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Curbing the rescuer within
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Therapy Today is published by the British Association for Counselling and Psychotherapy monthly (apart from January and August) and is mailed to members and subscribers between 15th and 20th of the month. Design by Esterson Associates. Printed by Polestar Stones.

ISSN: 1748-7846.

Subscriptions and articles
An annual UK subscription costs £75 and an overseas subscription is £94 (for 10 issues). Single issues are £8.50 (UK) or £13.50 (overseas). Hard-copy articles: £2.75 each. BACP members receive hard-copy issues free of charge as part of their membership.

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Advertising deadline
2pm on 18 March 2015 for the April issue. For more details, visit: www.bacp.co.uk/advertising

Our mission
Therapy Today is the official journal of the British Association for Counselling and Psychotherapy. Our aim is to inform, inspire and support counsellors/psychotherapists throughout their careers and provide a platform for discussion and debate.

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ABC
ABC total average net circulation 42,153 (1 January–31 December 2014)
How we become therapists

With another BACP Student Conference at the end of this month, we hear from Julia Buckroyd, one of the presenters, who sets the theme for this issue about developing as a practitioner. I find it hugely refreshing when I hear practitioners like Julia talk because she brings so much of herself into what she says about her work. Here she looks back at how she has evolved as a practitioner since her early days of psychoanalytic training when she ‘believed the party line about “abstinence” and “the blank screen”’. Thirty years on she has started to explore for herself what Winnicott’s ‘being myself and behaving myself’ means for her as a therapist in terms of being authentic and human.

There has been some debate recently in Therapy Today about whether just completing a training can properly equip you for private practice, where you will be working in isolation, without the support of an organisation. Julia writes that she was several years into her career before she realised that her training was just a beginning and that she needed to take responsibility for her own ongoing development. I wonder whether, as we move further towards professionalisation and automatic registration, we’re more likely to lose sight of this?

Carleen Robinson talks about her counselling training as a black African Caribbean woman and how good it felt to be able to explore for the first time what it means to be different in our society. But her experience of training also echoes that debated by Eugene Ellis and Niki Cooper in the December 2013 issue of Therapy Today. Some of her white peers would fall silent when the subject came up of what it felt like to be someone from an ethnic minority on the course. Perhaps it was too awkward to go there, Carleen suggests; perhaps they were afraid of causing offence. Looking back, she asks how, if this is not addressed during training, ‘can therapists relate to clients experiencing these issues and, most of all, challenge their own prejudices?’

In ‘How I became a therapist’, Myira Khan from Leicester describes how, during her five years of training she was the only Asian woman and the only Muslim on her courses. She has since set up the Muslim Counsellor & Psychotherapist Network to offer peer support and networking to Muslim students and practitioners. Myira has been named as a ‘Mental Health Hero’ by Nick Clegg for her work.

Sarah Browne
Editor

Contribute
We welcome readers’ letters, original articles, feedback and suggestions for features. Visit www.therapytoday.net for contributor guidelines or email the team at therapytoday@bacp.co.uk

‘The tidal wave of disclosures from survivors of these horrific kinds of abuse is lapping at the therapist’s door. We need to be better prepared to hear and respond’
Sue Richardson (p4)

‘I was the only Asian woman and the only Muslim on my courses throughout all my five years of studying counselling. I thought, surely I can’t be the only one?’
Myira Khan (p25)

‘Social change won’t happen from our cosy consulting rooms. We need to get out and do more, and I’m afraid that idea will be met with resistance for decades to come’
Caroline Vermes (p37)
It’s time to speak up for the sake of our clients

NHS frontline staff are the latest ‘squeezed middle’, writes Jeanine Connor

When the weather is inclement and the evenings short I find myself more aware than usual of what’s in the news. As I write this we are approaching the awards season (I will have been overtaken by events by the time you read this, I know) and there’s an air of anticipation surrounding the nominations for the Oscars, Grammys, Globes, Baftas and Brits, all weeks before the actual awards ceremonies take place, when there’ll be another consignment of frenzy. The entertainment industry likes to honour its heroes. Among the show biz glitz, healthcare industries have been a regular focus of our news too. But they’re not being awarded, rewarded or regaled: quite the opposite in fact.

Images of failing services are beamed into our homes, with accompanying narratives about scandal, abuse and exploitation. The names we recognise belong to those who have failed the most vulnerable members of our society. We hear nothing about the successes. Hospitals and GP surgeries deemed inadequate by the Care Quality Commission (CQC) have been named and publicly shamed, while those graded good or above remain anonymous.

Waiting times are up, patients are treated in corridors, staff are overworked and underpaid, blah, blah, blah. The names of the worst ‘offenders’ are touted. This is the antithesis of what happens in the entertainment industry, where achievement is publicly applauded and ineptitude ignored.

