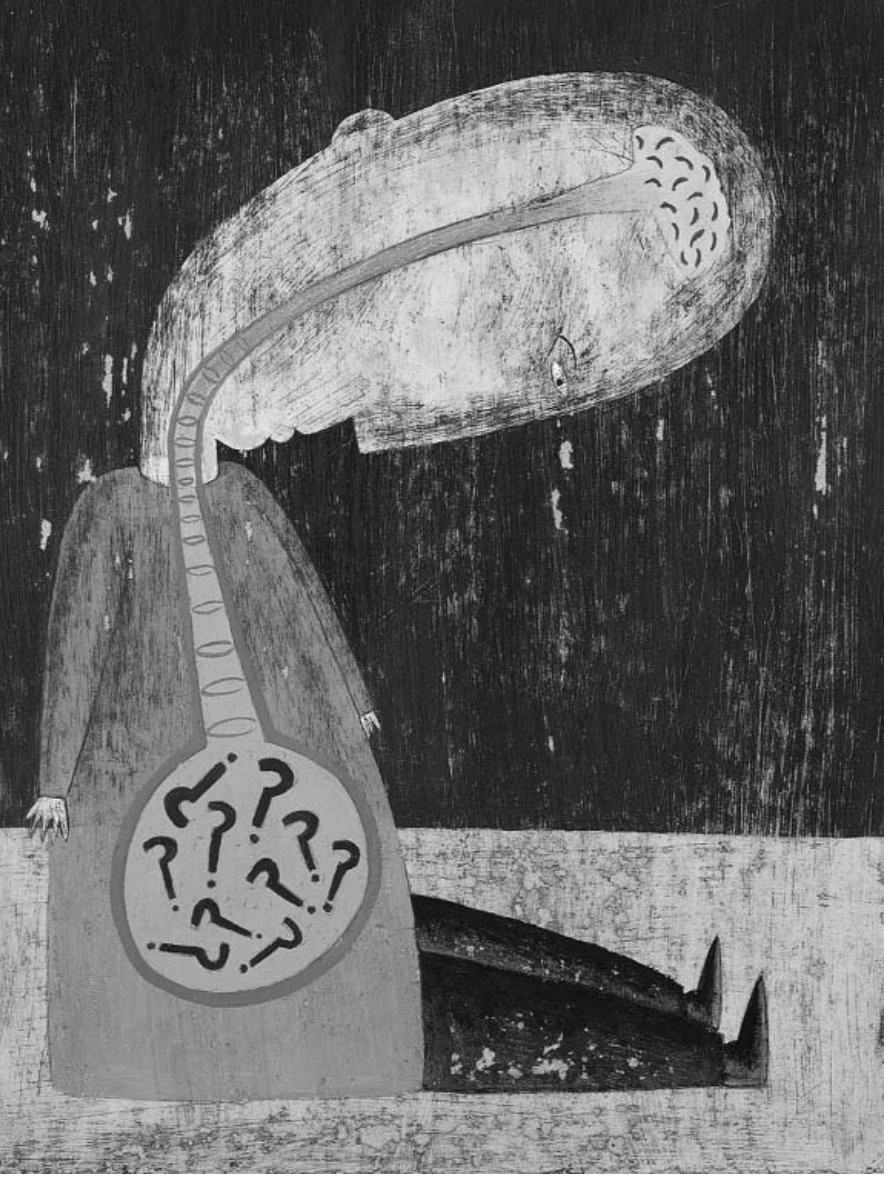

DIGITAL VISION/GETTY

Counsellors could supply a much needed workforce capable of delivering a listening version of CBT, says **Frank Wills**. But first they need to drop their prejudices about the model

Delivering CBT: can counsellors fill the gap?

There is a big shortfall in trained therapists who can deliver effective cognitive behaviour therapy (CBT)[1]. If the proposals of Lord Richard Layard, or anything like them, come to fruition, the shortfall is bound to get worse[2]. This raises the very legitimate question: who can fill the gap? Nurses are currently one of the largest professional groups involved in administering CBT[3]. However, nursing organisations have expressed concern that psychiatric nurses who are already under-strength should not be unduly plundered for this role[2]. This article will argue that those counsellors who would want to[4] are uniquely placed to take up the challenge. But for this to happen widely, the counselling profession may need to examine some of its negative beliefs and prejudices about the model.

CBT therapists who can listen

I have been conducting a longitudinal study of counsellors learning CBT for the past seven years. I presented some of my early findings to a conference of the European Association for Behavioural and Cognitive Psychotherapies in Cork in 1998. During my presentation, I made the slightly tongue-in-cheek comment that counsellors sometimes 'listened too much' for CBT: meaning that the counsellor's desire to hear everything their client is saying sometimes makes it difficult for them to focus on specific content in the way that is required in delivering CBT. After my presentation, a trainer involved in CBT training in the NHS told me that he had the opposite problem: he couldn't get his trainees to listen at all! I remember thinking that I preferred my training problem to his!

The skills training tradition has been strongly entrenched in counselling training, and results in a profession

What is CBT?

