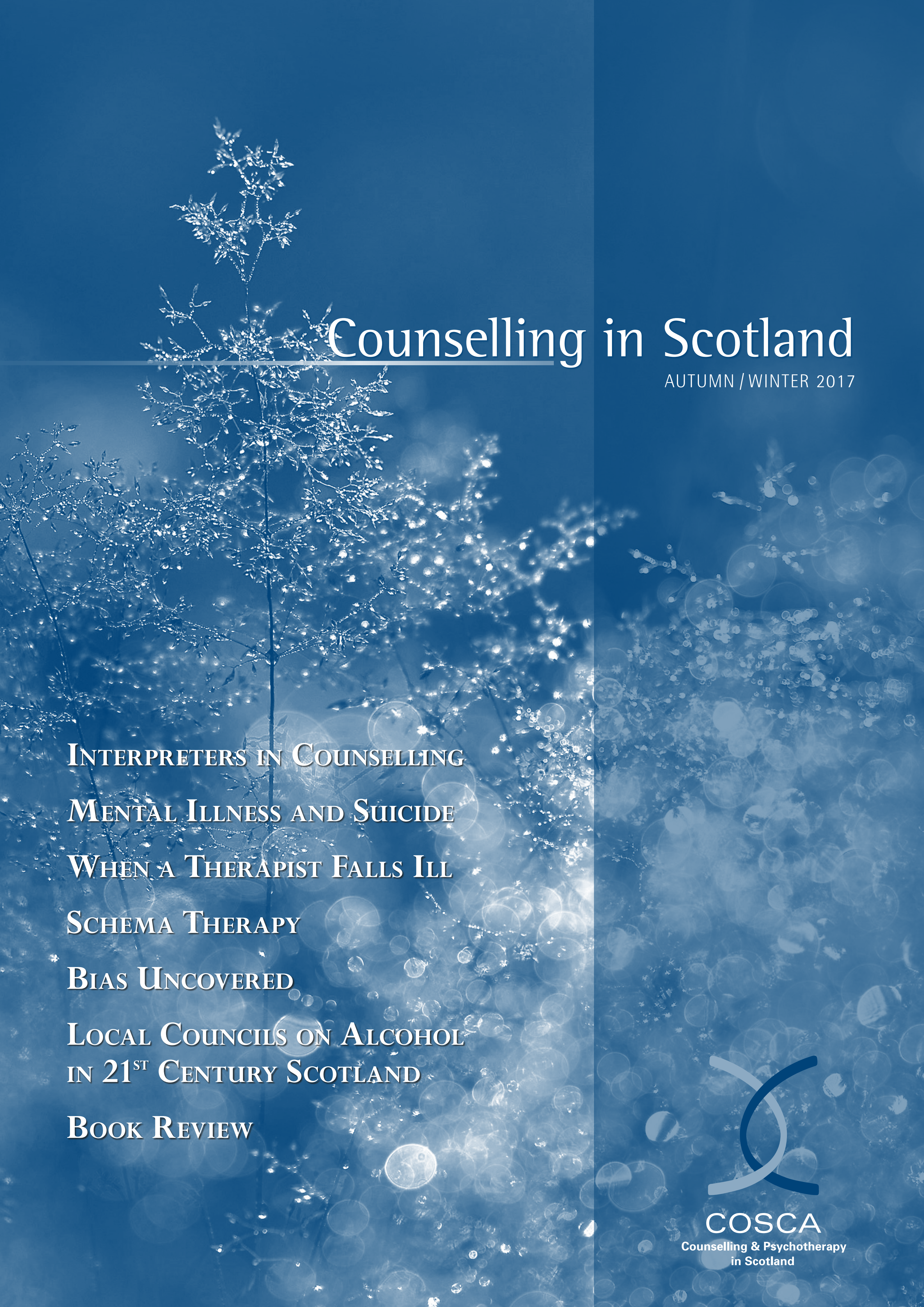

Counselling in Scotland

AUTUMN / WINTER 2017

INTERPRETERS IN COUNSELLING

MENTAL ILLNESS AND SUICIDE

WHEN A THERAPIST FALLS ILL

SCHEMA THERAPY

BIAS UNCOVERED

LOCAL COUNCILS ON ALCOHOL IN 21ST CENTURY SCOTLAND

BOOK REVIEW

COSCA
Counselling & Psychotherapy
in Scotland

Contents

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Editorial

John Dodds

WHILE it has taken somewhat longer than anticipated to assemble this issue of the journal (for a variety of good reasons), I am extremely happy with the contents, which comprise a spectrum of pieces, looking at everything from the use of interpreters in the counselling room, to what happens when the therapist falls ill, to mental health and suicide, all of which are written from a personal, and sometimes moving, perspective. In addition, we have an article about a therapeutic approach first developed in the 1980s which, I for one, was vaguely aware of but knew very little about.

We begin with a fascinating article by Gordon Hogg about the use of interpreters in the counselling room. It is a topic that raises all kinds of questions, such as what it means to have a third person present and what that might mean to the therapeutic relationship.

Then we move on to Samuel Reilly's moving account about his sister's suicide and what he learned from her writings collected in the book, *Tigerish Waters*.

Dr. Alistair McBeath's piece, "What Happens When a Therapist Falls Ill? ", asks some interesting questions about an aspect of the therapeutic which we may not wish to think too closely about. But inevitably may have to do just that at some stage and, when we fall ill (seriously or even in a way that prevents us continue working with clients for a period of time), to have as Alistair says, an "ethical imperative to have a contingency plan, for the benefit of clients". I should also point out that, linked to this subject, COSCA will be publishing guidance for members on clinical/professional wills in the Spring of next year.

From time to time in the journal we run pieces not specifically about, or connected to, person centred counselling, and journal readers have given some feedback to say they find it interesting to learn about other modalities and topics which can broaden our knowledge and understanding of how people are being supported in their process more widely. I am pleased, therefore, to offer in this issue an interesting article about Schema Therapy, which was originally developed by Jeffrey Young to treat individuals with Borderline Personality Disorder, but has since broadened as an approach for other issues, too, as Susan Simpson explains.

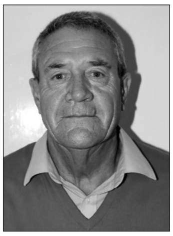
In "Bias Uncovered", Di Airey discusses equality and diversity, important aspects of working with others in a fully person-centred way.

Counsellors who work with people with alcohol addiction, indeed any of you who are interested in the subject, may wish to learn more about the work of Local Councils on Alcohol. Patricia Joyce looks at where they have been and where they are headed in the 21st century.

Finally, we move on to a subject that counsellors must wonder about from time to time, but may have limited experience of. It is this: how often do we get a client's perspective on counselling, besides the feedback we get directly from those we work with, or reflections from the counsellor's point of view? On this subject, we have to welcome a client opening up about the experience, which Lili Thomas does in her book *Monster in the Attic: A client experience of psychotherapy*. John McCormack reviews the title, and unstintingly recommends it, so I hope you will consider buying a copy.

I hope you enjoy this issue of the journal. As ever, we would very much welcome letters in response to the articles and always welcome offers to write articles for us.

John Dodds, Editor



Interpreters
in the Counselling Room

Gordon Hogg

The effectiveness of the work in a counselling session using an interpreter will depend on several factors.

The first factor to consider is the qualification of the interpreter. For clarity, the interpreter must be fluent in both the source and the target language and must be trained in the clinical setting.

The second factor is the training and experience which the interpreter has in the interpreting process. The interpreter needs to be trained to interpret communications to avoid the tendency to filter information (Marcos 1979). Marcos identifies three major areas of distortion: 1) deficient linguistic or interpreting skill; 2) lack of knowledge and sophistication in mental health; and 3) interpreter attitudes toward either the client or the clinicians.

The next factor to consider is the qualification of the therapist in working with an interpreter. The counselling process is very different when working through a third person than working one-to-one with the patient. In addition to language issues, the therapist must be aware of, and make allowances for, culturally embedded information. Such information is not readily discernible through interpretation and requires a level of cultural awareness (Glickman and Harvey 1996). The therapist must be conscious of the fact that using an interpreter alters the nature of the relationship. There is a third person in the room, bringing his or her own psychological issues into the session—issues that may reveal themselves in subtle nuances during interpretation. When the very skilled and experienced clinician is teamed with a highly qualified interpreter, both professionals will be constantly monitoring each other for such shading and skewing of the message.