I spoke recently to a senior practitioner in occupational health for a large NHS trust. He told me the department is inundated with referrals for mental health clinicians who are on the verge of collapse. They have become a kind of ‘squeezed middle’: pressured by management to treat more patients in less time while quantifying every move on electronic databases that aren’t fit for purpose; pressured too by patients who demand and deserve to be treated according to their needs. I heard that stress, anxiety and depression have seeped into the system so that mental health clinicians are now just as likely as their patients to receive such diagnoses.

I also heard about the upsurge in referrals relating to bullying. We hypothesised that the NHS has become a (top) dog eat (under) dog world, with the bullies marking their territory at the top of the tree by nonchalantly pissing on those below them. It seems that individuals with an unconscious desire for power and control are the very people most likely to rise to the top in organisations set up to support the needs of the vulnerable, exploited and abused, so that the system itself becomes abusive. Professionals on the ground feel neglected by supervisors and abandoned by managers who are preoccupied with the business of accounts rather than accounting for the quality of their team’s work. In organisations where numbers matter more than people, clinical safety feels dreadfully precarious.

The majority of clinicians who work in the healthcare sector do so because we are passionate about implementing positive change for those entrusted to our care. Could this be the reason that professionals in these industries have so far put up and shut up? But perhaps the wind is changing. We’ve heard in the news that NHS organisations are to be required to appoint guardians to protect whistleblowers from the fallout of speaking up about bullying and clinical safety issues. So I wonder how long it will be before someone, somewhere blows the whistle loud enough for a media kingpin to hear. Lips are pursed, but many remain too depressed to blow. Jeanine Connor MBACP works as a child and adolescent psychodynamic psychotherapist in private practice and in specialist Tier 3 CAMHS and is also a writer, supervisor and trainer. See www.seapsychotherapy.co.uk

No healing without justice

It’s time to put the issue of organised abuse in all its forms on our agenda, argues Sue Richardson

I’ll be honest: I have little faith in the process of public inquiry as a means of establishing the truth. I see the overall aim as containment of legitimate disquiet and the construction of a narrative that consigns contentious events to the past. Will the inquiry into historical child sex abuse, now to be chaired by Justice Lowell Goddard, prove to be an exception? Will the truth be established about allegations of organised sexual crime at the highest level? Whose narrative will prevail? Will it reflect that of survivors seeking justice? Or will the outcome be experienced as another institutional betrayal?

Whatever the answers to these questions, a paradigm shift is occurring that places the existence of interconnected networks of paedophilia, child prostitution, trafficking, pornography, cult abuse and mind control on the public and professional agenda. The tidal wave of disclosures from survivors of these horrific kinds of abuse is lapping at the therapist’s door. We need to be better prepared to hear and respond.

As a therapist, I find recurring episodes of increased public awareness of child abuse a mixed blessing. On the one hand a changed climate enables many survivors to break their silence and seek help. On the other it can be experienced as exposing and re-traumatising. Sometimes I dread the outpouring of grief, anger and feelings of injustice that media publicity can precipitate in traumatised clients. In addition there is the associated increase in referrals with which most organisations and individual therapists are struggling. Finding the right supervision is an issue too, especially for therapists new to working with torture-based
trauma common to organised abuse and mind control.

In my opinion it is time for the therapy world to place the issue of organised abuse in all its forms firmly on its agenda too. Individual therapists are learning to bear witness to previously unspeakable crimes, often in isolation from colleagues and without prior knowledge or training in work with complex trauma and dissociation. A higher profile is needed in training at foundation and post-qualifying levels and collegial support is essential at all levels.

Survivors have made the Home Secretary listen and respond to their demands concerning the forthcoming inquiry. I do not know if they will get the justice they hope for. It is not part of the inquiry’s remit to determine criminal or civil liability. It is regrettable that a robust police inquiry team has not been set up to work alongside it. Helping individuals towards healing in the absence of justice is a huge therapeutic challenge. Is it enough to be a compassionate witness and that the survivor’s narrative is heard? We need to bear in mind that the majority of child and adult victims are trapped in silence and depend on others to recognise their plight if they are to be heard at all. If we can deal with our own fear we can reduce the impact of the fear and intimidation to which they have been subjected.

I hope Justice Goddard will be fearless enough to blow the whistle loud and clear on perpetrators who have hidden in our public institutions and those who have helped to conceal them. Even if she succeeds, nothing can remove our professional responsibility to address the issue of organised sexual crime as therapeutically as we can. In effect we are all acting as whistleblowers when encountering through our clients such secret and appalling crimes. I will be taking a close interest in the parallel UK Child Sex Abuse People’s Tribunal – a model used in other places where healing cannot be had without justice (details at www.thepeoplestribunal.org.uk).

Sue Richardson is a UKCP registered attachment-based psychotherapist and member of the John Bowlby Centre in independent practice.

