Counselling in Scotland

WINTER/SPRING 2009

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Editorial

John Dodds

COMMUNICATION. It's something we take for granted with friends and family and even, to some extent, our counselling clients. The idea that we can communicate on some level is not always something we give much thought to. Except when we run into a serious breakdown in communications, or when thoughts, feelings and emotions have been mis-communicated. Politicians know the consequences of poor communication all too well, and for counsellors it's an ongoing learning experience.

But what if we are working with people where the usual means of communications are not available? Living in Bulgaria, with only an incredibly limited knowledge of the language, has made me realise how creative I need to be (and how empathic with the Bulgarian people I meet) in order to communicate in even the simplest of ways.

So I draw your attention to two fascinating pieces in this issue: one on working with deaf and deafblind people, the other on working with people who are blind or partially-sighted. These are areas you may wish to explore more fully as a counsellor, and you will find routes to further information in both articles.

Over the past two years or so you will have been aware of developing changes in legislation which affect the counselling profession. I urge you, therefore, to take particular note of the pieces in this issue on data protection and protection of vulnerable adults. It will affect you as counsellors and you need to be fully up to speed on the implications and what actions you will need to take now and in the future to ensure your practice is compliant with current policy and the law.

On a lighter note we're publishing fiction for the first time. A children's story, if you will. Or maybe not. Read The Hare and the Tortoise and decide for yourself.

Another piece which is a bit different for the journal is one on Vedic healing therapies. The idea that body energies are responsible for negative emotions, rather than our thoughts, may be an alien concept in the West. But as an alternative to talk therapy – or even complimentary, in my view – this form of therapy provides much food for thought.

By the time you read this I expect your Christmas and Hogmanay celebrations will be over, so all that remains is for me to wish you the very best new year for 2009.

John Dodds

The Hare

and the Tortoise Based on a true story of self-discovery

Debbie Paterson
Skills Student, Moray College

Once upon a time there lived a hare named Hurry-up, who loved to run and do everything super quick! One sunny day, Hurry-up saw a flier for a race called Certificate in Counselling Skills.

'I can do that! I'll enter, finish it in no time and it'll make me better at my job. Easy peasy!'

So Hurry-up entered and received her race number and an outline of the directions for the route. Hurry-up saw that she had to go around 'LISTEN LOUDER LAKE', along 'CONGRUENT COVE', through 'EMPATHY EDGE' and up 'ACCEPTANCE ALLEY'.

'No bother to me! I know what to do. I can't wait to get started!'

The race start line was just outside Moray College. Hurry-up looked around to check out the competition and saw a tortoise. Not being terribly accepting, Hurry-up laughed and handed out her 'advice':

'I think you should have brought your rollerskates! Hee hee!'

The tortoise turned gently to Hurry-up and said 'You're very fast, Hurry-up.' Hurry up raised an eyebrow.

BANG! The race begins and Hurry-up sprints off to the first check point 'LISTEN LOUDER LAKE'. The race marshall stopped Hurry-up and said,

'To get through this check point, I invite you to listen to the boy at the lakeside.'

Hurry-up puts her paw up to her ear and shouts 'yep, he's crying. Okay where to next? Hah, no sign of that tortoise!'

Hurry-up quickly reaches 'CONGRUENT COVE'. The next race marshall announces,

'Look in the mirror and admit one thing to yourself'.

'Okay…I am a hare!' and with that Hurry-up zoomed off again. As she approached 'EMPATHY EDGE', she had a quick glance over her shoulder to check she was still in front. She was. The third race marshall said,

'To get through this check point, I invite you to talk to the lady who has just lost her husband.'

Hurry-up felt sorry for the lady and said, 'Oh, you must be feeling really sad and lonely.' But eager to get to the final check point Hurry-up bounded off.

At 'ACCEPTANCE ALLEY', the race marshall asked Hurry-up to 'look down the alley and describe what you see.' Hurry-up rolled her eyes and said, 'some little youth who should really have an ASBO!' and off she went.

There was still no sign of the tortoise or any other runners for that matter. 'I'm going to win! I'm going to win!'. But just where the finish line should be, Hurry-up came to a roundabout where there were no other exits than the one she had come from. She felt very confused. So Hurry-up kept going round in circles, getting very tired and even more confused, until she saw the tortoise plodding steadily towards her. Hurry-up looked a little sheepish and eventually asked the tortoise for help.

'Where do I go now? I've been to all the check points and this should be the finish!'

The tortoise looked up to Hurry-up with a gentle expression and said, 'You're very fast Hurry-up. I sense that this route hasn't helped you to change.'

'But I'm here to change other people, not me!' Hurry-up declared emphatically.

The tortoise maintained that gentle expression and said, 'First you must understand yourself before you

can understand others. Go back to the checkpoints and give each one time. Stand still. I'll wait for you here.'

So Hurry-up jogged slowly back to the first checkpoint and reflected on what the tortoise had said. At 'LISTEN LOUDER LAKE', Hurry-up's initial thought was 'He's still crying' but as she stood there she realised he was crying because he had dropped his fishing rod in the lake and therefore could no longer fish. Hurry-up walked over to the boy and gave him that same gentle look the tortoise had given her. The boy stopped crying and watched as Hurry-up reached into the lake and pulled out the rod. The boy felt relieved and Hurry-up began to feel something change inside her.

At 'CONGRUENT COVE', Hurry-up stood still and looked in the mirror and, as she did so, she began to see what thoughts she held. 'I must always rush because stopping to think about things can be painful sometimes.' Hurry-up sat down to think about this a little more.

When she was ready, she jogged to 'EMPATHY EDGE'. Hurry-up realised that she hadn't spent any time with the lady and had just sympathised with her. So she let the lady talk and discovered that the lady was actually feeling angry with her husband for leaving her, not sad or lonely.

Once Hurry-up reached 'ACCEPTANCE ALLEY', she was beginning to see things very differently. This time when she looked up the alley, she saw a young man who liked football and wore his baseball cap and Adidas tracksuit so he could feel accepted by his peers. 'I suppose we have more in common than I thought.' Hurry-up pondered.

