An Introduction to Counselling for Breastfeeding Counsellors

Richard & Shirleyanne Seel

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Introduction: becoming a counsellor

In this booklet we take a brief look at some of the essentials of counselling. It is not exhaustive, but it does cover most of the major topics which you ought to be aware of. But before looking at the counselling process, let's take a look at the counsellor herself.

Is a counsellor a special sort of person? Or can anyone be a counsellor? As so often, the answer lies between the extremes. There are people who seem to be naturally gifted as counsellors. Although even they can benefit from training, they possess basic skills and attitudes which enable them to relate effectively to almost anyone they meet.

On the other hand, there are people who are not suitable to counsel. This is not necessarily a permanent state of affairs: changing circumstances or personal growth may alter the situation. People in deep trouble themselves are often not able to cope with the burdens of others, and it is not fair to ask them to.

Personal qualities may hamper you as well. For instance, people with strong leadership qualities often find counselling difficult; being used to inspiring and motivating others, they find the 'second fiddle' status of the counsellor hard to accept.

However, the majority of those who are have the time and courage to examine and prepare themselves are able to become excellent counsellors. With this in mind, let us look at some of the implications and consequences of becoming a counsellor.

Motivation:

Why do you want to become a counsellor? Perhaps you want to help people and this seems a good way to do so. Perhaps you think that a counsellor has high status with NCT, and you want to be looked up to as well. Perhaps you were helped by a counsellor when you were breastfeeding and want to give back something of what you received. Perhaps you learned something from your breastfeeding experiences which you believe will make you better able to understand and help other breastfeeding mothers.

Most people will have a number of motivations, and the important thing is to be as aware as possible of yours. It isn't a question of judging them—as if some motivations are 'good' and others are 'bad', rather you should try to see the strengths and weaknesses in each of your motives. Remember that this is something which you can do better than anyone else. Your tutor may be able to help, but it is your self-knowledge which is important.

Rewards:

One motive for counselling is that you obtain some reward from it. If you don't, you will not be able to stick it out for very long. So what sort of reward might you get? You might get a 'buzz' from being able to help others; you might enjoy the maturity which comes from learning more about yourself; you might enjoy the challenge of developing those personal qualities which go to making a good

counsellor; or the sense of purpose which comes from knowing that part of your life is spent looking beyond your own needs and desires.

As with your motives, it is important to be honestly aware of the rewards you get from counselling. It is up to you to evaluate them and to assign 'right' and 'wrong' to them.

Pitfalls:

There are 'wrongs' in counselling, and it is good to be aware when they start becoming important to you. Some of the potential pitfalls include: wishing to convert others to your point of view; wanting the opportunity to demonstrate your abilities; getting satisfaction from the fact that others confide in you; getting satisfaction from the fact that others may depend on you. These things are not necessarily wrong in themselves. But if they become motivations or rewards then you need to reassess your commitment to counselling.

Penalties:

Finally, counselling has is costs as well as rewards. For one thing, it can be emotionally draining; when you give support to others you need to make sure that you are getting it for yourself. It can also be very time consuming and this may precipitate conflicts within your family over the use of the phone, interrupted meals, and so on. There are also times when the counsellor needs courage to make the commitment to help others; times when you want to say "no", but the commitment seems to mean that you must say "yes".

Knowing yourself

"Physician, heal thyself" says the old proverb. If it had been directed towards breastfeeding counsellors it would have read slightly differently: "Counsellor, know thyself." Self-knowledge is one of the most important assets any counsellor can have. The following diagram (it is called the Johari window, after the men who thought it up: Joe Luft and Harry Ingham) is sometimes used to show our areas of knowledge and ignorance:

	Known to self	Unknown to self
Known to others	Free and open: *You know and others know*	Blind self: *You don't know, but others do*
Unknown to others	Hidden self: *You know, but others don't*	Unknown self *You don't know & nor do others*

Your goal as a counsellor is to make your own 'Free and Open' part as large as possible by becoming self-aware and understanding yourself better. Then you will be in a better position to help others do the same.

The aim of the breastfeeding counsellor

The primary aim of the breastfeeding counsellor is to enable a mother to breastfeed successfully for as long as she and the baby want. This may seem to be a simple statement, but hidden in it are quite a few assumptions and implications.

In particular, what does "successfully" mean? Who defines it? The mother? The counsellor? A health worker?

And what about "as long as she and the baby want"? Does the mother really know how long she wants to feed? Does the baby—and if so, how can the mother tell?

Finally, there may be conflicts arising from the above. Perhaps she wants to give up breastfeeding but her toddler wants to continue. Perhaps she and her partner disagree about breastfeeding. Perhaps she has conflicting desires within herself. How can the counsellor enable the mother to come to a decision in such cases?

In the course of her work, a breastfeeding counsellor will need to use a number of different strategies. Two of the most important are information giving and non-directive counselling. The skill of the counsellor lies in knowing when each is appropriate as well as knowing how to give information or how to counsel. Much of this skill can only be obtained with experience, but this booklet will help you to appreciate some of the issues involved.

Structure of the counselling encounter

It has been suggested that the 'typical' counselling process goes through a number of stages. In practice, life is rarely as neat as theory would like, and some stages may get missed out, or occur in a different order. Also, since breastfeeding counselling is almost always open-ended (there is no agreement about how many times counsellor and mother will interact), there is an ever-present possibility that the counselling process never gets 'properly' concluded.

Despite this, it worth having an ideal scheme in mind because it helps to structure the counselling experience in a way which will be of help to both counsellor and mother. One way of visualizing the steps (which may all occur in the course of one counselling session, or over a number of them) is:

1) Opening
2) Building a relationship
3) Exploring the issues
4) Facilitating change
5) Closing

In this booklet we will examine these five stages as they relate to breastfeeding counselling.

Opening

In some kinds of counselling the opening is fairly standard because the 'client' and the counsellor agree to meet at a particular place and time. The breastfeeding counsellor is seldom so fortunate! The opening nearly always takes place at a time of the mother's choosing, and usually occurs on the counsellor's own telephone.

On the other hand, the mother nearly always comes voluntarily to the breastfeeding counsellor, which is not always the case in some other counselling situations. Occasionally the mother may be told, by a health worker perhaps, that she 'ought' to contact you, and this may cause some resentment or hostility. But this will be a rare occurrence, and you will usually encounter no resistance to the encounter itself, even if the mother subsequently finds it difficult to express what is really troubling her.

First impressions are important, and the way you handle the opening will have a big effect on the development of the counselling relationship.

If you can, let the phone ring about three times before you pick it up. It can be very disconcerting to a mother to have the phone answered before she is expecting it. In this context, it is worth knowing that the 'ringing' noise the caller hears actually occurs after the bell has rung at the receiver's end. So if you pick up the phone after only one ring, the caller may not even realise that the connection had been made.

When you realise that it is a counselling call, try to put yourself into a receptive 'counselling' frame of mind.

Her first impressions of you are important: ideally she will sense that you are calm, receptive, ready to give her your time and attention. You will give a sense of unhurried competence, and a willingness to hear whatever she has to tell you without making any adverse judgements (what about positive judgements?)

Examine your feelings: if you cannot respond to the mother in a way which approaches the ideal given above, it is best to postpone the encounter until later either by asking the mother to phone back or by taking her number and contacting her yourself. If you sense that she is fraught too, then fix a definite time at which to speak to her. This will help to ease her immediate anxiety.

The phone may not be answered by you. How do others in your family answer the phone? Do you want to change this? Should you try? Perhaps it's better just to be aware and to make any compensation necessary when you start the counselling session.

What are your first impressions of the mother? There are two aspects to consider: how does she seem to you, and how do you respond to her?

Is she calm, panicky, tearful, aggressive, demanding, wimpish? Make a note (mental or on paper) of your initial impressions but do not let them determine the course of the encounter. Initial impressions are often wrong.

How do you respond to the mother? Do you like her? If you do, then things will be easier. But what if you do not? Perhaps her manner seems brusque and you discover that you are feeling irritated. Put your feeling of irritation on side for the moment. Promise yourself that you will explore it later—it may turn out that she

reminds you of someone you knew, perhaps an old school teacher, and that your response is based on that resemblance. Throughout your training your tutors will have stressed the importance of being aware of your own feelings. This is one reason why—unless you are aware of them you may find yourself responding in a negative way without meaning to.

Building a relationship

Some people see the relationship between counsellor and 'client' (the mother, in our case) as the key to effective counselling. They suggest that if the relationship is right then desirable changes will take place because the client will become enabled and empowered to take charge of her life in a way that she did not before. Building this relationship, then, is a crucial activity in counselling and one which the counsellor must continue to work at throughout the period of counselling. Given this, it is worth considering the key qualities of the counselling relationship:

- The mother feels valued by the counsellor
- The mother feels accepted by the counsellor
- The mother feels understood by the counsellor
- The mother realizes that there are decisions she can make
- The mother is enabled to take charge of her life

One of the most influential figures in this approach (usually known as 'client-centred' or 'person-centred') was Carl Rogers. His view was based on a recognition of the importance of the 'personhood' of every individual. As a result the counsellor should do nothing to impose herself upon the client. Therapy should be led by the client, and the role of the counsellor is to facilitate this. There are several consequences which flow from this view:

The counsellor avoids judgement

Avoiding judgements about the mother should be seen as a positive attitude of mind, rather than a rule which prohibits certain kinds of statements. Of course you shouldn't say, "I think that you are a really bad mother if you don't breastfeed your baby." But supposing that deep down that is what you believe. If so, there is a good chance that the mother will sense this and feel rejected by you. In this case she may end up worse off than if she had never contacted you at all.