Cognitive behavioural therapy (CBT) can be regarded as the parent group of therapies that draw heavily on both cognitive and behavioural traditions. Beck's model of cognitive therapy is one of the most influential CBT models. Others include Ellis's rational emotive behaviour therapy (REBT), Meichenbaum's stress inoculation therapy (SIT) and Young's schema focused therapy. In fact the structure parallels the psychodynamic parent group, consisting of Freudian psychoanalysis, Jungian analytic therapy and object relations therapy, among others.

Beck's model of cognitive therapy suggests that there are specific cognitive profiles of thoughts and beliefs that typically accompany problem areas such as depression and anxiety. Once these profiles have been formulated, therapist and client engage in a collaborative, empirical process to test out these thoughts and beliefs and their accompanying emotions and behaviours to promote enduring therapeutic change.

that is remarkably well able to listen[5]. Even before I became a CBT therapist, however, I found that many trainees wanted something more: 'Ok, now I can get the client to tell me his story, but what do I do now?' My general response to this often-asked question has been, 'Well one of the things you could try is focused cognitive-behavioural work.' There is, I hear, a little bit of evidence that such work can be quite effective in helping people with common psychological problems such as anxiety and depression[4].

The joys and perils of learning CBT

Diana Sanders and I[6-8] have written about the many, sometimes seemingly intractable, ways in which people misunderstand CBT. My longitudinal research has been following trainees' reactions to the principles of CBT before, during, and after training, and the ways in which these reactions may influence the way they are able to learn CBT skills[9].

The main principles of CBT espoused by Aaron Beck and Judith Beck[10-13] are:

- Cognitive therapy is brief and time-limited.
- Cognitive therapy is structured and directive.
- Cognitive therapy is problem- and goal-oriented.
- Cognitive therapy is based on an educational model.
- Homework is a central feature of cognitive therapy.
- Cognitive therapy uses primarily the Socratic method.
- The theory and techniques of cognitive therapy rely on the inductive method.
- A sound therapeutic relationship is a necessary condition for effective cognitive therapy.
- Cognitive therapy is a collaborative effort between therapist and patient.
- Cognitive therapy is based on the cognitive model of emotional disorders.

For my research, these principles were operationalised into an inventory, and this was administered to trainees before and after training and at follow-up. Trainees were also interviewed. Trainees' responses to these surveys were compared to their subsequent performance in CBT skills assessments. The results showed that many of the CBT trainees went into training with a strong belief in other modes of therapy, and had significant reservations about CBT principles, especially those implying direction and structure. In the case of trainees with a psycho-dynamic background, however, these reservations did not seem to affect the achievement of competence in CBT: in fact, psycho-dynamic trainees did slightly better than any other group in cognitive behavioural skills assessments. Some of these trainees had 'conversion' experiences, and have ended up as cognitive behavioural therapists. Others found, sometimes to their surprise, that CBT theory had more overlaps with psychodynamic theory than they had imagined[14], especially in the concept of 'early maladaptive schema' used in schema-focused cognitive therapy[15]. On the whole, psychodynamic reservations about CBT seem to be more at the theoretical level, and may therefore have less impact on practice.

In the case of trainees with a person-centred background, most were able to learn CBT without too many problems. However, a significant minority took significantly longer to master CBT skills than those from other training backgrounds. The difficulties seem to be linked to these trainees' reactions to the principles of direction and structure in practice. Unlike the more theoretical objections of those trainees with psychodynamic backgrounds, their reservations seemed to impact more on their practice. In interviews conducted after training, the trainees beginning from a person-centred background described these struggles as follows:

Although I didn't want to become over-structured, I almost did. The structure became a kind of safety blanket for me ... I thought, 'I can't play with it' ... for a short while I lost trust in myself. I didn't give myself permission to play with it. I had to do it [by rote] or else it wouldn't work... (Trainee: 343)

I remember getting wound up about having to set the agenda ... Going in saying to myself, 'You've got to do it; you've got to do it!' I was scared that I might be taking over. (Trainee: 345)

I thought I might be controlling and I really struggled with that. (Trainee: 347)

I felt uncomfortable with being directive: scared I might be patronising – you know, telling people what to think. But I could also see that my work lacked direction. (Trainee: 356)

There was some fear ... I didn't want to do therapy by rote. It sounds stupid but I couldn't say the word 'home-

work' to clients. I find it difficult even now. (Trainee: 477)

Sometimes these trainees referred to the price paid in their previous training to overcome their personal tendencies towards directiveness:

I'd had to work so hard to learn to listen in my previous training ... now I wondered if it was important any more. (Trainee: 356)

... the structured format, homework, objectives, socialisation ... all play to my more directive attributes: the therapist in charge ... It is vital that I remain aware of this tendency. (Trainee: 601)

Padesky[16] has pointed out that therapists sometimes get restricted by their own negative 'therapist beliefs' in the same way as clients get restricted by their negative thinking. Assumptions such as 'If I structure the session, the client will feel controlled' and 'If I ask the client to do homework, they will resist me' have been quite widely reported by CBT trainees. Such negative beliefs often disregard other parts of the perceptual field: in this instance, the CBT principle of collaboration. So, what tactics can be used to overcome these restrictive tendencies?

