He came round to meet his two sons each week, sitting with them in a local pub for the afternoon. Megan thought that Peter was very moody and so might upset the children, and felt that Peter should not be taking them to a pub. She said she was too frightened to ask him not to, and felt that no-one else would help enforce a ban on contact.

There was no direct evidence from Megan's account that the children were currently being abused or maltreated by Peter, but I felt concerned given Megan's accounts of her experience of Peter. Discussing these feelings with my supervisor helped me manage my anxiety about the case and encouraged me to take a more active approach with Megan in considering possible problematic future scenarios.

In order to get to a point where Megan and I could work together on possible alternative futures and solutions which could help protect the children's safety, it seemed necessary to help Megan articulate a more explicit vision of what a 'feared future' implied by the problematic past and present might be. This was done through future-oriented questions such as 'How long do you think this is likely to go on for?', 'What are you worried might happen as a result of these mood swings?' etc. Before the fifth session, Megan confronted Peter in the street in front of neighbours and told him not

to come round again or else she would hit him and call the police. Peter left without an argument. Megan described her confrontation with Peter as a voicing of great anger which she had long felt but which had been largely 'buried' under fear and shame.

> ## Second reflexive commentary
> I remember feeling quite pleased about the way I handled this, and I also recall a sense of satisfaction that this had helped to 'push Peter out of the picture'. Perhaps I resented his continuing presence in the warmer, more resourceful textual world (a 'nicer' story) that Megan and I were co-constructing in language. And yet, bearing in mind the other possible titles I could have chosen for this case study that would demand a focus on male accountability and attention to the social context of male abuse of women, I wonder now whether it is significant that I did not write more about Peter, or talk more with Megan about Peter and his future rather than Megan and hers. As I suggested earlier, my understanding of the dominant narrative in her story concerned bad versus good mothering, but this was an act of interpretation on my part. I could equally have 'reflected' back to Megan that the problem affecting her life seemed to be lack of male accountability and control (cf. Jenkins, 1990).
>
> What are the possible consequences of my inattention to Peter and preference for talking about resourceful motherhood? Peter remained at large in the community as a violent rapist whose crimes had never been reported to the police. From another perspective, Peter remained a patient who might be suffering from untreated neurological problems and/or poorly managed mental illness. An emphasis on male responsibility and actions in the therapy with Megan might have led towards measures to address these issues, or would at least have acknowledged the injustice of the situation.
>
> As a responsible therapist, it is important to consider ways in which the textual conduct of therapy with a client may have consequences in wider contexts and communities (such as Peter's potential future partners or children). This implies a broader focus than understanding how contextual considerations shape a client's life.

> Necessarily, any therapy can still only address a limited number and range of issues, but a responsible practitioner should endeavour to make such selections knowingly and accountably.

Original commentary

A revised narrative towards the end of therapy

Megan felt that she had been badly treated in her marriage but had been resilient and survived still able to work, love and care for her children. She felt angry and damaged by the abuse, but no longer ashamed - she felt the shame 'belonged' to Peter. Megan was no longer frightened of Peter, but thought it would be important to help her daughter understand more about the dangers of 'some men out there'. Megan remained very concerned about Cary, but felt that she needed to concentrate her efforts on caring for the two younger ones with Cary taking more responsibility for herself. She felt very pleased at having acted to keep Peter away from the younger children, and felt she could do this again if necessary.

Megan's vision of the future for herself was unclear but included some glimpses of possible growthful changes. She started thinking about returning to work, and at the very end of therapy Megan told me that Brian was dropping hints about marrying her. She said she 'wasn't going to get trapped again in all that, no thanks!', but also looked and sounded much happier and more relaxed than at any other point in the therapy - it was perhaps possible for Megan to begin to view possible futures which did not revolve so strongly around a 'caring mother' identity.

> ## Second reflexive commentary
> Figures 1 and 2 both suggest a kind of textual mapping process, in which a self-narrative suggests a route forward, and therapy aims to mark alternative routes. However, the map has no contours, representing a world of level playing fields. Attention to material and socio-cultural issues should remind the psychologist that there are plenty of uphill slopes and

impassable swamps on the territory. Historically, British justice is not easy terrain for Irish people given the colonial tensions on the island of Ireland and infamous miscarriages of justice such as the imprisonment of the Guildford Four. Failure to recognise this interdependence between textual route maps and the contextual territory implies a simple deficit model, that clients just lack the imaginative capacity to devise new stories and routes.

It follows that such route maps must be developed in combination with careful attention to the contextual territory for any given client.

The terrain for a middle-class male is different than that open to a working-class female. This is not a radical relativist position; rather, it is a recognition that our materiality (the presence and history of our embodied selves) signifies in the social world. To say that sexism, or racism, or ageism, is socially constructed is a long way from denying that these have real effects. There is a complex dialectic (Levins & Lewontin, 1985) between our construction of the world and the potentialities for construction which it offers us (Willig, 1999), theorised by Bhaskar (1978) as 'critical realism'.

Figure 2: New narratives produced and practised - a broader range or different base of past and present experience implies a greater variety of futures - some more clearly envisaged than others, but developed with a greater awareness of resources and solutions and with a different personal relationship to the original 'problem' leading to the feared future.
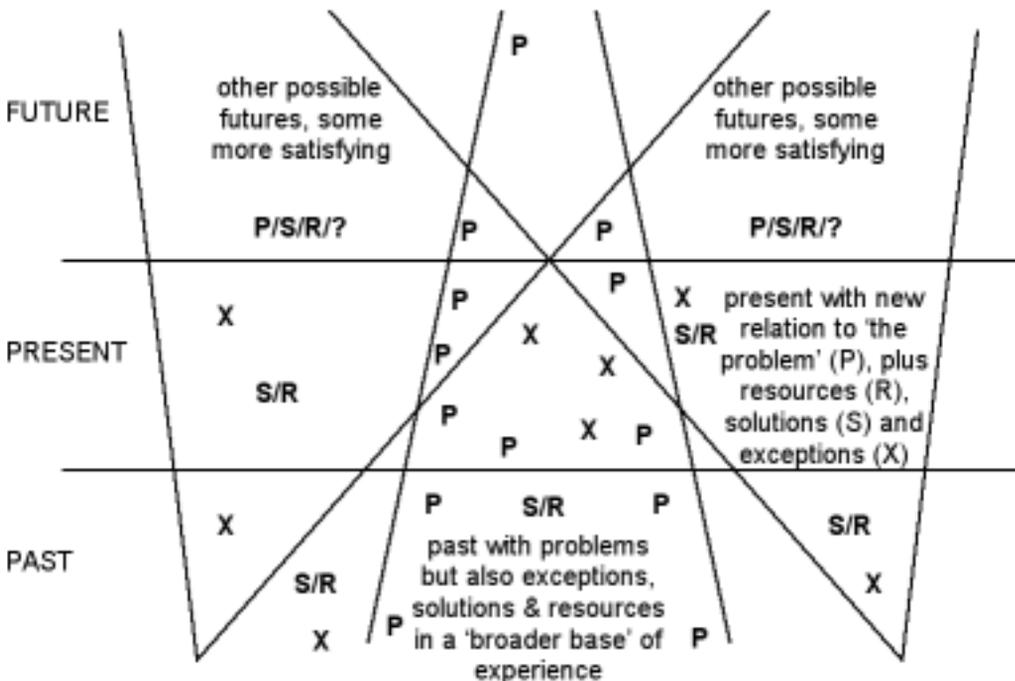
Original commentary