Considerations of the alliances are critical:

- Is the client allied with the therapist or the interpreter?
- More importantly, is the interpreter allied with the therapist or the client?
- Do both the client and the therapist trust the interpreter and the interpretation?

Being unprepared to deal with these dynamics will make the therapeutic work less effective.

On the other hand, in many cases, interpreters allow for opportunities for transference and countertransference that do not exist in dyads. In this respect work can be done that is not possible using any other approach.

Developing a strong working relationship between the counsellor and the interpreter is one of the pillars on which effective therapy can be built. An essential element in building this relationship is the regular use of briefings between the interpreter and the counsellor before and after the clinical sessions to discuss the material. The pre-conference brief allows the counsellor to brief the interpreter about therapeutic goals for that session and to give background information necessary to allow for accurate translation of concepts raised in therapy. Debriefing after a session allows the interpreter to share information of clinical importance that would not be brought up in the session.

Interpreters in the group room

There is very little literature addressing the inclusion of an interpreter in groups. However, my experience suggests that this arrangement can be successful as the psychotherapeutic groups are facilitated by a therapist who is aware of the requirement to meet the cultural and therapeutic needs of the patient. In addition, the intentional, therapeutic goals can be realised in the brief/

debriefing with the counsellor and interpreter prior to and after group. Because the group therapist and the interpreter are working together toward a specific therapeutic goal, it is critical that there is a strong alliance between the interpreter and the clinician. The consistent use of pre- and post-conferencing helps ensure this happens, and that it is therapeutically productive.

The inclusion of an interpreter in groups did not alter the fundamental nature of the group. Inculcating sensitivity to the special needs of someone who lacks fluency in the language of the community

The interpreter's presence in the group could have been seen as a distraction to the therapist and the patients. Rather than viewing this negatively, it can be seen pragmatically as merely broadening circumstances in which the group facilitator observes the patients. How patients incorporate the interpreter's presence into their defence mechanisms is useful to the counsellor who is experienced in the dynamics of using an interpreter. Group counsellors can also use the limited English proficiency of patients and interpreters to reinforce social skills such as turn-taking and tolerance of diversity

Working in practice

Our offices abroad were in a position to resource suitably qualified interpreters who had a background in the model of addiction treatment used in Castle Craig. The interpreters would spend some time in Scotland at Castle Craig hospital and were comfortable in working with the therapeutic team. The interpreter will be allocated a supervisor to provide support during the period of the patient's admission and subsequently when they would return home.

The relationship with the patient usually began with an enquiry to the admissions office, and a review of suitability by a clinician. This was followed up with a visit from our professional in the country of the client. This is an important phase in the forming of a relationship, and if necessary, the counsellor, who will be working with the patient, will fly out to the country of the client and undertake further assessments while forming a therapeutic relationship with the client and his family. The interpreter will meet the counsellor prior to the meeting. The client will be aware of the interpreter's background. It is essential practice to ensure that there is an explicit signed confidentiality agreement by the interpreter; the interpreter would be vetted for their professional status, their understanding of the ethics of counselling and confidentiality.

The patient/client would meet the interpreter and the treating healthcare professional; an explanation would be given of the role the interpreter will provide. The patient would then sign a declaration of informed consent to work through the medium of an interpreter.

The client, and if appropriate his family, will now fly to Scotland and visit the hospital. They will meet the consultant psychiatrist, medical team, counsellor and other members of the treatment team. They will meet members of the therapeutic community, view the accommodation and living arrangements and arrive at a final decision regarding admission. The various release forms and confidentiality considerations will be signed. Arrangements for family counselling will also be arranged where appropriate.

The clinician working with the patient will assist and facilitate the patient's engagement with the therapeutic community, having already prepared the foundations for the community. The patients have been happy with this arrangement and have seen it as a challenge, enhancing the community and adding to its positive spirit. The translator becomes part of the community and in the early days spends considerable in the community with the patient and his peers.

After a few days, the patient is oriented and becoming familiar with the routine of life in the therapeutic community. So many questions to be asked, so many things to find out in this phase. The interpreter pays a vital role at this point and they themselves are forming a relationship with the community, indeed becoming an integral part of it.

After an extensive series of assessments involving counselling and medical staff, a personalised treatment plan is formulated for the patient. The treatment plan is a combination of medical treatments, specialised therapies and complementary therapies for each patient. The preferences and needs of the patient are considered and formal agreement in writing is sought. The interpreter has been involved in the assessments, translating and assisting the patient. The interpreter will also be translating the written agreements regarding confidentiality, information release, contact with his family and other professionals working with the patient.

As well as individual counselling, the treatment process is centred around group therapy facilitated by a counsellor. On admission, a patient is allocated a group, which usually numbers around 8 patients with a maximum of 12. In the case where interpreters are to be in the group room, the patients' group has been asked if they are willing to have an interpreter and matters of confidentiality have been explained and written contracts signed. If they agree, the interpreter and the patient will introduce themselves at their first group session. It is interesting how unobtrusive the interpreter becomes in the group process; the interpretation becomes like a "quiet whisper" in the background and does not disrupt the group process and indeed may enhance it as it introduces another dynamic. We have never had any negative feedback regarding this arrangement.

Processing assignments in the treatment plan takes place with the focal therapist and in the group. The interpreter will have prepared the assignment with the patient and present the piece of work to the group for feedback from the group. This arrangement with the translator worked well.

The interpreter, as well as being in the counselling room, is busy in many other ways. Treatment involves didactic components, lectures, videos identification films and so on. Each lecture and video has a handout covering the main point which must be translated. Assignments in the patient's individual treatment plan need to be written and translated for taking into group and to be processed with the patient's counsellor.

With individual counselling, eye contact is between the counsellor and the patient. The interpreter sits discreetly at the side of the patient. This experience has further highlighted to me how meaningful nonverbal communication can be; so much is articulated through the eyes, facial expression, a smile can say so much, the brow talks, a frown says so much, the angle of the head — was that a nod? Each patient/interpreter relationship is unique and should be considered as such. The personality and needs of the patient will dictate how the therapeutic relationship develops and the style of working with the interpreter. In the background, the interpreter is linked and very much part of this threesome.

Family involvement is essential when appropriate. Family therapy will be tailored to meet the needs of the patient and their family, typically three sessions over the six-week period. Also, there is a dedicated family weekend programme, facilitated by our family systems specialist therapist, every six weeks or so. The goal is to re-establish effective communication within the family unit and develop support systems for the family in the community when treatment in the hospital ends. The family returns home after the patient's admission and returns for the structured family therapy and family programme. Our team in the country of origin will have identified suitable aftercare resources for the family and introduced the family to these resources whilst the patient is in treatment. The interpreter is a link with the family whilst the patient is in treatment.

Aftercare arrangements for the patient's return home begin to be put in place as soon as the referral is received. In cases where the counsellor has flown to the country of origin they will identify and contact suitable support organisations and individuals. Alcoholics Anonymous is a worldwide resource and is an excellent avenue for continuum of care, as well as being free and very accessible. Local meetings will be identified, and contact made by the patient before discharge from treatment. In addition, the treatment plan involves developing an extensive relapse prevention plan in the last two weeks of treatment. The patient identifies high risk relapse situations and develops strategies to deal with them. This, together with the psychiatrist, focal therapists and medical team's recommendations, go to developing a comprehensive aftercare plan. At the end of treatment, closure is accomplished with farewells in his focal group and by all the patients in the community, and in this case to the interpreter as well.

Conclusion

It became apparent, at our first meeting with the patient and their family in their home, that the use of a translator in the counselling room could work and that the various challenges in accepting the patient for treatment could be overcome. Meeting with the patient in his home country, prior to admission, gave valuable insights into the family background. The patient's admission and progress through treatment was successful and

I am pleased to report that the patient is doing well and we remain in touch from time to time. Working with a translator in the counselling room was a wonderful experience and it has led to more admissions in the last few years.

In this age of equal opportunity and limited access to counselling, the use of interpreters in the counselling room opens the door to many who would otherwise receive no help. It fits in well with our code of ethics to offer help whenever needed.