Overcoming difficulties by developing new learning heuristics

Most trainees who struggled in this way eventually realised that CBT principles were not 'fundamentalist', but 'pragmatic': the aim is to help the client feel better. A fundamentalist view of CBT leads people to over-apply the model and blocks their learning. Interestingly, MacKay et al[17] report a similar phenomenon among those training for interpersonal therapy. The trainees seem to get overwhelmed by a learning heuristic along the lines of: 'I have to do it in the prescribed way', and this prevents them from 'playing with' the model and thus slowly working their way into it. There is frequently a crisis when previous expertise seems 'de-skilled' and new skills will not come: a zone of uncertainty like that of a trapeze artist who has let go of one swing and is waiting for the other one to smack into her hands. The result is anxiety, which can further block learning[18]. Happily, most trainees are able to transcend this moment of crisis by allowing themselves to rethink some of their attitudes and then to play with the new model, as illustrated in the following quotes:

Then I was able to say to a client, 'This is new to me – we could try it.' It had been difficult to feel, 'I can be flexible and play with it and still help my client.' Passing my assessment showed that I could do it up to standard – at least as far as the tutors were concerned. I really like doing CBT, but it will always be just one of the things I do ... I wouldn't impose it on anyone. (Trainee: 343)

Then I calmed down ... It wasn't reasonable to think that I could go straight from one model to another just like that. I could bring it in bits at a time ... I stopped thinking, 'I have to do it properly for the college' and thought, 'I can't do it that way. I'm going to do it my way and if the college don't like it, that's tough!' (Trainee: 345)

As well as such task-oriented problem-solving strategies[19], there was sometimes evidence of more purely conceptual changes:

I talked over my worries (about being controlling) with a tutor and she said, 'Are you confusing "being controlling" with "giving direction?"' And I thought, 'Yes, I am confusing "direction" with "control"'. (Trainee: 345)

Once the message was fixed in my mind that there was a difference between giving direction and being controlling then I felt settled. (Trainee: 347)

I realised that you don't have to go in there with great hobnail boots. Being directive is often just what my clients need. Actually, CBT does have the potential to be over-directive, and avoiding that is what it means to become an experienced practitioner. (Trainee: 351)

Once trainees were able to 'free up' their thinking and allow these less 'catastrophic' and more 'task-oriented' approaches and thoughts to direct their learning, they often moved rapidly to CBT competence. (And of course there are interesting parallels here with the therapy process itself[20].) Follow-up surveys showed that the changes were lasting ones; and while some former trainees subsequently went over fairly fully to CBT practice, most still regarded it as 'one of the things I do' (343 above), though by this time obviously in a much more organised and effective way.

Opening up one's constructs is often easier in an educational environment of exploration and acceptance. So I want to end this article by suggesting that involving counsellors in delivering CBT may be enhanced by fostering a little more exploration and acceptance within our own profession.

Does the counselling profession want CBT to be 'on the team'?

I am an accredited BACP counsellor

and fellow, and an accredited cognitive psychotherapist with the British Association for Behavioural and Cognitive Psychotherapies (BABCP). I was present at the BACP research conference in May 2005, when a leading speaker said: 'If we are not careful, it will be CBT, not us...'

Suddenly it seemed I was 'not one of us'. I thought of Mrs Thatcher's famous description of the Tory 'wets'. If this was an isolated incident, it would be of little significance. However, I have heard this kind of comment made quite frequently at BACP meetings – often when the incipient competition between models has been reactivated by the latest treatment guidelines issued by a government body.

The fact is that this comment reveals a severe 'category error' in that it defines the terms 'counsellor' and 'cognitive behaviour therapist' as mutually exclusive[8] – which is not the case. A significant proportion of BACP members cite CBT as a prime influence on their work[21]. Moreover, counsellors make up one of the largest professional groups among cognitive behaviour therapists[22]. I should add that I have never heard negative comments about counsellors at CBT meetings, though doubtless readers will be able to write in with examples.

I believe that some of the negativity in this area arises from the fact that certain medical professionals who have always felt sceptical about counselling and therapy use CBT as a stick with which to bash counsellors and therapists. I regard such people as very unreliable allies for CBT – likely to turn on CBT therapists at a later date, just as they have done with psychoanalysts and counsellors in the past. However, I am not calling for a blandified unity among therapists. Let's have some good arguments, but let's also be open to what we might learn from each other!

Counsellors could supply a much-needed workforce capable of delivering the listening version of CBT. CBT cannot work without close and careful listening, and there is evidence that cognitive behavioural therapists are just as capable of this as other psychological therapists[22]. We must ask, though, whether counsellors are likely to be open to taking this role on while senior figures in the profession imply that CBT is 'not one of us' or, even worse, is 'the enemy'? Perhaps the time has come for us to lie back, open our constructs and think of England! ■

Frank Wills was born and brought up in Birkenhead and supports Tranmere Rovers FC, facts that he believes account for his remarkable skills in dealing with anxiety and depression. He is a cognitive therapist living and working in Bristol. He has written, with Diana Sanders, Cognitive therapy: an introduction *(Sage, 2005) and is working on a volume on CBT skills for the Sage* Skills in therapy *series.*

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This article was first published in the Healthcare Counselling and Psychotherapy Journal *(HCPJ Vol 6, No 2), a quarterly journal of the British Association for Counselling and Psychotherapy.*

Pre-empting panic attacks

Paul Bress suggests being proactive so your client might not need CBT for help with anxiety

The prevalence of anxiety in advanced capitalist societies has been well documented. Moreover, treatments are also quite widely known by the layperson – usually antidepressants, together with either cognitive behavioural therapy or possibly psychodynamic therapy – depending on whether or not the client wants to focus on deeply embedded problems.