Learning about myself and about psychological counselling

Post-modernism's specification of possible 'constructions of meaning' in contrast to modernist 'truths' has led some therapists (e.g. Flaskas, 1997) to express concern that clients' lived experience and abusive experiences may be invalidated in some sense if they are seen as 'just another story' which can simply be re-edited to produce a more comfortable view. Flaskas cites Harari on the match between narrative metaphors and Holocaust survivors' experience:

> *'The narrative approaches... have provided bridges between subjective experiences and the social and historical contexts in which subjectivity is constructed. However, the Holocaust survivor is not just telling a story. He/she is also a witness, someone who is giving testimony. For the survivor, there is not the plurality of readings or multiple perspectives of equivalent validity from which the story may be told. The survivors fear that if the empirical links between life experience and its narration are modified in any way their story will be lost'* (Harari, 1995, p.13, in Flaskas, 1997, p.14 with her added emphasis).

I have felt uneasy in the past about using narrative therapy for such reasons, worrying that helping clients re-author their lives could seem tantamount to dismissing their experiences as 'just stories'. However, this case has helped me to appreciate that narrative therapies can also be about helping validate and witness narratives of oppression and survival which might otherwise be unperformed and unavailable for the client and others as a resource for future living.

Instead of assuming narrative therapy is only about co-writing new stories with clients, I now understand narrative therapy as about working with the client to develop narrative resources, such as finding and rehearsing an effective voice to tell a previously subjugated narrative.

Second reflexive commentary

I have not written this paper as a confessional story which I can now narrate from a morally superior position. My reflexive commentary is not a 'better' reading of the case in any simple objective sense, although my own understanding of narrative therapy has progressed since I wrote the original case study. Rather, I am aiming to demonstrate the partiality of possible readings and some implications of this, through an impressionistic account focusing on the process of knowing, as well as the knower and the known (van Maanen, 1988). I approach this task with a perspectival position that has changed over the last few years as I have read and reflected more on work identified with feminist psychology. This paper is therefore performative rather than simply instructional, since I am hoping to illustrate how deconstructive processes applied to one's own professional studies and writing can be used to develop different sensitivities and hence possibilities for responsible action.

Afterword

Many 'helping' professions encourage the use of reflective journals and case study writing as an aid to the development of professional skills and identity (e.g. Allen & Bowers 1989; Holly 1989; Palmer *et al.*, 1994), and as a way to make sense of complex clinical experiences (e.g. Noble, 1999).

Game (1991) suggests that writing can be seen as a transformational process which creates possibilities to rewrite cultural texts and reformulate issues of social change, but emphasises that reading is itself a form of writing practice. She suggests that texts should be evaluated for their capacity to provoke 'disturbing pleasure', in which the reader comes to re-evaluate their own purposes and desire for knowledge, opening up new questions. Using Barthes' terminology (1981), I have tried to present my case study as a 'writerly' text – i.e. one which invites readers to write themselves into it and extend its meaning – rather than as a 'readerly' text, in which the reader's task is simply to 'receive' what the writer intended.

I suggest that therapists need to practise and develop their reading skills and sensitivities as much as their writing, learning to apply these systematically to their own texts and to themselves as a form of critical reflexive practice. Whenever we write, we are writing about and through our beliefs and biases. Each text we create is an act with functions and consequences (cf. Austin, 1962; Wittgenstein, 1958), not simply a neutral representation of the world. Just as our writing has effects for clients, so too will our texts act on ourselves to sediment or perturb our own identities.

Some specific recommendations arising from this line of thought in relation to professional development include:

● Training courses should help psychological therapists to experiment with a broader range of writing formats and genres, introducing ideas from cognate disciplines such as literary theory, poetics (Mair, 1989) and creative writing.

In particular, it may be helpful to encourage forms of writing which counterpose different voices or interpretations of the 'same' situation (e.g. analysing different transcription styles for the 'same' interview segment (Gee, 1985; Mishler, 1991; Riessman, 1993)), and which acknowledge the writer as a subject within the system of inquiry who will have mixed feelings and multiple motivations for their (in)actions (MacMillan, 1992).

● Training courses should teach critical reading skills (Lather, 1995), and assess psychologists on their interpretative capacities as much as their descriptive skills.

● Trainees could be asked to re-read previous case studies to analyse their own developing process and emergent professional sensitivities in relation to their new understanding of the text. This would promote an ongoing hermeneutic approach to training and self-work, rather than the simple accumulation of core competencies (cf. Davy, 2003).

● There may be a need for continuing professional development for experienced psychological therapists in relation to these issues. In particular, many trainers will have developed through professional trainings that emphasise the coherence, clarity and 'central meaning' of accounts (Potter & Wetherell, 1987, p.168), rather than diversity, ambiguity and creativity.

● All therapists need support to examine the political complexities inherent in ethically motivated practice. In particular, there is a need to avoid overly reductionist emphases on isolated identity categories, while still retaining focus on the constitutive effects of social structures, injustices and inequalities.

References

Allen. D.G. & Bowers, B. (1989). Willing to learn: A reconceptualisation of thinking and writing in the nursing curriculum. *Journal of Nursing Education, 28*(1), 6–11.

Amos, V. & Parmar, P. (1984). Challenging imperial feminism. *Feminist Review, 17*, 3–19.

Austin, J.L. (1962). *How to do things with words.* Oxford: Oxford University Press.

Barthes, R. (1981). The death of the author. In J. Caughie (Ed.), *Theories of authorship.* London: Routledge.

Bateson, G. (1972). *Steps to an ecology of mind.* New York: Ballantine.

Bertrando, P. (2000). Text and context: Narrative, postmodernism and cybernetics. *Journal of Family Therapy, 22*(1), 83–103.

Bhaskar, R. (1978). *A realist theory of science* (2nd ed.). Brighton: Harvester Press.

Bograd, M. (1984). Family systems approaches to wife battering: A feminist critique. *American Journal of Orthopsychiatry, 54*, 558–568.