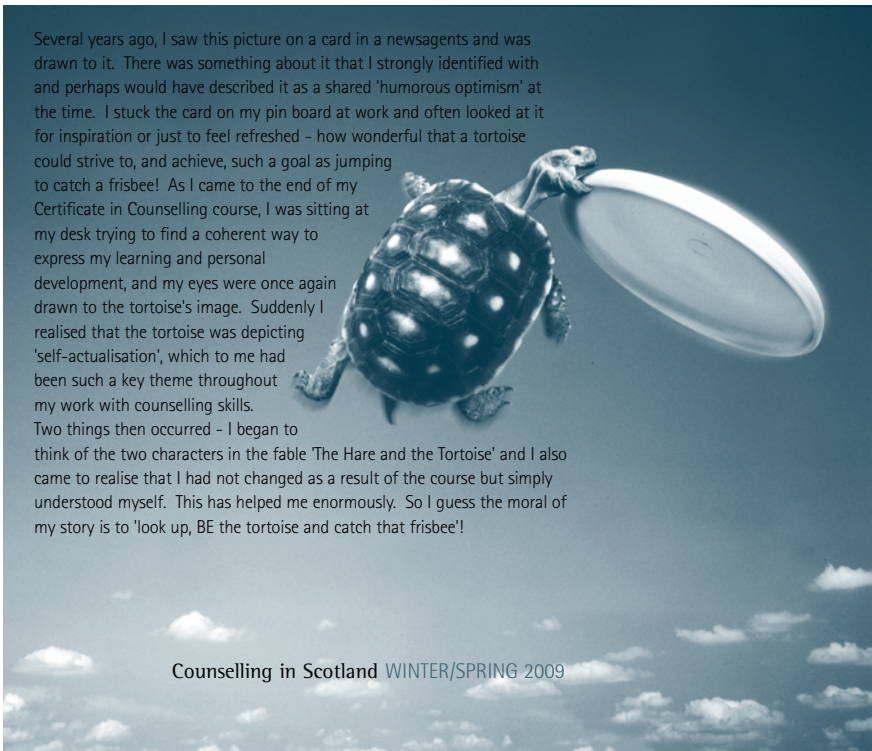
When Hurry-up gets back to the roundabout she notices there is a new exit with 'FINISH' above it. Hurry-up then saw with surprise that the tortoise was waiting just before the finish line. The tortoise saw the surprised look and said, 'Counselling is about trust and support'. Hurry-up smiled and looked back to the finish line, acknowledging the urge to race ahead and beat the tortoise, but let it pass. They crossed the line together.

The race marshall shook their paws and puts their medals round their necks. Suddenly, Hurry-up started to see everything around her so much more clearly and with a different kind of light. She turned to the tortoise:

'I have learned so much about myself today. I was always in a rush because I didn't want to have time to think about who I was or what I'd done but now it's not so scary. I feel ready to listen to others because I now know who I am!'

The tortoise smiled and said, 'Well, Hurry-up I think you have just started your journey towards self-actualisation…'

THE END?



Several years ago, I saw this picture on a card in a newsagents and was drawn to it. There was something about it that I strongly identified with and perhaps would have described it as a shared 'humorous optimism' at the time. I stuck the card on my pin board at work and often looked at it for inspiration or just to feel refreshed - how wonderful that a tortoise could strive to, and achieve, such a goal as jumping to catch a frisbee! As I came to the end of my Certificate in Counselling course, I was sitting at my desk trying to find a coherent way to express my learning and personal development, and my eyes were once again drawn to the tortoise's image. Suddenly I realised that the tortoise was depicting 'self-actualisation', which to me had been such a key theme throughout my work with counselling skills.
Two things then occurred - I began to think of the two characters in the fable 'The Hare and the Tortoise' and I also came to realise that I had not changed as a result of the course but simply understood myself. This has helped me enormously. So I guess the moral of my story is to 'look up, BE the tortoise and catch that frisbee'!

NHS
Living Life

Margaret Finnerty
Team Leader, NHS Living Life

A new cognitive behavioural telephone-based counselling service (based on materials developed by Dr Chris Williams of Glasgow University) was launched on August 25 2008 by NHS24. This article describes in part how it developed and its current status.

Scotland has long recognised the importance of depression as the most common mental health problem, and the burden this condition places on people and society. It is estimated that around 300,000 patients seek help from their GP for depressive symptoms each year in Scotland. It is also believed that only about half of those experiencing symptoms currently seek medical help.

The treatment and management of common mental health problems places a high burden on primary care. Treatment options are largely confined to medication (which may not be effective as a first line treatment for mild to moderate depression) and psychotherapeutic and psychosocial treatments (where demand currently outstrips supply). For those with more moderate to severe depression, psychological therapies, either on their own or combined with anti-depressants, have been shown to be superior to the usual placebo or treatment and to provide more long term benefits and reduce the occurrence of relapse.

A growing body of evidence demonstrates the benefits of time-limited psychological interventions and guided self-help approaches to manage common mental health problems (where depression and depression related disorders, such as anxiety, constitute the majority of problems). However, the lack of trained therapists and the resultant lengthy waiting lists means that access to such effective therapies is limited.

In response to the problem, new ways of delivering self-help cognitive behavioural therapy (CBT) are being tested. *Beating the Blues, Mood Gym* and *Living Life to the Full* are among the best and most effective computer and internet programs to help people manage depression.

Telephone CBT is another way that time-limited, cost effective CBT can be offered to larger numbers of patients as an alternative to traditional face-to-face therapy. A recent systematic review of telephone-based help for mental disorders (which included six papers specifically on telephone interventions for depression) indicated that studies showed that such interventions could be effective[1]. However, this conclusion was qualified by the assessment that many of the studies were of too poor quality to draw any firm conclusions and that further trials were necessary.

Following its success in delivering a national phoneline for people with low mood or depression – *Breathing Space* – NHS24 plans to implement a telephone-based CBT and guided self help service for people of 16 years of age and over. The new service aims to increase access to psychological therapies for people with mild to moderate depression. If the approach employed by the current project is successful NHS24 expects that NHS boards will commission them to provide the service beyond the two year funding period.

Aims of the new NHS24 Living Life service:

1. Increase access to CBT for those who are experiencing mild to moderate depression.

2. Provide GPs with more alternatives to medication or face-to-face therapy.

3. Work closely with partner agencies to help meet target figures and provide access to telephone CBT and guided CBT self-help through local services.

4. Provide a cost effective CBT service which would be free to users and easy to access.

5. Empower individuals in a variety of ways, helping them to use the service and coaching and mentoring them to treat their own depression.

6. Provide guided self-help material and assistance to access CBT.

7. Give advice, support and information as appropriate.

8. Provide cost effective alternatives to traditional means of treating mild to moderate depression.

9. Establish the project initially in specified health board areas, with the intention thereafter of providing a national service.