But what I want to do here is explore what the person prone to anxiety can do for him/herself to *pre-empt* a panic attack. Let's say that we can divide the anxiety sufferer's experience of the world into three types, depending on the degree of vulnerability:
Type 1: no vulnerability
Type 2: beginning of vulnerability
Type 3: total vulnerability.

In Type 1 there is *no chance* of a panic attack (so if it ain't broke, why fix it?); in Type 3 a panic attack feels *inevitable* (so the client can't do anything anyway). But in Type 2, the person in question feels as if s/he *might* have a panic attack. This may be expressed by unnecessary thoughts crowding the consciousness, the beginnings of fear, and some physical sensations, such a difficulty breathing. In this Type 2 situation then, *things could go either way*. The incipient anxiety could develop into a full-blown panic attack (Type 3), or the feelings could settle down and the person might then return to a less vulnerable state (Type 1).

So what can the client do? Let's look at this in the form of a flow diagram (*right*). This means that if one strategy fails, then the client should proceed to the next one. For each strategy I explain why I think it's necessary, and I suggest some sample 'internal' language.

Perhaps the biggest problem facing the anxiety sufferer is how to cope with everyday life before the full effects of therapy and/or medication have taken place. In particular, the client needs strategies for situations in which there is incipient vulnerability. In this case, if the flow diagram above is followed, the panic attack may well be avoided. In fact, a negative association with a situation might well be replaced by a positive one. ■

Be aware of the here and now

Why? Anxiety is normally propelled by our taking ourselves away from the here and now. We torture ourselves by our preoccupation with the past and the future (and the connection between the two). Being aware of the here and now is less likely to result in veering from the here/now.

Internal language: 'Mm..this is a comfortable chair...that's a nice breeze...what an attractive voice.'

Remind yourself of your positive qualities

Why? We can all get into a vicious circle of thinking/feeling if we aren't careful. But we have the power to turn this round 180 degrees – by creating a virtuous circle.

Internal language: 'I am a highly intelligent, articulate and insightful person.'

Remind yourself that a panic attack is not inevitable

Why? We tend to associate certain situations with feelings and these feelings become fixed in our consciousness and appear as if they are immoveable. The reality is that we have free will and have some power to determine how we behave in different situations

Internal language: 'I have the freedom to think and feel whatever I like.'

Think of the best scenario (in the situation to come)

Why? By visualising what may happen we are more likely to make that positive scenario happen. The visualisation process affects our subconscious in some way – and creates a reality of our choosing.

Internal language: 'I am going to speak loudly, clearly, and confidently throughout.'

The gentle art of pottering – or body-mind unfocused

Ros Pirani points out the usefulness in what might otherwise be considered idling your time away

Pottering in the garden is what most springs to mind for me from the word *potter*, but I suppose you could just as well be fiddling with maggots while waiting for the fish that never comes and enjoying being in the fresh air. I am surprised by the Wordsworth Concise English 1994 edition: 'to busy oneself in a *desultory* way' (my italics); 'to dawdle' (that is better), and had no idea about their n. pottering; 'diffuse talk', although after the first shock it does seem mysteriously encouraging. Chambers 1994, obviously the year in which dictionaries were upgraded in our house, adds 'in a desultory way with trifling tasks' and 'to progress in an unhurried manner'. *Desultory*, according to them, is 'jumping from one thing to another; without rational or logical connection; rambling; hasty; *loose*' (my italics). I have jumped to the wrong conclusions about the word *desultory* and must have been using a merely depressing rather than the obviously psychotic meaning intended. I can see why they invented a TV programme where you can produce evidence to change the current usage of a word.

Sometimes when at your most focused, a bout of unfocused activity may come over you as a kind of safety valve. Over focused, you could be out of touch with what is going on around you, or what is going on inside you in terms of stress and discomfort. Pottering is one of the best forms of self-help, done preferably alone and spontaneously, but members of a group could go off on their own and meet up when they are required to be less desultory. Just going off on your own may not lead to pottering but it is worth a try. Even if you encourage it, pottering feels as if it comes out of the blue. There must be unconscious forces at work for it to happen.

Anything creative appears to come from nothing, yet if we look closely we see that it is made up of ingredients stored in the memory at some level, which are triggered by unconscious associations. Pottering is creative, although the end product is usually refreshment, distraction and a building up of depleted resources. When we potter, something in us, aided by the safety of life allowing us to be free of pressing tasks for a while, accidentally pushes the 'pause' button. We then pause from being operational and purposive while experiencing through a kind of unstructured, spontaneous play, a richer sense of who we are.