Bor, R., Legg, C. & Scher, I. (1996). The systems paradigm. In R. Woolfe & W. Dryden (Eds.), *Handbook of Counselling Psychology.* London: Sage.

Brah, A. (1996). *Cartographies of diaspora: Contesting identities.* London: Routledge.

Bruner, E. (1986). Ethnography as narrative. In V. Turner & E. Bruner (Eds.), *The anthropology of experience.* Chicago: University of Illinois Press.

Bruner, J.S. (1986). *Actual minds, possible worlds.* Cambridge, MA: Harvard University Press.

Burman, E. (1999). Whose construction? Points from a feminist perspective. In D.J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice.* Buckingham: Open University Press.

Butler, G. (2000). Formulating meanings: Integration from the perspective of a cognitive therapist. *BPS Psychotherapy Section Newsletter, 27,* 25–46.

Carby, H. (1987). Black feminism and the boundaries of sisterhood. In M. Arnot & G. Weiner (Eds.), *Gender and the politics of schooling.* Basingstoke: Hutchinson.

Clarkson, P. (1996). *The bystander (an end to innocence in human relationships?).* London: Whurr.

Curt, B.C. (1994). *Textuality and tectonics.* Buckingham: Open University Press.

Davy, J. (1999). How to write a case study. In R. Bor & M. Watts (Eds.), *The trainee handbook: A guide for counselling and psychotherapy trainees.* London: Sage.

Davy, J. (2003). Dead but not forgotten: A self-reflexive commentary on the death of resistance. *Counselling Psychology Review, 18*(1), 12–19.

De Shazer, S., Berg, I., Lipchik, E., Nunnally, E.,Molnar, A., Gingerich, W. & Weiner-Davis, M. (1986). Brief therapy: focused solution development. *Family Process, 25,* 207–222.

Flaskas, C. (1997). Reclaiming the idea of truth: Some thoughts on theory in response to practice. *Journal of Family Therapy, 19*(1), 1–20.

Gadamer, H.G. (1975). *Truth and method.* New York: Seabury Press.

Game, A. (1991). *Undoing the social: Towards a deconstructive sociology.* Buckingham: Open University Press.

Gee. J.P. (1985). The narrativization of experience in the oral style. *Journal of Education, 167,* 9–35.

Goldner, V. (1991). Feminism and systemic practice: Two critical traditions in transition. *Journal of Family Therapy, 13*(1), 95–104.

Gouws, J. (2000). Transgenerational family therapy in an African context. *Context, 49,* 20–21.

Habermas, J. (1971). *Knowledge and human interests.* Boston: Beacon.

Harari, E. (1995). The longest shadow: A critical commentary. *Australian and New Zealand Journal of Family Therapy, 16,* 11–13.

Hare-Mustin, R.T. (1986). The problem of gender in family therapy Theory. *Family Process 26,* 15–27.

Holly, M.L. (1989) Reflective writing and the spirit of inquiry. *Cambridge Journal of Education, 19*(1), 71–80.

Jenkins, A. (1990). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive.* Adelaide: Dulwich Centre Publications.

Jones, E. (1990). Feminism and family therapy: Can mixed marriages work? In R.J. Perelberg & A.C. Miller (Eds.), *Gender and power in families.* London: Routledge.

Kaschak (1978). Therapist and client: Two views of the process and outcome of psychotherapy. *Professional Psychology, 9,* 271–277.

Kelly, G.A. (1955). *The psychology of personal constructs.* New York: Norton.

Kitzinger, C. (1993). Depoliticising the personal: A feminist slogan in feminist therapy. *Woman's Studies International Forum, 16*(5), 487–496.

Kutchins, H. & Kirk, S.A. (1997). *Making us crazy.* London: Constable.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* London: Sage.

Lather, P. (1995). The validity of angels: Interpretive and textual strategies in researching the lives of women with HIV/AIDS. *Qualitative Inquiry, 1,* 41–68.

Law, I. (1999). A discursive approach to therapy with men. In I. Parker (Ed.), *Deconstructing psychotherapy.* London: Sage.

Lax, W.D. (1992). Postmodern thinking in a clinical practice. In S. Mcnamee & K.J. Gergen (Eds.), *Therapy as social construction.* London: Sage.

Levins, R. & Lewontin, R. (1985). *The dialectical biologist.* Cambridge, MA: Harvard University Press.

MacMillan, A. (1992). Communicating about clients: Speaking for myself and others. *Clinical Psychology Forum, 49,* 8–12.

Mair, M. (1989). *Beyond psychology and psychotherapy: A poetics of experience.* London: Routledge.

Mair, M. (1999). Inquiry in conversation: Questions, quests, search and research. *BPS Psychotherapy Section Newsletter, 25,* 2–15.

Masson, J.M. (1989). *Against therapy.* London: Collins.

McClintock, A. (1995). *Imperial leather: Race, gender and sexuality in the colonial contest.* London: Routledge.

McNamee, S. & Gergen, K.J. (Eds.) (1992). *Therapy as social construction.* London: Sage.

Miller, J.B. (1976). *Towards a new psychology of women.* London: Allen Lane.

Mintz, J., Auerbach, A.H., Luborsky, L. & Johnson, M. (1973). Patient's, therapist's and observers' views of psychotherapy: A 'Rashomon' experience or reasonable consensus. *British Journal Of Medical Psychology, 46,* 83–89.

Minuchin, S. (1974). *Families and family therapy.* London: Tavistock.

Mishler, E.G. (1991) Representing discourse: The rhetoric of transcription. Journal of *Narrative and Life History, 1,* 255–280.

Noble, C. (1999). Silence: Absence and context. In I. Parker (Ed.) (with the Bolton Discourse Network), *Critical textwork: An introduction to varieties of discourse analysis.* Buckingham: Open University Press.

Ochs, E. (1979). Transcription as theory. In E. Ochs & B.B. Schieffelin (Eds.), *Developmental pragmatics.* New York: Academic Press.

Page, S. & Wosket, V. (1994). *Supervising the counsellor: A cyclical model.* London: Routledge.

Palmer, A., Burns, S. & Bulman, C. (Eds.) (1994). *Reflective practice in nursing: The growth of the professional practitioner.* Oxford: Blackwell Science.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* London: Sage.

Ricoeur, P. (1971). The model of the text: Meaningful action considered as a text. *Social Research, 38,* 529–562.

Riessman, C.R. (1993). *Narrative analysis.* California: Sage.

Rowbotham, S., Segal, L. & Wainwright, H. (1979). *Beyond the fragments: Feminism and the making of socialism.* Newcastle and London: NSC/ICP.

Scheflen, A.E. (1978). Susan smiled: On explanations in family therapy. *Family Proceedings, 17,* 59–68.