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Biography

Before retiring after Christmas this year, Gordon Hogg worked for 25 years in the Intensive Care Unit at Castle Craig Hospital, a residential treatment centre for alcohol and drug dependence. He was the head therapist for many years, leading a team of counsellors treating addiction. For five years in the 1990s he was on the board of COSCA. Prior to his career in counselling, he had been an officer in the Royal Fleet Auxiliary for twelve years and subsequently an engineer with Philips Electronics in Cambridge specialising in Electron Microscopy.

Castle Craig is in the Scottish borders and has a varied and diverse patient group both in the United Kingdom and overseas. The hospital also has a number of contracts with Dutch insurers, as well as established representation in most European countries. Recently, another residential treatment programme, Smarmore Castle a private clinic, opened in the Republic of Ireland. Castle Craig treats alcohol and drug addiction as a primary, chronic illness, and abstinence from these mood-altering substances is considered necessary for a complete and long-lasting recovery. It combines medically managed treatment, with a 12 step programme, as well as providing cognitive behavioural therapy (CBT) and other evidence based therapies.

Over the years, as its reputation as a centre of excellence for the treatment of addiction grew, Castle Craig began to receive requests from abroad to treat patients who had a very limited proficiency in speaking English. Accepting such a patient into treatment would of necessity involve him/her in participating in the programme. This would involve individual counselling, group therapy and living in a therapeutic community of around 35 people, for a period of four to six weeks.

Mental Illness
and Suicide

Samuel Reilly

The greatest obstacle to understanding mental illness is our fear of vulnerability.

When I collected my sister's writings, after she took her life at 21, I discovered how our anxieties about the mentally ill can preclude real empathy.

When Sophie was seventeen, she sent me by email some fifteen pages of drama she had been working on over the previous few weeks. I recall, with all the unexpected clarity grief gives your memories – you'd think there'd be a kind of dulling – the minute development of my feelings as I read it. I remember what I said to Sophie, afterwards, with a regret that's sharper still.

There was first a kind of joyful recognition, of the sheer passionate effusion that was my sister through and through and that I could now see, transcribed on the first few pages, in wild, unruly, poetic prose. Before long though, phrases like "the hole in my chest" had begun to open one in mine. By the end I was left with a profound, ineffable, but entirely familiar sensation of uneasiness. It was the feeling – though it couldn't then have found these words – that "I'm completely out of my depth". Or, "I don't know how to respond to this".

But I couldn't own up to her about the disquieting force the piece had held. Instead, I gave a few peremptory tokens of praise, to a couple of the more sparkling moments of dialogue, and then – as though it constituted a failure of imagination – I asked her, "Why don't you try and write about something that isn't yourself?"

An element of self-preservation was at work here. To confront her play on the emotional level it demanded, I would have had to admit to myself that the kinds of harrowing mental experience which Livvy – Sophie's proxy – so eloquently and insightfully expounds were *real*, that this was how Sophie actually thought and felt. How much easier it seemed, to try and get her to write fiction. But there was also an impetus not to indulge Sophie in the kinds of obsessive self-criticism I knew by then were integral to her depression, as though that might protect her from them. I was scared that her illnesses were taking over her life.

I didn't read *Before the Snuff of the Lights* again – not until last August, in the days after Sophie took her life, at 21. Then, almost immediately, I began poring over every word she had ever written. Then, for the first time, I was grateful that she had bared herself like this.

I found that every hang-up I'd had about her play had been pre-empted, and worked through, in the figure of Livvy's interlocutor, Luke. The sheer acuity of Sophie's self-knowledge, suddenly, astounded me. I understood that my request, that she simply change the focus of her thought, had been a little like instructing a shadow just to feel the sun. Above all, I realised that when Sophie wrote about herself, I should have listened.

We should all be listening. Suicide is the leading cause of death for young people in the UK, and while this summer's news regarding an additional £1.3bn funding released for specialist nurses in England and Wales is welcome, it isn't nearly enough to compensate for the steep decline in mental health provision nationwide since 2010. So few of those in power really understand anything about the beast they're wrestling. Towards the end of last year, Jeremy Hunt spoke to the Commons health committee on suicide prevention efforts. He used his time to take up the subject of sexting, declaring that "social media companies need to step up to the plate and show us how they can be the solution to the issue of mental ill health amongst teenagers".

I don't really want to dwell on Hunt's utter temerity, in proposing a kind of nebulous, "blue-sky-thinking", to distract from the lack of concrete financial provision for psychiatric care, as though if only tech companies could keep closer tabs on how teenagers behave – as though Hamlet's problem could just have been too much unsupervised time on Twitter – the whole thing might sort itself out. No, there are a couple of deeper misunderstandings underpinning Hunt's words, which stem from the same warped relationship to vulnerability and to madness of which we are all, to a degree, guilty, and which mirror the mistakes I made with my sister.

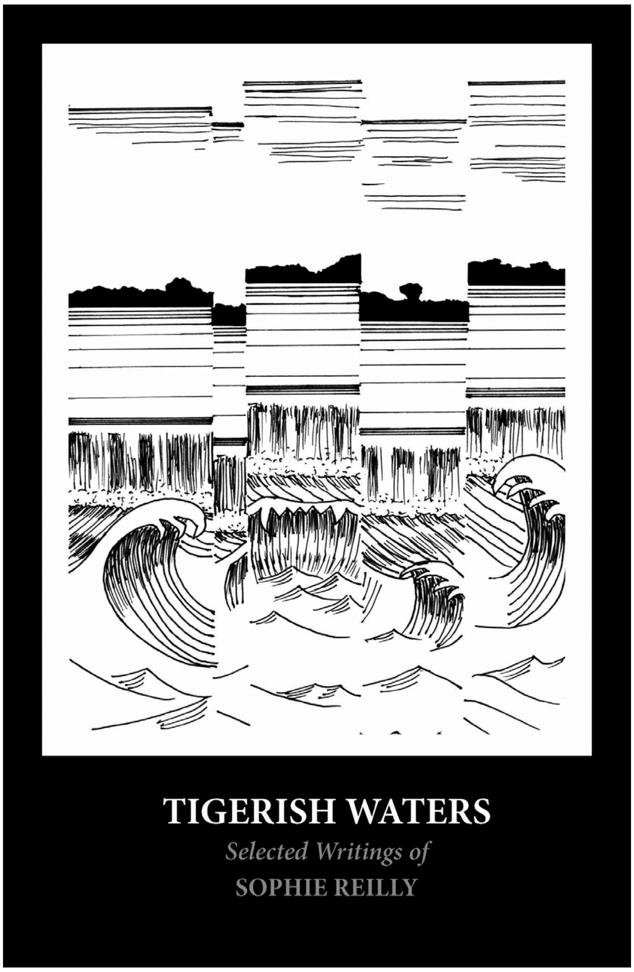
First, there is that nagging, insidious implication that mental illness is the sufferer's own fault – that it's just a species of that self-pity which once caused Rosa Luxembourg (of all people) to declare that "howling is the business of the weak". It's because of how *you* have behaved, how *you* exposed yourself to malevolent influences in your youth, and the only solution is for you to take ownership of your life, learn some proper self-reliance.

More damaging still is the suggestion that we can solve the problem by somehow just fixing the world, by removing all there is that's negative and that might impose itself upon a vulnerable consciousness. If the first is typically stoic emotional dysfunction, this second is a bizarrely utopian solution for what is, at heart, a medical problem. Hunt's proposition was a bit like slashing the budgets for chemotherapy, and promising to make it up to cancer patients with better weather.

When Sophie and I were growing up, I was morbidly terrified that anything to which I might expose her would have an adverse effect – that she would latch onto a horror movie I watched with her and find in it a certain logic that suited her, or that having a couple of drinks with her would directly cause her to descend into alcoholism. However, all the efforts I took to tread so gingerly around her never stopped the worst from happening. And had I understood and engaged with her more closely, on her level, from an earlier age, then I might at least have been able to take more pleasure in this wonderful, dynamic personality while she was alive, and given to her moments here more joy.

There's a certain risk, in whatever we do, that trauma will strike. But now, with grief's keen memory, I know that all of the most important moments I shared with Sophie, in her brief adult life, were those when I let the sombre reticence drop, and instead showed her love and levity. I can't help but wonder how my relationship with her might have been different, if I'd found a more consistent way to temper that two-fold and contrary impulse: the urge to blame Sophie, for being unable to change her moods, and the urge to closet her from a world which might make them worse.

This duality is the chasm in our public conversation about mental illness; it's the impasse, beyond which we've failed to see. It means we view the mentally ill as irredeemably ill-equipped with the tools they need to navigate the vicissitudes of modern life, while at the same time, we make them culpable.



