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COSCA
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Contents

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Editorial

John Dodds

BY the time you read this it will be summer and the sun will be blazing across Scotland (some hope!).

In this issue we kick of with a great piece from Guardian journalist, Lorna Martin, about her experience as a counselling client. For me as a counsellor it's a rare priviledge to read a client's account of the process, especially one so insightful, witty and thought-provoking. I hope it will inspire you to rush out and buy Lorna's book, *Woman on the Verge of a Nervous Breakdown*.

The subject of the dearth of research has come up in the journal before. And certainly it's one which has come up for me on counselling courses, in supervision groups and in the health practice where I worked. So it should be of interest to many of you to read a summary of a research study carried out on a COSCA counselling skills course in Pilton. I found much that mirrored experiences I've had on counselling groups, so I was unsurprised by much of what has been reported. What did surprise me, though, was that some of the issues that arose when I was training appear to be reflected in other groups. And there we thought we were unique. Some of the results, though, do offer a surprise or two, and I'd be keen to get your views as journal readers on these.

Amanda Cornish's reflections on family and children's therapy is fascinating, particularly on how it looks at the needs of an organisation for training individuals and teams and how this then impacts on work with their clients.

And for those of you of a nervous disposition…look away now. I suppose we must all have wondered at one time or another "What happens if a complaint is raised against me?" Well, Brian Magee's account of a mock complaints panel, and a fictional case study, should help clarify the process, and hopefully offer some reaassurance about the process being fair and balanced. And, in the worst case scenario, when a complaint is upheld, clear guidance on what will happen.

I hope you will find these articles, and the others in the journal, interesting and a rewarding read. As ever, I'm holding out the begging bowl for letters and articles. We really do want to know what you think, and I am always keen to get offers of articles– we can never have enough of them.

Take care, and remember not to go out into that scalding sunshine without at least factor 15 on.

John Dodds

Therapy
the Talking Cure?

Lorna Martin

Before I went into therapy I dismissed the 'talking cure' as a waste of time and money for weak, pathetic, self-indulgent losers. Apart from those who'd suffered a major traumatic event, I thought it was for people, troubled celebrities mainly, who wanted to whine about their weight/self-esteem/ alcohol/cocaine problem while blaming their emotionally absent father and/or overly critical mother.

My attitude probably had something to do with my sister Louise and our mutual friend Katy, who both work in the famous Priory hospital chain. They have a psychobabble explanation for just about everything.

Their analysis of me was less than flattering. A few years ago, on a night out to celebrate Louise's upcoming wedding, I burst into the restaurant, over an hour late, with a gushing apology and a rosy glow on my face: I'd been having fun, lots of it, with my lovely new boyfriend. It was the first time in six years that I'd managed to sustain a relationship for more than half a dozen dates and I was feeling somewhat euphoric. But I was brought quickly back to earth when they launched their verbal assault. Could I be any more selfish? How special did I think I was? How consumed with anger and jealousy? Did I not realise that my constant tardiness indicated passive-aggression and an overdeveloped sense of self-importance combined with massively low self-esteem?

'I just lost track of time,' I whimpered. 'I'm not angry or jealous. Or passive-whatever. Or lacking self-esteem. I was just having fun. I thought you'd be happy for me.'

Their conclusion was that I was 'deep in denial' and seemed to enjoy sabotaging my own true happiness. They suggested therapy. I scoffed. I needed therapy like the proverbial fish needed its bicycle. I thought they required help far more than I did.

But around my 35th birthday, I was forced to reconsider.

On the outside there was still nothing wrong with me. I wasn't an alcoholic, drug addict or anorexic. My childhood wasn't misery memoir material: I hadn't been abused or neglected. I had a dream job as a journalist with The Observer, great friends, close family and perfect health.

But underneath the cheery façade, all was not well. I was back on antidepressants. I was on the verge of quitting my job even though I didn't have another. I'd missed three flights in ten days and narrowly escaped losing my driving licence. I was crying so much I began to think I might dehydrate. And, although I'd always regarded adultery as a sin almost as heinous as murder, I was clinging without a shred of dignity onto the remnants of a relationship with a married man. I went crazy when I heard he'd moved on to someone new and I was terrified, disgusted and thoroughly ashamed of my behaviour.

Many of my friends were settling down. I wondered why, while part of me longed for an honest, intimate relationship, I seemed incapable of forming one.

At first I relied on my trusted arsenal of self-soothing strategies – I counted my blessings; I pulled up my socks; I immersed myself in work; I tried new hobbies; I got drunk; I detoxed; I went swimming. I thought about remarkable people I'd met who'd suffered unimagineable losses but found strength to carry on. I thought about my gran, who raised nine children in a Glasgow tenement. And I felt even more weak and guilty. What was wrong with me? I wasn't happy, fulfilled or content. I felt inadequate. I had commitment issues. It all seemed pathetically trivial and inconsequential.

Eventually, however, I became scared of the way I was feeling, so I put my reservations to one side, took out a bank loan and embarked on the strangest journey of my life.

At first I thought my therapist, Dr J, was crazy. (Her

identity has been completely changed to protect her privacy.) Despite all this money I was paying her, she didn't tell me what was wrong. Nor did she promise to make me happy. In the early days, she was just like the Hollywood caricature of a shrink: she said little and looked at me with an unreadable expression on her face. It was very weird.

I'd thought she'd be a bit of a hippy type, but she seemed more like a head teacher. In fact, on first impressions she was like a grimmer Helen Mirren in her portrayal of The Queen. For the first two months, I sat across from her but at the beginning of the third month, when I realized I hadn't told her anything I hadn't spoken about before, I decided to lie on the couch, which felt even more uncomfortable and bizarre.

Over the months, she made more observations and challenged me much more. Gradually, she stripped away my defences – my humour, my rationalisations, my protestations of niceness. At times I hated her. At others I felt an overwhelming affection towards her. Every session was different and unpredictable. Some were sad and I cried for 50 minutes. Some were boring. Others enjoyable. Some uncomfortable. Despite the fact that two were ridiculously early in the morning, I rarely dreaded them.

For a while, she seemed fanatically keen to focus on anger and envy. I was having none of it. I told her repeatedly that I regarded such emotions as ugly, pointless and destructive.

But the kind of therapy I was having – psychoanalytic /psychodynamic – has a bizarre way of stripping you of self-deception and forcing you to look at yourself from a completely different perspective.

One day we'd been talking about family matters. I'd told her all about baby Lewis, or King Lewis as we affectionately called my adorable nephew.

The absurd idea was raised that I might have some feelings of jealousy towards him and my sister for making my parents the happiest, proudest people on the planet.