Spence, D.P. (1989). Rhetoric vs. Evidence as a source of persuasion: A critique of the case study genre. In M.J. Packer & R.B. Addison (Eds.), *Entering the circle: Hermeneutic investigations in psychology.* New York: Addison-Wesley.

Steinberg, D. (2000). *Letters from the clinic.* London: Routledge.

Street, E. & Downey, J. (1996). *Brief therapeutic consultations.* London: Wiley.

Ussher, J. (1991). *Women's madness: Misogyny or mental illness?* Hemel Hempstead: Harvester Wheatsheaf.

Van Maanen, J. (1988). *Tales of the field.* Chicago: University of Chicago Press.

Von Foerster, H. (1981). *Observing systems.* Seaside, CA: Intersystems Publications.

Vygotsky, L.S. (1978). *Mind in society: The development of higher psychological processes.* Cambridge University Press: New York.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends.* London: Norton.

White, M. (1989). The externalizing of the problem and the re-authoring of lives and relationships. In M. White (Ed.), *Selected papers.* Adelaide: Dulwich Centre Publications.

White, M. (1997). *Narratives of therapists' lives.* Adelaide: Dulwich Centre Publications.

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionist work. In D.J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice.* Buckingham: Open University Press.

Wilson, J.E. (1997). *Time-conscious psychological therapy: A life stage to go through.* London: Routledge.

Wittgenstein, L. (1958). *Philosophical investigations* (2nd ed.). Trans. G.E.M. Anscombe. Oxford: Blackwell.

Correspondence

Dr John Davy is a Chartered Counselling, Educational and Health Psychologist, a UKCP registered Systemic Family Psychotherapist and a founder member of the new BPS Register of Psychologists Specialising in Psychotherapy. He works part-time at Brookside Family Consultation Clinic in Cambridge for Cambridgeshire and Peterborough Mental Health NHS Partnership Trust. He can be contacted at john.davy@cambsmh.nhs.uk

Book Reviews

The Therapist's Use of Self; Core Concepts in Therapy
John Rowan & Michael Jacobs
Series editor: Michael Jacobs
Open University Press, 2002.
ISBN: 0-335-20776-6 (pbk); 0-335-20777-7 (hbk)
Paperback £14.99.

Within counselling psychology, most practitioners focus on developing their skills in critically reflecting on the therapeutic relationship, particularly self-awareness, consequently, texts such as this are timely and relevant to our profession. Rowan and Jacobs have presented an extremely well written and interesting consideration of the 'use of the self'. Like other texts in this area, the authors claim that one of their main aims is to avoid focussing on the different schools of therapy. Furthermore, although others have discussed the various modalities or components of the therapeutic relationship (between the client and therapist), this text takes an original slant on the subject, irrespective of the model of therapy. It explores three 'ways' or 'positions' of the therapist in relationship to the client. These are the instrumental self, the authentic self and the transpersonal self. These three ways of being are presented as co-existing throughout the process of therapy, the therapist moving from one to the other, depending on the process of therapy.

The chapter on the instrumental self seemed to be suggesting that this aspect of the self was concerned with the therapist adopting a set of skills that they draw on and engage with whilst with the client, almost as if this

might be a role. For example, there would be a focus on the therapist 'being empathic' without perhaps engaging with the meaning of this within his or her own self-awareness. Furthermore, this level of interaction would perhaps suggest that the negative side of the therapist's thoughts and feelings would be monitored, so as not to interfere with the process of therapy, rather than considered 'helpful' to the process. The third chapter deals with what the authors refer to as the 'authentic self'. This level of working deals with the implications of the therapist 'being real', at this level of interaction the therapist would more closely attend to both the range of feelings they were experiencing in the therapy, reflecting and engaging with this process in the best interest of the client. Consequently, the therapist cannot simply adopt an authentic stance, as exploration of their authentic self would be an important aspect of their own personal development as well as engaging more meaningfully with clients. These two chapters critically discuss these positions thoroughly, mainly from a psychoanalytic perspective, particularly the acknowledgement of countertransference.

The fourth chapter deals with what the authors consider the transpersonal self. Here, from a variety of theoretical perspectives, the authors have crafted an interesting discussion that suggests a level of engagement which goes beyond the instrumental and authentic self and is concerned with a deeper level of empathy, almost an altered state of consciousness, where 'there is a 'simultaneous union and separation

of self and other'. This altered state is, therefore, something that we do not construct but allow it to occur. My understanding of this level is that the therapist would need to have a deepening sense of personal development and experience with authentic being in order to allow for this aspect of the therapeutic process to transpire.

Overall, this is a text that has been well researched, each point has been deeply considered and clearly explained. The introduction to the text provides a succinct overview to the main arguments, but it seemed necessary to read the whole text thoroughly in order to get a full grasp of the proposed ideas. At times I found some of the concepts hard to grapple with as it attends to ideas (such as the transpersonal self) which some may not necessarily agree with. Indeed, for the many of us who work in time limited settings, it may not be feasible for the process of therapy to reach this level of engagement, although that is not to say that transpersonal aspects do not arise in shorter briefer therapy.

What I particularly liked about this book was its close attention to the development of and constant need to critically reflect on therapeutic practice, especially the inner world of the therapist. Furthermore, I liked the way the authors importantly addressed the role of negative feelings that might arise in the therapist, and how these might be understood and usefully engaged with during the process of therapy. However, even though the authors argue that the book aims to transcend models of therapy, my main observation was that in the chapters concerning the instrumental and authentic self, the discussion was mostly grounded within psychoanalytic language and concepts. It may be that this is a discourse preferred by the authors, but it seemed as if terms such as transference and counter-transference were the primary language, or 'truths' in which to describe aspects of the therapist's self awareness. What this might infer to the reader is that other schools of therapy, such as person centred therapy, do not have such a language, therefore suggesting that these concepts might not be considered as important. Indeed, I noticed in the text that although there was some suggestion that Carl Rogers considered 'negative' feelings in the therapist, the main attention within therapy would be on the 'positive'. Although I am not a scholar on Rogers, I think that his main texts would have something to say about these issues, even though he might not directly refer to psychoanalytic discourse as a way of conceptualising therapist self awareness.

I think that this book takes an excellent and original stance on the importance of attending to the therapist use of self in therapy. It is extremely relevant to the work of counselling psychologists; however, even though it addresses the implications for training and supervision, I think it might be more appropriate to a more experienced practitioner rather than trainees.

Kendra Gilbert

Working with Interpreters in Mental Health
Rachel Tribe & Hitesh Ravel (Eds.)
Brunner-Routledge, 2003.
ISBN: 0-415-18879-2 (pbk).
Hardback £40.00; Paperback £15.99.