10. Undertake research to evaluate the service.

The service is available Monday to Friday, between 1pm and 9pm. To access the service patients must first be referred by their GP and then make contact for an appointment.

The five Health Boards taking part in the pilot exercise are: the Western Isles, Shetland Isles, Greater Glasgow & Clyde, Lothian and the Borders. In the Greater Glasgow & Clyde, Lothian and Borders areas, a small number of GP practices have been included in the pilot. All GP practices in the Western Isles and Shetland Isles are taking part.

As was to be expected of a new service, it was slow to start. However, meetings with the GPs to talk through the aims of the project and the patient referral process was, hugely beneficial in promoting the service. The majority of the GP practices are now involved, and volume of patient referrals has increased significantly since the project began.

To date, around half of the patients referred by their GPs have chosen to access the service, with half of them being allocated guided self-help and the remainder offered CBT.

The service aims to work closely with the GPs to monitor the progress of the patients.

NHS Living Life can offer treatment or self-help coaching for 3,000 people, and telephone CBT – with up to nine sessions a person – for 500 people each year. It can also offer up to four coaching sessions for 2,500 clients using self-help programs.

Throughout the pilot The Scottish School of Primary Care Consortium, made up of representatives from the Universities of Stirling, Glasgow, Edinburgh, Dundee and St. Andrews, will conduct an evaluation. This will research the effects of the service in its first two years of operation and provide robust evidence to support its continued existence.

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1. Leach LS, Christiansen H: **A systematic review of telephone-based interventions for mental disorders** *J Telemed Telecare* 2006,12:122-9

Protection of Vulnerable Groups (Scotland) Act

What impact for counsellors and psychotherapists?

The following article has been produced by the Protection of Vulnerable Groups (PVG) Act implementation team to help staff, members, and affiliates of COSCA better understand the impact the PVG Act will have on their activities.

The Scottish Government recently published its latest policy on a Scottish vetting and barring scheme established by the PVG (Scotland) Act 2007: www.scotland.gov.uk/Topics/People/Young-People/children-families/pvglegislation/consultation. The details of the draft secondary legislation will be consulted upon in the spring of 2009, and introduced for Scottish Parliamentary approval later in the year. If approved, the PVG Act is scheduled to commence early in 2010.

The PVG scheme will:

- ensure that those who have regular contact with vulnerable groups through the workplace do not have a history of harmful behaviour; and

- deliver a fair and consistent system that will be quick and easy for people to use and end the need for multiple, written disclosure applications.

The PVG Act will establish a membership scheme, operated by Disclosure Scotland on behalf of the Scottish Ministers, and the policy intention is for counsellors and psychotherapists to be members of this scheme in order to do regulated work with vulnerable groups (children and/or protected adults). Depending on the regulated work to be undertaken, an individual may be a scheme member in relation to working with children, with protected adults, or both. It is important for the scheme to know this, and the application form will ask for this to be made known. In joining the scheme, each member will have a scheme record.
Disclosure Scotland will also maintain two lists of barred individuals – those barred from working with children, or barred from working with protected adults. A key concept is 'unsuitability' – an individual will not be accepted into scheme membership if Disclosure Scotland considers that person's past behaviour makes them unsuitable to do regulated work. Consequently, denial of an application for scheme membership will be because an individual's past behaviour merits being barred from regulated work, leading to being placed on one or both of the barred lists. The only way to find out if someone is barred from such work is to do a scheme record check.

As you'd expect, where compliance is a feature of legislation there are also penalties attached to non-compliance. These obligations principally fall on employing organisations, supply agencies, and those doing or seeking to do regulated work in Scotland. An employing organisation commits an offence if they offer regulated work to an individual barred from that work. A supply agency commits an offence if it offers or supplies an individual who is barred from regulated work to an organisation to do regulated work, and it will be an offence for an individual to do, or seek or agree to do, any regulated work from which the individual is barred. 'Regulated work' and 'work' are terms prescribed within the PVG Act, so it's important these are understood. For the avoidance of doubt, 'work' includes paid or unpaid work, and work done under a contract, but excludes this if done in the course of a personal relationship for no commercial consideration.

The process involved in becoming a scheme member replaces, and expands upon, the existing enhanced disclosure process that many who work with vulnerable groups are familiar with. Like the existing disclosure process, the way it will operate is linked to safe recruitment practice, and is aimed at ensuring those who have a history of behaviour that indicates they are unsuitable to work with children or protected adults are prevented from doing so, and that those who become unsuitable are quickly removed from such work. For the first time however

it will also permit the self-employed and personal employers to directly engage with the scheme to support safe recruitment, allowing the self-employed to demonstrate to service users that they are not considered unsuitable for such work, and for personal employers to check the person they wish to employ is a scheme member.

So what will this mean for counsellors and psychotherapists? There are two relevant issues. First, there is little doubt that the nature of their role means they will be doing regulated work activities with children and/or protected adults such as 'unsupervised contact with children' and 'providing assistance, advice or guidance to protected adults'. Schedules 2 and 3 of the PVG Act set these out more fully and, importantly, also include where such work is undertaken in certain establishments. For example, schools and residential establishments. Second, it is necessary to know on whose behalf regulated work is to be done as this dictates how an individual becomes a scheme member. In effect, whether this is regulated work done for an employing or contracting organisation, or done on a self-employed basis.

Where there's an employer or contracting organisation, their recruitment procedures will have determined which posts meet the regulated work criteria. These procedures will either require a scheme record disclosure application to be made as part of their recruitment practice or, where the worker is already a scheme member, a short scheme disclosure check to ascertain whether new information has been added to the scheme member's record since the last full scheme record disclosure. This is because employers or contractors will want to avoid committing the offence of recruiting an individual who has been barred from regulated work. Determining whether regulated work with children is to be done will be relatively straightforward given that it is primarily determined by age of the recipient, or by the establishment in where this work is to be done.

But how will counsellors and psychotherapists know if they're doing regulated work with protected adults? Section 94 of the PVG Act specifies a protected adult as someone over aged 16 who receives one or more of four categories of services. There are regulated care services (including private and independent health services) as defined within the Regulation of Care (Scotland) Act 2001, NHS, community care, and welfare services. The Scottish Government intends to further clarify in secondary legislation what are NHS and welfare services. In the latter category, the welfare services criteria is to be broadly defined to capture the type of non-statutory services and support that voluntary and charitable organisations tend to specialise in providing to meet adults' personal needs.