We need to talk about CBT

To heal the gulf between CBT and counselling, we need to talk to each other, say Mike Trier and Elaine Davies

Late last year the three of us (Elaine Davies, a CBT therapist, Mike Trier, a person-centred counsellor, and Catherine Jackson, Deputy Editor of Therapy Today) were involved in a spat about CBT in the pages of this journal. It was sparked by Catherine’s review, in the September issue, of Thrive, the book about IAPT by Professors Richard Layard and David Clark. Elaine felt the review was unfair to CBT practitioners; Mike agreed with the stance of the review and challenged Elaine to an open debate on the issues. She accepted, and so began a triadogue about how this might go forward.

John Wilson of Online Events soon joined our conversations and the four of us have devised a programme of online discussions, which we hope others in the counselling profession will join. The CBT vs person-centred counselling schism has been rumbling for many years, although IAPT and the NICE guidelines on depression have added a sharper, economic and political edge. Our aim is to provide a safe, respectful and holding space for counsellors to talk about and tease out the differences between us and to dispel myths, at both practice and policy-making levels. From our experience, we may find more kinship between us than we expect.

I felt that Mike was expressing anger and hatred towards me in his letter purely because I was a member of the CBT community, and I have experienced hostility from other counsellors as soon as they have found out that I am a CBT practitioner.

Mike: I met a few times via Skype, and quickly developed a warm relationship. I felt protective towards her, both on hearing about the hostility she has already experienced from other counsellors and because I worry we might open a can of worms when we ‘go public’ in the online discussions.

Elaine: I think it’s important for the counselling community to express their feelings. I would hope that we will then be able to move beyond the political issues and start to compare how each of us work with our clients. I believe dialogue will reveal similarities and even new ways of working.

Mike: I am interested in how we as counsellors process and express our own anger. We spend much of our time helping others understand their feelings, but how effective are we at empathising with ourselves?

Elaine: At the start of our relationship we were just words on a page, letters in a journal, angry at each other and what we represented. After a few telephone and Skype calls, what we offered each other was empathy and acceptance. We have engaged in a reparative relationship by valuing and understanding each other’s perspectives.

Mike and Elaine’s discussions will be continued in a series of debates hosted by Online Events. The first, on 30 March, will explore the differences and similarities between CBT and the person-centred approach. The second (22 April) will discuss how the two approaches deal with anger. The third (31 May) will address the predominance of CBT within IAPT services. In the final event on 27 September a panel will discuss the issues raised from a wider, policy-making perspective. For details, visit onlinevents.co.uk/events/category/conversations-about-cbt

Elaine: Anger, envy and hatred can be linked. CBT therapists and other counsellors agree that the understanding and expression of feelings is important. I felt that Mike was expressing anger towards me in his letter purely because I was a member of the CBT community, and I have experienced hostility from other counsellors as soon as they have found out that I am a CBT practitioner.

Mike: Elaine and I met a few times via Skype, and quickly developed a warm relationship. I felt protective towards her, both on hearing about the hostility she has already experienced from other counsellors and because I worry we might open a can of worms when we ‘go public’ in the online discussions.

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NHS therapists at risk of burn-out

Counsellors and therapists working on the frontline of NHS services need better support to reduce stress and burn-out, BACP Chair Andrew Reeves has said.

Speaking in the closing debate at the 8th New Savoy Partnership conference on Psychological Therapies in the NHS, 11–12 February, Reeves told delegates: ‘People are leaving the profession because they are struggling to deliver a service that falls short of what the client might need.’ He said that was certainly his experience in his own field of suicide and self-injury.

He said too many practitioners have become disillusioned with working in NHS psychological therapy services because they feel they are not providing an adequate service to their clients. Speaking personally, he said: ‘I find it really disillusioning to not be able to deliver a therapy that the client is asking for, that I have to deliver a therapy that I think is possibly not the right thing but is evidence based. I find it disillusioning when I am not professionally valued, that I sit somewhere down the hierarchy.’ He called on the profession to get rid of its professional and research hierarchies. While he worked well with colleagues, ‘it would not be the first time I’ve heard that I am not delivering what the client needs because I am a counsellor.’

Earlier delegates heard initial findings from a joint British Psychological Society/ New Savoy Partnership survey that has found rising levels of depression and stress among psychological therapists in the NHS. Of 850 respondents, 58.7 per cent said they found their job stressful often or all of the time; 69.7 per cent said they felt pressured into meeting targets often or all of the time; 40.4 per cent reported episodes of depression; 42.4 per cent said they felt a failure some, often or all of the time, and 67.8 per cent reported sleep problems.

Richard Pemberton, Chair of the BPS Division of Counselling Psychology, said: ‘It’s great to have improved access to evidence-based psychological therapies but the whole target culture has had a toxic effect. We did need to improve access to psychological therapies on an industrial scale but in doing so we seem to have damaged our own workforce.’

University staff ‘scared’ to reveal mental illness

University staff and students are not seeking help for mental health or emotional problems for fear of stigma and discrimination, a survey by the Equalities Challenge Unit (ECU) has found.