Sophie suffered from Bipolar Disorder, which would cause wild swings from high to low. At her lowest, she'd be suicidal; at her highest, she would tip into florid, effervescent, sometimes hallucinatory psychosis for weeks at a time. She had Emotionally Unstable Personality Disorder, which would cause an exaggerated "splitting" of her selfhood in the way she spoke to people, with the effect that wherever she went, she'd find people who adored her, and others who hated her. The causes are extremely complex; the effects were stark. My dad once called them "Cinderella conditions"; the sheer, dramatic unpredictability of Sophie's oscillation, between unreserved generosity and utter vitriol – between abjection and bliss – saw so many friends become alienated, unable to comprehend or to cope with what was happening. It must have been very lonely, being her.

We need more funding for mental health – nothing else will provide the kinds of research into these conditions that will improve our knowledge of their causes and develop our ways of treating them; nothing will more directly prevent young suicides in the short term than properly equipped hospitals and care units. But if all of us, responsible as we are for the broader social discourse surrounding these conditions, could find ways of dealing with our fear – of fronting up, and learning how to identify – then we may collectively help to avert further catastrophes.

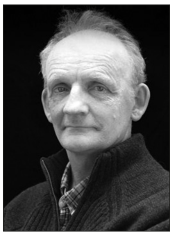
Sophie puts it more emphatically than I can:

"We go through hell in here. We see terrifying visions of things that aren't there – hallucinations of an attacker beating you, when in reality it's you punching yourself in the face.... We deserve anything but being thought of as merely "crazy" or "mental" or "loopy" or "schizo" or "a screw loose" and never trusted, or taken seriously, as everyone's too scared of us or thinks we're just broken or plain doesn't give a shit.

"We are people, not diagnoses."

Tigerish Waters: Selected Writings of Sophie Reilly is published by Mad Weir Books, and edited with an introduction by Samuel Reilly. All profits will be donated to Scottish mental health charities.

Price: £6.99 with all profits to the Scottish Association for Mental Health. Curently available on Amazon or at www.tigerishwaters.co.uk.



When a Therapist

Falls Ill

Dr Alistair McBeath

Introduction

As someone who has been a therapeutic practitioner for fifteen years I have acquired a familiarity or perhaps a confidence in dealing with the various key facets of our business. Over the years I feel that my experience of working in the NHS, establishing a private practice and working for a coaching-psychological consultancy has allowed me to feel quite grounded professionally. However, one experience that I had no familiarity with, and one that filled me with unknowing and anxiety-evoking uncertainty was falling ill and, at some point, having to concede that I was not fit to see clients.

Whilst training I recall reading some analytic material to do with the impact of a seriously ill or dying therapist and the need to consider various transference dynamics (e.g. *Halpert*, 1982, *Dewald*, 1982). At the time I was intrigued by the material but considered it in a theoretical way and undoubtedly, at some level, concluded that such things *happen to other people*. But, no, eventually I was wrong and this shallow defence mechanism was found wanting as I was to experience unexpectedly falling ill and confronting thoughts and possibilities that I had never seriously entertained before. What had once been only theoretical had become starkly real and threatening.

Although I'm sure that I'm still processing this unwelcome interruption to my well-being I hope, in this paper, to share some of my experience and also to touch on some of the unexpected emotions that were evoked; these include fear, confusion, guilt, anger at times and despair. In addition, I intend to offer a focus on what is seemingly not a mainstream topic in therapeutic practice, namely, what I see as an ethical imperative to have a contingency plan, for the benefit of clients, should a therapist encounter unexpected debilitating illness or even death. This is the concept of a clinical will.

Background

Considering its potential significance within the therapeutic relationship there is only a very small body of literature that explicitly deals with illness or death of a therapist. This situation undoubtedly reflects the reluctance of the profession to entertain such threatening thoughts. From a historical perspective it's noteworthy that Freud, who endured more than thirty operations for mouth cancer, never once wrote about the impact of his illness (Haynal, 2008).

As a group there's little doubt that therapists can be seduced into feelings of omnipotence. By the very nature of their work they are the healers of the sick and vulnerable. To entertain the idea that they could be just as prone to sickness as anyone else fundamentally disturbs their inner model of the therapeutic relationship and, indeed, might well evoke some unwelcome death anxiety.

As Counselman and Alonso (1983) have noted, the therapeutic relationship is very much inclined to promote collusion, at some level, between the therapist and client to promote their healer-sick polarity. They wrote that:

> *Patients like to see their therapists as invincible and try hard to deny their vulnerability to mortal circumstances. It is very tempting for therapists to agree with this flattering view, and to deny their own vulnerability to illness, aging, and inevitable death. (p 593).*

In my own situation the onset of my illness and experience of pain was quite sudden and yet, somewhere within myself, I could sense a denial of what was happening. But, as the situation continued I felt that some part of my identity was diminishing or disappearing. In reflecting upon the impact of illness on therapists, Adams (2014) has written that:

> *When pain or illness arrives, this may constitute a painful, internal process of reorganising the 'self' to accommodate this new more vulnerable 'me'. This may be particularly difficult for therapists, many of whom consider themselves 'copers'. (p42).*

From a slightly different perspective Counselman and Alonso (1983) capture the impact of illness on the therapist with these words:

> *Therapists who are ill lose an occupationally familiar sense of omnipotence and a feeling of being above what happens to regular people, and that can be a painful loss. (p 594)*

Disclosure to clients

Before my condition became acutely uncomfortable I sensed that something was not right but clung to an uninformed belief that it was some temporary annoyance and that it would simply go away. The turning point for me was the realisation that I was really quite distracted by my discomfort both with a client and also in a closely following supervision session. In short, I was not fully available and therefore, inevitably, not fit to practice. This realisation conjured up a potent mixture of emotions and I found myself in very unfamiliar and threatening psychological territory.

One of my first dilemmas was, simply, "what do I say" to clients and organisations that employed me. I knew I had to inform people but I really didn't want to communicate a sense of finality – that I was finished as a therapist. In the end I chose a revealing combination of words. Here is what I communicated to organisational bodies.

Unfortunately, I'm currently unable to see clients due to an ongoing health issue.

What I told clients contained more or less the same words but in a personalised manner.

Looking back, it's clear how my words reflect a heavily defended position. I consciously decided that I would not use the words illness or sick. Also, within my words is an emphasis on "ongoing". In other words, there was no sense of finality and, to my mind, I was suggesting, "I'll be back".

Once I'd sent the emails that informed clients and organisations of my situation I felt a very temporary sense of relief that was followed by a nagging fear that my professional life had come to an end. There was also a sense of guilt or perhaps shame that I had let clients down. Perhaps more deep-seated was a real fear that other practitioners would make a judgement that I was now someone outside of their professional group.

Perhaps the greatest impact upon me was the very sudden and immediate transition from therapist to patient. It seemed to deliver a shocking experience of powerlessness. One day I was a therapist and the next I was in hospital with tags on my wrist and ankle with my name and date of birth; soon I acquired a very disturbing sense of depersonalisation. And, of course, running through my veins was an unquestionable sense of fear. At some point I reflected upon the very real possibility that I was genuinely experiencing what many of my clients may have encountered in their own lives. This particular reflection and sense of awareness has, fortunately, stayed with me.

In disclosing that I would be unavailable due to a health issue I had three different types of communication to make. The first was to private clients and in doing so I recommended a therapist I knew should they want to continue therapy with another practitioner. The majority of clients replied wishing me well. The second was to do with clients seen by me in the psychology-coaching consultancy that I work for. Here the emphasis was on handing over clients to another member of the team with a full briefing of the work done to date. I found this process quite problematic and I felt a strange sense of resentment at handing over "my" clients to someone I knew. The third type of communication was to Employee Assistance Programme (EAP) providers that referred clients to me for occupational support work. The EAPs were very efficient and asked for a written summary of clinical issues identified and progress in their treatment. I was reassured by this process and, indeed, received positive feedback from some of the EAPs about my summary notes.

Having informed all those that I thought should be informed it dawned on me that, for the first time in fifteen years – I had no clients. My sense of loss was greater than I could have imagined. Not only did I feel that I had lost my health but I also felt that I had lost my professional identity and value. As the days became weeks and the week became months I feared that this loss would be permanent. At times I wondered whether some of my longer-term clients were coming to the same conclusion.