So those organisations providing, or contracting to provide, any of the section 94 services will know that adults receiving such services will be accorded 'protected' status under the PVG Act. This means they then need to identify which of their workers will be doing regulated work with protected adults. The Scottish Government believes that this approach ensures the most effective means for employing organisations to comply with the PVG Act, bringing the vast majority of 'employed' counsellors and psychotherapists into the scheme, and delivering protection for those vulnerable groups who receive their services.

The Scottish Government recognises however that some counsellors and psychotherapists may not have an employing or contracting organisation requiring them to join the scheme. For these individuals only ever doing 'self-employed' regulated work with either children or protected adults, they will be able to apply for scheme membership unilaterally. In this way they avoid committing an offence by doing or seeking to do such work. It also provides them with some flexibility should they wish to take up regulated work for a provider organisation on a short-term/seasonal basis. Moreover, it will also give reassurance to their clients that they have joined a scheme intended to afford improved protection for vulnerable groups.

It is accepted that for this category of employment the process is self-regulatory, but is nonetheless an important quality assurance tool that such individuals will be interested in utilising. This is also an area that the Scottish Government expects will complement the fitness to practice standards required by statutory professional regulatory bodies.

What else should counsellors and psychotherapists know? There's an equivalent piece of legislation that will apply for England, Wales and Northern Ireland (using similar terminology like 'regulated activity') called the Safeguarding Vulnerable Groups Act 2006. This will be operated by the Independent Safeguarding Authority, and is scheduled to commence in October 2009. The intention is for both Acts to deliver a consistent and UK-wide approach to vetting and barring. This means that someone who is barred from working in the relevant workforce in Scotland would also be barred from doing regulated activity throughout the rest of the UK and vice versa. It will also ensure effective information-sharing regarding individuals who seek to do such work around the UK.

The PVG scheme is designed to support safe recruitment processes. It is one part of the Scottish Government's wider strategic aims to improve protection, encourage better practice, and drive up the quality of services and professional standards. The PVG scheme will replace the Protection of Children (Scotland) Act 2003, and will work in tandem with the Adult Support and Protection (Scotland) Act 2007. The PVG Act has powers to require information from various bodies, and must provide information to others, including regulatory bodies and employers, on its decision-making. For example, when Disclosure Scotland places someone on one or both lists, or informs those with an interest that someone is under consideration for listing, or when they don't list after a referral. This will improve information-sharing with employers, courts, local authorities, health boards, police forces, and regulatory bodies. It will also encourage and promote individual and corporate ownership for protective practices, and will complement expansion of workforce regulation in Scotland.

The PVG scheme's success will ultimately depend on awareness of the legislation, and the robust application of safe recruitment practices. In this sense, there is an advantage that it builds on the existing disclosure and disqualification processes which many employers and regulatory bodies presently use. While good practice guidance for safe recruitment already exists, the Scottish Government is committed to developing user-friendly guidance on the PVG scheme for users. A Guidance Advisory Group has been established to support this process, comprising a broad range of stakeholder interests, and it is making good progress. The Scottish Government expects to consult on the format and structure of guidance in 2009, and intends this will be finalised in good time for users to prepare for the Act's commencement. This will, in turn, be supported by a range of awareness-raising activities and training materials. Further information on the PVG scheme (including FAQs) can be found at: www.scotland.gov.uk/pvglegislation.

Different Horizons: Experiences of sight loss

Counselling people who are blind or partially sighted

Susan Dale MBACP. Accred. MSc Counselling

Susan Dale, MBACP. Accred. MSc Counselling 2005-2008 Senior counsellor and co-ordinator of the RNIB Bristol Counselling Project, currently in private practice, and undertaking doctoral research with the University of Bristol

"I live a lie"
"I'm ok"
I tell my friend
"I'm coping well"
I've got a stick
and this guy who comes and tells me I'm doing ok, and I am.
I get out, walk the walk, talk the talk

Stumble my way through pavements strewn with bins, people, cars.
So cheerful – "well done" they cry.

The lie kind of protects me,
like the stick I suppose;
moves people away from me.
Being vulnerable is something
I've always dreaded.

Reality though is that it's shit.
I'm not ok.
I hate it." (Andy) (Dale 2008:a)

Every day 100 people begin to lose their sight in the UK, some of whom go on to seek counselling, many of whom have asked for 'a counsellor who understands sight loss' yet, there is surprisingly little literature available for counsellors on this issue.

To begin to address this, Royal National Institute of Blind People (RNIB) successfully applied to the Department of Health to fund the development and publication of guidance within a wider specialist counselling project in Bristol for people affected by sight loss.

The guidance, called *Different Horizons: Experiences of sight loss: counselling people who are blind or partially sighted*, was written by Susan Dale, who worked as the senior counsellor and coordinator during the project, has now been published and is written for counsellors working in a variety of settings, not only specialist services, with the aim of encouraging further dialogue, debate and sharing of learning.

In setting about the task of developing this publication the big questions have been:

- What exactly is it about sight loss that people want their counsellor to understand?
- What would help our clients feel 'understood' at a time when their life is changing so irrevocably?
- How can learning from the counselling project be shared without pigeonholing or defining our clients by their vision alone?

Sight loss, visual impairment, blindness and partial sight are all labels used as a description of vision, which is considered less than 'normal' and is not correctable by treatment or glasses. However, every person's perception of what these labels mean is unique and depends upon their life experiences and how they perceive sight loss. This could be in terms of medical understanding, which see blindness as a physical impairment and places emphasis on diagnosis and treatment, or it could be that they consider their different vision as being 'normal' but feel disabled by society's attitudes and inaccessible facilities and information.

Some have said:

"Blindness is the defining factor in my life; I am never just me but 'that blind man'."

"A gift, part of who I am."

"I am part of a blind community and that is a cultural thing."

Others have said:

"Isolation, that is my experience of sight loss."

"I can't see the point in going on if I cannot see."

"It's the worst, most traumatic thing which has ever happened to me."

Some have likened it to bereavement, with feelings of grief, anger, and denial, others have described it as the beginning of a new life:

"When I knew that they could do nothing for me I cried and cried and raged, and then I thought this is a new beginning. I can choose who I am from now on."

Society also has varying perceptions of what visual impairment or blindness might mean. These perceptions are often negative. Rebecca Atkinson, writing about her own sight loss says, "misconceptions start to spout from even your oldest friends' mouths because negative attitudes about blindness permeate us all. You are about to cross over into the dark side and see what wriggles and writhes on the underbelly of society. Folk will see you as the sufferer, the pitiful, the afflicted, the subhuman." (Atkinson 2007).