I was appalled and, not for the first time, considered quitting. A 35-year-old woman jealous of an infant I loved more than anything? It was the most ridiculous and offensive thing I'd ever heard.

Later that evening I called my mum (who was at my sister's for dinner). I asked if she'd read a piece I'd written. She said she'd skimmed it. Then she moved on. 'Have you heard Lewis say nose?' I hadn't. 'Have you heard him say "love you"? Have you seen him do eye, nose, cheeky, cheeky chin? Do you know if you say one, two, he says "freeee". He's a very clever little boy, you know.'

I then spoke to my dad, a previously emotionally reticent man, who had changed beyond recognition since the arrival of his first grandchild.

'All well?' he asked, but before I could reply there was applause and squeals of delight in the background. I thought, perhaps, that the little curly-haired miracle had just recited the alphabet backwards or said 'love you, granny and granda' in Latin.

But no. Bursting with pride, my dad revealed that Lewis had just put his empty yoghurt carton in the bin. All by himself. My dad sounded close to tears.

I poured myself a large glass of wine, then lay down on my living room floor. You are a strong, confident, independent woman. You are not jealous of a toddler. Or his mother. You can't be.

But reality slowly dawned.

The image I'd long held of myself was gradually eroded. I was capable of feeling anger, envy and resentment. And that was only the tip of the iceberg.

I'd always thought I was more in touch with my emotions than most, especially for a cynical Scot. In fact, I was anaesthetised from them.

Underneath the façade, I discovered that I was very insecure. My sense of self-worth depended on the approval and opinion of others, including my parents. I realised that, although I was 35, I behaved in many ways like a little girl, always trying to please others, still looking for unconditional exclusive love and with a child-like fear of criticism or rejection.

The self-sufficiency and independence I prided myself on masked an acute fear of intimacy. Striving for the elusive perfection was a flimsy way of deluding myself into feeling superior. What I'd thought was love – true, mad, deep, passionate love – was hideously far removed from the reality.

On reflection, I think I was so incapable of dealing with difficult emotions that I ran away from them. I screwed up relationships or got involved in dysfunctional ones, I kept friends at a distance, I quit jobs regularly and I set myself totally pointless challenges.

Like many women in my thirties, I'd spent years piling immense pressure on myself as I struggled for 'success', happiness, contentment. But it was only when I took this bizarre trip inside my own head that I began to really understand that nothing – no achievement, no amazing job, no man, no material possession, no external approval, no amount of Prozac or positive thinking, no skinny body, no child – will bring happiness if your inner life is in turmoil and you don't have your own approval. What you have on the outside has little to do with how you feel inside.

I have been asked why on earth I 'outed' myself. There was a bit of me that wanted to challenge myths and taboos about both therapy and infidelity. I thought I could reveal a little bit of myself and in the process hopefully help other people. I realised that these repressed feelings that I had – around anger, jealousy, sibling rivalry, competitiveness, dependency – were not unique to me but were universal, and can be perfectly healthy and normal, even though our culture tells us otherwise.

But I do think I was a bit naïve and impulsive. Therapy forces you to explore all aspects of your motivation, especially the darker, hidden elements. I discovered that there was part of me that actually found it easier to have a relationship with a large anonymous audience than an intimate relationship with one individual. And there was the uncomfortable realisation that writing and having a fragile ego are quite closely connected.

People have asked whether I wanted to 'out' the married guy. This was never my motivation. I was never doing a kiss-and-tell or naming and shaming anyone other than myself. If he'd been a hypocritical politician spouting family values, then perhaps I'd feel differently. But I realised that infidelity is far more common than we can bear to acknowledge. I'm not suggesting it's okay, I'm just saying it happens. A lot. And I thought it was better to admit that and explore some of the reasons why, rather than deluding ourselves into thinking it only happens to celebrities and politicians. Having previously experienced the agony of being betrayed by a guy who cheated on me, then being the 'other woman' I felt I could write about experiences that many people go through.

I also wanted to raise the idea that depression may be a bit more complex than a chemical problem requiring a chemical solution.

So am I cured now? Not quite. There is no cure for this human condition. But I feel much better equipped to deal with the conflicts, difficulties and losses that are an unavoidable part of life. I also realise the importance of not ignoring emotions. Which is not the same as 'letting it all out'.

I'm aware some people have negative experiences in therapy and that there are some bad therapists out there. But for me, it was hugely beneficial. It was an honest, intimate and challenging relationship from which I learned a great deal about myself.

As a result, I feel lighter (I'm not). It just seems as if the weight of the world has been lifted off my shoulders. I feel, and I know this will sound so corny, that I have made peace with myself. I am honest with myself about how I feel, and I'm much more realistic in my expectations from myself, from others, from love and life generally.

Before I went into therapy, I think I was quietly quite a judgmental and intolerant person. I realise now that there is no such thing as a perfect, infallible human being. We are all flawed and imperfect and capable of making mistakes. In the past, I noticed other people's weaknesses. I had a blind spot to my own. But when you take a long, hard look at yourself, flaws and all, I think it makes you a much more tolerant, accepting and forgiving person. Of yourself and others.

I went into therapy lamenting the fact that I had neither a man, nor a mortgage – not even a cat. I came out with something worth so much more – a true sense of who I really am and, even more crucially, my own acceptance and approval.

Woman on the Verge of a Nervous Breakdown by Lorna Martin is published by John Murray.

Evaluation of Brief Counselling

skills training for community workers

John McLeod,
Brian Rodgers
and Tom Daniel

Abstract

Although COSCA-validated counselling skills have made a significant impact on a range of professional communities in Scotland, there has been little research that has examined the outcomes and processes of this training package. This paper presents an evaluation of a counselling skills course (Module 1 of the COSCA Certificate in Counselling Skills programme) undertaken by 45 frontline community workers in a voluntary agency in Edinburgh. Data was collected through questionnaires completed before the course, at the end, and at follow up. Trainers took part in focus group interviews. The findings of the study suggest that the module had a positive effect on participants' competence in the use of counselling skills. The results of the study are discussed in relation to implications for further research.

Introduction

Counselling skills training courses are increasingly popular in a wide range of professions whose work involves dealing with the emotional and relationship problems of the people with whom they work. However, in recent years little research has been published into the effectiveness of such programmes, or the factors that make them successful (Hill and Lent, 2006). In Scotland, the COSCA Certificate in Counselling Skills provides a standardised, quality controlled counselling skills training package, comprising four modules. It has been taken by many thousands of people. The aim of the present study was to evaluate the delivery of Module 1 of the COSCA package in the context of a community health agency in a major urban area in Scotland. The specific objectives of the study were to:

- describe the background of people enrolled on the course;
- analyse changes in their counselling skills as a result of the course;
- collect their views of the course; and
- collect trainers' views of the operation of the course.