The charity questioned more than 2,000 staff and 1,400 students. Some 38 per cent of staff said they had not told colleagues about their mental health difficulties, often because they feared they would be treated differently or thought less of. Less than half (40%) said they had received support.

Over half the students with mental health difficulties (54%) said they had not received help or spoken to anyone about getting help and most of these also thought they would not get the support they needed or would receive unfair treatment, but of those who did seek help from university services, the majority (78%) said it benefited their academic work; only five per cent reported any negative effects.

Three quarters of students answering the survey had shared their difficulties with their peers, and 78 per cent said they had received supportive or very supportive responses. A smaller proportion of staff had disclosed to colleagues (62%), but 84 per cent said they received a positive response.

Chris Brill, ECU senior policy adviser, said: ‘Although a wide range of support and adjustments are available, a lot of staff and students aren’t accessing it. We need to focus on developing environments that not only make it more acceptable and comfortable to disclose mental health difficulties, but also translate this into encouraging people to access vital support.’

http://tinyurl.com/nr3elq4

Businesses neglect staff wellbeing

Three quarters of employees would prefer to discuss their mental health with someone outside their workplace, a study by the Institute of Directors has found.

The Institute surveyed 1,150 employees and 586 UK employers. Only 23 per cent of companies had a mental health programme or company-wide policy, and less than seven per cent of business leaders had discussed emotional or mental health with their employees in the last year.

Over half (51%) of employees felt that their employer had some responsibility for their emotional wellbeing, but only 19 per cent said they got enough emotional support.

http://tinyurl.com/ozzjmju
Psychotherapy ‘not valued’

Psychotherapists are reporting longer waiting lists for their services, increasingly complex cases and more people coming for help after being failed by the NHS, a survey of their members by the British Psychoanalytic Council (BPC) and the UK Council for Psychotherapy (UKCP) has found.

Of 2,000 practitioners working across the NHS, third sector and private practice, 57 per cent said client waiting times had increased over the last year; 52 per cent reported fewer psychotherapy services being commissioned by the NHS in the last year, and 77 per cent said they were being expected to deal with an increasing number of complex cases.

The vast majority of the therapists working in private practice (94%) said they regularly saw clients who felt let down by the NHS either because the waiting lists were too long (56%) or they weren’t getting the help they needed from the NHS (58%) or the course of therapy offered was too short for their needs (63%).

Nearly three quarters (72%) of the psychotherapists said they were deterred from working in the NHS because they felt it did not understand or recognise psychotherapy as a profession or value the contribution of longer-term approaches.

Janet Weisz, chair of UKCP, said the survey revealed ‘a worrying development. The therapists whose views are represented by this survey are a significant asset to our public health service. The loss to the NHS of their skills, commitment and dedication is a tragedy.’


Government to review BSL access

The Government is to review access to IAPT BSL counselling services for deaf people. SignHealth, which has been providing BSL counselling through the IAPT programme, says clinical commissioning groups are no longer commissioning specialist BSL counselling for local deaf people.

Parliamentary Under-Secretary of State for Health Earl Howe has now promised to set up a working group to review the issue and to ‘remind clinical commissioning groups of the importance of commissioning IAPT services that are accessible to BSL users’.

‘This needs to be done quickly,’ Steve Powell, Chief Executive of SignHealth, said. ‘A service with 75 per cent recovery rates is withering.’

Parents question counselling

Almost a third of parents would be embarrassed if their child asked to have counselling, research by Place2Be has found.

Its survey of 864 parents, launched to mark the UK’s first Children Mental Health Week in February, found that 22 per cent would not encourage their child to have counselling even if they asked for it, and 30 per cent would feel embarrassed if their child wanted it. Fathers reported this more often than mothers (38% vs 25%). Parents who were separated were less likely to feel embarrassed than those who were married or in a civil partnership – 25 per cent compared with 30 per cent.

But the majority of parents whose children had counselling said they benefited: 84 per cent said that their child’s problems improved; 73 per cent said their learning improved; 73 per cent said their child now had more friends and 64 per cent said home life was better.

Parents who

In brief

• Older carers may become even more depressed when they no longer have carer responsibilities, a study from the International Longevity Centre – UK (ILC-UK) has found. Caregiving itself is linked with poorer quality of life, but researchers found that many former caregivers experienced even worse depression when their loved one had either died or moved into residential care. ILC-UK says carers should be offered continued support.

http://tinyurl.com/uglk57a

• Frontline health and social care workers will be required to report cases of female genital mutilation (FGM) to the police. New legislation will be introduced under the Serious Crime Bill to ensure the new duty comes into effect before the dissolution of Parliament. The duty will apply to all regulated health and social care professionals and teachers but will refer only to girls and women under the age of 18.