In order to be a client-centred counsellor, you have to accept that each individual is responsible for their own actions. The counsellor's 'correct' response if she finds herself in the situation above is to accept her judgements for herself—"If I had not breastfed my children, I would have judged myself to be a bad mother"—but to refuse to let herself transfer that judgement to another person.

(Incidentally, if the counsellor is able to isolate her feelings this way, she may then be able to go on and evaluate them: "Where did this judgement come from?" "Is it really valid for me?" "Is it really my judgement, or has it been imposed on me by other people?")

Of course, there could be a moral dilemma here. Supposing that the mother tells you that she is battering her baby. Should you make no judgement about this either? A certain amount of common sense is clearly required, and we will look in

more detail at the ethics of counselling in a later section. But it is also worth being aware that there is a question mark against client-centred counselling in this area. In its purest form it does rely on assumptions which might lead to the conclusion that any way of behaving or any life-style is as 'valid' as any other.

Client-centred counselling is not just about keeping your negative judgements to yourself. It also implies that positive opinions should be suppressed. The reasons for this may not be so easy to understand, but the principle is the same: any judgement you make about the mother is an imposition of your world view upon hers.

The counsellor is not directive

Making judgements about people is one way of devaluing them. Another, according to the client-centred approach, is to tell them what to do. The client-centred counsellor will not make statements which begin, "I think you ought to..." because that is setting herself in a position of superiority over the client. ('I know what is best for you, because I am a more competent person than you'—hardly the best way to bolster someone up.)

The client-centred counsellor does not begin by saying, "How can I help you?" or even "Can I help you?" because that starts the whole relationship off on a basis of inequality.

Even when the client asks for advice: "What should I do?", the counsellor resists the temptation to answer in those terms. Instead, the response is focused on the needs behind the plea for advice: "You feel the need for someone to tell you what to do?" In this way the client may be enabled to confront her own feelings of powerlessness and start to deal with them. (Note that there is a big difference between advice and information, which we will deal with later.)

The counsellor reflects back

Carl Rogers suggests that the role of the counsellor is to provide a mirror to enable the client to see herself clearly. But this mirror is not passive or mechanical. The counsellor, through her training and experience, is able to sense the 'communication behind the communication' as in the example above.

The client asks for advice. The untrained helper offers an opinion with alacrity. The mechanically trained counsellor just gives back what was offered on the surface: "You want to know what to do?" This is little help—it shows that the words were heard, but not the message. The empathic (we will meet this word again) counsellor hears beyond the words: "You feel the need for someone else to tell you what to do."

The client hears herself, and asks the question, "Is that what I want, for someone else to make decisions for me?" She may reject the counsellor's response—"No, I'll decide what to do. I just need more information." That's good, communication has been clarified. On the other hand, she may start to wonder and to realise that she may be able to take control of her own life a little bit more.

The counsellor accepts the client

The client-centred counsellor is not just a sensitive mirror, she is an accepting mirror. This is the positive side of the counsellor's refusal to make judgements. The client discovers that the worst she can reveal about herself is accepted by another. This gives her strength to look again. "If she can cope when I tell her that, then maybe I can learn to live with it too."

Sometimes a revelation from the client is a challenge to the counsellor: "I find the whole idea of a baby sucking at my breasts quite repulsive!" It's a test; if you accept this, the relationship can continue and grow. If you reject it or judge it, the relationship will wither. Note that she wants a response which shows that you hear and accept. Silence will not do. "Lots of women feel that way" will not do. "I felt that way myself" will not do. "You feel that way now, but you'll probably get used to it" will not do.

She needs to hear you acknowledge her in the here and now. The words can be a simple repetition of what she has just said, "You're repelled by the thought of a baby sucking at your breasts?" What is really important is the tone of voice and intonation. Detachment is not enough. She needs to know that you accept her now just as much as you did before she made her announcement.

To summarise, there are three basic requirements of the effective client-centred counsellor:

The counsellor should be genuine in the counselling encounter, not putting on an act or playing at counselling.

The counsellor should provide a non-threatening and trusting atmosphere through her acceptance and non-possessive warmth for the client.

The counsellor should demonstrate an ability to understand and 'be with' the client on a moment-by-moment basis (this is often referred to as `empathy').

Limitations of the client-centred approach

The client-centred approach to counselling has been very influential. Yet in its purest form it is not right for every situation. In particular, breastfeeding counselling cannot always be conducted on purely client-centred lines (because there isn't time, because the client's needs are not suitable for this kind of counselling, etc). This will become clearer as we progress. But the basic principles outlined above will remain important.

There is evidence to suggest that the attitude and approach of the counsellor have a significant effect on the outcome of counselling: the optimistic counsellor has more 'successes' than the pessimistic, and so on. Counselling is not a game which can be played by anyone with 'good technique'; genuineness, acceptance, and empathic understanding are just as crucial for a breastfeeding counsellor as for any other.

Exploring the issues

One of the key aspects of the counselling relationship is that it has a purpose: to bring about some change in the client—the breastfeeding mother. The mother will

not contact the counsellor unless there is some aspect of her life (normally related to her breastfeeding) that she wishes to change.

The change may be relatively trivial, from uncertainty to certainty, perhaps (she doesn't know if it is safe to eat stewed prunes while breastfeeding, and contacts you to help ease her uncertainty). It may be more serious, from pain to relief, perhaps (her nipples hurt like hell, and she contacts you because she wants the pain to stop). Or it may be deep-seated and hard to deal with (her mother-in-law bottle fed, and can't see what all the fuss is about...).

So there is always a desired change, and it is your task to discover it. Incidentally, we are using the term 'issues' when writing about the desired changes rather than 'problems' even though that is a convenient shorthand way of thinking, and even though we know that this is the way the mother will usually present the issues to you. But let it be her label, and not yours. You cannot genuinely accept a mother if you label her experiences or feelings as 'problems'.

Sometimes the mother will state her needs simply and clearly. "I want to know who to contact to buy another Mava bra." Fine. If you know the answer, tell her. If you don't, give her the number of someone who will. If she then thanks you and terminates the conversation and rings off, you can assume that the encounter was indeed as simple as it seemed to be. However, things will not usually be like that. In one way or another you will have to be involved with the mother in eliciting exactly what the issues are. There are two basic ways in which you can help to do this:

- Active listening
- Appropriate responding

Neither of these is easy, since both go against the grain of what we normally do in everyday life. But their power lies in just this fact, because in counselling someone really listens to the person with a problem, perhaps for the first time in her life.

Active listening

Active listening requires a commitment on the part of the listener. It is not easy, and cannot be undertaken when you are distressed or preoccupied yourself. Listening requires that you open yourself to the intrusions of another. There are five requirements for active listening:

- A willingness to give your attention to another person.
- An openness to perceive the other's feelings and values.
- A readiness to suspend judgement and evaluation.
- A patience to wait for the other's own expression of her thoughts and feelings.
- A desire for empathy which tries to experience the world as the other experiences it.

Without these qualities, your ability to listen will be impaired. Assuming that you have them, or want to develop them, there are some practical steps which can be undertaken in order to develop your listening skills:

Listen with undivided attention: Listening itself is easy. The problem lies in trying not to think about a dozen other things as well. Our natural temptation is to be aware of what else is going on in the room, or the fact that you've got a headache, or even what to cook for supper tonight. It takes practice and conscious effort to give all your attention to what is being said without wandering off on your own private journeys.

It is hard to give another our undivided attention. There are a number of 'blocks' which may get in the way. If you know which ones you are prone to, and can recognize them when they occur, it will be easier to work round them.

Ruling out the speaker: "I can't listen to you because of what you are (a lesbian; a social security sponger; a stuck-up snob; an officious overbearing prig; etc)." To rule someone out because of the label you have given them, is to deny them the chance to be human. Counselling stands no chance if you do this.

"I can't listen to you because of what I know (my friend says you are a fanatic; when we spoke a couple of years ago I thought you were stupid; John works with your husband and he says you are both totally bigoted; etc)." These things may be true, but if you let them affect you now, you deny the other the chance to change.

Reaching a premature conclusion: "I've heard enough to know where this will end up. I've heard it all before, so there's no need for me to hear it again." But if you don't listen, you'll never know if you were right. It is good to have hunches while you are listening, but don't turn your theories into someone else's facts: check them against what the other has to say.

Reading in expectations: "I already know what you are going to say. I can tell that you are (depressed; angry; incompetent; frightened; etc) and so I will interpret everything you say in the light of this 'knowledge'." The Queen of Hearts in Alice in Wonderland had a similar perspective: "Sentence first—verdict afterwards" she

cried. Don't assume you know the answer—you may not hear the question if you do.