We need that built-in safety of circumstance in order to potter. I felt strangely privileged when for some years I had to take a lengthy train journey twice a week to work. It gave me time to talk randomly to fellow commuters, read my neighbour's book instead of mine, wander round stations and platforms and generally let myself go without involvement or purpose. Pottering became a crucial part of my life, responding to warning signs from the embodied mind that it was not always good to write notes on the train (although sometimes I had to) nor to read academic articles. I read more when the novelty wore off and the trains got later so that the situation felt less safe and more of an irritation. Yet the need to potter before and after a hard day's work would still come over me to make me pause and stop what I was doing, stretch and let thoughts wander with the motion of the train, eyes unfocused on the speeding countryside.

Individuation and diversification

Pottering occurs developmentally in young children playing by themselves in a safe environment where an adult is keeping an eye. Typically, the child is talking to itself and one form of play leads by association into another in a sequence understandable only to them. Although others may be imagined, the rules, if there are any, are such that they cannot be shared. Unselfconsciousness and talking to oneself is lost by the age when solitary rehearsal and imaginative acting out is no longer necessary, but comes back in another form when we are alone yet safe as adults. A child potters in

PHOTODISC/GETTY

‘Pottering occupies the borderline between being alone and being with others. In adults it restores us to a state of individuation from being a part of the fabric of society’

anticipation of activities to come whereas adult pottering is a harking back to that time when life was unexplored.

Pottering occupies the borderline between being alone and being with others. It is not possible if a state of aloneness becomes overpowering. For the child, it enables them to move away from a parent who is keeping them in mind. In adults it restores us to a state of individuation from being a part of the fabric of society.

Novel ideas arise and are rehearsed in little activities that mimic the possibility of larger projects. Pottering round a garden gives rise to the thought of next year's planning, what to have for tea, memories of other times, and of one's own bodily condition. As a break from a stressful focused activity where the mind is concentrated on one thing, it allows us to become unfocused and broaden our gaze, movements, and feelings, to refresh before returning to something where we become instrumental rather than alive.

Pottering is creative in the sense of being consciously able to dream. It often seems impossible to make our dreams come true, so pottering is a kind of subversive activity. The bridge between the dream and its fruition needs a gigantic leap of faith. It may be that what is needed is not more action but more pottering in which to cradle the state of mind where dreams are nourished before they can bear the light of day.

Cultivation in moderation

Too frequent or large amounts of pottering are not a good idea. Pottering loses its meaning if not contrasted with all our other activities. Everyday life requires us for the most part to remain focused on what we are doing. The exception can be repetitive tasks, which are good for the soul in that they allow the mind to wander. Pottering is synonymous with contentment, where less and more conscious elements run in tandem. By the end of the state of pottering a decisive focus to do something else may have been reached unconsciously.

Pottering isn't something we can really decide to do, but instead find ourselves doing, so has its own built-in safety valve. It only occurs when other needs have been met and there is a fortuitous space that fits into a slot between one activity and another. So it will regulate itself for the most part. But if we haven't been doing it for a while, we may ask why not, and set the scene to allow it to reappear. It could be that we have been living too hectic a lifestyle.

We cultivate the art of pottering by giving in to the urge to potter. By seeing it as both a healthy and a pleasurable part of our lives, noting its absence during times of stress and overwork, and by naturally ending a spate of pottering rather than trying to prolong it. If it becomes procrastination it would revert to its dictionary definition of being not an art but an aberration. Think of birds playing on the wing in proportion to hunting, migrating, defending from attack, or propagating the species.

Connection with self and environment

Pottering is a means of touching base. When we are involved in a focused task we don't have time to think

about where we are or who we are. Pottering gives us space to reconnect. Senses and perceptions become sharpened. Feelings are allowed. We emerge after having been receptive to details of our environment that we do not usually have time to appreciate. The spontaneous switching off of purposeful action removes constraints: timeless and unpressurised, and is perhaps the best unconscious memory of childhood we can experience.

Communion and clarification
Pottering is communicating, not with other people, but with oneself, and to some extent, with the environment. Not about anything in particular, a wordless state on the whole, it can nevertheless engender a feeling of clarity. The space in which we find ourselves pottering is full of awareness of objects outside ourselves at the same time as awareness of what is going on inside, on all levels, physical, mental and spiritual.

Pottering alone in the room reminds us of the absence of loved ones. If they are dead, their presence may seem to fill the room and as we wander they seem to come with us, asking how we are, what we might need from them, appreciating possessions we have acquired since their demise. I am aware that this is a highly personal example, but what other kinds are there? The personal may also be the universal.

True pottering is free from anxiety, a relatively rare state in the human existence. Without anxiety we see more clearly. A sense of being safe, as if there were someone else there, could be a memory of first learning to potter, when an adult was around to watch for our safety while we played to an imaginary audience, talking out loud, spontaneously changing from one activity to the next until the call, 'Dinner's ready!'