Looking back, I can see how I progressed from a position of being concerned for myself and for my clients to one of self-absorption and disconnection from my clinical work; as time passed there were days when I never thought about my work or my clients. This type of journey of disconnection has been movingly expressed by Edwards (2015) in reflecting upon her own experience of illness.

So, it was strange indeed to observe how little I cared about anything much beyond my immediate family, and if I'm really honest, I didn't much care for them either. I literally had no energy for anyone else. I didn't have the capacity, or shockingly, the desire, to care for my clients. I wasn't fit for purpose.

Return to work

My return to work followed an unexpected path. I can still vividly remember coming round from a general anaesthetic to see my consultant walking towards me. He patted my shoulder and simply said "all good". What that meant was huge – he'd found nothing serious or problematic. However, I still had and would continue to experience painful symptoms for some time. My consultant told me that sometimes pain comes for reasons not fully understood and that sometimes it simply goes. In the end, that was largely my experience bolstered by some effective long-term medication.

Then there came a day when I decided that I could see clients again. Having made this decision I was visited by an uncomfortable mix of relief and unsettling apprehension. I started with booking just a single client into my otherwise bare work calendar. As the session date grew closer I was surprised at the level of my unease; it was uncannily similar to the feelings I had experienced many years ago as I contemplated seeing my first 'patient' in a large NHS hospital. I was undoubtedly nervous and feeling de-skilled. This first session seemed to go well but after the client had gone I quickly sunk into a feeling of numbing exhaustion. But, I was back.

Clinical wills

As part of the reflective process that followed my temporary unfitness to see clients I was reminded of an article I'd read in a BACP publication about the importance of having what's termed a clinical will (Byfield, 2016). The emphasis here is that practitioners should have a documented system that allows a trusted third party to contact clients and other relevant organisations should a therapist be seriously incapacitated or, in fact, die. The clear overarching intent is to prevent clients from experiencing a sudden, unexplained, and for some, a truly traumatic fracture to an established therapeutic relationship.

As my interest in clinical wills deepened I began to feel unease that, as an experienced practitioner, this subject had not been something that I'd considered as a key component of my professional responsibility. This feeling led me to research to what extent the issue of clinical wills has been publicised or progressed by the major practitioner professional bodies (e.g. BPS, BACP, UKCP).

My efforts revealed a rather surprising situation. As a profession there is an almost unquestioned need to ensure that client endings are handled with great sensitivity and that endings are planned rather than sudden and fractured. So, what do the major professional bodies have to say about handling therapist incapacitation or death – as it might impact upon clients? I contacted the BPS, BACP and UKCP for their latest position on clinical wills.

Only one professional body, the UKCP, has a direct statement about the importance and need for clinical wills. The following is the relevant excerpt from their code of ethics:

> *The psychotherapist commits to carefully consider how, in the event of their sudden unavailability this can be most appropriately communicated to their clients. This will also include careful consideration of how a client might be informed of a psychotherapist's death or illness and, where appropriate, supported to deal with such a situation. (Section 9.3)*

So, here we have a strong steer towards the value and need of a clinical will but it is still not made fully explicit. Both the BPS and BACP have no mention of the value or need of a clinical will in their code of ethics although the BACP does very briefly note the importance of the issue in their *Guide to Good Practice* publication.

It's somewhat ironic that the clearest and most direct statement of the need for a clinical will comes from a small membership professional body – the British Psychoanalytic Council (BPC) which has a membership of approximately 1500.

Within its Code of Ethics, it states that:

> *Registrants must nominate two colleagues to hold a list of their patients and supervisees in confidence, in the event of death or an inability to work. The names of these nominees must be lodged with the constituent societies. (Section 20)*

These words are important as they state that it is a mandatory requirement for BPC members to have some form of a clinical will. The absence of a mandatory requirement for clinical wills in the codes of ethics of the main practitioner professional bodies is a finding previously reported by Byfield (2016).

In America it seems that the issue of therapists having a clinical will is taken more seriously than in the UK. For example, Florida is a state that requires the heirs of deceased therapists to place newspaper advertisements saying the therapist has died, and where their files can be found (Steiner, 2002)

Conclusion

In some ways the unexpected interruption to my health seems to be an experience that is gradually being consigned to the past. However, I realise that it could return as mysteriously as it appeared so my awareness of the fragility of life is heightened and this may be a good thing.

Clearly, I was unprepared for the impact that my ill health had upon me as if one could ever be well prepared. I now value my work more than ever and perhaps in some strange way I've moved closer to clients as I have had the lived experience of true vulnerability and powerlessness.

Finally, it seems somehow wrong that my interest in clinical wills and being able to offer some security for clients should we become incapacitated or die was only truly facilitated by my own experience of illness. There seems more work to be done to persuade therapists to afford this subject as much importance as they do to such matters as supervision and personal therapy and thereby incorporate it as an ethical imperative within their practice.

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Biography

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Schema Therapy:
Current Evidence and Applications

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What is Schema Therapy?

Schema Therapy (ST) was initially developed for those with self-defeating personality traits and interpersonal patterns that do not respond to standard therapeutic approaches. However, since its beginnings in the 1980s, ST has increasingly been applied within a wide range of clinical settings, including depression, relationship problems, eating disorders and general self-awareness-based psychotherapy, and garnered a substantial evidence-base.

ST systematically draws on aspects of a range of therapeutic modalities, including psychodynamic, object relations, gestalt, person-centred and cognitive-behavioural (CBT), with clear links to attachment and developmental theory and research. This has culminated in an integrative, process-oriented model which interweaves experiential, interpersonal, cognitive and behavioural techniques. The selection and application of these techniques and processes is guided by an overarching unifying theoretical model, based on the notion that a state of emotional homeostasis can only be achieved when core emotional needs are met.

ST was developed by Dr. Jeffrey Young, who was Founder and Director of the Cognitive Therapy Centers of New York and Connecticut and the Schema Therapy Institute, to address the limitations of current therapies for those with more complex and chronic psychological difficulties, including those diagnosed with personality disorders (PD). In particular, he noted the gap between intellectual and emotional change for many clients who were struggling to make the transition from *knowing* that they were lovable/worthwhile /safe to actually *feeling* this as a reality within their day-to-day experience.

The enduring and self-defeating patterns that are the focus of ST are referred to as “early maladaptive schemas” (EMS) and “modes”. EMS refer to pervasive themes of interpersonal experience, comprising beliefs, emotions, memories, and sensations that drive self-defeating behaviours. It is theorised that EMS develop as a result of pervasive unmet emotional needs, which occur as a consequence of the interaction between a person’s temperament and their early environment. When specific core emotional needs remain consistently unmet during childhood and adolescence, this naturally shapes the child’s view of themselves and their relationships with others. Coping mechanisms (coping modes) develop as an adaption to these childhood circumstances, but become maladaptive in adulthood, thereby perpetuating EMS and preventing the person from learning healthy ways of fulfilling their emotional needs.

The Schema Mode Model is the most recent development to the approach, and is particularly suited to working with clients with more complex presentations and multiple EMS. Schema *modes* are the moment-to-moment emotional states, coping responses and behaviours that are currently active for an individual. Modes are activated by life events to which we are overly sensitive (our “emotional buttons), and that in some way function as a preconscious reminder of difficult experiences in childhood or adolescence. A wide range of techniques are used to address cognitions, emotions, somatic experience and behaviours in the here-and-now. The goal of therapy is to overcome self-defeating EMS, whilst facilitating the development of self-compassion and resilience through internalizing and strengthening the ‘Healthy Adult’ side. In addition, therapy aims to weaken coping modes (similar to the concept of defence mechanism) that drive dysfunctional behaviours and prevent the fulfilment of core emotional needs.

Who might benefit from Schema Therapy?

ST is particularly useful for those clients who have become "stuck" in therapy. Many clients seeking psychological help describe enduring characterological and attachment-based patterns that hinder the effectiveness of standard therapeutic approaches. Those with problems linked to personality disorders and other lifelong difficulties tend to experience greater rigidity in their cognitions and behaviours and often struggle to engage in conventional techniques such as those used in cognitive behavioural therapy (CBT) (for example, identifying thoughts and emotions, completing thought records and homework assignments). In addition, for this client group there tends to be a more prominent gap between cognitive and emotional change. Although cognitions may have shifted at an intellectual level, their problems may remain entrenched and ego-syntonic. In ST, powerful experiential techniques bridge this gap, thereby facilitating a shift from intellectual (for example, "I understand that I am not worthless, but I still *feel* worthless") to deeper "core" level emotional change.