Reading out things you don't like: "I know you didn't really mean that you (hate your baby; are having an affair with your paediatrician; think I'm unfeeling and insensitive; etc) so I'm just going to ignore it." There is a great temptation to be deaf to the things we do not want to hear. Sometimes it takes courage to be able to listen honestly.

Racing ahead or rambling: "What you say is very interesting and stimulating. It reminds me of..." The temptation to follow up your own thoughts or feelings can be very strong, especially when powerful emotions or memories are evoked by what the mother is saying. The counsellor needs to stay with the speaker and to arrive at the end of the statement at the same time as she does.

Rehearsing a response: "What you have just said is important and challenging. While you carry on talking I must think about how I am going to respond to it." If you stop listening in order to prepare your response to one important statement, you may miss an even more important one while you are not listening properly. If you are mentally saying "Yes, but..." or "I agree..." or "On the other hand..." you will not be able to concentrate on the speaker.

If you are really convinced that a response is necessary, it is best to stop the mother and tell her so. Don't worry about preparing a clever answer; it's much better to be honest with her: "May I stop you there? What you've just said seemed important to me, but I don't quite know how to respond to it. I would like to explore it a little further before continuing."

Reacting to trigger words: A mother is telling you about her crying baby when she suddenly says, "Men are such bastards, I hate them!" Would you be able to carry on listening, or would your own responses take over and block out what the mother was trying to say?

"How dare she swear at me!" "Oh no, not another feminist!" "Too bloody true, you should meet my husband!" The response will rise up unbidden—there is no way to stop it without losing your humanity. But the counsellor must not let it take over. She must be aware of it and then put it to one side. This woman is sharing something important with you; that is why it is hard to listen to. For her sake you must stay with what she is saying, and try to hear exactly what her message is.

You might not react strongly in this particular situation, but everyone has their own blind spots where words have become loaded. When you come across yours, make a note of them, explore the negative meanings and associations they have for you, and try □€to add some more definitions to the word by seeing the meanings it has for others. For instance, "the old sod" may be a term that you would only associate with extreme disapproval, but for her it's an affectionate way of referring to the man she loves. Can you learn to let her have her meanings when she is speaking?

Responding with evaluation: "The way you just put that was very (clever; witty; stupid; elegant; vague; etc)." Unfortunately, I spent so much time evaluating the way you spoke that I completely ignored what you were saying! We've already

stressed the need to avoid judgements; but we will stress it again and again, because it is so important a principle and so hard in practice.

Remember what has been said

One of way of helping yourself to concentrate on listening to the mother is to aim to remember what she has said. This isn't easy for most of us, and it certainly can't be done if your mind is wandering off what the mother is saying.

Remembering also helps when you come to respond to her—after all, if you haven't remembered what she said, your response may not be very relevant to her. It is also important to remember some details—the mother's name, her baby's name, and maybe some other facts as well. If you are counselling on the telephone, it is easy to jot these down on a pad which you keep by the phone for just this purpose (but if you intend to write down any more, then you must make sure that it is not available for anyone else to read—confidentiality is crucial in a counselling relationship).

If you are counselling face to face, then you will have to make the effort to remember without any props—and even if you are on the phone, the more you can commit to memory and the less to paper, the better. If you are busy making notes, it will be hard to concentrate on what is being said—it won't be a lecture, with well-organized thoughts flowing out in a steady stream.

Finally, it isn't just the broad outline of what the mother says that should be remembered, but also as much detail as possible. People often give clues to their deeper feelings by the way they phrase things: "She's entirely breastfed now, but I feel very close to her." Why the word "but"? Perhaps "and" would be more expected. Was it just a slip which signifies nothing, or does it indicate a deeper uncertainty about breastfeeding itself? When the time comes to respond, it may be helpful to feed this back to the mother and see how she responds.

Listen to what is 'behind' the words

Most of the time we have 'mixed' feelings. Those we express are usually only the tip of the iceberg—especially at times of stress or distress. The counsellor tries to hear the submerged feelings as well as those which are on the surface. This isn't always easy, and you need to check out your conclusions with the mother. Some of these feelings may be a surprise to the mother herself (they come from the 'Blind Self' part of the Johari window on page 2) so they will need to be handled with care.

"My husband says that it'll be easier if I bottle feed—what with going back to work and all. I'm sure he's right, it will mean no more sore nipples, and after all we do need the money."

This mother is telling you that bottle feeding is best for her and her husband because it will 'cure' her sore nipples and make it easier to go back to work. But perhaps she's also expressing some feelings about the decision. Did she make it, or did he—the phrase "I'm sure he's right" make actually be expressing the exact opposite of what it says. She may also have some reservations about going back to work. They need the money, perhaps, but does she really want to go back—the phrase "after all we do need the money" might indicate this.

Don't be afraid of silence

In normal conversation we don't usually leave long silences between our contributions. Indeed, some people are so keen to say their piece that they interrupt or else finish the other person's sentence for them. As a counsellor, you must learn to be more sensitive.

When the mother pauses, do not respond until you are sure of the meaning of the pause. She might be just taking a breath, or just trying to arrange her thoughts or feelings before continuing. Or perhaps she is finding it difficult to find adequate words to express what she has to say. If any of these are possibilities, then give her more time. Don't be afraid of silence in such a case— the mother will be using it productively.

If you are certain that the mother has finished her statement—perhaps because of her tone of voice or intonation, or because she invites you to respond—then it is proper for you to say something. But if you are not certain, wait a little longer just to be on the safe side.

The point is that the more opportunity you give the mother to speak, the more she is likely to say and the more chance you have of exploring the issues. The only danger in such silences is that the mother will think that you are no longer paying attention to her.

In face-to-face counselling you can indicate your continuing interest by your body position and expression, perhaps nodding or giving a little smile of encouragement during the pause. On the telephone this cannot be done, and then it may be helpful to make minimal responses—"Mm", "Uh huh", "Yes", and so on—to let her know that you are still at the end of the line. But keep them to a minimum, and make sure that they only convey the fact that you are listening and do not contain any form of comment or judgement. "Wow!" is not a minimal response!

Use non-verbal clues to help you understand

The words the mother uses are not the whole of her message. There are many other ways in which to convey meaning—and sometimes there is a conflict between the meaning of the words and the meaning conveyed non-verbally. The counsellor becomes aware of this, and feeds it back appropriately.

Much breastfeeding counselling is done on the telephone. When you cannot see the person you are speaking to, the range of non-verbal information is restricted. This is a mixed blessing. It may deprive you of vital clues to the mother's true feelings, but it also helps to make listening more manageable. After all, the more information you are receiving, the harder it is to process it all. So when on the telephone, you can concentrate on the two levels of verbal communication: the words themselves, and the way in which the words are spoken. These are some of the things to listen for:

Tone of voice: Do the mother's words and tone go together? When she says, "I really love my little baby" does her tone of voice agree? Or is there a hint of irony there, or resentment, or anger? The tone of voice often belies the plain meaning of the words. Hear both, and don't assume that if one is right the other must be wrong.

She probably does love her baby, but she may also resent him. Indeed, the conflict between these two attitudes may be one of the issues which this mother needs to explore.

Volume: Is the mother speaking loudly or quietly? Why? It may just be the vagaries of the telephone system, but perhaps she is showing aggression or anxiety.

Vocal stress: Is her tone of voice lively or flat? Why? If she is speaking in a very monotonous way, is she depressed or tired? Or perhaps she is finding the communication very difficult because it is hard to express what she has to say.

Pitch: Is the pitch of her voice high or low? Why? If high pitched, does this mean that she is angry, or about to lose control of herself?

Clarity: Is the mother speaking clearly, or is she mumbling? Why? Perhaps her enunciation seems too precise. Does this mean that she is making a great effort to keep her emotions under control? Is she mumbling because she finds it hard to get the words out?

Pace: How fast is she speaking? Why? Are her thoughts and feelings tumbling out so fast that you can hardly keep up? Is she out of control, or perhaps she's still unsure just how long you are prepared to listen before dismissing her like everyone else does? Is her speech halting and slurred? Is she tired, or reluctant to talk, or unable to find the words to express the things she wants to say?

So many questions! But it is important not to jump to conclusions. It is easy to misinterpret another's way of speaking—especially if this is the first time you have spoken together. So be very tentative in your assumptions, and always check them back with the mother.

Body language

If you are counselling face to face, then you have a much wider range of potential information at your disposal. Whole books have been written about 'body language' but the following are some of the points to look out for:

Proximity: How close is the mother sitting to you? Was it her choice or yours? Are you comfortable with this distance? Is she?

Body posture: Is she leaning towards you, or away from you? Is her body turned towards you, or trying to face away? Does this suggest that she is eager to share with you, or is there some reluctance?

Muscle tone: Is she relaxed and open or sitting stiffly, displaying tension, or maybe she's slouching in her seat—tired perhaps, or maybe bored?

Facial expression: One researcher has suggested that the proportions of the impact of a message in a face-to-face encounter are 55% facial expressions, 38% non-verbal aspects of speech, and only 7% for the words themselves! So what is the mother's face saying as she speaks? Is she displaying anger, or disgust, or contempt? Does her facial expression reinforce her words, or does it contradict them?

