Counselling and the doctor

COUNSELLING and training for counselling are issues of concern to doctors. Many doctors are aware that their counselling skills are increasingly required as an adjunct to their medical work. Some feel comfortable in practising these skills; others feel unsure and lack confidence. Most observe that they were not trained in the counselling skills needed for working effectively as general practitioners.

There are many definitions of counselling. The most appropriate one for a medical setting is 'to enable an individual to make his own choices and live his own life without being more dependent than he wants to be upon the decisions of others'.[1] In other words, the work of doctors is not to prescribe a lifestyle but to assist the person to live the life he has consciously chosen. Although the British Association for Counselling want to see it established as a professional activity, counselling is essentially a process and not a profession.[2] It is a particular way of relating to persons in need of guidance, using the qualities of understanding, warmth and genuineness to the full as well as some of the specific techniques and skills of those who are acting as counsellors. This does not imply that the counsellor cannot become more competent: the effectiveness of a counsellor is related to the quality of the processes they are engaged in rather than to status within an organization or a professional body.

One problem for doctors is understanding the language of counselling. Doctors look upon psychology as a jargon jungle, and some see counselling as a particularly dense jungle. This is not surprising. Herink[3] listed 250 forms of counselling. Yet the underlying features of many of these therapies are simple and accessible. According to a survey in the United States,[4] the important forms of counselling are behavioural, humanistic, rational-emotive and Rogerian. While the majority of the counsellors claimed to be electic, these were the four types of counselling used most frequently.

Behavioural counselling is concerned with modifying behaviours from the unacceptable to the acceptable. Various techniques have been developed for this purpose and these have been summarized for those people in medical settings by Winefield and Peay.[5] Humanistic forms of counselling begin from a different base and are more concerned with personal growth and human potential. Workers in this line of counselling make use of encounter groups and personal therapy, massage, meditation, dancing, co-counselling and any other experimental method likely to enable patients to understand themselves more clearly. The difference between the two branches of counselling is rather like the difference between surgery and holistic health: behavioural counselling is concerned with the alleviation of a specific symptom-complex while humanistic counselling is concerned with the integrated health and well-being of the person as a whole.

Rational-emotive counselling is concerned with the way in which people worry about being worried. Developed by Albert Ellis[6] and elaborated by his co-workers,[7] this counselling process involves identifying the irrational ways in which a patient thinks about problems and then substituting less anxiety-provoking approaches to these problems. Specific techniques of rational-emotive therapy,[8,9] have been developed. Many behavioural counsellors have been using these ways of tackling emotional problems such as anxiety, boredom, aggression, depression and sexual impotency.

The final school of counselling to be mentioned here is that associated with the work of Carl Rogers.[10,11] Rogers has argued that the only necessary attributes for effective counselling are empathy, warmth and genuineness providing that the counsellor remains non-directive. For Rogers, the counseller's task is to facilitate self-understanding in the patients by 'mirroring back' to the patients their own understanding, reshaping their thoughts and feelings with them, sharing their experiences and engaging them in a dialogue about their development. Rogers' methods are time-consuming and demanding upon the counsellor, especially his instruction to be non-directive; nonetheless, his influence in Britain seems to be considerable.

These observations about different forms of counselling are intended to help unwrap the language parcels. There are alternatives to general practitioners' developing and enhancing their own skills and competences in counselling. One alternative is for general practitioners to make contracts for counsellors to be available for referral either locally or within the practice premises. Some practices already involve clinical psychologists in this way and there are also experiments using voluntary counsellors. General practitioners may also refer to psychologists for specific tasks. For example, there are counselling skills in aiding individuals to cope with surgery.[12] Also, there are programmes for management

of stress that may be more effective than some stress-related medications.[13] While there may be difficulties in locating counsellors with relevant expertise, doctors may find the search for volunteer counsellors useful in identifying local resources, and productive in enhancing the range of services for patients.

Counselling psychology is now well established in Britain. This is clear from the number of available courses on the subject, from the number of textbooks being published,[14,15] the existence of the *British Journal of Guidance and Counselling,* The British Association for Counselling, a section of counselling psychology within the British Psychological Society, and from the investment by the British Broadcasting Corporation and other broadcasting companies in counselling-related television and radio programmes. Doctors could benefit from sharing actively in these developments.

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Livingston: an enduring concept

LIVINGSTON New Town lies in West Lothian in the central belt of Scotland, 30 miles east of Glasgow and 15 miles west of Edinburgh where the A833 takes one past a large road sign 'Make it in Livingston'. One group of people who have 'made it in Livingston' are the general practitioners, nurses and other health professionals who contributed to *The Livingston scheme—a ten year review.*[1] The title of this report from the Scottish Home and Health Department is somewhat misleading since it is now 17 years since the appointment of the first general practitioner in Livingston.

The principal objectives of the Livingston scheme were (a) to prepare a prototype of an area health services plan, (b) develop the concept of the general practitioner specialist, (c) bring the hospital service out into the community and, (d) promote preventive medicine. A consistent picture throughout the report, which consists of seven chapters and 17 contributors, is the unique model of primary medical care that the health care professionals in West Lothian have provided, despite the fact that an integrated service along the lines of the one created does not fit easily into the structure of the National Health Service.

Livingston's current population of 40,000 is now served by three practices with 22 general practitioners. With three exceptions, general practitioners in the town have medical lists limited to 1,500 patients and, in addition to practice responsibilities, have sessional commitments (hospital practitioner grade) to a variety of specialties in the community and the local district hospital. The 19 conjoint appointments are: general medicine/geriatrics (four); paediatrics (five); psychiatry (four); obstetrics and gynaecology (two); community medicine and rehabilitation (two); anaesthetics (two). The specialist component of the general practitioners' work has tended to be within the community setting and a range of clinics—the most notable being in paediatrics, obstetrics and gynaecology, general medicine, psychiatry and psychology—have provided services within the three health centres where the general practitioners have, both individually and with visiting consultants, extended the boundaries of primary care. This has lowered the rates of outpatient referrals and lessened the fragmentation of follow-up care of the handicapped and chronically ill. The policy has always been for general practitioners to remain personal doctors to