Preliminary work in ST was focused on the treatment of Borderline and other personality disorders. In more recent years, ST has become more widely used for a range of psychological difficulties, including chronic depression (Carter et al., 2013; Renner et al., 2016), chronic and complex anxiety disorders (Hawke & Provencher, 2011); eating disorders (Simpson, Morrow, van Vreeswijk & Reid, 2010; McIntosh et al., 2016), ruminative disorders (Thiel et al., 2016), substance misuse, alcohol dependence (Kersten, 2012), and forensic populations (Bernstein et al., 2012). In addition, the ST model has been specifically adapted to working with couples, children, families.

What are the components of Schema Therapy?

ST has four main components: cognitive, behavioural, interpersonal and experiential.

ST is a relational model. The therapeutic relationship serves as an antidote to childhood experiences that led to the development of EMS through "limited reparenting", the cornerstone of the ST approach. This involves providing experiences, within the bounds of the professional relationship, that provide a secure attachment and fulfil the emotional needs that were consistently unmet during childhood. Depending on the individual conceptualization, these include warmth, attunement, nurturance, firmness and playfulness, as well as limit setting and empathic confrontation to address relationship-interfering behaviours. One of the most powerful means of providing limited reparenting is through imagery-work, which facilitates a direct connection with emotional vulnerability. Transference and countertransference reactions function as a compass to help identify and work with EMS, modes, and in particular, patterns of behaviour that hinder emotional connection. Unlike many therapeutic approaches which aim to increase autonomy through teaching coping skills and reducing dependency on the therapist, "limited reparenting" works in parallel with healthy parenting, with the underlying assumption that some level of dependency is normal in the first stages of therapy.

The therapist's healthy compassionate stance becomes internalised and integrated, and through the assimilation of therapeutic containment and regulation, over a period of time, the client's own Healthy side is developed and strengthened. This is based on the premise that if early (unmet) dependency needs are validated and met to some extent within the bounds of the therapy relationship, this will facilitate growth through normal emotional-developmental stages, eventually leading to autonomy in the latter phase of therapy.

Experiential techniques, including imagery rescripting, historical roleplay and chairwork (Arntz & van Genderen, 2009) draw on processes used within psychodrama, Gestalt and Cognitive Therapy models (e.g. Arknoff, 1981; Beck, Rush, Shaw & Emery, 1979; Moreno, 1987; Perls, 1973). These are used to challenge EMS at emotional and visceral levels, through externalizing self-destructive messages learned from past experiences and internalising new corrective emotional experiences. These techniques draw on psychodrama, Gestalt and cognitive therapy approaches. They facilitate dialogues between sub-personalities ('modes'), and transform the meaning of early events through highlighting new or previously unseen information. These exercises precipitate an increased conscious awareness of emotional needs and a reduction in the maladaptive coping behaviours that hinder connection.

Cognitive techniques are aimed at moderating self-defeating core beliefs at an intellectual level through a range of structured exercises such as Reviewing the Evidence, flashcards and schema diaries. Clients are encouraged to track and challenge EMS and modes in their daily life and to develop the capacity to mentalise within their relationships.

Within the latter phases of ST there is a strong emphasis on behavioural change work. Techniques such as roleplay and future-oriented-imagery are used to reduce avoidant and other maladaptive coping mechanisms, whilst increasing healthy behaviours that result in getting needs met. Without a change in self-defeating coping responses, the underlying EMS will continue to be reinforced and perpetuated.

What is the evidence-base?

A seminal randomised controlled trial (RCT) by Giesen-Bloo et al. (2006) demonstrated greater effectiveness of ST compared with transference-focused psychotherapy for Borderline PD across a range of measures, including Borderline PD–specific and general psychopathologic dysfunction, and quality of life. Attrition rates were significantly lower in the ST condition. These results were replicated in a RCT implementation study that compared ST with/without crisis support (Nadort et al., 2009). In addition, a RCT by Farrell, Shaw and Webber (2009) compared 30 sessions of group ST with Treatment-as-usual for borderline PD, and found that 94% of ST as compared to 16% of Treatment-as-usual no longer met diagnostic criteria for Borderline PD at end of treatment. More recently, ST has been found effective with Cluster C and Narcissistic PDs (Bamelis et al., 2014).

Several recent reviews synthesise the recent growth in evidence (Bakos, Gallo, & Wainer, 2015; Hawke & Provencher, 2011; Hopwood & Thomas, 2014; Jacob, Arntz, 2013; Masley, Gillanders, Simpson & Taylor, 2012; Roediger & Zarbock, 2015).

What training is available for Schema Therapy?

There are currently six ST training programs in the UK, including one in Scotland, that have been accredited by the International Society for Schema Therapy (ISST). Details are available at: http://www.schematherapysociety.org/United-Kingdom-Training-Programs. Workshops can be attended as stand-alone training, or as part of a standard or advanced accreditation program. The accreditation programs include 20-40 sessions of specialist supervision, feedback and ratings on treatment fidelity.

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Biography

Dr. Susan Simpson is a Clinical Psychologist with over 20 years of experience using schema therapy with complex clinical problems. She is a Schema Therapy trainer and supervisor, and has specialist expertise on Schema Therapy for Eating Disorders. She currently works part-time in the NHS, and provides training through Schema Therapy Scotland.

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Bias

Uncovered

Di Airey

Have you ever met someone for the first time and immediately felt at ease with them? You just click; you get on. We feel like we have known each other for a long time. You feel comfortable in their company and as you talk you realise you share similar views on life and have lots in common. What we have going on here is affinity bias, the natural draw we have towards people who are like us or like the people we most spend our time with. They are part of our comfort zone and these relationships even serve to validate our own sense of self. As human beings we are selective by nature. Clearly, we do not make friends with everyone we come across (except perhaps on Facebook!). As human beings we are biased, we are prejudiced, and we are predisposed to like some people more than others because of our life experiences to date. This can really jar with our sense of self. Most of us like to think we are nice people, treating others fairly and respectfully; and perhaps even moreso for those of us working in the helping professions, since we are all about inclusion and treating clients with respect. It is anathema to believe we might act otherwise and our ego can prevent us from facing the reality that our biases could be sabotaging our intent. It is a hard pill to swallow, but to acknowledge our biases is to open ourselves up to change. It is the first step to managing our biases in a way that allows us to still build deeper connections with others, to avoid discrimination and to work authentically, whatever our role might be.

Once upon a time, in the early days of Diversity Programmes and Awareness Training, I think we assumed that discrimination we attributed to bad people. Whether that was a staff member making racist or sexist comments or a line manager bullying others because of their lack of people skills, the implication was that they were at fault and there was a gap in their knowledge or skills that we could try and fill. So, we invested in awareness training to explain about topics like race, religion, disability or other characteristics. Then, if that did not work we could hold them to account against the employment policies we had carefully developed to promote Dignity at Work. Our efforts were not wholly wasted and things did generally improve. People learned more about a whole schema of differences. Blatant discrimination was more likely to be challenged and many barriers to inclusion were removed. But through all of this we were missing a trick. While we focussed on the Awareness of Others we were neglecting Awareness of Self.

Fast forward to the last decade or so and I would argue that we now have the most comprehensive anti-discrimination legislation found anywhere in the World. We have nine protected characteristics. *See Figure 1.*

Figure 1.

Race
Sex
Disability
Age
Religion & Belief
Sexual Orientation
Gender Reassignment
Pregnancy & Maternity
Marriage & Civil Partnership

There are still some gaps but overall, we have made impressive progress on the legislative front. Yet, we still do not have equality. Discrimination still happens. Take a look at the reality of peoples experience. Woman still get paid just 83% of the median wage of Men.[1] Only 46.3% of working-age disabled people are in employment compared to 76.4% of working-age non-disabled people.[2] Black workers with degrees earn 23.1% less

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[1] OECD (2017), Gender wage gap (indicator). doi: 10.1787/7cee77aa-en.

[2] Labour Force Survey, Quarter 2, 2012.

on average than White workers.[3] Of course there are complex factors at play here, not least a legacy of societal trends and occupational segregation. Against this backdrop of persistent inequality, we finally started to look inward, and the concept of Unconscious Bias gained traction as a way of explaining why we are not wholly inclusive. Whether it is what we say or what we do, the effect is that we do not treat everyone with equity; and most of the time we are not aware of this. Our Awareness of Self is somehow lacking.