Gaze: Eye contact is important too. Do not expect her to meet your eyes much while she is speaking, but notice if she seems to avoid looking at you altogether. If so, what is she finding difficult? Is it because of what she is saying, or is this the way

she always behaves? Does she look at you a lot—challenging you, perhaps? If so, can you remain calm under that gaze and try to see if there are any other clues to her mood?

Gestures: Does the mother use her hands and body a lot? If so, how is she using them? Is she relaxed and free in her motions, or is there stiffness? Does there seem to be a correspondence between her gestures and what she is saying?

Clothes and general appearance: Has she taken trouble over her appearance? How does your impression of her relate to what she says about herself?

Summary

Active listening is not easy. Do not despair if there seems an awful lot to master. Much of your learning has to be done 'on the job'—there is no way you can know it all when you start counselling. So be easy on yourself; do your best, and that will be good enough.

Appropriate Responding

Meaning is never communicated perfectly. I perceive the words, actions, gestures, silences and expressions of another and then I filter them through my experiences, prejudices, and feelings. Only after all this do I infer your meaning. The chances of error are very great. So I must check, I must respond. And in your reaction to my response, I will be able to make more secure my inferences about your meaning.

In counselling, the purpose of response is always this: to clarify the meaning, to develop the relationship, to explore the mother's issues. It is not for the counsellor's benefit (though she will benefit), and the appropriate responses are not the same as they might be in a conversation between two friends or lovers or others sharing an intimate relationship.

If active listening is hard, appropriate responding is even harder! The temptation for the new counsellor is always to say and do too much. The responsibility of the situation weighs heavily upon you—it is up to you to 'help' the mother! It is only with experience that you learn to let go of this position, and to let the mother lead; to learn, indeed, to enable her to lead. Then you will experience that mixture of pride and amusement when you hear her say how helpful your 'advice' was—and you will know that you told her nothing, and all the advice came from her.

Perhaps until some such breakthrough comes for you, you will need to struggle mechanically with the guidelines for responding which we have included below. But persevere; in the end they will seem natural and inevitable to you.

Guidelines for appropriate responding

Be as simple and accurate as possible: The first guideline is simple: be simple! Use as few words as possible, and be as direct as possible. You will never provide the 'mirror' for the mother to come to know herself if you beat about the bush, indulge in high-flown language, and display your own cleverness.

Use minimal prompts: One of your aims is to help the mother keep the 'flow' going. If she feels supported and acknowledged as a person she will be enabled to continue her self-disclosure. In the section on listening we suggested the use of neutral encouraging words and noises such as "Mm", "Uh huh", and so on. Nods and smiles can perform the same function if you are face to face with the mother.

Another technique, which can be very effective if used sensitively, is to repeat a little of what the speaker has said—often from her last few words. This can have a dual effect: it shows that you are listening, and it can encourage the mother to continue and develop what she is saying:

M: I don't know what I'm going to do, he just keeps crying and crying..."

C: Just keeps crying.

M: Yes. It sometimes seems as if he cries all day long.

C: He cries all day long.

M: Yes. Well, no he doesn't really. In fact I suppose its just that he cries when I'm busy trying to do other things.

C: He cries when you're trying to do other things.

M: I suppose he gets hungry then. Perhaps I've got to decide between his meals and the family's meals!

The counsellor has not asked a single question, but the mother has passed on a lot of information. Not only that, she has been given some space to enable her to start thinking about different aspects of her difficulty and even to consider some tentative solutions. In a minute she's going to thank you for all your helpful advice!

Use your empathic understanding: In normal conversation feelings tend to be masked. One of the factors which make the counselling encounter so powerful is the fact that the counsellor acknowledges and responds to the mother's feelings. The ability to do this, to be able to gauge another's feelings accurately, is sometimes referred to as empathy.

Empathy means 'feeling with' the other. It is different from sympathy which means 'feeling the same as' the other. The difference lies in the focus of the feeling: when I am being sympathetic I am focusing on my feelings and trying to respond to you on my terms (no wonder you so often reject my claim that my feelings are the same as yours); when I am being empathic I am focusing on your feelings and trying to respond to you on your own terms. Carl Rogers suggested that empathy has a number of characteristics, including the following:

- Entering the private world of the other and becoming thoroughly at home in it.
- Being sensitive, from moment to moment, to the changing feelings and meanings which are present in the other person.
- Sensing meanings of which the other is scarcely aware—but not trying to uncover feelings of which the person is totally unaware, because that would be threatening.
- Frequently checking with the other to assess the accuracy of your perceptions, and being guided by the responses you receive.
- Pointing to the possible meanings in the flow of the other's experiencing to help her focus on her own experience.

Empathy exists when the counsellor collaborates with the mother in the exploration of the mother's situation. It can be blocked by inappropriate responses from the counsellor. We have already covered some of these, but the following list gives a guide to most of the common pitfalls:

- Directing or leading. "I don't think you ought to spend so much time talking about your relationship with your husband."
- Judging or evaluating. "Your attitude towards your health visitor is very hostile."
- Moralizing. "You really must put your baby's welfare first, you know."
- Labelling. "You've just got the baby blues, that's all."
- Humouring. "You're worrying too much, everything will turn out all right."
- Rejecting feelings. "You mustn't be depressed about this."

- Being over-concerned. "Oh, I really am most terribly sorry."
- Being impatient. "Look, can you just get to the point?"
- Patronising. "You've done jolly well so far."
- Ridiculing. "Don't be so stupid—everybody knows that formula milk is cows' milk."
- Directing. "You need to see your doctor and do what he tells you."
- Threatening. "If you don't tell your health visitor, then I will."
- Interrogating. "Tell me about your relationship with your first husband."
- Over-interpreting. "Your mixed feelings about breastfeeding show your inability to come to terms with your own body. It's a problem most women have."
- Self-disclosing. "That's nothing. My baby chewed my nipples until they were so sore they actually bled!"
- Being 'professional'. "You may believe that four-hourly feeds are OK, but as a breastfeeding counsellor I can assure you that you are mistaken."
- Encouraging dependence. "If you run into any difficulties, you must ring me straight away."

After a list like this you may wonder whether it is safe so say anything at all! But in fact all these examples share common features. They all focus on the counsellor's thoughts, feelings, experiences, and opinions. They are not centred on the mother herself. So there is the general rule: your response will probably be OK if it is focused on what the mother has disclosed to you.

Keep questions to a minimum: We saw above, in the example of encouraging by repeating a little of what the mother has just said, that it is possible to obtain a lot of information without asking questions at all. Counselling theory suggests that questions should be avoided whenever possible. One reason for this is that they tend to break the mood of empathic response. A question usually comes from the counsellor's frame of reference, rather than from the mother's.

(The exception to this is the prompt: which is often just a bit of reflecting back which is offered as a question, "So feeding is difficult at present?" This could often be offered as a statement rather than a question. With experience you will learn which is the more natural form in a given situation.)

Another difficulty with the question is that it tends to force its own answer. For instance, suppose that you sense that I am feeling troubled in some way. If you make an empathic statement such as "I sense that you are feeling troubled", you leave me free to decide whether or not I want to share my feelings with you. If you ask me a question, "How are you feeling?" I seem to have been put under some kind of obligation to share my feelings with you even if I don't want to.

Actually, it could be worse. You might ask a very specific question such as "Are you feeling angry?" In this case, not only am I under an obligation to answer you, but if my feelings are of frustration rather than anger I may find it hard to share this. The answer which your question evokes is a simple "No, I'm not." It is hard for me to go any further.

Nevertheless, there are times when a breastfeeding counsellor will need to ask questions. These occasions fall into two broad areas: when you need information, and when you want to open up an area for exploration. These two areas actually require different kinds of questions: 'closed' and 'open' respectively.

Closed questions are specific; they define the kind of answer required. If you ask, "How much does the baby weigh?" the mother should not answer by telling you that she doesn't seem to have enough milk. In fact, there is only one 'correct' answer to this question—that is, the baby's current weight.

Open questions allow more scope for the responder. "What about the baby's weight?" is far less specific. The mother may tell you the baby's current weight, his birth weight, her worries about the baby's weight gain, what the clinic said, or even that she thinks that she doesn't have enough milk.

The closed question is very good for obtaining information. If you want to know how much the baby weighs now you should ask a closed question. "What about the baby's weight?" may not get you the answer you want, and may confuse the mother. So when seeking information, be careful to ask a precise question which will clearly indicate exactly what information you want.

The open question can be used to enable the mother to explore issues. "How do you feel about that?" is a classic counselling open question. It directs the mother's attention to her feelings, but does not attempt to indicate what sort of feelings she is permitted to talk about. That choice is hers.

The open question can be useful when you sense that there is a difficult area for the mother but you are not yet sure what it is. Suppose the mother has mentioned the baby's weight a couple of times in passing. She also seems to feel that feeding is not going successfully but isn't really sure why. In such a case a question like, "What about the baby's weight?" might be worth trying.

You might get "I don't know what you mean" in which case you would have to say something like "I just wondered whether there was anything about his weight which was bothering you." On the other hand you might strike gold: "Well, my friend's baby was born a week after him and already weighs twice his birth weight..."