Method

The study consisted of an evaluation based on questionnaires completed by the participants at the start and end of the course, and a follow-up interview six weeks later. The questionnaires included a combination of standardised rating scales, and comments. Participants were free not to take part in the study, and were assured that individuals would not be identifiable in any reports arising from the research.

The counselling skills module

The skills training course is Module 1 of the COSCA Certificate in Counselling Skills programme. The whole Certificate consists of four 36-hour modules. Module 1 provided an introduction to basic counselling skills, personal development, and principles of ethical practice. The key competencies addressed included establishing an appropriate, safe and supportive relationship, and evaluating and monitoring self in using a counselling approach. These competencies were explored through intensive practice of skills such as active listening, encouraging the speaker to be able to speak at his or her own pace, asking clarifying questions, and clarification of the speaker's meaning. The course was run in the Pilton Community Health Project, Edinburgh, and operated over 12 three-hour sessions. The course was based on training materials published by COSCA, widely used across Scotland, which specify a mix of teaching, skills practice in triads, and group-based personal development work.

The organisational setting

Pilton is an area in the north of Edinburgh,

characterised by high unemployment and deprivation, and a lot of local authority rented housing. Pilton Community Health Project was established in 1984 as a temporary "action research" project to work with local people to identify their health concerns and then look together for ways to address them. The need for a counselling service in Pilton had been recognised for a long time by both local residents and professionals, and in 1994, Mental Illness Specific Grant funding secured a counselling service for the project. The service continues to develop and currently offers over 1,000 sessions a year to adults and 480 sessions at local schools. However, provision remains well below the BACP recommended figures for areas of deprivation (4.5 sessions per 1000 population annually). This lack of adequate counselling provision places additional stress on non-counselling workers to manage complex emotional issues. For example, workers and volunteers in local youth clubs often meet people who are in distress. In 2002, PCHP applied for funding to run the COSCA Module 1 training in response to a request for local community workers for training to improve their listening skills so that they could feel confident that they would handle the subjects that were being raised with them appropriately, keeping the discussion within safe boundaries and with a capability to refer cases to more specialist services when necessary.

Participants

The module was run four times:

- Course 1: 11 participants (9 women; 2 men)
- Course 2: 9 participants (8 women; 1 man)
- Course 3: 13 participants (11 women; 2 men)
- Course 4: 12 participants (all women)

The average age of participants was 41 (range 19-71 years). The majority described themselves as ethnic 'white'; one participant described themself as 'Scottish mixed race'. Everyone was involved in some kind of paid or voluntary community work, including nursing, project work, befriending and social work. They were recruited through community networks with which Pilton Community Health was involved. Participation was free to those who enrolled.

Educational qualifications included people with no formal qualifications, some who had left school with 'O' levels/Standard Grades (or equivalent), and 19 (42%) who had studied at Degree/Higher National level. Thirteen (28%) had some previous counselling training, most between one and two days in length.

Participants gave variety of reasons were given for applying for the skills module. The most frequently cited were about the wish to gain skills that would be relevant to their work. Some mentioned that they hoped to contribute to their own personal development by taking part in the course. Seven (15%) were interested in pursuing further counselling training.

The trainers were experienced counsellors and trainers, who met the trainer criteria outlined by COSCA. Two of them worked on each module.

Data collection

In addition to the questionnaires and a follow-up postal questionnaire, a focus group interview was held with the trainers. A pre-course questionnaire included items on the age, gender, ethnic identity, education, occupation, and previous counselling training of the participant, and their reasons for taking the course.

All three questionnaires encompassed the following scales:

Counsellor Activity Self-efficacy Scale – Revised (CASES-R).

A 12-item inventory, with a 10-point (0-9) rating scale that participants used to indicate their level of confidence with series of basic counselling skills, such as attending, listening, paraphrasing, exploration of meaning, and so on.

Free response counselling vignettes. In order to provide a record of the performance of counselling skill, a free-response format was used in addition to the CASES-R scale. Six vignettes were tested on experienced counsellors to determine equivalence of stimulus quality. Each vignette consisted of a client statement, description of context, and invitation to the participant to write down what they might say in response to the person seeking help. Two vignettes were included in each questionnaire completed by participants. These free response answers were rated by an experienced counselling researcher in relation to four dimensions of empathic listening: paraphrasing, use of exploratory questioning, reflection of feelings, and the identification of underlying or implicit meaning. In addition, a rating of overall empathic quality was made. The ratings made on each of these dimensions (using 10-point scales) were summed to give a total empathic listening score for each vignette. Another experienced researcher independently rated a sample of the responses; any disagreements were discussed and resolved. A satisfactory level of inter-rater agreement was obtained. In addition, a thematic analysis was made of the qualities of responses judged to be low in empathic quality.

The end of counselling questionnaire contained space for any further comments that the participant might wish to make about the course. The follow-up questionnaire included the Use of Counselling Skills Form, which asked participants to describe two situations in which they had made use of what they had learned on the course, and a section inviting comments about the most and least helpful aspects of the course, and suggestions for improving it. Copies of all of the questionnaires used in the study are available from John McLeod.

Results

Thirty-one of the original 45 participants (66%) completed the module. Comparison of completers and non-completers did not yield any consistent differences in terms of age, gender, education, previous training, or skills competence at the outset. Follow-up data was received from only 11 participants. The low return rate for follow-up data meant it was not possible to carry out a full and systematic analysis of this material; instead, reference is made to follow-up data for illustrative purposes only.

Participant self-ratings of skills

The key findings to emerge from analysis of training participant self-ratings of competence were:

- statistically significant improvements in self-rated counselling;
- even at the end of the course, the majority of participants described themselves as less than completely confident on the majority of skills– the exception was attending, where some reported having complete confidence in their ability;
- a wide range of self-reported competence at the beginning of the course; some participants entered the course with a fair degree of confidence in their counselling skills abilities, while others reported said they had little competence. By the end of the course, confidence levels across the group fell within a somewhat narrower range;
- before beginning the course, participants felt most confident about their ability to attend and listen to clients, and least confident about their capacity to understand clients, help the person to achieve their own understanding, to discuss concerns in depth;
- the competencies that were most enhanced by course were the capacity to encourage exploration, the counsellor being clear about what they were trying to do, using open questions, and understanding the client's issues;

- there were quite striking differences between groups. In the beginning Group 2 was less confident in all competency areas, but improved more than any of the other groups. Group 3 reported lower rates of improvement than any of the other groups. The information available makes it impossible to interpret this finding with any confidence;
- the post-training ratings are similar to those found in experienced, rather than novice, counsellors, in an American study conducted by Lent et al (2003).