'Certain questions cannot be applied or approached without first considering cultural differences.' These are the words of one of the participants involved in a study on interpreters conducted by one of the contributing authors and outlined in the book. Although succinctly put, this notion is fundamental to the interpreter's work. It is what elevates it above mere verbatim translation. For not only is it the sense of what is being said that must be communicated, rather than just the words, but also how this sense relates to meaning in the cultural framework from which it comes. Because optimal communication involves each party understanding the perspective of the other, the interpreter here takes on the roles of educator and consultant, without detracting from the content of the therapy itself.

However, this is just one of the issues involved in skilled interpretation within a mental health setting. Others include establishing rapport with both clinician and service

user; advocacy for service user and wider community; conflict resolution between both parties; management of power dynamics in the three-way relationship; and having sufficient mental health knowledge to convey accurately and appropriately the specifics of the communication. *Working with Interpreters in Mental Health* explores these issues as they pertain to clinician, interpreter and client, providing a comprehensive and detailed analysis of the subject matter. The contributing authors are experts, academics and clinicians who display a profound and critical understanding of clinical work through interpreters. Their expertise is delivered with literary skill and authorship: theory and clinical insight are interwoven with real-life examples and dialogue, keeping the book interesting and readable. Chapters include interpreting in health work with medical consultants, children, learning disabilities, adult mental health and refugees. There are also chapters looking at training issues for interpreters, language provision in health care, applying theoretical frameworks, collaborative therapy, power and narrative theory. Three chapters are dedicated specifically to interpreters them-

selves, one looking at the daily life of an interpreting service, another written by a qualified interpreter and another describing research exploring the role and experiences of interpreters. These chapters reflect the authors' underlying philosophy of understanding perspectives and promoting engagement from all sides as well as providing unique insight into the experiences of interpretation.

In an increasingly cosmopolitan society it becomes increasingly necessary that mental health workers have the skills to understand, relate to and work with service-users from different cultures. However, one of the consistent criticisms of Britain is that it fails to provide culturally appropriate services to people from ethnic minorities. For those who don't speak the host language, service access and use can be problematic and intimidating. For those who work in mental health and who might potentially work through an interpreter, awareness of the issues when doing so is not just an added benefit but also a professional responsibility. *Working with Interpreters in Mental Health* seems like a good place to start.

Ashley Goff

All book reviews and correspondence regarding book reviews should be sent to Kasia Szymanska, Book Reviews Editor, CPR, Centre for Stress Management, 156 Westcombe Hill, London, SE3 7DH.

Newsletter Section

LETTER FROM THE CHAIR

Three notable milestones have been achieved since you received your last issue of *CPR*. The first is that the brand new Qualification in Counselling Psychology has been formally accepted by the Society as the template for training to become a Chartered Counselling Psychologist. It is an innovative and leading edge document, bringing the independent and course routes into harmony and specifying learning outcomes in the language of the competencies required to practise as a professional counselling psychologist. It is a model of its kind, which the other divisions will probably now seek to emulate. I think the whole Division should thank and congratulate those who wrote and guided it through the relevant BPS committees, particularly the respective Chairs of the Board of Examiners and the Training Committee for Counselling Psychology, Dr. Diane Hammersley and Dr. Ralph Goldstein. Others were also heavily involved in this important endeavour and equally deserve our thanks.

The second milestone is that Applied Psychologists are to be statutorily registered under the auspices of the Health Professions Council. It is likely that each of the applied psychologies offering a service to the public will be registered in its own name, so that, in our own case, Counselling Psychologist will become a statutorily protected title. The details are yet to be finally decided but the principle is in place.

The third is that in the Draft Gender Recognition Bill, which proposes to extend the same rights to transgender individuals as those enjoyed by the rest of the population, Chartered Psychologists have been granted equal rights to Registered Medical Practitioners. Medical Practitioners and Chartered Psychologists are considered to possess the most suitable competencies to adjudicate in the granting of new-gender certificates and to sit on the relevant panels. The proviso is that they should practise in the field of transgender, as some counselling psychologists do. If the Bill becomes law then this will be the first time, so far as I am aware, that the training and competencies of Chartered Psychologists have been officially recognised as equivalent to those of Medical Practitioners.

A milestone shortly to be reached is the launch of the Register of Psychologists Specialising in Psychotherapy. This has had a high level of input from counselling psychologists and reflects our growing influence in the Society. Counselling psychologists will almost certainly be amongst the most numerous of new registrants.

I think all of this reflects a degree of energetic, healthy development in the profession of psychology as a whole and in counselling psychology in particular.

Stephen Munt
Chair of Division Committee for the Division of Counselling Psychology.

DIVISIONAL NEWS

THE BPS QUALIFICATION IN COUNSELLING PSYCHOLOGY – A MAJOR REVISION

Introduction

The Diploma in Counselling Psychology has been a BPS award for about 10 years, enabling trainees to follow an independent route to achieve full membership of the Division and registration as a Chartered Counselling Psychologist. The Division Committee decided to revise the syllabus for Counselling Psychology and make it a common one for both accredited courses and the independent trainee and this work was completed in 2002. The BPS Membership and Professional Training Board which oversees both accreditation of courses and independent routes to BPS awards, approved new criteria for courses in February 2003 and new regulations for an award in Counselling Psychology in November 2003.

The Board of Examiners in Counselling Psychology set out to re-design the Society's award with a number of specific aims. We wanted to simplify the process while increasing its appeal and accessibility to counsellors and psychotherapists as well as members of the Society who use counselling in their work. We also wanted to draw on our experience of examining for the Diploma, to keep what was good about it and to revise what needed to be changed, in order to bring it up to date within a changed training and employment environment. The Board members undertook this task with great enthusiasm and are pleased with what emerged. I hope people will find it practical and workable as well as inspiring them to use this route to achieving competence as a Counselling Psychologist.

What has changed?

The first and most obvious change is the name, because the Diploma is replaced by the Qualification. For some time employers have been confused by the title of an award at postgraduate level which is called a diploma but is above a master's degree. Universities often award a postgraduate diploma as an exit award along the way to a master's degree, whatever they call the final award – master's degree, practitioner doctorate, post-MSc diploma and so forth. So this qualification is equivalent to any award for three years full-time (or equivalent part-time) postgraduate study in Counselling Psychology.

The second important change is that this qualification has been designed as a competence-based award which measures outcomes of training rather than inputs. So demonstrating what you can do in terms of knowledge, skills, underpinning philosophy and value base, to show you are competent to practice is more important than how you got there. This means that there is only one standard, competent or not yet competent, since it is not useful to be judged half-competent! This is one of the reasons that there will no longer be parts 1 and 2 to the qualification and, therefore, the number of assessments is reduced. While there are fewer assessments, the variety of assessments has increased offering more ways for competence to be demonstrated and assessed.