Avoid questions beginning with "Why..." If questions are dangerous, questions beginning with "Why..." are the most dangerous of all. "Why" may ask for a reason which the other may not be able to give. "Why" may be an attempt to get the other to justify herself or her behaviour. "Why" can be an intrusion and should be used with great care.

Beware of the mother's questions From time to time the mother will ask you questions. Listen to them carefully before you answer. If her question is closed, seeking specific information then you should answer as directly and clearly as you can. But there are other mother's questions which should be treated with great care.

For instance, what do you do when the mother invites you to agree with her: "As long as the baby puts on weight, that's all that counts isn't it?" "It's really important that I carry on breastfeeding, isn't it?" Even if you believe that she is right, it is best not to collude with questions such as these. If you do, you will be taking on some responsibility for the mother's decisions, and will no longer be counselling her.

Try treating these questions as statements and reflect them back: "You believe that the baby's weight gain is the most important thing?" "It's really important to you that you carry on breastfeeding?" This will normally be sufficient to enable the mother to get back on track with her own feelings and expectations.

The other 'trick' question is the plea for advice: "What do you think I ought to do?" It is not your job to tell a mother what to do. She must make her own decisions. Of course, you can give her information and outline the possibilities, but the final decision must be hers—even though she will often thank you for your 'advice'!

Don't be afraid to challenge when you are sure it is appropriate There are times when it may be right for the counsellor to challenge the mother. For instance, she tells you of a difficult situation with her mother-in-law. You hear anger in her voice, and 'underneath' the words she is saying. You respond, "You're angry with your mother-in-law because of the way she is behaving?" But the mother repudiates your interpretation: "Oh no, I'm not angry with her, I'm just hurt that she doesn't trust me."

What is going on here? When you try to focus attention on the mother's feelings she tries to deflect your attention. Notice what she has done. She is not 'angry', but 'hurt'. What is the difference? Anger belongs to me—it is my anger, my response to a situation. Only I can deal with it, control it, or use it. But hurt comes from someone else—the hurter. I have no control over hurting, so I am a victim; it isn't my fault.

Is this what this mother is doing? And if so, is it perpetuating the situation which is giving her pain? If you think it possible, a gentle challenge may be in order:

C: "Your mother-in-law's actions have hurt you? She is to blame for the way you feel?"

M: "Well, I don't know about blame... but, yes, I suppose that's right."

C: "Yet I am still getting the feeling that your response to this is one of anger. How are you responding to the hurt which has been inflicted on you?"

M: "Anger...? Well, yes I am angry at the way she's been behaving. She's got no right to interfere in this way."

C: "She's got no right to interfere the way she does, and you respond to this with anger. Do you feel that your anger has any effect on the situation?

M: "(laughs) I suppose it doesn't exactly help things along..."

You've been quite challenging here. When the mother rejected your interpretation, you persisted. It seems to have worked. The mother has accepted that she has some responsibility for the situation, that she is an active participant, but just a passive victim who can do nothing to change her situation. With care, you may be able to enable her to to devise ways of understanding and coping with the situation.

When appropriate, try to summarize Another useful thing which the counsellor can do is to summarize what the mother has said. Summarizing can be done from two perspectives: from the mother's perspective or from the counsellor's perspective.

We mentioned earlier that it is important to remember what the mother has said to you, but this is not always easy. Sometimes she will pour out a mixture of facts and feelings in an apparently incoherent order. You find yourself in danger of getting totally swamped and confused. This is a good time for a reflective summary: "Let me get this straight. What you telling me is that..." This gives both you and the mother a chance to review what she has said and to correct any errors which might have crept into your assessment.

Sometimes you may feel it necessary to interrupt the mother and force a summary upon her: "I'm sorry, but I'd like to interrupt you for a moment so that I can be clear about what you are saying. As I hear it..." Don't be afraid of doing this; one of the positive benefits of counselling can be that it provides the mother with a structured way of coming to terms with her own feelings.

The second kind of summary can go further than simple reflection. As you listen to the mother, you may think that you see patterns or links which the mother herself does not see. These links might be between facts: "You've told me that your baby takes the breast for a little while and then rejects it. And you also mentioned earlier that you've been using a breast spray. I'm just wondering whether there is any connection between these two facts and whether he might have thrush in his mouth..."

But the links may also be more speculative, relating to feelings and experience: "You've just said that your husband seems jealous when you breastfeed. A little while ago you mentioned that his mother died recently. Do you think there could be any connection? Perhaps he is wanting you to mother him at the moment and you aren't able to as much as he would like?"

This kind of creative summarizing can be very helpful, but it is also dangerous. If you are not careful you could force your interpretation upon the mother, who might then come to believe it even if it is quite wrong. So always be tentative when you offer a possible link, and be wary if the mother accepts it too readily - it might be flattering to be right, but it is most satisfying when your (wrong) interpretation helps the mother to find her own (more correct) way of looking at her situation.

Summary

Listening and responding may now appear to be more complicated than you ever could have imagined. But don't be daunted. You won't be called upon to exercise all these skills at once. In many cases, exploring the issues will be quite straightforward. The key thing to bear in mind is the aim of the breastfeeding counsellor: to enable a mother to breastfed successfully for as long as she and the baby want.

As you listen to the mother you will discover what she means by "successful breastfeeding". It may mean freedom from her sore nipples, a good night's sleep, the acceptance of her bottle-feeding friends, an acceptable weight gain for her baby, or any one of a thousand different things. Your listening and empathic responding will help her to discover just what wants now, without you having to impose your own ideas of successful breastfeeding.

It may be a little harder to discover "how long" for the mother, and even harder to do so for the baby. In many cases you will not have to: the duration of

breastfeeding will often not be an issue for the mother. However, when it is, you may need to listen extra hard for hidden messages. And don't forget the baby: does he want to give up? Has he enjoyed breastfeeding?

Clarifying the goals of success and duration may turn out to make things seem more difficult because there may be built-in conflicts. The mother wants to wean her toddler, he wants to carry on feeding. Remember, it is not your job to solve the problem. But you will have to listen very carefully and sensitively, and you may be called upon to help the mother formulate her plans—which brings us neatly to the next phase in counselling!

Facilitating change

The reason the mother has contacted you is because she desires some kind of change in her life. Having discovered what sort of changes are desired, it is possible that you decide that helping the mother further is beyond your competence—for instance, she may be severely depressed or undergoing severe marital difficulties. In this case you may want to move to close the counselling relationship—a topic which we deal with later on. But this is a rare occurrence, and in nearly every case you will be faced with a problem in which you can potentially help to facilitate change.

Kinds of change

The change desired by the mother may be of one of two kinds: external or internal. External changes are brought about when we alter our environment in some way: change a feeding position, apply cold cabbage leaves, stop giving supplementary bottles, and so on. Internal changes are brought about when we alter our perceptions of a situation or our responses to the situation. Some case situations might help to clarify the issues involved here:

1) A woman contacts you complaining of sore nipples. You ascertain that the baby's feeding position is quite wrong and that he has been chewing her nipples for the past two months. You offer her information about correct feeding positions and ways of relieving pain and distress to the nipples between feeds. Armed with this knowledge she alters her environment and her nipples recover. In this case the mother has sought and effected an external change.

2) After an antenatal talk a woman contacts you concerning her ambiguous feelings about breastfeeding. As you help her explore this she becomes aware that her uncertainties are connected to her ambiguous feelings about her body and her sexuality. She realises that these are not issues that she is going to sort out overnight, but now that she can make sense of her conflicting feelings about breastfeeding she feels much more confident of her ability to cope when the baby arrives. In this case the mother has sought and effected an internal change.

3) A mother contacts you. She desperately wants to breastfeed but her baby does not appear to be thriving. In the course exploring the issues she tells you that she had radical cosmetic breast surgery when younger. She has not mentioned this to any of her medical attendants. You explain that although lactation is sometimes possible after breast surgery, she will not discover the facts in her case unless she has a thorough medical examination. After seeing her doctor she gets back to you, having discovered that she is physically incapable of lactating.

In this case the mother has come to you seeking an external change. But counselling has led her to discover that the environment cannot be altered, and the counsellor's task now becomes one of helping to facilitate internal change—helping the mother come to terms with the reality of her situation. (In fact even this case isn't quite as clear cut as it might seem at first sight because there are some external changes which might be attempted and which might help with the internal change—using a nursing supplementer with formula milk, for instance.)

4) A mother contacts you. She doesn't present a 'problem' to you but just talks rather generally about her baby and how he is getting on. Gradually it becomes clear that the problem is related to her mother, and her mother's ideas about the way the baby ought to be fed. Further exploration seems to show that the woman does not feel that it is possible to change her mother—"She's too set in her ways now to be able to change"—and has actually come to seek help in her own adjustment to the situation.

The woman is seeking an internal change, but what she does not see is that as a result of such changes, external changes might also follow. For instance, suppose she were able to become more assertive in her relationship with her mother; this might lead to her mother becoming less dogmatic and more co-operative. Furthermore, you might be able to help the woman with strategies which would enable her to 'manage' her mother's interactions with her and the baby in a way that she found easier to cope with.

To sum up: most situations offer scope for a mixture of both internal and external changes to be made; a few are more clear cut. As a general rule, external change appears to be easier to effect, but internal change actually offers the greater scope—when it comes to the crunch, I can take responsibility for myself in a more radical way that I can for other people or the rest of the universe.