Unfocused on specifics, the specifics we toy with do not matter, only the general quality of the experience, which is more being in the here-and-now. The child playing her solitary game in the shadow of the parent who guards against the intrusion of the world is in preparation and rehearsal for becoming the adult and taking her place in that world. Perhaps adult pottering is a retreat from that world and a return to childhood whence we came.

Applications and comparisons
Pottering in context is not the same as pure pottering but has certain comparisons. Freud's asking the patient to free-associate may lead to a state of pottering even though constrained to lying on a couch, trying to reconstruct the child at play watched over by the thoughtful adult. In psychotherapy both client and therapist may be engaged in a free form of mutual endeavour where the greatest fruits come from a kind of pottering which, again, cannot be wilfully induced, but if the therapeutic climate is right, may naturally occur.

Creative people may try to induce a state of pottering to enhance the creative muse, via perhaps listening to music as a way of calming and distracting the mind from more mundane activities. Doodling or desk-top games may induce a state of wakeful dreaming where the mind is more open to novel or break-through ideas. It has been said that mathematicians dream the solutions to problems they then are able to see clearly on waking. Pottering is a must for the over-coper. Less focusing is, in the end, more productive than too much. ■

Contributions are welcome!

Visit www.aiponline.org.uk or write to the editor at the address on page 1. Articles should include references in the current BACP format, as in therapy today. Feedback – positive or otherwise – on what you read in The Independent Therapist is always welcome. Deadline for next issue: 25 April 2007.

Books available for review

The following books are available for review by readers. If you would like to submit a review on any of them, the book is yours to keep. Reviews should be between 500 and 1000 words. A style guide is available for reviewers.

Custody minefield, by Michael Robinson, published by Orana Publishing. A self-help work for separating parents wishing to resolve where their children live, who can see them and who decides important questions of education, religion, health treatment and so on.

Who is it that can tell me who I am by Jane Haynes, published by Cromwell. The journal of a psychotherapist, with foreword by Hilary Mantel.

Integrative therapy: a practitioner's guide, second edition. Maja O'Brien and Gaie Houston, published by Sage.

For more information contact the editor, Margaret Akmakjian-Pitz. email: o2quiver@aol.com or write to: Glanrhydw Lodge, Cloigyn, Pontantwn, Cydweli SA17 5NB

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Seven steps to creating **a secure therapeutic environment**

Paul Bress suggests ways to provide a holding environment in the counselling room

In recent times more and more mothers have become increasingly frank about not having maternal instincts. They don't feel easy about or confident around babies – they don't know who to hold them or how to communicate effectively with them. Unfortunately, this can lead to significant problems for the child in question. He/she will not have had that 'cotton wool' experience that is so important – and may not develop that sense that everything is right in the world.

If an infant has not been fortunate enough to have had this 'cotton wool' start in life, he/she may find some life events more threatening than will others. If this infant undergoes physical/sexual/verbal abuse, for example, then what might usually be experienced as simply frightening will be experienced as an out-and-out trauma. What this means is that any fluidity in the infant's behaviour prior to the trauma may be replaced by a controlled response. In other words, the experience is so painful that the infant doesn't allow him/herself (unconsciously) to experience a natural fear response, but, instead, puts that reaction on hold. The normal fear response is replaced by a tensed-up body and a mind that, henceforth, controls its thinking very rigidly.

This lack of ability to experience normal fear clearly has a function. It prevents the experience of something very painful. Unfortunately, though, the consequences can be very long-lasting and very damaging. If the infant's dysfunctional reaction to the traumatic event continues into his/her everyday life, the child will have severe difficulties experiencing a whole range of emotions in later life. He/she will have lost his/her spontaneity – this will be replaced by a life in which natural emotional responses are shielded. This shield cannot last forever, however. The trapped emotions press against it, until, when there is some health scare, bereavement, or disturbing event later on in life, the emotions break through the shield and manifest themselves in the form of panic disorder.

It's at this point (when he/she is experiencing a clear syndrome) that the client will probably seek the help of a counsellor or therapist. And this counsellor or therapist needs to create a situation in which the client feels completely secure. This is a pre-condition because, without this sense of security, he/she will not be able to process the traumatic events and start to tune in to his/her natural body responses to stressful events.

In the light of the above, how can the counsellor/therapist create a secure therapeutic environment? Let's look at seven steps:

1 Sit face-to-face (without any desk!)

A desk would create a barrier to intimacy between practitioner and client.

2 Keep reasonably still

Otherwise, the client will feel unimportant and peripheral, and his/her self-esteem will plummet.

3 Let the client direct the agenda/direction of the dialogue

This is very important, because the client needs to work things out for him/her self – and his/her own pace. In time, the client should start to have a sense of power because of his/her ability to set the agenda.

4 Give the client your undivided attention

See 2. Note: if you do give your undivided attention, your body won't move around much anyway!

5 Tune in to the feelings the client is experiencing

The client will desperately need to be understood. This means not only

the surface information they give you but also the feelings (which may be covered up by excessive rationality).