Most trainees who have not already taken a counselling or psychotherapy course will be required to attend one as part of their core training, in order to acquire theories and therapeutic skills, and learn how to write and present case studies and process reports. In this way, there will be opportunities to submit work for assessment during the course and get face-to-face feedback. This should be more helpful than having to submit work for assessment which may not be of an acceptable standard in order to get feedback. For a number of reasons some trainees in the past have tried to make up their hours of training through a mixture of short courses, and this has not always proved a satisfactory preparation for examinations. It will still be up to each trainee to ensure that they have integrated sufficient psychological knowledge into their practice with the help of the co-ordinator of training.

Other changes to the assessment of competence mean that the written examination paper is unseen rather than a seen paper, which requires candidates to demonstrate they can 'think on their feet'. Another new feature requires three academic papers to be submitted which asks candidates to show that they can research and write at the level required for publication. Perhaps this will encourage trainees to write on a wide variety of issues and seek to publish their work. A final paper which will be a reflection on the whole of their training and development as Counselling Psychologists will culminate in an oral examination or *viva voce.* For the first time all candidates will present themselves in person rather than in writing alone.

The introduction of a competence logbook which will provide a complete statement of what a qualified Counselling Psychologist can do is another major change. This should be useful when people are seeking employment, because although each candidate will have put different emphases on parts of their training and may have specialised to some extent, everyone will have core competencies which can be transferred into other contexts. This will require each competence being 'signed off' both by the person supervising the work as a witness but also verified by the Co-ordinator of Training who takes overall responsibility for the trainee throughout their training.

So the main differences between the Diploma and the Qualification are that the Qualification is competence-based, has final assessments but no interim assessments, has an unseen written examination paper, includes a final examination with a viva voce, and all the occupational standards in Counselling Psychology will be witnessed and verified in a logbook. What remains the same is the standard of the award, the requirement for personal therapy and hours of supervised practice in a variety of settings. As before, all trainees will be guided by a Co-ordinator of Training who is a Chartered Counselling Psychologist, whose responsibility for the trainee is being emphasised by a contract with the Board and the opportunity for training.

Who may benefit?

The Board has tried to ensure that nobody is at any disadvantage because of the changes but some people may benefit. It is not easier or more difficult in any way, it takes the same amount of time to complete whether you do it full-time or part-time, and the cost for the Qualification is slightly less than the Diploma in terms of fees, but undertaking a course may cost some people more than before. However, because competence-based qualifications do not re-assess what has already been demonstrated, some people will find that they do not have to repeat training or assessments that they have already completed. This has meant a change from accrediting prior learning (APL) to accrediting existing competence (AEC), and if a trainee can show evidence of having achieved a satisfactory standard elsewhere, that will be considered for accreditation.

So people who have completed courses, been accredited through other organisations such as BACP or UKCP will probably find they do not have to repeat some of the assessments. What they may have to show is that they have sufficient psychological understanding and that it is integrated into their therapeutic practice. The same principle will apply to trainees who have master's or doctoral research degrees, who will not have to demonstrate their research competence all over again, but instead, show how that competence can be applied to Counselling Psychology. So people may be able to use experience and training that took place before they enrol on the Qualification, always with the proviso that all training has to take place after achieving the Graduate Basis for Registration (GBR).

What will happen to people already enrolled for the Diploma?

Most people who have been studying for the Diploma were well aware that a change was in the offing and will have discussed with their Co-ordinator of Training whether to try to complete the Diploma before the change. This is clearly the better option if they have nearly finished it. Other people have delayed their enrolment so that they could start off under the new regulations of April 2004. Because the regulations that apply, have always been those in operation when candidates sit the examination rather than when they enrolled, some people will find they cannot complete the

Diploma because it will cease to exist except for re-submissions after April 2004. These people already enrolled will transfer to the Qualification by a process of submitting a new training plan and applying for accreditation of existing competence for the work they have already done. By comparing a number of plans and applications when transferring trainees, the Registrar and the Board will try to ensure that trainees are treated equitably.

Which is better – Qualification or course?

Some people may be wondering how the BPS Qualification in Counselling Psychology compares with an accredited course. For the first time the syllabus or programme of learning by either route will be the same, because the Division Committee set up a working party to devise a syllabus which was competence-based and all courses will chart themselves against those occupational competences. That will not mean that courses will be identical, since the Division's working party hoped to encourage greater diversity. The independent route will remain just that, a unique plan of training that each person devises for themselves and gets approved by the Registrar in advance. It is hoped that trainees will recognise the advantages and disadvantages of both routes and choose the one which suits their individual circumstances best.

Further information

The regulations for the BPS Qualification in Counselling Psychology for April 2004 will be available from the BPS office in Leicester early in 2004, and details will be on the website. The Registrar in Counselling Psychology, who can give guidance on applications, can be contacted by letter, e-mail and telephone and details are available on the website. A number of experienced Co-ordinators of Training advertise in the BPS *Directory*.

Diane Hammersley
Chair, Board of Examiners in Counselling Psychology.

TRAINING WORKSHOPS

The Division of Counselling Psychology Divisional Committee is currently looking for ways of introducing self-funding workshops across the UK to further training opportunities.

The Committee would appreciate suggestions of both topics of interest and geographical locations from Counselling-Psychologists-in-Training and also from psychologists who would be prepared to lead workshops on this basis.

In the first instance please contact **Sally Greenfield**, c/o Subsystems, The British Psychological Society, St Andrew's House, 48 Princess Road East, Leicester LE1 7DR, or e-mail me on DCopworkshops@fsmail.net.

DIVISION WEBSITE

The DCoP website will shortly be expanded to include details of committee membership and who does what, as well as the agendas for meetings. You can access the website via the main BPS site.

NEWS FROM THE SURREY COURSE

We were pleased to be able to welcome another new cohort of trainees to the course and to see them preparing for placement. We are very pleased to have them with us and feel that the difficult job of reviewing 70 applications and interviewing about 25 candidates has been well worth it.

The welcoming of these trainees comes after a very busy year in which we have had many highlights. Some of which include:

- Successful examinations period in September where all the trainees who went to viva were successful in achieving their Doctorate.
- All but one of these graduates have obtained posts as Counselling psychologists with various NHS Trusts; one is taking time off to travel before seeking employment.
- We were successful in appointing of a new staff member Mrs Chris Newbery as Professional Tutor.
- We were able to diversify the range of placements on offer to trainees to include: student counselling services, staff counselling services, primary care contexts, community mental health teams, NHS psychology departments, NHS psychotherapy services and some specialist services such as forensic services, eating disorder services, schools and CAMHS. As you can tell our Professional Tutors are kept incredibly busy!
- Our trainees and graduates continued to publish their research and we were pleased to see their work make it into the pages of a range of journals including *British Journal of Social Psychology, Existential Analysis, Counselling Psychology Quarterly,* and, of course, *Counselling Psychology Review.*

The most immediate development for the course in the next academic year is to explore the ways in which the course can be developed in line with the newly published criteria for the BPS Qualification in Counselling Psychology. This is likely to require both a different form of expression as well as the opportunity to plan course developments over the course of the next five years.