Analysis of free response counselling vignettes

The free response vignettes allowed data to be collected on how course participants were able to apply counselling skills in community settings. The main focus of this analysis was on the degree to which participants had mastered, and were able to use, the skill of active empathic listening. In order to simplify the presentation of this data, ratings of participants' empathic responses have been categorised in terms of whether they indicate improvement in skills, no change, or deterioration in the ability to offer empathic listening. Of the 31 participants who completed pre-training and end-of-training questionnaires, a significant improvement in their capacity to respond empathically was found in 20 (65%), with 9 (29%) showing no difference, and 2 (6%) getting worse. There was a high level of agreement between the ratings of each of the two vignettes completed by participants at each stage. Considering the 11 participants who provided follow-up data, 2 of these trainees had significantly improved in empathic ability, 8 had stayed at the same level, and 1 had got worse.

Qualitative analysis of the vignette responses reveals that the statements made by participants in the pre-training questionnaire were generally helpful and constructive, but comprised interventions that primarily consisted of practical advice-giving and sympathetic reassurance. By contrast, many of the post-training statements comprised highly sensitive empathic responses. Some examples of the types of responses that were made by trainees are provided below.

Participants' responses to a client: examples of empathic and unempathic statements

Vignette: Maggie is someone who has a lot of difficulties coping with stress in her life. She never seems to be able to deal very well with any pressure that comes her way. She says to you:

"Thank goodness I can speak to you. I've been storing this up for ages. Its just that when people expect things of me, I start to get this knot in my stomach. I feel really scared that I'll let people down, and that they'll get angry with me or think that I am useless. It just goes round and round my head all the time. These thoughts. I can't sleep at nights".

Write down here what you might say in response to Maggie:

Statements rated low in active empathic listening:

- "Try not to think too much of other people, try to think more about the things you expect from yourself. Sometimes these feelings are more about thinking rather than doing. Try maybe saying no to yourself and other people when you get a knot in your stomach" (Advice-giving)
- "You obviously put the other person before yourself instead of feeling anxious when people expect things of you - say to the other person you will get the job done to the best of your ability. If you still feel stressed consult your doctor" (Advice-giving)
- "I think you expect too much from yourself (that you will let people down). Nobody will think you are useless so don't be so hard on yourself" (Reassurance)

Statements rated high in active empathic listening:

- "You seem to be bottling everything up inside. Its making you feel nervous in your stomach. You're scared people will get angry with you and this is affecting your sleep at nights"
- "So you can't sleep at night because you're so scared of letting people down? And you're afraid they'll get angry or criticise you? That must be really uncomfortable. (Pause for responses) Or: You seem very relieved you've finally got someone to talk to about this."
- "You feel scared that you'll let people down and this makes you feel useless?"

Note: This vignette was used in post-counselling data collection, so all of the responses reflect post-training competencies

Participants' views of the module

Twenty-seven participants contributed comments in the open-ended section within the end-of-counselling questionnaire. In addition, 11 of them supplied further comments in their follow-up questionnaires. The main themes that emerged were:

- how much participants had learned, and how much they had enjoyed the course;
- the importance of being in a small group;
- the value of having two tutors;
- more modeling of good skills, by tutors or on video, would have been helpful;
- mixed feeling (positive and negative) around being required to have skills practice recorded on video; and
- some questions about how readily the skills could translate into everyday life situations.

How participants used what they had learned on the skills module

Since only 11 participants returned the follow-up questionnaire, it is difficult to draw any firm conclusions form the analysis of the Use of Counselling Skills form. One participant did not complete this part of the follow-up questionnaire, and another was not able to provide any specific examples. Of the 9 participants who provided scenarios, it was striking that half of the examples were based on incidents from the person's private life (family and friends), and half from work situations. This finding provides evidence of the personal impact of the course for participants. Examples of scenarios that were described by participants are provided below.

Scenario 1

What was happening:

A friend and I both left an area up north a few years back as it held no life for us. She did not settle in her new area and decided to move back. I thought this would be a mistake to which after a course of weeks she has acknowledged.

What I did:

- I listened and responded in a non-judgmental way and supported her with her decision.
- How this was different from what I might have done in the past.
- I would have related to my own experiences and offered advice.

Scenario 2

What was happening:

I was in a one-to-one support situation with a woman service user. There was a silent period after the women had finished describing a recent trauma in her life. After a few minutes time continued speaking.

What I did:

I stayed with/in the silence – using it to process what was going on for myself emotionally and to allow the woman space with her feelings , which we then went on to explore. The woman's story had echoes of my own personal history which generated feelings.

How this was different from what I might have done in the past:

I have always had difficulty being okay with silences. Through the counselling skills course I was able to recognize the value of silences in the process and also to identify that I was 'jumping in' to fill silences because of personal anxiety.

Trainers' views of the module

The trainers took part in a focus group interview and key issues from their perspective were:

The significance of personal development. They had observed many examples of trainees dealing with major life issues within the skills practice and groupwork on the course: "It was stunning what they brought. I've never experienced that. I suppose the groups I've taught before have been bigger and maybe a bit more varied, but it was quite awesome at times….the issues that people took to their triads. I mean, people were saying that it had been life changing. That they had resolved big life issues, some of them, in the triad so in that sense…they were surprised some of them at how much they had brought, the ones who were perhaps a bit scared at the beginning".

Losing group members at the start. There appeared to be a number of factors that influenced some group members to leave at an early point in the course, for example insufficient prior information about the demands of the course, and other work pressures.

Inaccurate trainee perceptions of competence. Some trainers believed that participants tended to over-estimate their competence at the start of the course, and took time to become aware of their limitations with counselling skills.

The setting for the course. Sessions were held in the Pilton Community Health building, which was where some of the participants worked – this could be a source of distraction (for example, participants returning to their desks during breaks).

The impact of pre-existing relationships between trainees. As one trainer put it, there were many "cross-connections" between participants, and it took time to resolve the boundary issues associated with these relationships.

The importance of ethical issues. Participants spent a lot of time discussing ethical issues associated with the use of counselling skills within the kinds of community settings in which they worked.

The impact of the course on the local community. Trainers believed that the existence of the course helped to enhance awareness in the local community of the value of counselling: "I think one of the chief things that has come out was that it's been a marvellous PR exercise for counselling in the locality….working here and seeing counsellors floating in and out not really knowing what they do, but now a huge proportion of them know what happens roughly…. we had at least one person in our group who was actually quite anti-counselling and absolutely amazed themselves by what they did and what they got out of it".