• Children from the age of five should spend at least one hour a week in school talking about their emotions and learning life skills, an inquiry led by Professor Richard Layard recommends. The report, Healthy Young Minds: transforming the mental health of children, says schools should measure pupil wellbeing regularly and life skills should be given the same priority as reading and writing.

http://tiny.cc/gogcux

Visit www.therapytoday.net to read our weekly news bulletin.
What are they looking for?

There are no simple answers when working with young people at risk of radicalisation

Catherine Jackson reports

The ease with which three Asian Muslim girls were able to leave their homes in East London, fly to Turkey and cross the border to join the Islamic State (Isis) forces in Syria has reignited public and political concern about the dangers of radicalisation. What, policy makers are asking, makes young people – and young Muslims in particular – vulnerable to following the siren call of extremist groups? Even more important, how do we stop it?

The Government is currently consulting on new duties that the Counter-Terrorism and Security Act, currently going through Parliament, would place on all public sector organisations to contribute to the national strategy to prevent terrorism and extremist violence. The strategy, Prevent, is overtly not about criminalisation; rather, through its multi-agency Channel programme, it uses existing health and social care safeguarding procedures for children, young people and vulnerable adults to identify and support those at risk. The language is of risk and vulnerability, support and advice, not crime and punishment.

Many counsellors will be working with the age group at highest risk: young people in their teens and early 20s. Counsellors in secondary schools and further and higher education settings may already have been involved in their organisation’s training programmes and be familiar with the procedures they should follow if they identify a client who may be at risk of radicalisation. Their statutory duty in relation to reporting concerns is clear: BACP’s ethical guidance reminds its members that any legal requirement to disclose information, with and without their client’s knowledge or consent, over-rides any professional ethical guidelines on client confidentiality. This is absolutely the case with regard to terrorism.1

Kalsoom Bashir is Co-Director of Inspire, the Muslim women’s anti-extremism campaign group. She sees the vulnerability factors for young women as a combination of the personal – trauma, family upset, family break-up or relationship break-up – and external issues – a sense of grievance, injustice, experience of racism, difficulties getting a job. They may also be searching for an identity or struggling with their Muslim identity in British society, she says: ‘There isn’t one factor. But we need to recognise that the earlier you can help someone with whatever vulnerability they have, the better chance you have of mitigating that risk of crossing the line into radicalisation.’

Young girls in particular are vulnerable to a form of grooming, she says. They may be well educated but they may still have had a very conservative upbringing and restricted social lives. ‘It can be quite lonely. They may be looking for romance, for affection, for that sense of someone wanting you, particularly if it isn’t available from their family. Extremist movements exploit that in the same way that paedophiles hook onto vulnerable young women. They tell them they will have a hero husband waiting for them and they will play an important role in establishing a new country. Young women are drawn towards that.’

Teachers and others working with these young people need to give out a clear and consistent message, she says: ‘It’s like stranger danger – you need to talk with young women about the risks and consequences.’

Kam Bhui, Professor of Cultural Psychiatry and Epidemiology at St Mary University of London, has researched the psychosocial factors that may ‘push’ and ‘pull’ young people from the UK’s Muslim communities into supporting violent protest and terrorism. Surprisingly, he found no correlation between extremist sympathies and adverse life events: in fact, in his research wealthier people emerged as marginally more sympathetic to terrorism, as did people in full-time education. ‘That was a surprise as one of the dominant discourses is that poverty, discrimination and social exclusion are driving these movements,’ he says.

But perhaps what emerged most strongly is the need to resist simplification: ‘The Government is in search of certainty but there are so many factors.’ He is clear that counsellors and psychotherapists need to be alert. ‘They are privy to all sorts of fantasies and material. If they come across this phenomenon, they have to be very clear about their duties with regard to safeguarding.’

What works?

Professor Bhui’s research also uncovered factors that echo Kalsoom Bashir’s description of young women brought up in boundaried, close-knit communities. Those in his survey most likely to have extremist sympathies were not the most socially isolated; in fact they tended to enjoy richer social capital in terms of family and friendship networks. But their networks were more likely to be tight-knit, rather than spread across a wide social spectrum. This also gives a clue to what may work to prevent radicalisation. ‘Positive socialisation is such an important intervention,’ Professor Bhui believes. ‘Young people are in a phase of huge transition. It only takes one charismatic figure to give us a sense of identity and coherence and make us feel better in the world. It’s ordinary human vulnerability.’ We need to be offering young people positive identities and positive alternatives, using proven successful interventions such as those aimed at reducing gun crime. ‘You don’t focus on the guns and the crime. You offer them employment, music, dance, a group identity with a T-shirt and badge.’
This is certainly the experience in mainland Europe, where countries like Germany and Holland are further advanced in devising preventive approaches to all extremism – far right as well as religious. Harald Weilnböck, Co-Chair of RAN-Derad, the Radicalisation Awareness Network, based in Germany, has extensively researched and evaluated anti-radicalisation and hate crime programmes across Europe.3

His research suggests group approaches are more effective than one-to-one, although they can operate well together. Groupwork offers social contact and socialisation. ‘Most of the people using the programmes we researched came from broken families and were raised by single parents. They are very expert on how to manipulate the one-to-one relationship. In a group you have witnesses; you can’t play those tricks. Also the learning effect is multiplied. Once you have managed to trust that group, it has a much greater and more lasting impact.’