Martin Milton
Course Director
Practitioner Doctorate (PsychD) – Psychotherapeutic & Counselling Psychology.

AGENDA FOR CHANGE

All Counselling Psychologists working in the NHS will be aware of this by now. It is important that you make sure that you have an accurate and up-to-date job description, ready for the Agenda for Change process as it begins. Your union or your Trust should be able to advise you on this.

THE BRITISH PSYCHOLOGICAL SOCIETY
DIVISION OF COUNSELLING PSYCHOLOGY

STATEMENT OF INTEREST IN VACANCIES ON THE SUB-COMMITTEE FOR CONFERENCE (SCC)

The SCC has vacancies for the following:

1 **A new committee member who is interested in being the conference co-ordinator for the Division of Counselling Psychology's 2005 conference, in the first instance, this entails shadowing the present conference co-ordinator.**
2 **Honorary Secretary for the SCC.**
3 **SCC Chair from 2006, in the first instance, this entails shadowing the present Chair during 2005.**

DEADLINE for receiving statements of interest for the above: 28th February 2004.

From time to time, this committee also looks for people to nominate for election or to co-opt to membership. Some posts are representative of a particular group, e.g. trainees, some posts require particular expertise or interest, e.g. Honorary Secretary. In order to promote openness, the widest possible participation and equality of opportunity, the Sub-Committee for Conference invites expressions of interest from any Accredited, General, Affiliate or trainee members (trainees are needed from both course and independent routes). Individuals may nominate themselves directly to the SCC.

HOW TO APPLY
Please complete the section below and send to:
The Acting Honorary Secretary Maureen Leyland, c/o Division of Counselling Psychology Sub-Committee for Conference, BPS, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, together with a letter indicating your desire to serve, specifying in what area, whom you could represent and any special expertise or experience you have to offer. A willingness to learn, together with energy and enthusiasm, are particularly welcomed. CVs are not required.

....✂

STATEMENT OF INTEREST IN VACANCIES ON THE SUB-COMMITTEE FOR CONFERENCE (SCC)

Name: ....

Address: ....

....

Contact Number: Home:..................................Work:..................................Fax:..................................

E-mail: ....

EVENTS DIARY

Format of events listed is:
date: event
venue
contact

FEBRUARY 2004

20–21: Integrated Care Conference 2004
Birmingham Botanical Gardens.
Organised by the *International Journal of Integrated Care*, in co-operation with the Health Services
Management Centre of the University of Birmingham and the WHO European Office for
Integrated Health Care Services Barcelona.
Ms Astrid van Wesenbeeck, IJIC's managing editor. E-mail: ijic@igitur.uu.nl
Web: www.ijic.org/portal/

MARCH 2004

11: Kidscape Conference – Preventing Bullying: What works (and why) for Key Stages 2 & 3
The Law Society, Chancery Lane, London WC2A 1PL.
Lisa Flowers, Kidscape, 2 Grosvenor Gardens, London SW1W 0DH.
Tel: 020 7730 3300 Fax: 020 7730 7081 Web: www.kidscape.org.uk/events/eventsindex.shtml

APRIL 2004

14–16: The Ergonomics Society's Annual Conference 2004
University of Wales Swansea.
Sue Hull, Conference and Marketing Officer, The Ergonomics Society, Devonshire House,
Devonshire Square, Loughborough, Leicestershire LE11 3DW.
Tel: 01509 234904 E-mail: s.hull@ergonomics.org.uk
Web: www.ergonomics.org.uk/events/AC2004.htm

15–17: British Psychological Society Annual Conference 2004
Themes: Positive Psychology, Creativity and Innovation, Perception
(including Division of Clinical Psychology Conference)
Imperial College, London.
BPS Conference Office, The British Psychological Society, St Andrews House,
48 Princess Road East, Leicester LE1 7DR.
Tel: 0116 252 9555 Fax: 0116 247 0787 E-mail: conferences@bps.org.uk Web: www.bps.org.uk

**20–21: UK IOSH (Institution of Occupational Safety & Health) 2004 Conference and
Exhibition: 'Growing professionally – developing influence'**
Harrogate International Centre.
Kate Pallett, Special Events Co-ordinator, PR Department, IOSH, The Grange, Highfield Drive,
Wigston, Leicestershire, LE18 1NN.
Tel: 0116 257 3100 E-mail: kate.pallett@iosh.co.uk Web: www.ioshconference.co.uk

**29: IHPE (Institute for Health Promotion & Education) Annual Conference: Health Promotion
and Education – What shall we tell the public and who should tell them?**
MANDEC Centre, Manchester.
Professor A.S. Blinkhorn, Hon Sec. IHPE, University Dental Hospital, Higher Cambridge Street,
Manchester M15 6FH.
E-mail: honsec@ihpe.org.uk

MAY 2004
14–16: 2004 BPS Division of Counselling Psychology Annual Conference
York.
BPS Conference Office, The British Psychological Society, St Andrews House,
48 Princess Road East, Leicester LE1 7DR.
Tel: 0116 252 9555 Fax: 0116 247 0787 E-mail: conferences@bps.org.uk Web: www.bps.org.uk

21–22: 10th Annual BACP Counselling and Psychotherapy Research Conference:
'The World of Counselling Research'
London.
Angela Couchman, Research Development Officer, British Association for Counselling and
Psychotherapy, BACP House, 35-37 Albert Street, Rugby, Warwickshire, CV21 2SG.
Tel: 0870 443 5237 Fax: 0870 443 5161
E-mail: angela.couchman@bacp.co.uk Web: www.bacp.co.uk

SEPTEMBER 2004
8–10: BPS Division of Health Psychology Annual Conference –
Health Psychology: A positive perspective
Queen Margaret's University College, Edinburgh.
BPS Conference Office, The British Psychological Society, St Andrews House,
48 Princess Road East, Leicester LE1 7DR.
Tel: 0116 254 9568 Fax: 0116 247 0787 E-mail: R.Povey@staffs.ac.uk
Web: www.health-psychology.org.uk

15–17: The Promotion of Mental Health and Prevention of Mental and Behavioural Disorders:
The Third World Conference – From Research to Effective Practice
Auckland, Aotearoa, New Zealand.
Organised by The World Federation for Mental Health, The Clifford Beers Foundation and the
Mental Health Foundation of New Zealand in collaboration with The Carter Center.
Mental Health Foundation of New Zealand, PO Box 10051, Dominion Road, Auckland,
New Zealand.
Tel: 0064 (0)9 300 7010 Fax: 0064 (0)9 300 7020
E-mail: conference@mentalhealth.org.nz Web: www.mentalhealth.org.nz

---

Please send details of all appropriate conferences to me:

By post: People in Progress Ltd, 5 Rochester Mansions, Hove, East Sussex BN3 2HA.