In order to help a mother to find an acceptable change, there are a number of skills and strategies which the counsellor will find helpful. These overlap with the skills which we outlined for the exploring stage of counselling, but they are rather more directive and interventionist and are more appropriate when the exploration has been done (always remembering that in a real counselling encounter there will probably a constant inter-mixture of exploration of issues and exploration of ways of changing).

Positive attitude

The mother desires change, but what will make it most likely to occur? Quite a lot of research has been done into the factors which are most helping in promoting positive change in counselling. One of the most important of these is the attitude of the helper.

Consider the two following statements:

"Many mothers have found that rubbing a little breast milk into their nipples after a feed really helps with sore nipples."

"Well, I suppose there's always that business of rubbing breast milk into your nipples after a feed. I heard somewhere that this seems to work for many mothers."

The factual content is the same in both statements, but research suggests that the first is much more likely to lead to a positive change. If the counsellor believes that her suggestion is likely to achieve results, this helps to reinforce its value. If she is uncertain, this uncertainty will be communicated to the mother and will probably result in the suggested course of action 'failing'.

In general, if the counsellor has a positive and optimistic attitude, the mother will be much more likely to find the information helpful. This is one reason why

counselling improves with experience—the more you do it, the easier it becomes to be positive and self-assured.

Allied to your belief that change is possible is the importance of being supportive and encouraging to the mother. This needs to be done with care as it can easily be judgemental and become an imposition on the mother.

If you are face to face with the mother much of your encouraging can be non-verbal, indicating with smiles, nods, and an open body posture that you accept and value her as a person. On the telephone you are more restricted and your support will have to be verbal. Some simple guidelines will help to keep your responses to an acceptable level of comment.

Firstly, offer your thoughts as your own. Don't say "You are doing well" but "I think that you are doing well". This gives the mother the chance to challenge your assessment if she disagrees with it. If you present your opinions as if they are facts it becomes harder for the mother to dissent. This may have the effect of making her more resistant to what you have to say.

Both the responses above focused on the whole person rather than some aspects of her character or behaviour. This also helps to avoid becoming judgemental. If you want to make specific comments, try to reinforce the mother's own positive assessments of herself rather than introducing your own judgements. So if she says "I seem to be coping a little better this week" it is better if you respond with something general like "I'm so pleased, you seem much more positive about yourself at the moment" rather than "I'm so pleased, I knew you'd be all right if you decided to grit your teeth and just get on with things."

The first response affirms and reinforces the mother's own attempt at a positive assessment of herself, while the second offers the counsellor's own judgement about the way the mother ought to behave. This is always dangerous, not only because it risks imposing the counsellor's will upon the mother, but also because if the expectations of mother and counsellor do not match it will be harder to promote effective change.

As you talk with the mother, listen to her expectations of you. Does she see you as a miracle worker who will wave a magic wand to solve all her problems or are you a last resort in whom she no real faith or hope? Research suggests that there are two factors here which might affect the outcome of counselling. Firstly, the more 'status' the counsellor has, the more likely there is to be an effective outcome. We are not suggesting that you should try to build yourself up as someone 'important' or 'professional', but it is worth being aware of the fact that the mother's opinion of you will influence the way that she responds to you.

Secondly, if the expectations of mother and counsellor are similar, an effective outcome is more likely than if they conflict. This can be a problem in a counselling situation where the counsellor is very non-directive while the mother expects her to 'do' something. If you find yourself in such a situation, do what you can to respond to the mother's expectations without compromising your basic position that she must take responsibility for her own decisions.

Self-disclosure

One of the first warnings you are given as a trainee counsellor concerns the dangers of sharing your own experiences with the mother. However, that doesn't mean that it is always wrong, and the good counsellor will sometimes feel it appropriate to expose herself to the mother. In order to explore this matter further, we will first look in more detail at the dangers of self-disclosure, and then look at some of its benefits.

Dangers of self-disclosure

Burdening the mother with the counsellor's problems. If the counsellor has unresolved problems (and who doesn't?) she may be tempted to reverse roles with the mother and get the mother to give her support. This is unfair to the mother, who presumably has enough problems of her own. It also makes it very hard for the counsellor to maintain objectivity. If you discover yourself wanting support from the mother, try to restrain yourself for the time being, and then share the issue with another counsellor or bring it up at a support meeting.

Appearing ineffective. We saw in the section above that a successful outcome is more likely if the mother has confidence in the counsellor. Too much self-disclosure may undermine this confidence. "Why is she telling me all this?" the mother may wonder, "If she's got so many problems herself how is she going to help me?"

Being too dominant. The vulnerability of the person seeking help can be a temptation for the counsellor to respond in a domineering fashion, taking her over and demonstrating a position of superiority. Self-disclosure may be used in order to try to achieve such a position. For instance, in the section on the barriers to empathy we gave the example of the counsellor who responds with her own experience. In that case the response was not just a self-disclosure but also a put down ("My problem is 'better' than your problem, so there!").

Transferring feelings to the mother. Sometimes the counsellor's desire to share her own experiences with the mother springs from a wish to create a relationship which mirrors another relationship in the counsellor's life. This may be because the mother reminds her of someone she knows, or because she evokes feelings in the counsellor which the counsellor then transfers back to the mother. If this happens, the counselling relationship can take on an importance to the counsellor which goes beyond anything needed to help the mother. The counsellor may find herself trying to prolong the relationship, or offering help which goes beyond what she would normally consider (lending money, or baby sitting, or giving lifts to the clinic for instance).

All of the above show some of the dangers which accompany any sharing of personal experience or feeling by the counsellor. They also suggest some of the hidden depths and processes which can go on in the counselling process. But there are some equally strong reasons for considering self-disclosure as a positive part of counselling.

Advantages of self-disclosure

Being genuine. There is a danger that the counsellor may appear to be too cold or detached—especially when she is inexperienced and is desperately trying to be non-judgemental. If the mother perceives the counsellor as someone who never responds as a human being, but is always a little aloof and too self-controlled she may find the counselling relationship artificial.

Effective counselling is not based on a mechanical set of skills, but on a genuine relationship of caring and warm support from the counsellor. Sometimes this can be promoted when the counsellor shares something personal. After all, if I did not care for you at all, I would not be likely to share anything personal with you, would I? Again, the ideal blend of spontaneity and control required from the counsellor is hard to achieve and will certainly take most people a long time to achieve.

Sharing experience. You may have had an experience which has some similarities to that of the mother. In this case you may consider it helpful to share this experience with the mother so that she may perhaps learn that some resolution is at least theoretically possible. As long as you offer this as your own experience, and make it clear that you recognize that the mother's experience is in some ways unique to her, this may be very helpful to the mother. It can help to build up positive expectations and lets her know that she is not alone in her discomfort.

Sharing feelings. As the mother talks with you, you will experience feelings of your own. There may be occasions when you will feel it useful to share these feelings with the mother. We are not talking about the usual expressions of sympathy that one friend might offer to another, but rather something much more deliberate, as in this example:

A mother has been telling you about her difficulties with her doctor and health visitor. In the course of doing so, she keeps telling you how sorry she is for taking up your time, for not being able to express herself clearly, for making mountains out of mole hills and so on. You discover yourself responding with strong irritation to this constant stream of apology.

Having identified your reaction, you may now choose what to do about it. One possibility is to put it to one side and try to ensure that it does not get in the way of your counselling. But another option is to share your feeling with the mother: "I hear you keep apologizing to me, and I find that I'm responding by feeling quite irritated. Do you think that the doctor and health visitor might be responding in a similar way?"

By sharing your feelings you focus on an aspect of the mother's behaviour which might be relevant to her difficulty (though it might not) and try to initiate an exploration of it. This is something which can be very effective, but it is quite dangerous; and if you find yourself doing it a great deal, you ought to ask yourself about your motives.

Modelling a skill. If the counsellor shares her feelings openly and without embarrassment, it suggests to the mother that such behaviour is acceptable (to the counsellor at least). This may have two benefits. Firstly, it may encourage the

mother to be more open with the counsellor and secondly, it may give her a model to follow in difficult situations.

A mother contacts you with a query about weaning. As you explore the issues with her it appears that the root of her difficulty lies in the strength of her husband's expectations about breastfeeding. She wants to start weaning the baby onto solids at five months, but he has read that it is 'better' to wait another month. Because he is so certain she doesn't really know how to share her own feelings with him. By sharing openly with the mother, the counsellor may model behaviour which the mother may be able to follow with the husband.

Guidelines for self-disclosure

- Be direct. If you are going to talk about yourself, be as simple □€and direct as possible. Don't beat about the bush or start something you cannot finish. Being coy or evasive will not be helpful to the mother, and may well harm the counselling relationship.
- Be sensitive. Only offer personal material if you are reasonably sure that it will be helpful to the mother. If you are unsure, then do not share.
- Be relevant. Try to ensure that your disclosure is relevant to the mother and to the current state of your encounter. If you suddenly think of something which might have been helpful ten minutes ago, don't try to introduce it now.
- Be non-possessive. Make sure that you do not force your experience on the mother. She must feel free to be able to reject or question the relevance of your experience to her own situation.
- Be aware. Be aware of the mother while you are sharing with her. If she seems to have stopped listening, you should stop sharing and check out with her whether she is finding you disclosure helpful.