6 Accept, unconditionally, everything the client says (and the feelings associated with it).

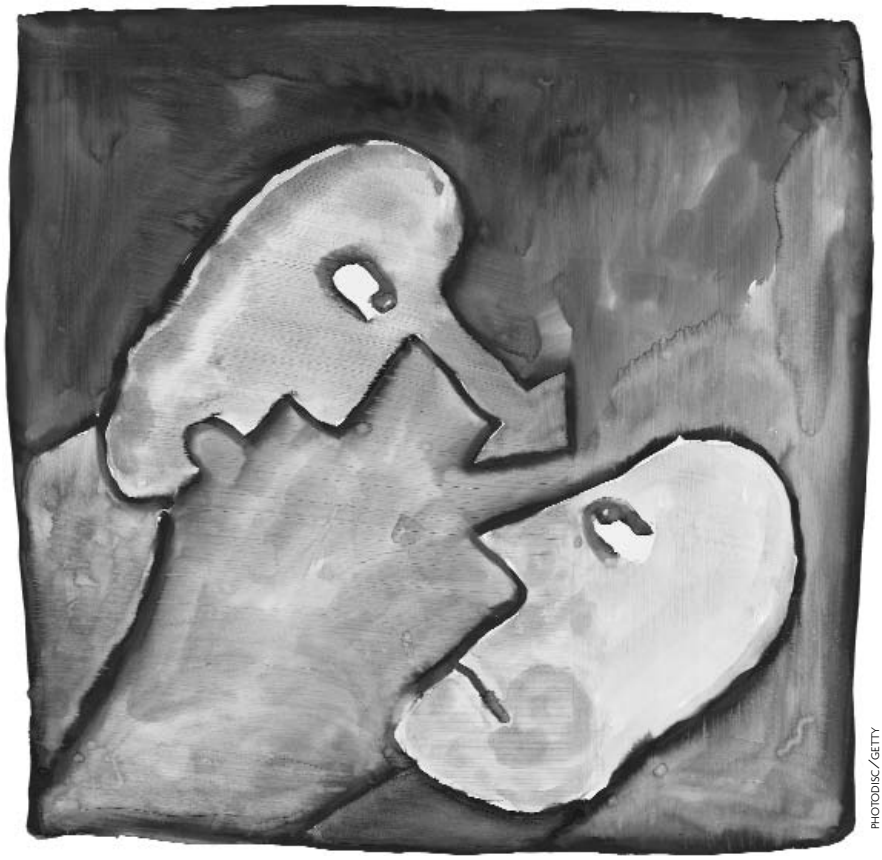
This is key. This is the practitioner playing the role of the mother. The client needs to get in touch with repressed feelings in his/her infancy, and the practitioner must encourage and accept these feelings. The result should be an acting out of what should have happened in infancy. And the client can begin to express feelings in a more normal, natural, way.

7 Wait until the client's 'turn' has completely finished before intervening with a quiet, but warm, voice

Such interventions show 'attunement'. Their subtext is: 'I understand you, and I'm here to protect you'. Consequently, the client feels understood, safe, and able to let go of his/her pent-up emotions.

Most of the above points will be considered to be blindingly obvious to counsellors/therapists. But I'm wondering whether all practitioners, do, in fact, follow these 'steps'. I wonder how many allow their clients to follow their own agenda? How many give their undivided attention? How many can really accept the opinions/feelings of the client without judgement? How many make genuinely timely interventions that reflect the experience of the client?

I think that practitioners would do well to follow these seven steps before going on to develop various therapeutic techniques that are designed to accelerate the development of the client. If they don't, they will be working on very shaky foundations and may even do more harm than good. ■



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A home-grown theory

Ros Pirani muses on bullies and victims: what drives them to their particular behaviour?

Observations of human behaviour give rise to rule-of-thumb explanations, many of which are assumptions based on very little and do more harm than good. Someone labelled me a victim. Eventually this made sense but also left questions. When and how did it happen? Was it reversible? Or was I stuck with it forever?

I was brought up believing people were intrinsically good and sometimes behaved badly. Having been called a victim, I felt compelled to investigate its opposite, 'bullying', in all its forms. The straightforward 'what you see is what you get' was the easiest to recognise. Then there was the 'wolf in sheep's clothing' or 'the iron fist in the velvet glove'. Worst to work out was the 'poor me' tactic. All of these guises can be confused with being a victim, whereas a victim often appears able, confident and overly independent.

Being accused of seeing people as the summation of their maladaptive behaviour, I became in favour of degrees along a continuum, with the desirability of reaching the middle. I decided being a victim is essentially not knowing you are one, as with

What does a typical AIP member look like?

Part one of the analysis of the 2006 AIP membership questionnaire

We are a diverse lot. Apparently about all we have in common is that we are counsellors or psychotherapists (or both), we belong to BACP and AIP, and we took the trouble to fill in the AIP profile questionnaire last year. Unfortunately, only 5.3 per cent of our (then) 730 members responded to the request, but possibly some conclusions can be drawn.

Because it is such a small sample and because the ranges are so diverse, it does not seem useful to give averages, but rather to give ranges for the various answers. For example, in question one (How long have you been a member of BACP?) the answers range from 'just joined' to 28 years. The median (as many answers above as below) is nine years. Similarly, for question two (How long have you been a member of AIP/PRG/PRSF/PSMFT?) the answers range from 'just joined' to 25 years, and the median is two years.