So how does this twin phenomena of unconscious bias and low levels of self-awareness affect those of us working in the counselling and psychotherapy field? A few years ago, I completed my COSCA certificate and I was delighted that diversity and inclusion topics frequently came up in our discussions and not just because of my personal agenda as a D&I specialist. It is likely that as a profession you are ahead of the general population in our own self-awareness. You learn about transference, counter-transference and talk a lot about ethics and boundaries. You work on being objective; on valuing the client as having their own resources and solutions; and believing that change is possible. There is also an underlying foundation of encouraging openness and you are often naturally curious with a desire to understand others. You also build your own empathy whilst still appreciating that we never quite walk in their shoes. All of this bodes well but it is an absolute imperative that we do not get complacent. No one is immune from being tripped up by their own biases and preferences.

So, what can you do in order to mitigate the effect of bias? Firstly, we need to let go of our egos a little to acknowledge we all have some biases. Secondly, we need to understand why we have them. And thirdly, we need to surface those biases that are mostly unconscious so that we can then hold them in check. Let's look at acknowledgement and understanding as a starting point. Fundamentally, we all have a very basic human flaw in that our brain is simply incapable of dealing with all the minutiae of data and information that is around us at any point in time. Because of this we make selective perceptions, which means that our view of the reality is simply that – our *personal* view – and not the totality of the reality that actually exists. Think about those times when you have shared an experience with someone yet their recollection of it is quite different to yours. Two people might walk down the same street at the same time but what they see and recall is different. We connect more with the things that resonate with us, whether that is something about a current life stage e.g. a newly pregnant woman will typically start to notice other pregnant women and babies and pushchairs to the extent they wonder where they all suddenly came from; or the resonance or connection could come from something that is about our own core identity like our gender, race or religion. Our brain also deals with the complexity of the world by making implicit associations between bits of data. We make assumptions on what is most likely and, when it comes to people, we constantly categorise them against a generalised set of assumptions that we recognise as a stereotype. Add into this our own in-groups: the groups we belong to because we share some common characteristic or circumstance. We tend to be positively orientated towards members of our in-groups; we see them as individuals; we trust them and we are more likely to perceive that they will support us. As opposed to the out groups where we might refer to people like that and recognise their homogeneity rather than their differences; our trust levels will be lower and we won't necessarily expect support; and because we don't know them as individuals we tend to rely on the stereotype of what people like that are typically like. The more removed and distant we are from an out-group; the less we are able to distinguish differences. Which is why we can sometimes travel to a country very different to our own and think people all look the same; or why we cannot tell the difference between accents from places thousands of miles apart yet in your hometown you can tell the difference with someone who is practically a village away. Consider then the client seeking therapy who prefers a therapist with the same gender, similar age and ethnicity, perhaps unconsciously believing that it will mean they will understand them better. Or the therapist who feels some unease at taking on a client who is twenty years older than they are or has a disability they are not used to. And the collusion that can occur when both client and therapist bond over the fact they share an accent. That is bias in action.

When it comes to surfacing our own biases, we have to start with some reflection on our own world view. Here are a few activities you might want to try:

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[3] EHRC, Healing a Divided Britain report 2017.

Take a moment to think about your trusted circle of friends. List their names on a piece of paper then note things like their gender, age, sexuality etc. Use the Protected Characteristics list above but go further. Note things like their profession, socio-economic status, and family circumstances too. Then look at how similar or different they are to you. Is there a homogeneity that you could challenge yourself on?

Make an Identity Pie. Draw a pie chart to represent yourself with sections sized to reflect how significant different aspects of your identity are. Think about both the identity aspects you have been born into (nationality, sex, race, sexual orientation etc.) and also those where there has been some element of choice (income, career, religion etc). Also, think about significant experiences or people that have had a profound effect on you. Once completed, reflect on how your identity shapes how your view others.

Test your biases by completing an Implicit Association Test. There are commercial tests (ask me about implicitly) which provide a focus for a coaching session; and there are on-line tests such as Harvard University's IAT where you can help add to their database of research as well as getting individual feedback: https://implicit.harvard.edu

If you are a practising counsellor you may want to take your findings and reflection to your next supervision session, where your supervisor could help you to hold up a mirror to yourself to enable you to really witness the impact bias may have on your practice.

When it comes to managing bias, the inherent structure of counselling sessions will enable you to overcome some bias pitfalls. If there were no time constraints we would be likely to spend more time with clients with whom we have some affinity bias meaning others could be short-changed as a consequence. We also need to be careful about how we manage our day as a whole. Consider how many client sessions is your personal optimum? When we are tired, hungry, stressed and under pressure we create a breeding ground for bias to show up. We start to lose our objectivity and we become less tolerant of others.

And finally, within the therapy session itself I would encourage you to always keep in mind what I refer to as the MAP for managing bias.

Be **M**indful – stay in the moment; notice what you are feeling; identify what is within and without your comfort zone.

Be **A**ppropriately Curious – ask yourself why you feel the way you do; step into those out-groups from time to time and experience things from a different perspective.

Be **P**ositive – believe that bias can be overcome; see the best in people; look for what connects us not what divides us.

Biography

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Local Councils on Alcohol in 21st Century Scotland

Looking back and Moving forward

Patricia Joyce

It is said that the third sector is driven by a passion often missing from the public and private sectors. Value driven, third sector organisations often evolve from group need and have a closeness to their communities that is often missing from both the public and private sector. With an ethos of flexibility and creativity they allow for the creation of solutions of need to be answered quickly and cost effectively. This way of being can easily be observed within the voluntary addiction services in Scotland which have historically seen many of its volunteers, from board to front line level, having an experiential as well as a theoretical knowledge of addiction.

Among these addiction services, Local Councils on Alcohol (LCAs) have been viewed as a successful grass roots movement since their birth in 1965. However, these difficult political times, with the integrated care agenda and the move to tendering for contracts, have led to uncertainty for many of them.

Local Councils on Alcohol are very much part of the passion-driven third sector; unique to Scotland they are a grass roots community driven concept that was originally entirely volunteer based with reliance on individual donations and small contributions from local authorities. The first, Glasgow Council on Alcohol (GCA), was established in 1965 as an alternative to Alcohol Anonymous (AA). The movement continued to grow through the cities and towns of Scotland, at its peak consisting of 32 members. Their model was to offer a one to one counselling service provided by volunteers trained in alcohol counselling technique. Recent evidence suggests that this grass roots way of delivery is useful for the service user (Collins & Elefteriades, 2012).

To ensure equity of service delivery, Alcohol Focus Scotland (AFS) was established in the early 1970's to support the LCAs by providing training, to set standards and to provide governance. This way of working became prevalent with the recent acknowledgement that LCAs were the most utilised non–statutory service in Scotland (Slattery et al. 2003). As the issue of drug use become more attractive to funders many of the local councils on alcohol, recognising that the counselling approach their volunteers were trained in could be transferred to other addiction issues, began to diversify and offer their services to those affected more generally by addiction.

The withdrawal of support from Alcohol Focus Scotland (AFS) in 2010 gave rise to the Scottish Addiction Consortium (SAC) whose aim to *'promote, encourage and co-ordinate, and where appropriate develop and deliver, training and accreditation of those wishing to develop knowledge and skills in a range of interventions in the alcohol and other addictions field'*. This was an opportunity for the existing LCAs to continue to work as a strong Scottish-wide group rather becoming fragmented and diluted.

By reflecting on both the history and the present situation that LCAs inhabit, the question that now may need to be asked is what happens to the community who have created the need and solution when there is wider change, for instance when the organisation faces the demands of commissioning? Are those grass roots organisations "eaten up" by the professional third sector that have the resources to bid more successfully for a decreasing pot of money? Of those who survive is there a question about the loss of passion as the volunteers who have provided a paraprofessional service often build on both professional and personal experiences are replaced by paid or placement professionals?