The relevance of the training materials. The trainers were critical of some of the training materials provided by COSCA, which they felt were too abstract for certain members of the group. They reported that they developed some of their own materials, as well as adapting the COSCA package.

The value of working with a co-trainer was a positive aspect of the programme.

The role of the research study. From the point of view of the trainers, the organisation of the research study had caused difficulties at the start of the course – time was spent filling in questionnaires that would have been better spent developing trust within the group. The research was seen as 'heightening anxieties' at the start, although by the end this was not an issue.

Discussion

It is important to acknowledge that there were some significant limitations associated with this study. Information was primarily collected through questionnaires. This method may not have been appropriate or congenial, or even threatening, for participants who had little previous educational attainment. It would have been more satisfactory, if resources had permitted, to interview participants and collect observations of their practical counselling skills work. Also, it would have been valuable to have followed up those group members who left the course, to learn more about their experiences and reasons for dropping out. Despite these limitations, data was collected from a variety of sources, and the analysis concurs with conclusions drawn from other forms of evidence.

The main findings of this study were:

- a brief 36-hour counselling skills course can make a significant difference to the skills competence of those who complete it;
- there were statistically significant improvement in participants self reported confidence in their own counselling skills ability;
- 65% of participants improved in capability to empathic response as measured by independent raters;
- there is evidence that skills acquired on the course were used in everyday work and home situations;
- personal learning and development is a significant outcome for many course participants;
- the COSCA skills training model, which encourages access from participants of varying levels of educational achievement, and is organised around an integration of practical, personal and professional learning, was appropriate for this group of learners;
- running a counselling skills course within a community organization raises issues in terms of pre-existing relationships between participants, and has the potential to generate an enhanced understanding of counseling within the organisation as a whole.

There are also a number of recommendations for further research that can be derived from this study:

- there are sensitivities around arrangements for collecting information at the start of a course, which require further attention;
- a fuller range of questions should be asked at the end-of-counselling stage, to avoid loss of information due to non-completion of follow-up questionnaires;
- it would be valuable to make plans to follow up individuals who leave a skills course before the end;
- participants on skills courses have a wealth of ideas about how courses can be improved – it would be useful to devise a standard way of collecting this kind of commentary, that could be used on all skills courses. For example, participants in the present programme suggested that greater use of trainer modelling would have been useful for them – a conclusion that is consistent with the findings of the Hill and Lent (2006) review of research into the effectiveness of skills training;

- the Use of Counselling Skills Form represents a promising technique for evaluating trainee use of counselling competencies in real-life situations (McLeod, 2007); and
- there appear to be differences between courses in terms of the amount of benefit that participants report – this question requires further research.

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Responsible Citizen and Effective Contributor

confident or compliant individual: do the children have a choice?

Margaret Wadsley

Responsible citizen and effective contributor, This This article considers two significantly different perspectives on replacing anti-social behaviour with 'community feeling' in children and young people. These can be broadly described as:

- a tendency to medicate an 'involuntary population' of children and young people, in seeking to solve their social, emotional and behavioural difficulties (SEBD); and
- aiming to engage family, social and educational alternatives to medication at a therapeutic level as the option of choice so that children, young people and parent/carers are engaged in resolving SEBD.

At the Newcastle-upon-Tyne 2008 Conference of Counselling Children and Young People (CCYP) I heard Dr Heather Geddes acknowledge schools' vital role in promoting emotional well-being in children and young people. Encouragingly, the Additional Support for Learning (ASfL) (Scotland) Act 2004 and "A Curriculum for Excellence" affirms this in enabling children and young people to develop four capacities as: successful learners, confident individuals, responsible citizens, effective contributors.

Fundamentally all approaches aim to effect a sustainable reduction in negative behaviour. However, in addressing SEBD where young children have disorganised, highly chaotic and anti-social behaviour GPs and others aim for compliance. In my view the evidence lies in psychiatric diagnosis followed by the prescription of drugs. The children diagnosed, more commonly boys (NHS Scotland 2007) are sometimes as young as four. They potentially enter the mental health system long term as evidenced by Place2Be (2008) and take medication or worse in adulthood (Lambert 2006).

Which option is likely to lead to the happiest, growth-enhancing outcome for each client?

Attention-Deficit Hyperactivity Disorder

To illustrate what is happening in medicalising SEBD, one aspect of need, Attention Deficit Hyperactivity Disorder (ADHD), is a useful illustrator. ADHD as found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV) describes children whose behaviour is "…characterised by inattention, impulsivity, and excessive unfocused activity…and frequently difficulties with socially inappropriate behaviour." (Sperry and Carlson, 1996). Statistical evidence from the past ten years supports the observation that prescribing Ritalin has increased significantly in that period.

Two psychiatrists of world renown challenge the prescribing of Ritalin and other medications. Dr William Glasser (2003) is the originator of "Choice Theory", "Reality Therapy" and "Cooperative Learning". He calls Ritalin, which is also known as Methylphenidate, synthetic cocaine and its use given to children as an "involuntary population when medicated by psychiatrists, GPs and paediatricians." (Wadsley 2006). Dr Peter Breggin also a psychiatrist and founder of the International Centre for the Study of Psychiatry and Psychology describes the inclusion of ADHD in DSM-IV diagnostic criteria as specifically aimed at suppressing undesirable behaviour in formal classrooms, moving children to a place of 'disease'.

Recent History in Scotland:

During 2003 NHS Scotland engaged in the process of developing a framework to promote the mental health needs of children and young people including consulting them. Young children were asked for their ideas on the important qualities of people who are helpful while young people in Aberdeen, Stirling and Edinburgh were consulted on the nature of the support they would wish to receive. The underlying message from them was that they wished to be

viewed non-judgementally, as individuals their needs be understood by those supporting them and have access to more community based facilities. They did not always want their issues/problems to be medicalised. Health professionals throughout Scotland have been trained on the framework, yet research shows that there has been a significant increase in the number of drug treatments prescribed. Between 2005/06 and 2006/07 the prescribing of drugs for ADHD grew by 20.1%, up from 49,258 items to 59,461 items (isds - Scotland 2008).

Medications, commonly dispensed are: Methylphenidate (Ritalin, Concerta and Metadate) and other forms of amphetamine such as Dexedrine. More recently Atomoxetine (Strattera) has been hailed as a new medication. The cautions and side effects of using all these medications can be found on Mind's fact sheet on drugs for ADHD. ICSPP has shown that both stimulants and anti-psychotic medications have side effects: convulsions, drowsiness, blurred vision, jerky movements, impaired mental abilities, sleep disturbance and migraine.