By fax: 01273 726180

By e-mail: events@pip.co.uk

I look forward to hearing from you.

Jennifer Liston-Smith

TALKING POINT

A series of short pieces by invited Counselling Psychologists on subjects of topical interest and debate. Responses to the views expressed in 'Talking Point' are welcomed: write to the Editor marking your letter 'for correspondence'.

INFANT, ADOLESCENT, OR ADULT?
Ray Woolfe

Around the time Windy Dryden and myself edited the first edition of *Handbook of Counselling Psychology* in 1996, I described the profession using the metaphor of an infant growing up. Like all infants it was somewhat obsessively concerned with exploring its sense of self and identity, investigating its own output in the potty, flexing its muscles, looking in the mirror and asking how am I different from my parents? Indeed there were questions about who exactly were the parents; psychology or counselling or psychotherapy? There was lots of discussion about how the new child would draw upon the genes of both its parents, the more tough minded scientist, psychological father and the more tender hearted humanistic counselling mother. Pursuing the family metaphor, the child was interested in understanding its relationship with its sisters and brothers such as big sister clinical psychology and siblings cognitive and psychodynamic psychotherapists and asking where its place was at the family table.

As the infant grew into adolescence and its verbal fluency developed, these developmental issues came to be more explicitly expressed in debates around whether in pursuing its life career, the young person should think of itself as a scientist-practitioner or as a reflective-practitioner or maybe think about some kind of integrated hybrid?

By the time the second edition of the *Handbook* was published in 2003, my co-editors (Windy and Sheelagh Strawbridge) and I felt able to assert that the child had now grown up. It had become less introverted, less focussed on obsessively examining its own body and more able to look outward into the wider world; a kind of young adult with its own views and opinions and taken seriously by its parents (the BPS), its siblings and its peers.

However, I have begun recently to question the extent to which the child has really grown into full adulthood. My doubts have surfaced as the result of an envelope which seems to consistently drop through my letter box. It contains a letter, a stamped-addressed envelope and a questionnaire from a student on a training course in counselling psychology asking me to complete the questionnaire which forms the basis of their research dissertation/thesis. Almost without exception, the topic of the research is what is counselling psychology and what do counselling psychologists do? To make matters worse, the questionnaire is invariably of the box-ticking variety and rarely encourages creative thinking about the why and how of what I do.

Now I'm not against students asking me to complete questionnaires and there will always be a need for the profession to keep track of itself through appropriate monitoring. However, I have become increasingly depressed by this apparent obsession with self. It suggests some kind of early narcissistic wound which leaves the victim highly sensitive to how others feel about it and as a result is always checking itself out to ensure that it looks alright. Perhaps the early injury derives from uncertainty about parentage and a felt need to achieve the same success as big sisters and brothers can be inhibiting. Perhaps the answer lies in sending the patient for a spot of CBT therapy in which it can have a look at the rather anxious template through which it views the world and replace it with one which takes more account of the evidence of what has been achieved.

CALL FOR PAPERS AND
NOTICE OF CONFERENCE

❋

THE BRITISH PSYCHOLOGICAL SOCIETY
DIVISION OF COUNSELLING PSYCHOLOGY
ANNUAL CONFERENCE 2004

❋

14–16 MAY

❋

THE MOAT HOUSE HOTEL, YORK, UK.

❋

Theme: 'Real life issues that affect our way of working'

❋

The Conference Organisers are keen to receive proposals for Papers, Symposia, Workshops and Posters on a range of topics. The aim is explore a broad range of issues that influence how we practice and present Counselling Psychology and also how we work in related fields.

Please note: A maximum of two presentations will be accepted by the organisers.

Abstract deadline: 13 February 2004.

Please request submission details from:

Gella Richards

c/o Conference Office, The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.

E-mail: g.richards@roehampton.ac.uk

REGISTRATION APPLICATION FOR WORKSHOPS AND CONFERENCE IS AVAILABLE ON THE DCOP WEBPAGE OR CONTACT BPS CONFERENCE OFFICE

The best new research to your inbox – free!

The British Psychological Society Research Digest

Notes for Contributors to
Counselling Psychology Review

Contributions on all aspects of Counselling Psychology are invited.

Academic Papers: Manuscripts of approximately 4000 words excluding references should be typewritten, double-spaced with 1" margins on one side of A4, and include a word count. An abstract of no more than 250 words should precede the main body of the paper. On a separate sheet give the author's name, address and contact details, qualifications, current professional affiliation or activity, and a statement that the paper is not under consideration elsewhere. This category may also include full-length in-depth case discussions, as well as research and theoretical papers.

Issues from Practice: Shorter submissions, of between 1000 and 3000 words, are invited that discuss and debate practice issues and may include appropriately anonymised case material, and/or the client's perspective. As with academic papers, on a separate sheet give the author's name, address and contact details, qualifications, current professional affiliation or activity, and a statement that the paper is not under consideration elsewhere.

These two categories of submission are refereed and so the body of the paper should be free of information identifying the author.

Other Submissions: News items and reports, letters, details of conferences, courses and forthcoming events, and book reviews are all welcomed. These are not refereed but evaluated by the Editor, and should conform to the general guidelines given below.

- Authors of all submissions should follow the Society's guidelines for the use of non-sexist language and all references must be presented in APA style (see the *Code of Conduct, Ethical Principles and Guidelines*, and the *Style Guide*, both available from The British Psychological Society).

- Graphs, diagrams, etc., should be in camera-ready form and must have titles. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

- Three hard copies of papers subject to refereeing should be supplied, together with a large s.a.e. and a copy of the submission on disk or CD-ROM (if possible save the document both in its original word-processing format and as an ASCII file, with diagrams in their original format and as a TIFF or an EPS). Two hard copies of other submissions should be supplied. Subject to prior agreement with the Editor, however, items may be submitted as e-mail attachments.

- Proofs of papers will be sent to authors for correction of typesetting errors, and will need to be returned promptly.

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

For publication in	Copy must be received by
February	5 November
May	5 February
August	5 May
November	5 August

All submissions should be sent to: Dr Alan Bellamy, Editor, *Counselling Psychology Review*, Brynmair Clinic, Goring Road, Llanelli, Carmarthenshire SA15 3HF.

Book reviews should be sent to: Kasia Szymanska, Book Reviews Editor, Centre for Stress Management, 156 Westcombe Hill, London SE3 7DH.