A trained (but not practising) psychotherapist himself, Weilnböck says the keys to opening doors to alternatives for young people at risk of extremism are fundamentally the same as those that counsellors and psychotherapists use to help clients choose healthier ways of being in the world: relationship, trust and narrative. ‘Whether the practitioners are social workers or police officers, they are basically able to do what psychotherapists do – use themselves as a relational counterpoint to the other; establish a relationship that is personal but not intimate and be present so that the young person can mirror that and express what they see for themselves,’ he says. How you communicate with the young people is also vital: don’t teach or preach or instruct or argue with them; instead get them to tell the story of their life. ‘Narrative is inherently therapeutic,’ he says. ‘It’s what psychoanalytic therapist Roy Schafer says about psychoanalysis – it’s nothing more than telling the same story over and over again for two years, only in the end you tell it much better.’

Interventions are also much more effective when they are led by practitioners with no statutory powers or remit – third sector, non-governmental organisations, rather than social workers or police or probation officers, he says. Risk assessment is not helpful. ‘We should be spotting challenges and then engaging with our young people. We should be supporting their development.’

But these are precisely the projects that have suffered under the UK Government’s austerity cuts, says Vicki Coppock, Professor in Social Sciences at Edge Hill University in Lancashire. She questions the emphasis on ‘psychological vulnerability’ in the Prevent strategy, arguing that it risks problematising normal adolescent developmental behaviours.4 Safeguarding might seem a better arena than the criminal justice system in which to manage these vulnerable young people but ‘it is no less implicated in issues of power and control, and it’s more insidious because it’s disguised as benevolent,’ she argues.

‘Young people have a right to be political. Isn’t that idealism precisely what we cherish about youth? For me, the way forward is supporting third sector projects that are able to engage locally with young people on the ground and provide safe places for them to express dissent and work through these things.’

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In pursuit of authenticity

Julia Buckroyd explores her journey from newly qualified practitioner to gaining the confidence to ‘be myself and behave myself’

I’ve been a long time admirer of Donald Winnicott,¹ the famous child psychiatrist and child therapist who was doing most of his work in the 50s and early 60s. He invented all sorts of useful mantras probably known to you, such as ‘There’s no such thing as a baby’, ‘the good enough mother’ and ‘alone in the presence of another’. He also provided himself with a set of rules for how he should behave as a therapist, one of which was ‘Being myself and behaving myself’. This still makes me smile – I think he knew himself and the therapist breed very well – but in the last year or two I have started to think about what that injunction might mean for me, and for therapists generally.

I guess that humans are pretty good at spotting inauthenticity – phonies, fakes, pseuds. We have all sorts of words and phrases that suggest we are constantly scanning for integrity, honesty, transparency: putting it on, faking it, pretending. I am sure that clients have a particularly heightened awareness of how real we are when we are wearing our counsellor hats, and are appropriately suspicious of us until we prove ourselves (or don’t). So how can we allow ourselves to be just who we are, while at the same time restraining our less attractive impulses?

What brought me into counselling

When I was 21 I had a depressive breakdown and was hospitalised for three months. I was extremely fortunate: instead of being heavily sedated or put on bed rest, as happened in many hospitals, I was admitted to an adolescent unit that attempted a therapeutic environment. There were daily group meetings; the staff were all engaged in getting us (about 25 of us) to think about what had brought us to our current state of mind, and we each had individual meetings with a psychiatrist. For me this was a revelation: I had no concept of how my difficult beginnings might have brought me to the state I was in, but I very soon found that making meaning of my situation was extremely therapeutic.

After three months I was discharged and had follow-up weekly sessions for six months (how awful that, 47 years later, this sounds like wonderful luxury). Although that period was more like a preliminary skirmish with my history rather than a definitive resolution, I was permanently convinced of the utility of the ‘talking cure’.

In my mid-30s I embarked on training to be a counsellor and later completed more extended therapy training. My immediate motivation for beginning training was to find some resources for managing the pastoral care of the students from abroad for whom I was responsible. The deeper-rooted urge was to provide for others the infinitely healing and enabling experiences from which I had benefited so much. Like most trainees I was idealistic, optimistic and naïve. I believed that, with the magic of therapy, I could cure all ills. In those 30 years since I first began to practise I have learned a great deal more humility, but I do still believe in the power of therapy to enable (some) people to develop into the individuals they have the power to be. However during those 30 years I have revised pretty extensively most of what I was taught.