Information giving

Earlier we discussed the two types of change: internal and external. Most mothers come seeking external change, and one of the best ways to bring about external change is to provide accurate information.

Much of your training is concerned with providing you with accurate and up-to-date information. The Checklist for Breastfeeding Counsellors provides an summary outline of the sorts of information which might be appropriate in different circumstances. But knowing the information is not enough. The counsellor's task is to communicate it to the mother. There are a number of guidelines which can help with this:

Be simple. When giving information try to express it in the simplest possible terms. Use common words whenever possible, and try to avoid technical terms. You may be very impressed by the fact that you know that contraction of the myoepithelial cells expels milk from the alveoli, but it is best to show off your new-found knowledge to your friends (who will know how to respond) rather than to the mothers who contact you for support.

There are two pitfalls to be avoided when seeking the goal of simple speech. Firstly, being simple should never be an excuse for talking down to a mother. You

may decide that the mother is not as well educated as you, or as clever, but it is your communication skills which are being put to the test, not hers. Don't say to yourself, "She'll never understand" but rather "What is the most appropriate way to express this information."

The second pitfall is using simple speech as an excuse for sloppy speech. It is vital that your information is not only accurate in itself, but that it is also communicated accurately. There will be occasions when you will need to use technical terms in order to be precise. When this need arises, use them without affectation and explain them simply as you do so: "If would be useful if you check that all of the bottom half of your areola—that's the dark area around your nipple—is in the baby's mouth when he is feeding."

Be appropriate. Simple speech is a generally desirable goal, but as you get to know the mother you are working with you may be able to gauge the level which would be most appropriate for her. For instance, if the mother has a medical background you can safely assume that you can be more technical than usual when talking to her. (But be careful that you don't get into playing 'I'm a professional, too' games with her.)

Be pictorial. We all know the old proverb about pictures and words, but when you are counselling over the telephone it is hard to show the mother a picture. So make your speech as pictorial as possible by being concrete. It is much easier to understand simple everyday ideas than abstract or technical ideas.

For instance, instead of talking about contracting myoepithelial cells and alveoli, you might speak of a gently squeezed sponge giving up its stored liquid.

Instead of talking about hormones and feedback systems when explaining supply and demand you might talk about putting notes out for the milk man.

If a mother is worried because her baby feeds too much or too little, you may help by talking about the way that at dinner parties or restaurants there always seems to be someone who finishes ages before the rest, as well as one who struggles on leaving everyone else waiting.

Check back. Do not simply assume that the mother has understood or taken in what you have told her. She may have a lot on her mind, she may be quite upset, and in such a state she will find it harder to absorb information. So check back with her; ask her if she is clear about what she has heard. Ask her if what you have said makes sense to her in her situation. She then has the chance to give you feedback "Oh yes, that makes a lot of sense to me" or "I hear what you are saying but it's different with me because..."

Encourage her participation. You want to avoid implying to the mother that she has to become dependent on you. Yet if you are the one with all the suggestions, this could happen. If you feel that there is too much one-way traffic in the information giving, you could consider referring her to a book (ask her whether she has any on breastfeeding or childcare and use them if possible) or else suggest an NCT leaflet. In this way the mother can discover for herself and take another step on the road to assuming personal responsibility for her situation.

Don't swamp her. You know a lot about breastfeeding. It can sometimes be tempting to keep offering more and more scraps of information until the problem is 'solved'. Try to resist this or else the mother will suffer from information overload and will not be able to take anything in. It is much better to offer her a few facts and then suggest that she try whatever seems most suitable and get back to you in a couple of days. It may help to set a particular time for you to talk again.

Be optimistic. Coupled with the need to ration the amount of information you offer is the importance of stressing to the mother that there are other possibilities if she does not experience immediate relief. Hope is a powerful agent for change, and the good counsellor gives subtle but positive messages that she retains hope that the mother's issues will be resolved.

Offering advice

The primary meaning of the verb "to counsel" in The Oxford English Dictionary is "to give or offer counsel or advice; to advise". Today the counsellor is urged to avoid giving advice at all costs—and this is certainly true of the breastfeeding counsellor. But why is this; what is wrong with giving advice?

The first reason why an NCT breastfeeding counsellor should avoid giving advice is that our insurers insist upon it. What worries is them is a scenario that goes something like this: Mother phones up wondering whether she can breastfeed after a breast reduction operation; counsellor has just read of a woman who did so, and says "I should give it a go. You'll probably be fine"; mother attempts feeding despite the increasing pain and discomfort; ends up with an severe abcess; sues the counsellor saying "She advised me to do it. She said it would be alright!"

It may be an unlikely sequence of events—surely the mother would consult a doctor before she developed the abcess, surely she wouldn't blame the counsellor anyway, surely the counsellor wouldn't be found liable in law... The problem is that nothing is sure in such cases, and the safest way to avoid the consequences of bad advice is not give it at all.

It's not that giving advice is bad in itself, despite the legal difficulties. But it is inappropriate in most counselling situations because the mother who approaches a counsellor is often emotionally vulnerable at the time of the contact. This means that she is much more likely to become dependent on the counsellor, instead of learning how to cope for herself. Advice *can* only be helpful when we are able to assess it dispassionately and then reject or accept it according to our true will—otherwise it can be manipulative.

Despite this, mothers will sometimes ask you directly for advice, bringing you either a problem to be solved (external change) or a dilemma to be resolved (internal change). "What do you think I ought to do?" she demands. The first thing to remember is that you are under no obligation to answer questions like this. The mother has no right to demand that you do something which is against your inclination and your training. Sometimes it will be right to gently, but firmly, point that out to the mother "I'm sorry, but I won't answer that question. Although I may be able to help you come to a decision, I am not able to make that decision for you."

On other occasions such directness may not be appropriate and you can best serve the needs of the mother by offering a summary: "You seem to be torn between hand expressing while at work and weaning completely. Listening to you, it seems to me that you really favour weaning. Is that right?" Sometimes this will be sufficient, but at other times the summary should be fuller, giving the mother a resumé, of her own arguments for and against the options under consideration. By treating the mother's demand for advice as a request for clarification you will enable her to come to her own decisions.

Goal setting

When we defined the aim of breastfeeding counselling as enabling the mother to breastfeed 'successfully', we pointed out that 'success' can be a rather elusive concept. One way of helping the mother to define it for herself is to help her in the setting of concrete goals: "I want to have completely weaned her by the time she is two years old"; "I want to be able to feed without nipple pain by the end of the week"; "I want to be able to get out of the house at least once a day"; "I want to be able to make love with my husband without the bloody baby crying!"

Sometimes the goal seems clear, but at other times the mother isn't really sure what she wants, or has two or more conflicting goals. In this case the counsellor can help by focusing on the mother's desires and helping her to couch them in specific terms. There are a few guidelines which can help:

Explore alternatives. If the mother is having difficulty in discovering a suitable goal you may be able to help by asking her about possible alternatives. Questions like "How else could you behave?" or "What would you like to be different?" may aid the mother in visualizing what she desires.

Be specific. Get the mother to concentrate on specific behaviour. If the mother says "I feel trapped in the house" try to discover what behaviour would enable her to feel less trapped. She may end up by discovering that what she really wants is the freedom to go swimming once a week, just as she did before the baby came.

Remember time. The mother will often make general statements like "I want to wean her". In order to convert this statement into a goal you will have to help the mother discover what she means by weaning—starting on solids? just one feed a day? none at all?—but you will also have to help her to set a time. Does she mean she wants weaning to be accomplished today, next week, by the end of the month? The timing element in goal setting is often crucial. In the example above the mother wanted to swim once a week, but if she had wanted to swim every day this would have been a different goal.

Don't be afraid to offer suggestions. Sometimes the mother is not capable of seeing how to translate her feelings into goals; that is why she has contacted you. In this case do not be afraid to offer suggestions. To the mother who says "I just can't cope with the house any more" you might suggest that 'coping' could be seen as having

Let the mother own her goals. The mother who says "I just can't cope with the house any more" may need considerable help before coming to discover exactly what behaviour might constitute coping for her. Perhaps the crux of the matter for her is just to have washed up the breakfast things, or to have hoovered or to have her

husband's dinner ready for him when he comes home. Whatever it is, the goal must belong to the mother.

There is a great temptation for the counsellor here. You may think that it is not important to do the washing up; you may even find yourself despising the mother for being so domesticated that she worries about her husband's dinner at a time like this. But if you do have such feelings, you must try to avoid sharing them with the mother—they actually come from within you and have nothing at all to do with the mother.

Help the mother explore contradictions. Sometimes we desire two contradictory goals. In such a case we may have to come to terms with the fact that one or other is unattainable and that a choice must be made. In such a situation a mother may fail to see the conflict and may be intent on achieving both. You can help by enabling her to see the situation more objectively.

For instance, a mother contacts you with a concern that she has too little milk for her four-week-old baby. In the course of exploration you discover that her partner gives the baby a bottle of formula twice a day in order that he can feel close to the baby and so that she may have some time to herself, which she feels she needs. You also discover that she has an intense aversion to expressing her milk either by hand or with a pump.