NHS Scotland (2007) reported that of 14 health boards surveyed neither undertook joint needs assessment work for children and young people with ADHD, involving children's services, additional support needs or additional support for learning nor accessing community based interventions such as school based counselling or other therapeutic options. Taken at face value, this suggests gaps exist between implementing the ASfL (Scotland) Act, "A Curriculum for Excellence" aspirations, Children's Services and CAMHS.

Trends in treating ADHD – lessons we can learn from the USA

Children who have been diagnosed with ADHD frequently have a difficult start to life: disruptions to primary relationships, chaotic home settings and socio-economic challenges in the family. Below are two case examples reported by a former school psychologist. They illustrate the context in which two children in the USA and their families found the medical system took over their treatment to an extreme degree. Names have been changed to protect identity.

The first case was a boy, Davy, who the psychologist knew while he was aged between five and 10 years old. When he came to school he was already on eight psychotropic drugs. From a pre-school age he had become a carer for his younger siblings whenever his mother was high on drugs. The children were often left to roam the streets. He was given up to the care of his paternal grand parents after his father had left the state to form a new family. Abuse in his birth home became indulgence with grandparents. He had hallucinations and didn't sleep at night. Davy was poor academically but clever with his hands. Eventually, after long-term pressure, Davy went to a therapist who worked with his attachment issues, while the school psychologist was able to work on discipline at home with the grandparents. Life then improved. The school psychologist believes that damage was done to his brain by the medications and that it added to the emotional trauma he experienced as a pre-schooler.

The second case was of a little girl Annie, a victim of neglect and abuse, who was removed from her mother at the age of three along with her sister who was still a baby. Her early childhood brought two failed adoptions, various foster homes and an adoptive parent who sexually assaulted her. Concurrently she was given a range of drugs including a psychotropic medication that brought on liver problems. Now fourteen she is in a juvenile facility because of assault by her in a group home.

It is hard to attribute genetic brain disorders or chemical imbalances as the origin of what evidently

began in early life where safe, nurturing relational attachments were unavailable to this little girl.

Evidence from a longitudinal study of children and young people diagnosed with ADHD and medicated with Ritalin raises an interesting link between cocaine dependence and conduct difficulties as Figure 1 suggests. It was undertaken in the USA.

Effect of ADHD & Pre-Exposure to Stimulant
(Lambert, 2006: 28 year old study of 492 children

	No Stimulant	Stimulant < year	Stimulant for 1 yr or more
Tobacco dependent	32%	39%	49%
Cocaine Dependent	15%	18%	27%

(Lambert 1998)

"…202 of 492 in this study reported some cocaine use by age 40. Treatment with stimulants in early childhood was associated with a **two fold higher risk of cocaine dependence**, an association **six times** stronger than the link between conduct problems and later dependence on cocaine." (Lambert 1998)

These are chilling facts taken in conjunction with the issues raised above.

Therapeutic alternatives

Drug treatments for behaviour imply behaviour has a physiological cause. It suggests people have no choice in their actions. In the humanistic therapies clients are respected as autonomous. Ethical practice requires it (Bond 2000). Medicating an involuntary population contradicts choice. Surely: "What he is when he is born is less important than what he does with it afterwards." (Dreikurs 1998)

Neuro-science has confirmed the link between emotional and social development and the mother-infant relationship (Schore 2000, Gerhardt 2004).

Daniel Stern (1985) stepped into the Interpersonal World of the Infant by observing mothers and babies interacting. He concluded that repeated patterns of relating between them formed the basis for relating to others in later life. Counsellors and therapists know that the characteristics of the therapeutic relationship have a "powerful impact" on the benefits of the therapy (Clarkson and Pokorny 1994, p166).

Place2Be is a national charity working with 120 primary schools throughout the UK including Edinburgh and therapeutically supporting 40,000 young children, their families and their schools. It embraces research-based practice to demonstrate the efficacy of its community-based practical approach. Does this not need to become an entitlement on our schools?

What stops the therapeutic profession in general joining thinking with educators as Place2Be does and making interventions that protect children's autonomy nationwide?

Family Alternative

Ninety percent of parents in a study reported by the BBC in 2007 expressed their belief that their child's ADHD has a moderate to severe impact on the family as a whole (BBC 2007). The report was based on a survey of 70 paediatricians, 55 child and adolescent psychiatrists, 101 parents of children with ADHD who were receiving treatment for ADHD and 147 parents who know a child diagnosed with ADHD. It stated that medications for ADHD had been found wanting. The report described key times of day medication did not seem to work: getting ready in the morning and at breakfast, mealtimes in the evening and bedtimes. Surely these are potentially challenging times of day for all parents for one reason or another, but here families with a child diagnosed with ADHD are singled out as different. Adlerian family education and counselling is an effective solution as evidenced

in the USA and throughout a worldwide network. Systematic training for effective parenting, based on addressing the issues described in the BBC's report, is the world's leading parenting programme for all families (McKay and Maybell 2004).
Acknowledging influences on parenting style brings a further dimension. Frank Walton (1998), Alderian Family Counsellor and Educator, developed an intervention during family counselling that enables parents to understand their parenting style (Walton 1998). He gave a case example of a six-year-old girl diagnosed with ADHD. Her father overcompensated for the lack of attention and neglect he experienced at her age, a natural parental response. However it meant that she had less opportunity to learn the skills of cooperation before attending school, meaning that she became disruptive because her attention getting behaviour was her way of gaining a sense of belonging: being noticed as she experienced in her family.

It can also be argued that families' difficulties described in the 2007 BBC report create dependency on limited social and health service resources rather then empowering parents to discover and develop their own skills and abilities. In reality is it the family who are in fact wanting or medicating that has limited effectiveness?

Educational alternatives

Dr Breggin argued that the origins of medicating children with ADHD lay in the education system. Dealing with disruptive children medically by securing compliance has taken precedence over teaching social skills and fundamental self-discipline.

In their book Happy Children Rudolf Dreikurs and Vicki Soltz (1995) described how encouragement is as important to children as light and water to a plant. The school system has adopted behaviourist approaches that do unto children rather than fostering self-generated satisfaction in tasks achieved. Encouragement helps people to accept their imperfections and remain motivated (Wadsley 2005). This figure illustrates the point.