The aim of a recent piece of research commissioned by SAC and funded by the

Robertson Trust was to try and answer some of the questions discussed above. It explored the history of Local Councils on Alcohol to understand fully how they came about and to investigate with those operating in these turbulent times whether or not this passionate “grass roots” work is still apparent or if the commissioning process and the “professionalisation” of the sector has meant compromise. All organisational members of SAC were invited to take part in the interview process, in total eleven organisations were contacted and nine (81%) participated. The opportunity to interview 9 out of 11 of the SAC membership allowed for a unique exploration of both the similarities and differences of LCAs as community resources and how they have risen to meet the need of the community they serve. Inhabiting both rural and urban settlements it seems that the agencies, in the main, have grown to reflect the distinctive geography of Scotland in which they sit.

There was difference in the ways in which the organisations operated at present. In the main, the larger organisations, that is Glasgow Council on Alcohol, Tayside Council on Alcohol, Fife Alcohol Support Service and to a certain extent Dumbarton Area Council on Alcohol, through their Board membership, saw themselves as a business and operated very much in the way of a private organisation. They recognised the value of service user involvement but did not see that as a Board function, instead using other methods, for example consultation to feed the needs of the user into the organisation. These LCAs successfully targeted potential Board members to ensure the organisations needs were met. The smaller organisations were less targeted and more encouraging of the grass roots; the service user at the decision-making table. All participants from the fragmented communities, Orkney Alcohol Counselling & Advisory Service, Ayrshire Council on Alcohol, Skye & Lochalsh Council on Alcohol and Ross & Sutherland Alcohol Counselling Services all struggled to recruit and retain Board Membership because of the limited ‘pool’ of volunteers in their area.

All agreed that the future of SAC needed to be focussed, in the first instance, on ensuring that the training needs of the organisations were met. For some this meant co-ordinating the delivery and development of the training, for others it was about the signposting of training and continuous professional development opportunities in addiction to a national perspective of LCAs that could, for example aid others to work more effectively, to move into other area or to access funding. Those more advanced in delivery of their organisational training needs, looked to a more long-term strategy of support and development.

Although diverse in their size and the communities they serve, several common areas of growth for LCAs were identified:

- **To continue to develop the training agenda** – although a 6-day course has been developed, further steps were seen to be needed so all have an understanding of the pathways to access and delivery. There was also felt to be a need for a CPD programme that again could be accessed easily.
- **To work with national governing bodies such as COSCA -** to recognise staff who have worked effectively but do not have the formal qualifications now required by commissioners of service.
- **To support LCAs to access funding opportunities** – as there was recognition that the smaller organisations may need further support to access funding to train and maintain staff developments
- **To develop quality standards** – and to support organisations to meet these standards thus ensuring a quality of service is maintained and recognised nationally
- **To provide governance –** by developing, disseminating and monitoring policies to ensure best practice is maintained across organisation within the consortium
- **To continue to expand their network to include other national decision-making bodies** – such as Alcohol Focus Scotland and COSCA to give strength to work of the addiction voluntary sector at national level

The construction of a robust development plan based on the findings of the above research will allow SAC to continue to build on its success in the next 5 years. SAC is now in a good position to support member organisations.

Electronic copies of the full research study discussed above are available on request from the COSCA office.

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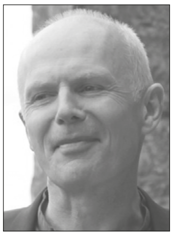
Biography

Patricia Joyce is based in the North East of Scotland. She is a practising counsellor, supervisor and trainer with 15 years of experience of working with both adults and young people who present with issues relating to their, or another's, addiction. She was previously employed as a development manager with the Scottish Addiction Consortium.



Book Review

Monster in the Attic: A client experience of psychotherapy

Book Review by John McCormack

"Until lions have historians, tales of the hunt shall always glorify the hunter."

There are many notable books by therapists describing their approach and experiences (Freud, Yalom, Sacks, among others) but much more rare are accounts from the client perspective.

What does therapy feel like? What does the client want? What actually happens behind those closed doors? Does it help?

These and indeed other trenchant questions are at the heart of this absorbing and illuminating account of Lili's therapeutic journey.

Lili is absolutely upfront, right from the outset, about her own back-story of childhood trauma, abandonment, neglect and mental distress culminating in serious attempts to take her own life.

Lili in many ways is the classic client in today's world of therapy. Complex trauma, attachment issues, self-doubt and a range of other challenges; yet despite this she has strengths, skills and abilities combined with a feisty determination to survive and thrive. This book helps us to see how crucial these "client factors," as they are called in research, are to the outcomes of therapy. It also shows us that, as per usual, the bulk of the work is done by the client outwith and between therapy sessions.

Lili's aim in writing this book is to "capture the authentic voice speaking from my heart" with a view to illuminating for us the rich and raw visceral experience of therapy. This ambition is achieved and more.

Therapist "Sue" sets the scene swiftly for Lili by declaring the work they are to undertake will be a collaboration of equals, a proposition familiar to therapists but which to Lili was simultaneously liberating and frightening.

So here we have it, the therapeutic dilemma, Lili secretly wants an expert and a guide to solve her problems, whilst also sick of being stuck in the child role she is ready to take responsibility and own the required changes. So many conflicts and we've only just begun!

Also of interest is Lili's description of the process of handing over money to her counsellor, and the inherent discomfort in that transaction. It reveals the true nature of the relationship and is a subject not always broached in other discussions of therapy.

This book is a page-turner, make no mistake. You will not be a dispassionate observer, no indeed; you are in there too. Why? Because in a very real sense this is your story, my story, the inner story. It's the story of our vulnerable, needy and frightened selves trying to find answers to the BIG questions. Why am I here? What do I want? Is happiness possible? Can I overcome and grow from very difficult experiences?

So, Lilli and Sue and Roja (Sue's faithful dog) set off on a quest. A mission to make sense of absurdity, madness and the meaning life.

This book is a boon to therapists and also to people contemplating attending a therapist. So many insights to reflect on. How many therapists consider the fact that their client may be worrying about them? Lili is as concerned with maintaining appropriate boundaries as any therapist ever will be. Did I cross a line? Was it okay to say that? Should I have complimented the colour of the therapist's jumper? Am I being pompous? Are there things Sue is not telling me?

"Each time we tell a story we remove ourselves a little from it, distilling its essence and healing its pain."

The internal dialogue of the client is not necessarily as positive or comfortable as we on the therapist side of the equation might imagine. Even our most encouraging and positive responses may well trigger an overwhelming sense of doubt in the person we seek to support. Such are the paradoxes revealed in this memoir.

Lili's trauma, as so often happens, comes to the fore in the middles phase of therapy where the damage caused by childhood sexual abuse is laid bare. This creates a tightrope on which both Lili and Sue are counterbalanced, each carefully trying not to knock the other into the abyss.

Despite being in the midst of her existential pain Lili is taking care of Sue with as much concern as Sue has for her. Isn't that the way of it? Is the distinction between helper and helped as clear as we perhaps imagine?

Lili's writing is spellbinding (well, she is a poet), the journey is epic and the insights are precious and a gift to anyone with an interest in mental health.

Ironically, bizarrely, and unexpectedly therapist Sue threatened legal action when Lili told her she was planning to publish this memoir. Often times therapists have written memoirs with thinly disguised case studies of "anonymised" clients but heaven forefend the reciprocal.

For this reason alone, all names in the book and this review have been changed to protect the innocent.

I commend this book highly. I have already incorporated wisdom from it in to my practice and teaching. I have incorporated its wisdom into my life. Buy a copy now, you will not regret it.

Biography

John McCormack is Network Manager: Projects with the Scottish Recovery Network where he led the development of the Write to Recovery website and groupwork.

John has been teaching counselling at Glasgow Caledonian University since 2004. With an interest in solution-focussed approaches, resilience and tackling adverse childhood experiences (ACEs). He freely admits he is on a mission to tackle the colossal level of distress associated with trauma.

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Please contact Marilyn Cunningham, COSCA Administrator, for further details on any of the events below:
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COSCA Events 2017/18

Some information is currently available on the COSCA website and this will be further updated when final details are known.

2018

7 MARCH
COSCA Annual Ethical Seminar
STIRLING

15 MARCH
COSCA Recognition Scheme for Organisations Information Sessions
STIRLING

11 APRIL
COSCA Recognition Scheme for Organisations Information Sessions
STIRLING

6 JUNE
COSCA 20th Annual Trainers Event
STIRLING

19 SEPTEMBER
COSCA Annual General Meeting
STIRLING

COSCA
Counselling & Psychotherapy in Scotland

VISION

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

PURPOSE

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

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