In light of the myriad of responses and attitudes, it is difficult to respond to the seemingly simple request for "a counsellor who understands sight loss" and to produce guidance which may help counsellors in their understanding. In describing the content of this publication it is probably easier to describe first what it is not:

- It is not intended to represent a specific model of counselling to work with clients who are blind or partially sighted;
- It is not intended to provide diagnosis or prognosis of how a blind person will think or feel;
- It does not intend to imply that all clients who come to counselling who are blind or partially sighted wish or need to talk about 'sight' issues.

It does, however, intend to raise counsellors' awareness of their own pre-judgments and feelings towards disability (particularly sight loss), and to share experiences both from the perspective of counsellors, and from blind and partially sighted clients who have accessed counselling at the Bristol project.

The publication is presented in two distinct sections.

Part one explores sight loss from societal, counsellor and client perspectives, including a narrative discourse based on both qualitative and quantitative data collected over the last three years from the counselling project. It is hoped this will help counsellors to consider the possible emotional responses to sight loss and to provoke thought about a possibly unfamiliar client group.

For example, the project data shows that clients are predominately white, single, and either retired or unemployed. Currently, nearly 50 per cent of all clients are over 60. While this is perhaps unsurprising given that an estimated 95 per cent of people with sight problems in the UK are over 65, this is unusual in counselling terms where in most mainstream services the majority of counselling clients are under 65 (CORE-IMS 2008).

Counselling themes

The emotional impact of sight loss has traditionally been understood as a process of loss – closely akin to grief and bereavement. This sees people as needing to grieve for what has been lost, and going through stages of denial, feeling emotionally numb, yearning

for what has been lost, strong feelings of anger and agitation, and bouts of sadness and depression, before arriving at a place of acceptance and new life. Although clients seen at the counselling project often express many of these emotions, these descriptions are too simplistic to describe what happens when they move from being part of a sighted world to becoming part of a blind or partially sighted one.

There are also questions about identity, feelings of isolation, changes in relationship dynamics, employment issues, high levels of depression, which tie in with research (Burmedi, Becker et al. 2002) that shows higher rates of depression, and incidence of suicidal thoughts and feelings, in people who are blind and partially sighted, than in the peer population. There are also many issues around travel and mobility, for example many have to give up driving, and learn new ways of getting round even well known locations.

Societal perspectives

The experience of being blind or partially sighted is not just about difference in a physical sense, but includes society's reaction to that difference. The most common way of thinking about blindness uses a medical model of understanding, which sees it as a disability, an illness, and works towards finding a 'cure' or medical intervention, which will restore vision. This may be how some clients view their situation, while others may consider their differing vision as just part of who they are as people, and viewing their difference as a deficit may leave them feeling unaccepted or unacceptable.

Our views are also increasingly influenced by social models of disability which have encouraged society towards viewing disability as a social phenomenon where people are disabled by the ways in which society exclude them. Hence the political drive towards producing accessible public transport systems and, in the case of organisations such as RNIB, campaigning for accessible communications and support systems for those with low vision.

This in itself seems very positive, but many partially sighted and blind people also consider that it pays lip service to their needs, and 'denies my feelings' (Tony).

Also included in part one are personal narratives from people living with sight loss, not so that they will give an 'absolute truth' about sight loss (or counselling) but so that they can provoke questions, and give a glimpse of the real, lived experience of people affected by issues that counsellors may not be familiar with.

People have often experienced counselling as positive. Andy (whose comments are included earlier) said:

"What a rollercoaster ride! You asked where I am, well I think that I am well out of the mouse hole and halfway back up from the death defying downhill!"

Defining myself by different stories,
as a feeler,
was the turning point,
and I have not looked back.
It doesn't make using the white stick
sorry, cane!
any easier,
I still whack it on the ground in frustration
sometimes,
but I allow myself to do this now
thinking,
It is ok.
I am ok.
I still exist as Andy
(Dale 2008:b)

Part two of the publication offers more practical information and guidance on making counselling accessible to clients who otherwise may never appear in the counselling room; how reduced vision could impact on the therapeutic relationship; a resource section; background and statistical information; and suggestions for further reading and research.

In the UK there are an estimated two million people with significant sight loss, of whom 364,000 are registered as severely sight impaired (blind) or sight impaired (partially sighted). There are an estimated 25,000 children in the UK with sight problems, and about 12,000 of these children also have other disabilities.

If someone tells you that they are registered as 'blind' you may assume that they have no sight at all, but it is estimated that 49 per cent of blind people and 80 per cent of partially-sighted people can recognise a friend at arm's length, so blindness does not necessarily men 'living in total darkness'.

There are many simple, inexpensive ways in which counsellors can make their practice more accessible in practical ways, for example, by producing information or materials for clients in non standard formats.

It is often assumed that people who are blind and partially sighted will use Braille, but this is not the case. Many people can read print if it is in large bold print, or can use accessible computer technology such as screen magnification software that enlarges the text, or screen readers that read aloud text from the computer, so electronic documents are sometimes preferred. Audio documents are also another option, that can be produced simply on a cassette or CD or can be professionally transcribed.

Within the publication and within the RNIB web site www.rnib.org.uk/counselling there are also suggestions about making the counselling room accessible, adapting counselling delivery, guiding and assistance and how sight loss may impact on the therapeutic relationship. For example we are trained to consider non-verbal communication as being very important within the therapeutic relationship, but however much empathy a counsellor be displaying, a client who is blind or partially sighted may not be able to pick up on routine visual clues such as nodding, facial expression, or maintaining eye contact.

Different Horizons: Experiences of sight loss: Counselling people who are blind or partially sighted is available as a download from www.rnib.org.uk/counselling or from www.bacp.org.uk/publications.

Free copies can also be ordered directly from RNIB 0845 702 3153 using the product codes:

Braille Version	PR12210B
Audio CD	PR12210CD
Print Version	PR12210P

To feedback on the publication or for further information about RNIB counselling and emotional support services please contact:

Mary Norowzian
RNIB Emotional Support Services
Email: ess@rnib.org.uk

References

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Scottish Council on Deafness

Counselling Awareness Project

Barbara Wylie
Project Coordinator, Counselling Awareness Project

In the following article I will describe the Scottish Council on Deafness (SCoD) Counselling Awareness Project. SCoD was awarded funding from The Big Lottery Fund for the two year project which will run from 2008–2010.