Encouragement	**Evaluative praise**
An attitude	A verbal reward
Task/situation specific	Person-centred
Emphasises effort and improvement	Earned by being superior
May be given during task	Job must be well done, completed
Shows acceptance	Is judgmental
Fosters independence	Fosters dependence
Emphasises	Emphasises other's
Self-evaluation	Opinions
Develops self esteem	Develops self-consciousness

(Lew & Bettner, 1996, p. 47)

Instead of responsibility for behaviour being held by adults, through encouragement and experiencing the consequences of their actions carried out in a constructive way children can learn to accept it for themselves. In my article published by CCYP in June 2006, I described group and individual work to develop empathy, cooperation and the ingredients of community feeling, in a successful programme for children with ADHD, or on the Autistic Spectrum and with SEBD generally (Wadsley 2006).

Conclusion

The agenda in Scotland's schools is directed to build on assets rather than addressing deficits as the medical model does. Clearly doctors address disease and physiological dysfunction that is appropriate for somatic illness. As therapists we need to reach across the professional divide to educators and social work professionals committed to the long-term emotional well-being of children and young people. To realise the children's services agenda to raise effective contributors, responsible citizens and confident individuals, professionals need to promote the non-medical alternatives described above for the benefit of future generations of Scots.

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Finding Treasure

in the couch

Amanda Cornish

The patient lying on the psychotherapist's couch is as much a cartoon staple as the solitary man on his desert island. This cliché in humour confirms the popular perception of counselling and psychotherapy as at best a fringe activity, at worst the butt of jokes, but always a one-to-one experience. Even for many practitioners, I suspect that the focus is on the individual's journey to recovery, or at least to self-acceptance.

I came to the Scottish Institute of Human Relations (SIHR) and to the world of counselling and psychotherapy from a background of marketing and general management, and shared these prejudices and perceptions. What quickly impressed and surprised me was the ubiquity and practicality of the application of psychoanalytic, psychodynamic and systemic thinking and I suspect that this observation could be made of many modalities – that the core practice and associated training, although possibly highly specialised, provide the basis for a much wider range of activity. If my surprise is representative of the lay community, perhaps practitioners need to inform and explain the wider importance and impacts of their work.

The driver for many of the Scottish and UK Government policies is towards increasing the capacity of front-line staff in our health services, and at first it seems unlikely that the seemingly rarified environment of specialist training in psychotherapy and counselling can fulfil such a generic and utilitarian remit. From my own experience of SIHR I can draw on many examples where the theory and concepts inform and add value to wider and far-reaching work, including contributing to national workforce development.

SIHR provides training in psychotherapy for those working with families, children, young people, and adults. These are of course highly specialised trainings from which only a few graduates emerge each year. And while the qualified psychotherapist might be seen to be at the apex of the triangle in terms of specialist skills, their impact has a wider reach – the teams who host these trainees and graduates have the benefit of their experience and skills, not just in terms of direct work, but as a resource to work alongside and support other members of a multi-disciplinary team: psychiatrists, psychologists, nurses, GPs, health visitors, occupational therapists, social workers and teachers. They provide supervision, teaching, and consultation across all tiers and professions, and work with other agencies, such as social services and education.

Part of SIHR's child and adolescent psychotherapy training programme is a modular course in therapeutic skills for those working with children and young people. Majoring on the development of observational skills, this course helps build the skills of teams which fit the national strategy: increased capacity to work with complex cases and the confidence to know when to refer on to other specialists. Similarly, a team from SIHR and Napier University was commissioned by NHS Education for Scotland to develop and write training materials for staff new to children and adolescent mental health services (CAMHS). The fact that they successfully met the brief for an accessible and practical training pack reflected positively on the specialist skills and experience of the individual writers.

Three years ago, the concept of infant mental health was unknown to me, and I would have had difficulty in understanding its importance. Since then I have followed the progress of a Scottish Government funded project to determine the availability of infant mental health training, identify the gaps and requirements, and then develop appropriate training for front-line workers. What has emerged is a demand from a wide range of care professionals from community services, social work, public health, education and other sectors, for an understanding of the development of the baby brain, and the impact of the early years experiences on the

behaviour and life chances of the adult. This knowledge is not only pertinent for those working with infants but also important for those working with young people and adults to understand the genesis of their clients' symptoms. This project is a fine example of where the theories and concepts embedded in specialist trainings and courses – in this case baby observation – not only fulfil the national strategy of improving the skills of workforce, but provide support for practitioners and teams in their day-to-day work.

Similarly the Social Work Education Initiative, also funded by the Scottish Government and completing its third and final year, reviewed some of the professional management issues of social work managers and supervisors: the use of authority, contracting with individuals and acknowledging organisational boundaries in working with professional relationships, the use of communication to shift patterns of practice, using frameworks for understanding and changing behaviours. Evaluation of these courses demonstrated the importance of enabling reflective practice in current organisational cultures. This is another example of theories and concepts which might be associated with narrow specialisms proving to have wider applications which benefit not only professional practitioners, but also their colleagues, employers, and most importantly, users of their services.

SIHR's programme of family therapy training takes as its context the cultures and practices of organisations and the role of 'self'. It considers how these inter-related concepts shape the relationship between professionals and their clients. The family therapy team has widened this application to medical professionals by examining the contribution that systemic practice and family based interventions make to understanding the impact of chronic physical and mental health on individuals and families.

So when I think of the wider applications of the theories and concepts which inform SIHR's training and services, there seem to be two mutually-inclusive areas of work. One is when trained professionals develop and deliver training to increase the skills and confidence of the wider workforce – to enable more people who work in care settings to be *therapeutically literate*. The other is where these ideas help those who work in complex organisations, and who are responsible for the well-being of some of the most vulnerable members of our society, to understand the dynamics within which they work, how their relationships with one another, with their clients, their colleagues, and the organisation itself affect their own performance and well-being.

So the image which emerges is not at all of the individual on the couch – or even the lone man on his desert island – but of vibrant individual and organisational development and the tools to help build personal and professional confidence through a deeper understanding of human relationships.

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COSCA Mock Complaints Panel

16 October 2007 in Relate Scotland, Edinburgh

Brian Magee, Chief Executive, COSCA
(Counselling and Psychotherapy in Scotland)

Notes of Event

Introduction

The purpose of the event was to look at the complaint handling process at the complaints panel stage. This was deemed important to ensure that the complaints procedure is robust, fair and ready for use in the same way that lifeboats need to be checked to make sure they are in good repair. The COSCA *Guidance for Panellists* was the source document to guide the work of the panellists. The event had four parts: preparation of the case; hearing of the case; decision; and sanctions.

At the mock and virtual Investigation Panel stage it had been decided that there was prima facie evidence for the case to go forward to the complaints panel stage (see *Guidance for Panellists* for definition of prima facie evidence).

The role of the Chief Executive in the complaints panel was described as per the complaints procedure.