Not many of the respondents log on to the BACP website (range: 0-10 times a month) and even fewer log on to the AIP website (range: 0-8; median: 0). Client hours per week range from two to 23, with a median of nine, and fees charged range from zero to £100, with a median of £32.50. The age range of members is harder to pinpoint as the options were themselves given as ranges. However, only one respondent is in the 20-30 range; seven are in the 31-40 range and 12 in the over 60 range. Which means the majority (9) fall into the 51-60 range.

One quarter of the respondents also belong to other divisions of BACP. The majority of respondents (27 to 12) are accredited counsellors, though only four are accredited supervisors. The number of years in practice ranges from 'just started', to 39 years, with a median of eight years. The distance travelled for supervision varies from none (telephone supervision) to more than 70 miles.

Half the respondents work (as therapists) in organisations in addition to working in private practice, and half (not necessarily the same people) have non-counselling paid work in addition to their counselling work.

Our diversity really reveals itself in the number of orientations and speciality areas each respondent listed. Seventeen different major orientations were given by the 39 respondents: Adlerian, behavioural, CBT, eclectic, existential, Gestalt, humanistic, integrative, interpersonal, NLP, PCA (evidence based), person centred, psychodynamic, reality therapy, shamanic, solution focused, TA, and transpersonal. And no fewer than 30 different specialities were listed, ranging from abuse and violence, through adoption, cultural issues, death and dying, decision making, life coaching and relationships, to sexual minorities and trauma.

Respondents are equally well spread over the UK, including Northern Ireland, and one from overseas. Predictably more respondents live in and around London than anywhere else. Fifteen respondents practise in urban areas, five in rural areas, with the remaining 19 working in mixed areas. Only 10 respondents rent somewhere to practise; the majority see clients at home (the therapist's home, presumably, for the majority).

The widest spread occurs in how respondents' working time is broken down. There is no pattern at all: some respondents do far more EAP work than anything else, some do more supervision than therapy, and some do more non-counselling work than anything else. All of which simply emphasises how very diverse our membership is.

Part two of this analysis – featuring respondents' personal thoughts and wishes – will be published in the summer 2007 issue of *The Independent Therapist*. ■

Margaret Akmakjian-Pitz

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the last word

Do you watch Big Brother? And possibly more to the point, do you admit that you watch it? Whatever your feelings about its value or lack thereof, you have to admit it causes more polarisation than almost anything outside the rightfulness of invading Iraq. Actually, Celebrity Big Brother last January, with its racial tension and bullying theme, probably moved its controversy rating up and over the Iraq war.

I'm sure there are a few people who are honestly neutral, but typically there seem to be four groups in the opinion stakes: those who watch it openly and with huge enjoyment; those who watch it 'professionally', as in 'I'm interested in the dynamics between people even though I dislike the whole premise'; those who watch it secretly (for either of the above reasons); and those who wouldn't watch it if it were the only programme on all channels.

If an excuse for watching is needed, then I think counsellors and psychotherapists – along with psychologists and others in the same general professional arena – probably have the best one. You can see first hand how stress brings out the best or the worst (and often not in the people you might have predicted) and you can learn some useful things about relationships from the phalanx of mind-professionals falling over themselves to air their views on screen and in print. I have a family systems/TA therapist colleague in the States who actually uses videos of the US version to demonstrate hierarchies, crossed transactions, hidden agendas, etc – though never to those clients who fall into the 'I-wouldn't-be-caught-dead-watching-it' group.

Do I watch it? Not telling – I wish to keep the respect of watchers and non-watchers, lovers and despisers, and everyone else in between.

One way or another, please keep in touch.

Margaret Akmakjian-Pitz
Editor

Contributions are welcome – book reviews, quotations, poems, cartoons, supervision issues, member news, difficulties facing the independent practitioner, 'thorny' issues of the moment and letters.

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Editorial copy deadline
25 April 2007 for the next issue

AIP mission statement

AIP is the division of the British Association for Counselling and Psychotherapy (BACP) that supports members who are primarily in, or about to embark upon, counselling or psychotherapy independently, including those who work in voluntary agencies.
The division has the following goals:

- to minimise the distortion of professional benchmarks arising from working in isolation
- to provide a supportive, encouraging and integrative network with opportunities to exchange ideas, work ethics, methods, and styles
- to alleviate the loneliness of the independent practitioner by disseminating relevant information, providing tips and techniques and revitalisation
- to develop a comprehensive, appropriate and professional training programme primarily for those working independently
- to engage in and encourage constructive dialogue about the profession of counselling and psychotherapy, including explanation and discussion of BACP developments
- to offer therapists an opportunity to interact with the wider world of counselling and psychotherapy
- to protect clients by promoting BACP standards and ethics.

The division provides a supportive network as well as training with an emphasis on maintaining clear boundaries and having sufficient support and supervision.

AIP provides an interactive sense of professional belonging for all members of our multicultural therapeutic community. Equal opportunities are an integral part of this division's philosophy.