SCoD is the lead organisation for deaf issues in Scotland. Its membership is made up of 90 organisations from all over Scotland, who work with or on behalf of deaf sign language users, deafened, hard of hearing and deafblind people. These include representatives from the Voluntary Sector, Social Work and Education Departments, NHS Trusts, Health Boards and the Government. We work together to improve the lives of all deaf and deafblind people in Scotland.

The funding from the Big Lottery Fund has allowed SCoD to employ one full time project coordinator and I was appointed to this post in September 2008. I have experience of working in both the deaf and deafblind world in a variety of roles. Invitations have been sent to those working with deaf sign language users, deafened, hard of hearing and deafblind people, as well as those involved in counselling, to join the project advisory committee which will oversee the project and advise the project coordinator. The project committee will meet every three months.

The overall aim of the Counselling Awareness Project is to 'Improve the mental health and wellbeing of deaf* and deafblind people in Scotland'. The project came about as a result of SCoD's previous counselling training project which ran from 2004–2007. That project, which provided counselling skills courses for deaf people as well as providing deaf and deafblind awareness training for mainstream counsellors, found that there was a lack of understanding among health professionals of the counselling needs of deaf and deafblind people as well as reluctance among deaf and deafblind communities to access counselling due to a lack of understanding of the counselling process.

The project aims are:

- Increase the knowledge and confidence of the counselling process among 160 deaf and deafblind people to improve their mental health and wellbeing.
- Increase the confidence among 10 deaf and deafblind people about training to become a counsellor.
- 10 counselling services will be more accessible to deaf and deafblind communities, enabling deaf and deafblind people instant access and the ability to enjoy the full benefits of counselling.

The project coordinator will be organising workshops in various locations throughout Scotland that will be fully accessible to deaf and deafblind people. The purpose of these workshops will be to fully inform deaf and deafblind people about the counselling process. The presentation will cover each step of the process of accessing counselling, starting with a description of what counselling is, moving onto why someone would want or need counselling, how to access counselling and what to expect during a counselling session.

The hope is that deaf and deafblind people will become more confident about accessing counselling services. During the workshop they will be provided with an information pack which will contain a leaflet that contains the names of accessible counsellors. The purpose of this leaflet is that it can be taken along to an appointment a GP and they can use it as a reference should they need to refer the person for counselling. Also contained in the pack will be a guide to mainstream services within their local area and a DVD that gives more information about counselling in British Sign Language.

There are only seven counsellors in the whole of Scotland who are either Deaf British Sign Language users or are hearing and qualified to Level 2 British

Sign Language, and who have deaf awareness training. The previous counselling training project provided counselling skills courses specifically for deaf and deafblind people but as yet none of that group are fully qualified. The second part of the project will be two workshops to give interested deaf and deafblind people information on training to become a fully qualified counsellor. Information will be provided on the training pathways as well institutions that run training courses and possible funding sources. The hope is that this will boost the numbers of deaf and deafblind counsellors to allow deaf and deafblind communities direct access to services on a one-to-one basis without having to rely on communication support.

Representatives from the counselling world who have experience of counselling deaf and deafblind people, as well as those from a counselling training background, will be invited to participate in the workshops to give the attendees the full information they require.

Over 60 counsellors attended the counselling training project's *Communication Tactics* course. These organisations will be contacted again to see what changes have been made to their services since the training and how accessible they are currently. Other agencies, as well as GPs will also be contacted to assess their accessibility. All will be offered advice and information as well as the chance to attend awareness raising workshops, run in conjunction other organisations who work on behalf of deaf, deafened, hard of hearing and deafblind people. These awareness training sessions will be, after discussions with GPs, counsellors and other health professionals, specifically tailored to their needs as they see them. It is the aim that through this more and more services across Scotland will become accessible for deaf and deafblind people.

If you would be interested in more information about the project please contact:

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*Please note the word deaf used in this article refers to Deaf Sign Language users, hard of hearing and deafened people.

COSCA Children and Young People's Working Group

A job well done

Hans Clausen
Chair, Children and Young People's Working Group

As we say goodbye to 2008 it is also time to say farewell and thanks to the long-standing and hard working COSCA Children and Young People's Working Group. The group has operated for seven years, providing consultation, education and advice and producing valuable papers and publications. Over the past six months it has reviewed the function and focus of its work and has concluded that it is time for the group in its present form to disband.

The group was established in 2001 and brought together experts working in counselling for children and young people. At the time counselling for this client group was still relatively rare in Scotland. However, the importance of this essential and exciting area of work was recognised and valued as services were developing and expanding in the voluntary sector as well as in education, health and social work.

The working was established with the aims of : "Promoting high quality psychotherapeutic support and counselling services for children and young people, and to offer expertise as a consultative group to government and organisations on matters related to the mental health and well being of young people".

During its existence the group addressed these aims through regular meetings and focussed pieces of work with notable achievements:

- Creating a database of all known existing counselling services for children and young people in Scotland and making it available to the public.
- Collating a directory of training opportunities for counselling young people in Scotland and posting it on COSCA's website.
- Consultative paper for the Scottish Executive on provision of therapeutic support to child witnesses
- Consultative paper for the Scottish Executive's action framework for children and young people's health in Scotland (Delivering a Healthy Future).
- National conference on counselling children and young people in partnership with APSA.
- Publication: Establishing Counselling Services for Children and Young People; COSCA Guidance on good practice and the law in Scotland.
- Competencies document for standards in training and practicing as a counsellor with children and young people published on COSCA's website.
- Dissemination of information through the COSCA website.

The de-commissioning of the group does not in any way reflect a reduction in the importance which COSCA gives this work. On the contrary, the evolution from a working group to a policy group recognises a need for a new direction and revitalised approach to maintain a proactive engagement with the changing political and cultural climate, and the effects of these on both the client group and the profession. The challenges to delivering accessible, effective and equitable therapeutic services to children and young people are as significant now as they were seven years ago, and COSCA's commitment to promoting this cause remains a priority.

A newly convened Children and Young Persons Standing Policy Group will be convened in 2009 and commissioned by COSCA to carry out specific pieces of work to ensure the continued promotion of the aims and principles that the working group established.

A very big 'thank you' to everyone who has participated over the life of the working group, and to the COSCA staff for their invaluable support and dedication throughout. This is not so much an end as a new beginning.

Data Protection Act 1998

Access to counselling and psychotherapy records by clients
Who has access to client records?

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

The Data Protection Act 1998 allows an individual (or 'data subject') to gain access to his or her personal files. The Act gives individuals the right to know what information is held about them, but the individual making the request for information needs to be verified by the person holding the information (or 'data controller') before the information is disclosed. The Act also provides a framework to ensure that personal information is handled properly.