The rules I thought I had to play by

Both of my original trainings were psychoanalytic. Emphasis on the past and the tracing of patterns of behaviour made perfect sense to me. It was a process that had started to make sense of my life to me and I could see how useful it might be to others and how it might illuminate current difficulties. I could also understand the power of the relationship, even if from a negative point of view: I had a series of therapists and one psychoanalyst who caused me enormous pain and was, I now think, sadistic. Despite this experience I believed the party line about ‘abstinence’ and ‘the blank screen’. I was newly qualified and was bound to follow what I had been taught; I certainly had no better ideas myself at that point. I can remember worrying about greeting a ‘patient’ with a smile.

Similarly, I allowed myself to be convinced by the idea that the interpretation of the transference was the crucial activity. This was severely dented by the ‘patient’ who asked me with some irritation why I was always bringing myself into my responses to her. It was finally knocked on the head by reading Robert Langs,² whose central conviction was that all communication in therapy is about the immediate situation with the therapist. It seemed to me that people had concerns that were a great deal more pressing than wondering how I would respond, and that Langs’ theory diminished the client.

Illustration by Elis Wilk
Other rules for practice delivered as revealed truth included the idea that the client should always speak first. My application of this rule to a shy, frightened, miserable teenager, so that we sat together in silence for 50 minutes, made me truly ashamed of myself. I think I tortured that girl and I am not proud of it. I began to realise that I needed to find my way to a practice that felt more authentic, more like me. I had rather little experience, but I had to resolve the incongruence between what I had been taught and the values of warmth, kindness, friendliness and humanity that felt core to me.

Finding my way to my own rules
While I was still in the early stages of my first training I wanted to explore other ideas about therapy. So, for a book review exercise, I contrasted a psychoanalytic ideas about therapy. So, for a book review first training I wanted to explore other routes for me into an interest in research. I had been an academic historian and researcher before I retrained, so it felt good to find my way back to writing that tested and explored theories. Attachment theory, it became obvious, was overwhelmingly the best researched and most convincingly argued account of emotional development. So then I started to use it as a guide. If our difficulties stem very often from our experience with our caregivers, then our role as therapists must surely be to present a more attractive and engaging version of relationship. I couldn’t see how that was to be done without smiling and without enabling communication with the clients. I began to think of the old-style analytic methodology, and indeed old-style person-centred therapy with a passive therapist who said very little, as a kind of do-it-yourself therapy. What originated, at least in Rogers’ writings, as a respect for the autonomy of the client seemed to get translated into a belief that the therapist had nothing to add and indeed should add nothing. In analytic work the danger seemed to be of gnostic utterances apparently coming from nowhere.

There have been other influences on me that have also affected how I practise. One of these is positive psychology. It is fashionable to mock this approach as a Pollyanna-ish disregard for the often brutal realities and miseries of people’s lives. But I have found that identifying strengths and resources to deal with those same brutal circumstances gives clients hope and energy. Psychoanalytic theory often seems to want to rub the client’s nose in the awfulness of their history and their way of being in the world. I didn’t like it myself and I don’t want to do it to my clients.

Another strand has been cognitive therapies. It seemed obvious to me from the beginning of my training that it included large chunks of cognitive teaching, whatever the claims of psychoanalysis that it deals only with the unconscious. The codification of these elements, especially into CBT, has often felt to me to strip out some features of therapy that I think are very useful – for instance, an interest in where the current problems may have originated, or an understanding that stories need to be told and feelings expressed. Still, the emphasis on behaviour change and the finding of strategies to achieve it are often helpful. I have certainly incorporated some of these ideas into my practice.

So I suppose what I am describing is a process of integrating a range of different ideas (and more than those I have mentioned here) about what can be useful to unhappy human beings. I have often heard therapists say that such an eclectic approach is intellectually worthless because each of these theories arises from a different view of the human being. I’m not really convinced by that idea. Theoretical ideas about human beings and how they function, if they are not backed by research, seem to me to be built on sand. I’m more of a pragmatist. I am interested in what will work for this client and how this situation can most usefully be addressed. I like the increasing emphasis on research and particularly on qualitative research. Nobody has demonstrated to my satisfaction that a passive therapist is holding the golden key.

Ironically my therapeutic heroes and gurus have mostly come from the psychoanalytic world and in their writing have demonstrated a warmth and a compassion that I seek to emulate. Donald Winnicott is one such; so is Josephine Klein; so too are Allan Schore and Sue Gerhardt.

So how do I square that circle of ‘being myself and behaving myself’?

I am all I have
I work only with people who have problems with food and eating behaviour, and have done for 30 years. My goal is to liberate them from the compulsions that damage their functioning and dominate their lives so that they can grow into the people they have the power to be. Of course, the fact that they are sitting in front of me means their strategy for living is not very satisfying to them, but most are pretty ambivalent about giving it up. (For eating behaviour read drugs, alcohol, obsession etc.) I am in competition with what they already use as their fix. What’s more, their fix is familiar, readily available, often cheap and legal. How shall I coax them into thinking there is something better, another way? How shall I get them to experiment with relating and self-soothing in less harmful ways?