Preparing the Case

The Mock Panel discussed the case. Ms Margaret Hydebound, the complainant, had been a client of Mr Robert Scotland, a counsellor and Practitioner Member of COSCA, for almost a year. Ms Hydebound had been a satisfied client up until after the event in question. She was in fact offered a lift to the station due to weather conditions, and this developed into a longer journey due to the railway station being closed. The Panel did not know if this had been the first occasion on which a lift had been offered. The nature of the disclosure was key to the client's complaint, and had been described by the client as inappropriate. The client felt exploited and harmed. The disclosure changed the counselling relationship for the client. The counsellor states that a breach of the Statement of Ethics did not take place, and that he acted in the best interests and welfare of his client without causing exploitation or harm. The counsellor denies the grounds of the complaint, and claims that the lift was offered due to bad weather conditions. The counsellor agrees that he talked about personal and family life. He stated that he recorded this matter. The panellists did not know why he chose to record it or whether he took it to counsellor supervision. He claims that no harm was caused and the matter did not affect subsequent counselling sessions.

Learning Points from Preparing the Case

- Panellists should not make judgements at the preparatory stage and should not use judgemental language
- Facts of the case need to be checked out and clarified in advance of the hearing e.g. was there deep snow on the day in question?
- Panellists should not make inferences
- Relevant information about counselling theory and practice should be available to panellists e.g. knowledge of the practice of self-disclosure for counsellors trained in different counselling orientations
- Panellists should stick to the words used by the parties in the case
- The Chair or a member of the Panel should prepare a draft summary of the parties' submissions in the correspondence with COSCA to be agreed by the Panel in advance of the hearing and read out by the Chair at the start of the hearing.
- Panellists should think of the areas from which they could obtain as much factual information by:

- checking the common ground in what has been stated by complainant and counsellor
- checking areas of disparity e.g. gaps between the correspondence submitted
- checking the training background/orientation of the counsellor

- clarifying the relationship of the client with the counsellor including anything that happened outside of the counselling context
- checking the subjective interpretation of the situation
- checking what was talked about in the car e.g. what personal matters were talked about
- checking what happened post the car journey e.g. was the counsellor prevented from talking about it?
- clarifying how counselling supervision related or did not relate to this matter

• The complaints procedure is silent on whether the Panel can use other parts of the Statement of Ethics and Code of Practice to apply sanctions.

3. The Hearing

Prior to the hearing a question from the floor was asked concerning whether a representative for either of the parties can appear at the hearing in the absence of either the client or the complainant. From the complaints procedure it is clear that the hearing can go ahead in the absence of either party, and there is nothing stated that his/her representative could not appear in their absence.

The Chair of the Panel introduced the case by delivering the Panel's prepared summary of the complaint from the correspondence. Then the complainant was invited to state her case followed by the counsellor. The Panellist then directed questions to both parties.

In the course of the hearing the counsellor asked whether new evidence could be submitted at the hearing. The Complaints Procedure permits the Chair of the Panel to use his/her discretion on whether new evidence can be submitted. The Chair decided to use his/her discretion. The new evidence was a letter from the counsellor's supervisor. It is important that new evidence is supplied to the other party and that sufficient time it given to consider it and respond to it.

Learning Points from the Hearing

• The role of the Chair of the Panel is to make sure that all parties have a fair amount of time allocated (it is good to let the parties know about time allocation in advance of the hearing) and to keep order. The Chair (and the Panel members) also needs to know thoroughly the contents of COSCA's Statement of Ethics and Code of Practice and the Complaints and Appeals Procedure.
• A timekeeper is needed and a decision about how to allocate time needs to be made in advance of the hearing.
• During the hearing the Panel needs to look at the ethical principles that counsellors need to abide by.
• The Panel needs to establish the key facts.
• Questions should take the following form: 'you (the client) say that the counsellor breached section 2a of the Statement of Ethics and Code of Practice. Can you say how this occurred? What harm did this cause you?'
• The Panel needs to ask open-ended questions and avoid giving suggestions of answers.
• This is a hearing on conduct and on external activity, not on internal activity. Panellists should avoid wanting to know more about the under-going issues.
• The Panel needs to have awareness that harm can be caused to clients without intent.
• Any new evidence submitted at the discretion of the Chair needs to be shared with everyone.
• Representatives of either party should be identified to each other in advance of the hearing.

4. Decision

The Panel then excused the parties in the case and began its deliberations.

The decision arrived at was that the Statement was not breached because of the lift in the car, even though the counsellor's orientation was integrative and best practice would have been not to have given the lift to a client.

However, the Statement was breached by the personal and inappropriate disclosure. Even though it was not intended and was an error of judgement, it happened and that is what matters here.

It was decided that the above breach amounted to serious misconduct.

5. Sanctions

The Panel decided to make the following sanctions:

1) the counsellor has to take time out from counselling and learn from this experience

2) the counsellor is to advised to; attend counselling sessions

3) the counsellor's Practitioner Membership of COSCA will be suspended for a minimum of three months

4) the counsellor is to appoint a new counselling supervisor and have the supervision sessions focus on management of boundaries and competence to practice

5) the new supervisor needs to submit a statement that the counsellor is fit to practice as a counsellor again prior to re-instatement of COSCA membership

6) additional counselling supervision hours must be arranged when the counsellor starts counselling again

Learning Points on Sanctions

- In the event of a complaint being upheld this means that the client has been harmed. The Panel should, therefore, consider a programme that would help the client.
- At a hearing, the counsellor's conduct needs to be taken into account in terms of consistency with previous statements, openness and transparency.
- Following the hearing, the Panel needs to alert the counsellor's supervisor to the decision of the Panel.

Brian Magee
Chief Executive
COSCA (Counselling and Psychotherapy in Scotland)
November 2007

New Members of COSCA

January and April 2008

FULL ORGANISATIONAL MEMBERS
BRIDGE PASTORAL FOUNDATION
COATBRIDGE COLLEGE
ENCOMPASS COUNSELLING AND SUPPORT
LIBER8 LANARKSHIRE LTD
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WEIR, ELAINE
WEIR, JOYCE
YOUNG, MARGARET

Gazette

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

2008

4 September
COSCA Course Validation Panel Meeting
All papers for consideration require to be in the COSCA office by
15 August 2008

30 September
Deadline for receipt of COSCA Accreditation applications

1 October
COSCA AGM 2008: **Stirling**

25 November
COSCA 5th Counselling Research Dialogue: **Stirling**

4 December
COSCA Course Validation Panel Meeting
All papers for consideration require to be in the COSCA office by
14 November 2008

2009

5th February 2009
Ethical Seminar on Exploitation: **Stirling**

Vision and Purpose

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

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