What information can be accessed by clients?

Information in electronic, word-processed, manual (hand-written), audio and video files can be accessed. Counsellors and psychotherapists do not have any privileged legal status that would necessarily limit or prevent client access to the above material. It is, therefore, very unlikely that counsellors and psychotherapists would be exempt under the Data Protection Act.

What client records of counsellors and psychotherapists can be accessed?

Under the Act, subjective and objective recorded material, including records not designed for sharing with the client, need to be disclosed. The Act does not allow for the distinction used by many counsellors and psychotherapists between notes or records kept for employing agencies (factual or agency records) and those that focus on the therapeutic relationship (process notes). These process notes provide a subjective account of the process and experience and are often used for the purpose of personal and professional development, training and supervision. Under the Act, it is not the intended purpose of the notes or records that matters. In respect of client access to records, what matters is the status and structure of the therapeutic record i.e. whether it is an electronic, structured or unstructured manual file. It should be assumed here that most files that counsellors and psychotherapists keep on clients are structured and, therefore, accessible under the Act.

Do clients have access to notes made by counsellors in medical records?

Some counsellors and psychotherapists may contribute to the medical records of their clients or make records within health settings. Even though counsellors and psychotherapists are not listed as such among the health professionals covered by the Access to Health Records Act 1990, it is better to work on the basis that if counsellors and psychotherapists do make the above contributions, then their clients have a right to access this information. There are a number of exceptions to access being given under this health Act, and these should be taken into account before giving access.

How can clients access their records?

It is worth bearing in mind the different ways in which clients who are legally due access to their records can access this information. Following a request in writing for access, direct inspection of the files is one way of accessing files. However, by law, eligible clients can request copies of the records held by counsellors and psychotherapists, providing they offer to pay a fee (maximum £10). In both of the above ways of accessing files, information from which another person could be identified should not be disclosed to the client making the request for information, unless that person gives consent for this to happen, although there are also exceptions to this right.

Can clients request changes to their records?

Clients have the right to request that information in their view that is 'incorrect, misleading or incomplete' be amended in the record. In the event that the holder of the record does not accept that there this is warranted, a note of the dispute should be entered in the record of the client concerned.

What are the legal responsibilities of holders of electronic data?
In addition, individuals and agencies involved in processing electronic data on living, identifiable individuals must notify the Data Protection Registrar and comply with specific data protection principles, including normally gaining the consent of clients for the processing of information on clients. Explicit consent is required in the case of 'sensitive personal data' e.g. relating to emotional or physical health, and sexual life.

The information that is kept must be:

- fairly and lawfully processed;
- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with your rights;
- secure; and
- not transferred to other countries without adequate protection.

What is the prescribed time period for access to client records?
The timing of access to client records by clients may be an issue for some counsellors and psychotherapists. In the interests of the counselling process, it may be deemed not helpful for clients to see the notes until the counselling sessions have been completed. For example, it may be in the interest of the client to not see notes until any existing projection or transference has been worked through. In these circumstances, reference to the Data Protection Act should still be made to ensure that the client's right to access is given within the prescribe time period. This prescribed time period is 40 calendar days.

What is the purpose of keeping client records?
Counsellors and psychotherapists should take into account the rights of clients to access their personal records under the data protection legislation when keeping records on counselling sessions. However, this should be done in a way that holds onto the purpose of keeping records or notes in the first place, namely to enhance the outcomes of the therapeutic work that counsellors and psychotherapists engage in with clients. Keeping adequate records can also help counsellors and psychotherapists to deal with allegations made by clients bringing complaints against them.

If you want to know more on the Data Protection Act 1998, please visit the Information Commissioner's Office website at www.ico.gov.uk or contact its Scottish office on 0131 225 6341 or 08456 30 60 60.

References

Data Protection Act 1998
Access to Health Records Act 1990

Supporting
Vedic healing touch

David B. Lingiah

Touch in any form has been shown to boost the immune system. When it is done in a loving environment with experienced healing hands it can be very powerful. It has a healing potential. The power of touch is miraculous in its simplicity. It is a necessary gift of nature, without which a human being cannot thrive.

In the New Testament (Mark Ch5:25-34) we read of a woman with a blood problem for twelve years and had seen many doctors to no avail. She knew the power of touch and the transfer of energy for healing. The great healer, Jesus, was in town and the sick lady decided to make her way with the intention of touching or being touched by Him with the intense expectation of being healed. In her mind she had formulated her set up statement thus: "If only I could be touched by Him, I will be healed." At once Jesus realised that power had gone out from Him. Immediately her bleeding stopped and she was freed from her suffering.

In the ancient scriptures the Vedas, touch has been used in ceremonial rituals with healing properties. Healing by touch and the repetition of the mantras (the problem statements) have been used by the ancient seers and healers. Among the Hindus the swamis are also healers using touch to provide relief, physical and psychological to their followers.

The word Veda comes from the Sanskrit root word 'vid' which means 'to know'. Veda means 'pure knowledge'. This knowledge is given at the time of creation for the entire humanity. Hence it is universal. It is the most precious intellectual wealth of everyone, irrespective of caste, creed, religion, sect, colour, creed or country. Havan is known in Sanskrit as Agnihotra. In English agni means fire and hotra means healing, so Agnihotra means healing fire. At the yaj or havan — or fire ceremony — the Hindu priest (therapist) is actually using a form of healing/cleansing/clearing the meridian (acupuncture) energy points.

The therapist or priest conducting the ceremony sits round a fire vessel with participants near and thinking about their individual problems and repeating certain mantras at the instruction of the priest/therapist. Then he asks them, using the index and the middle finger together, to dip these fingers in some water in the cupped hand of the other hand and touch the various energy points from eyebrows, near the eye, under nose, below the lip on the chin, the collarbone, the knees etc about three times. In those ancient times possibly the participants did not realise they were carrying some form of treatment for healing but the therapist would know as they were aware of the secret knowledge. Even today, among the Hindus very few would realize that they are participating in a healing ceremony; to many this is simply a religious ritual. It would be in the interest of all concerned if they were made aware of this healing approach.

This form of touching or tapping rituals is now called EFT (emotional freedom techniques) founded by Gary Craig. This has been further studied and researched by clinical psychologist, Dr Roger Callahan. Today this approach is being used by many health professionals including psychotherapists.

How does EFT work?