This mother wants to have enough milk but she does not want to feed more frequently or to express her milk. You will be helping €her if you point out that these two goals are probably mutually contradictory. You cannot make the choice for her, but once she accepts that she has to make a choice you can then move on to exploring which is the most important to her.

Task setting

Discovering goals can be liberating for a mother. To discover what it is that she really wants is a big step on the road to regaining control over her own life. But the ideal is to achieve the goal and this will probably require a bit more work. One way in which the counsellor can help is to assist the mother in task setting. By discussing practical ways of achieving goals the counsellor and mother can start to take the final steps towards the resolution of her difficulty. The nature of the appropriate tasks will vary with the situation, but a few useful guidelines can be offered.

Keeping records. One very useful task is record keeping. A mother phones to tell you that her baby never stops crying. One way for her to start managing his behaviour and her responses to it is for her to keep a diary of the times when he starts and stops crying. She could also note the kind of crying and perhaps how this relates to feed times and other significant events (but be careful that the mother doesn't agree to a task which is too hard for her). The advantage of this is that the mother becomes really involved in the management of her own situation (a possible side effect is that she may discover that the baby's crying is not as frequent as she thought).

Finding rewards. We all like prizes and rewards. Sometimes it may help a mother if she can reward herself. The mother who desperately wanted to cook for her husband's homecoming might permit herself a bar of chocolate in the evening if she

manages to get the meal on time (assuming that chocolate is something which would please her). It is a tangible symbol of her ability to cope that day, and an encouragement to continue the next day. Notice that the counsellor must not set the goals or prescribe the rewards—these must be done by the mother, in collaboration with the counsellor if necessary.

Encourage and motivate. Sometimes the mothers perception of her achievement will be faulty. She may consider herself a failure even when she has completed the desired tasks. In such a case the counsellor can encourage her and draw her attention to her achievement. Notice that this is not the same as making a subjective judgement about the mother as a person; you are being specific and accurate about her behaviour.

Facilitating change—a summary

Having explored the issues with the mother, you have moved to trying to help her effect a change in her circumstances—either within herself or in the world around her. You help her by offering information, helping her to clarify her goals and the tasks required to achieve them. In the course of this you may share something of your own feelings and experience. It is a difficult phase of counselling and can often be very frustrating, but it can also be most rewarding.

Closing

Relationships end in a number of ways: the holiday friendship that peters out despite the promises to keep in touch; the love affair that ends in tears; the goodbye a mother says when her only daughter gets married; the presentation of a certificate to mark the completion of a course.

All of these, and more, have their counterparts in the ending of the counselling relationship. Sometimes the ending is neat and tidy, but usually there are some loose ends. Sometimes the counsellor initiates the ending, but usually it is the mother who makes the break. In this section we explore four kinds of ending, basing them on our four analogies above.

The holiday friendship. This is the most common form of ending. The mother contacts you once, or twice, or more, and then you do not hear from her again. There is no formal ending, and you may never discover how things turned out for her. It is one of the frustrations of counselling that there are so many unanswered questions. Yet, paradoxically, it is also a sign of success: the contact has been made, but is no longer necessary. The mother continues her life as an independent being, not dependent on you for her well-being.

As you gain experience, you learn to read between the lines and make some fairly accurate assessments of the amount of help you were able to offer. These are checked from time to time when you come across the mother and can then get the feedback you never had before. Unfortunately, by then you may well have forgotten the details of the encounter!

The love affair. Occasionally the counselling relationship just doesn't work out. You interact strongly with the mother, each evoking powerful responses in the other. It will probably end in tears, maybe with some hurtful things being said. It's good experience, provided that you can share it with someone who can listen calmly—your local tutor or one of your fellow counsellors would be best.

A personality clash can happen to the best of counsellors but if you find yourself getting into a situation like this with any degree of frequency, you need to look very seriously at what is happening. It may be that you are using counselling to play out some needs of your own. If this could be the case you must discuss it with a tutor and stop counselling until the matter has been sorted out.

The wedding. There will be occasions when you will not be able to meet the needs of the mother, because she requires specialized help beyond your means. This will usually be medical help, but might involve a professional therapist, social worker, or even a lawyer. This can be a difficult area to handle. There are a number of issues which need to be considered.

Firstly, there are the feelings of the mother. Assure her that you are not deserting her, but that she could benefit from additional help or support. Let her know that she can still contact you whenever she wants—you'll be more readily available than most professionals!

Secondly, there are your own feelings. Are you reluctant to let the mother go? Do you feel that you have failed her? These are natural feelings in some circumstances, but you must not let them get in the way of what is best for the mother.

Finally, there is the difficult ethical question of what to do if the mother refuses to see anybody else. In this case you must consider your own needs as well as those of the mother. You do have a duty to protect the mother and to consider her needs, but that duty is not absolute. Let us consider three points of view:

The mother's right to autonomy should be protected as far as possible. If she refuses to see a doctor, you should accept her decision even though you do not agree with it. You cannot take responsibility for another person's life. The only exception to this would be if you believed that the mother was no longer capable of making rational decisions and that she was so mentally or physically disturbed that someone had to act for her. In such a case you might feel justified in contacting her doctor or health visitor. If you do so, you should inform the mother of your course of action.

In some situations the mother's rights may interact with the rights of others. You may discover that the mother is having an affair and that her marriage is disintegrating. You may suggest that she sees a Relate marriage guidance counsellor. If she refuses, you may be tempted to tell her husband about the affair on the grounds that he has rights in this matter. This would be a mistake, since it is not a matter of life and death and you cannot be reasonably certain that your intervention would do more good than harm.

On the other hand, if you had reason to believe that the mother was abusing her baby and would not seek professional help, you may well consider it essential to inform Social Services. If you do, you should also inform the mother of your decision. Even when the counselling relationship is at its worst it should still be based upon honesty and respect—at least on the counsellor's side.

Finally, there are your own rights. If you believe that a mother should seek medical advice and she refuses, you need to ask why she is doing so. It may be that she has become neurotically dependent on you and is exploiting you. If you believe this to be the case, you should terminate the counselling relationship, explaining as clearly as you can why you are doing so. You are not a professional psychotherapist, and no-one will expect you to □€try to perform long-term therapy with a mentally disturbed 'client'.

Thankfully, such issues are rare. You may go throughout your whole career as a breastfeeding counsellor without ever encountering a difficult ethical situation but if you do remember that you can always share your difficulties with your local tutor.

The certificate. Our final example is the nicest for the counsellor. After a number of calls, the mother contacts you to tell you that she is now feeding successfully and that she is really grateful for your caring and your support. Accept this thanks as caringly as you accepted everything else she offered you. You may be embarrassed, but don't put her down by refusing her gratitude: "Oh don't be silly, it was nothing!" If is was nothing, then her concerns were also nothing, and she wasted

your time! So thank her too, and let her know that you'll be there if anything else were to crop up.

In fact, sometimes you only discover the resolution when something else does crop up. "Hello, you may not remember me, but you absolutely saved my life when I was trying to breastfeed my first baby..." Now she's got a difficulty with her second, and naturally she turns to you and the counselling process begins again. But that's why you became a counsellor, wasn't it...

Conclusion

There is much more to learn—especially from experience. As you grow in knowledge and experience you will gradually become a better counsellor. At times you will be frustrated and even downcast at your own frailties. At other times you will become deeply moved by the suffering and courage of others. You may get discouraged one moment, and then really uplifted by the simple thanks of a woman who feels that mothering was a bit better for her because you were there when she needed someone.

However things turn out for you, we hope that you will enjoy your experience as a counsellor and that it will help you to grow as a person in your own right.

Reading list

We have drawn on a number of other works in preparing this booklet. Some of the ones which you may find useful are mentioned here.

A book which helped a lot is *Practical Counselling Skills* by Richard Nelson-Jones (Holt, Rinehart and Winston, London 1983). This is a general introduction to counselling. The emphasis is on developing your counselling skills rather than learning the theory behind counselling.

Counselling : A Skills Approach by E.A. Munro, R.J. Manthei and J.J. Small (Methuen (N.Z.), Aukland 1983) is shorter and also contains some useful material. Both these books contain a number of exercises for individuals and groups.

If you want to know more about Carl Rogers' client-centred approach, a good account of it in action is given in *Dibs: In Search of Self* by Virginia Axline (Penguin, London 1971). Axline was a follower of Rogers who introduced his principles into work with children. Dibs is a disturbed boy with whom she works. The book is very readable, and shows to what lengths a 'non-directive' therapist will go.

Much of the section on listening and responding has been drawn from two books:

Swift to Hear by Michael Jacobs (SPCK, London 1985) is a book specifically about the skills of listening and responding in caring situations.

Caring Enough to Hear and be Heard by David Augsburger (Regal Books, Ventura, California 1982) looks at listening in the context of personal relationships.

There are a number of books on body language. *Body Language* by Gordon Wainwright (Teach Yourself Books {Hodder & Stoughton} Sevenoaks, 1985) and *Body Language* by Allan Pease (Sheldon Press, London 1984) are both quite accessible. The book by Allan Pease is more copiously illustrated.