EFT is based on the statement that: "The cause of all negative emotions is a disruption in the body's energy system". This is quite a change from the idea that our thoughts cause our emotions. Yes, if you think about something upsetting you will feel upset but that is not a permanent disruption in your system. Instead, intense emotional experiences cause a disruption in energy system that is stored there and we experience as a recurring pattern or emotional state for years on until it is cleared. In EFT, clearing these disruptions is done by gentle tapping with the finger tips on easily accessible points on the face and upper body. While focusing on an emotion such as stress, fear, or

anxiety, you tap on the acupressure points while repeating a phrase to keep you focused on one issue, enabling a fresh perspective and forward movement.

Emotional freedom techniques

Gary Craig said: "We have long known that the mind and body are one. Emotional freedom techniques or EFT effectively forms the bridge between talk therapies and body therapies, from the premise that negative emotions are the conscious experience of a disturbance of body mind energy."

EFT is a simple and powerful therapeutic tool that uses words to tune into an emotional disturbance which is then balanced and cleared using acupressure tapping. EFT is a permissive technique that can be used with a therapist or coach or by you to empower self-help. Derived from Thought Field Therapy, EFT uses a unified approach that does not require diagnosis. This simple tool for emotional healing was developed in the early nineties by Gary Craig, a personal performance coach with a fascination for the human potential, a clear spiritual calling, a background in business and a university education in engineering. I can not tell you how EFT works because I do not know. Modern science has not yet caught up with EFT. There are differing schools of thought regarding possible explanations. One school offers the energy psychology meridian explanation, derived from the relationship of 'energy' and emotions and the study of acupuncture and kinesiology.

So, EFT is a therapeutic tool whereby someone taps on their face and body and repeats a form of words about their problem and the problem is no longer a problem. It used to be held in psychotherapy that a negative emotion was caused by a negative or traumatic memory or event. Every time this memory was accessed as a result of a thought or an environmental reminder of some sort the negative emotion was experienced.

Thought field therapy

Dr Callahan, however, discovered that there was a simple step in between the memory and thought and the negative emotion; and this was a disruption in the smooth flowing of the energy through the meridian system. Instead of the memory or thought causing the negative emotion, explained Dr Hartmann, the process is more like this: "A thought or memory triggers a disruption in the body's energy system which is experienced a physical or psychological pain." Consequently, instead of trying to undo the thoughts or memories in some way, which has been tried in therapy for many years with unpredictable results, the energy based therapies directly intervene in the intermediate step. When the disruption in the energy system has been calmed and relieved, the person experiences no more pain or negative emotions from the original memory or thought.

Scientific backing

Einstein demonstrated that everything is energy ($E=MC^2$); thought field therapy is based on the premise that even thought is energy, which in the brain can be measured by an electo encephalogram. TFT draws upon Eastern tradition and its understanding of the presence and importance of energy in the body. This energy system has not been disregarded by Western scientists who have applied hard science to this ancient knowledge (Callahan, pp26-27)

Heart rate variability (HRV)

The positive effects of TFT can be shown by a device long used in cardiological research to measure heart rate variability. The test quantifies variations in the intervals between heartbeats, which in turn are a window to the all-important autonomic nervous system. HRV has become a key to TFT; it shows TFT can directly influence the heart and balance the ANS thereby producing profound physical and

psychological changes. Dr Callahan notes: "As HRV improves, so do physical and psychological well-being. This finding has enormous implications for enhancing our overall health."

Dr Callahan asks: "In a psychotherapeutic tradition that emphasises talk therapy and/or drugs to treat emotional problems, what could be more peculiar than accessing energy systems by tapping specific points on the body — and, in the process, providing healing in just minutes?" TFT has been described the "power therapy" for the new millennium.

We have a lot to learn from our ancestors. Only now and gradually will science provide supporting evidence of their practices.

Further reading

EFT in Your Pocket by Isy Grigg, 2005

Tapping The Healer Within by Roger Callahan, PhD, 2001, McGraw-Hill

Adventures in EFT by Silvia Hartmann, PhD, 2003, DragonRising.com.UK

Energy Tapping by Fred.P.Gallo,PhD et al,2000, New Harbinger Publications, inc.

New Members of COSCA

November 08 CAG

FULL ORGANISATIONAL MEMBERS
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WOMEN'S RAPE AND SEXUAL ABUSE CENTRE (WRASAC)
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Course commences: April 25/26 2009 in Edinburgh

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CRUSE BEREAVEMENT CARE SCOTLAND SPECIAL TRAINING TO SUPPORT BEREAVED CHILDREN AND YOUNG PEOPLE

The pain of losing someone we love is like no other. It challenges the whole basis of our lives. The security we have built up on the foundation of loving relationships is shattered. Often we are told that children do not really understand bereavement and death. Our adult instincts are usually to protect our young against such difficult issues. But up to three quarters of all young people in Scotland will have been bereaved of a close relative or friend by the time they leave school. Most of them will cope well with their experience of grieving – especially if they have the support of their immediate family. However, if for any reason that support is not available – perhaps because the whole family is struggling with the same bereavement, then the young person may find it harder to deal with their loss. Children and young people grieve in a very real way. Often they have questions, but sometimes they hold back on asking those questions from fear of upsetting the adults. Providing the right kind of support at the right time for a bereaved child or young person is a very skilled task but one which can make a huge difference. As adults, it's easy for us to forget how bewildering death can be for a child. One 12 year old whose father had died very suddenly was terrified that her mum would die too, but she was too scared to talk her about it - fortunately she was able to talk to a CBCS volunteer about her fears. If children and young people feel their questions are not respected or heard, they may bottle up their feelings. This can result in difficulties in school, relationships and behaviour. Simple things can help – listen, allow children to ask questions, tell the truth, don't be afraid to show your feelings, keep to a routine, give reassurance… this can help the child or young person feel secure. And more…

For further information contact:

training@crusescotland.org.uk or phone **01738 444178**

Cruse Bereavement Care Scotland exists to promote the well-being of bereaved people in Scotland. With over 500 volunteers, in 28 local teams. CBCS receives in excess of 12,000 calls each year.

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:
email: **marilyn@cosca.org.uk**
telephone: **01786 475 140**.

2009

5 February
COSCA Ethical Seminar on Exploitation
Edinburgh

6 March
COSCA Diploma Trainers/Providers Forum

31 March
Deadline for receipt of COSCA Accreditation applications

27 May
COSCA 11th Trainers Event
Stirling

June (To be confirmed)
COSCA Accreditation Workshops

30 September
Deadline for receipt of COSCA Accreditation applications

30 September
COSCA AGM 2009
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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