I had a dear, elderly friend who was very upset about her dysfunctional relationship with her adult son. Very bravely she went to a counsellor and told her about her distress. The counsellor said nothing and expressed no empathy or understanding. You won’t be surprised to hear that my friend never went back. Wouldn’t you think that a conversation full of empathy, interest, curiosity and validation, an exploration of possibilities, might have been a useful modeling – a transferable skill that might have suggested how that relationship could be healed?

I have come to realise that only I can help me in my endeavours. Of course,
like everyone else, I am far from perfect: my goal is to create the best relationship I can as the basis for the work and to manage those bits of myself that can get out of hand and may not contribute to the client’s progress. So I aim to be friendly and approachable; to use the client’s language; to create an interaction and an engagement with the client. I think about the client’s attachment history, and particularly about the function of the eating disorder (or other complaint) for their life management. I teach the client better, less damaging ways of self-soothing and I model, as well as I can, the benign and soothing adult voice. I encourage the client to find resources to support her both from outside and within herself. I restrain as well as I can my own narcissism, vanity, impatience and other unhelpful qualities.

I think about the extensive work that has been done by BACP, and especially by Tim Bond, on developing an ethical framework for our profession. This started as a set of guidelines that seemed like rules. These had the inevitable limitation that they could not possibly cater to every possible situation and so have been superseded by principles and themes. It seems obvious that we should always act in the best interest of the client, that we should avoid dual relationships, that we should maintain confidentiality, but in practice these principles are very hard to sustain and, at least in my experience, need constant thought and attention.

I once supervised a counsellor who was working with a woman client whose daughter had an eating disorder. I aim to be scrupulous about maintaining clients’ confidentiality so I didn’t know the real name of either the supervisee’s client or the client’s daughter. After some weeks I realised that the supervisee’s client was in fact the mother of one of my own clients, so I was hearing my client’s story from two angles. (It was interesting that it took me so long to recognise it.) When I realised this I stopped the supervisee in mid-flow and told her I couldn’t supervise her for that client. So was that an ethical thing to do? It left the supervisee high and dry; it protected me from knowing more about the client than she herself had told me. Was that good? Should I have told my client? I didn’t because I didn’t think it was helpful for her. Whose benefit would that confession have served? Not an easy situation to resolve; not obvious at all.

Similarly, when I make presentations using client material and ask participants to use their own and their clients’ material, I always ask for their explicit agreement that we are in a privileged situation and that what we learn about others is not to be repeated outside the room. When I do day-long workshops I get participants to sign an undertaking to this effect. Yet I am not at all certain that we have any deep understanding of the undertaking. Does it mean that the client examples can’t be used in any other setting; does it mean they can’t be discussed in another setting? Am I requiring any reflection on the material to be done entirely privately by the individuals present? Is that the best way to learn? And if it isn’t, what exactly does that confidentiality mean?

So what about you?
What motivated you in the first place to take up counselling training? What were the immediate reasons and the underlying reasons?

What were the messages you took from your training? Were you critical of them at the time? Have you become so since? Have you modified your approach to clients? Have you integrated new theories and understanding in your approach to clients? What is it that you think you are doing when you work with a client? How do you understand the ethical challenges of your work?

Do you think that you have arrived at a place of authentic practice?
This article is partly about me and my own experience of counselling training as a black woman and partly about counselling and the black African Caribbean (BAC) community, which is my community.

I never thought I would train as a counsellor; it happened by chance. I did a counselling skills vocational course, which I thoroughly enjoyed, and my tutor encouraged me to apply to train professionally as a counsellor. I was very drawn to the person-centred approach; it seemed to resonate with aspects of me and my personality. I applied for a three-year, part-time foundation degree in person-centred counselling at Warwick University. The course was a stepping stone to my life’s path.

The cultural diversity training on the course was a wonderful experience. It gave me a taste of what it means to be different, addressing issues such as social status and discrimination. But there was no in-depth exploration of what it is like to be subject to racism; to live in a society where you are subject to the expressions of racism that I grew up with and still hear today – the accidental racism that is based on lack of understanding, as well as the obvious racism of overt discrimination and physical attacks.

Many people believe we are an integrated society today but racism is still there. People act and say things and are not being challenged; there is collusion in the wider society - and in counselling.

I really welcomed the interview with Ellis and Cooper in the December 2013 issue of Therapy Today.1 What spoke to me were their comments about the challenges black students experience when training for counselling, which rang true for me. Some white colleagues on my course were uncomfortable with delving into what it meant to be from an ethnic minority on the course; maybe some were even afraid to go there. When the subject was brought up, the dynamics would shift. It was palpable: the atmosphere would go silent; issues were not explored, maybe because no one wanted to cause offence. Those of us who were black and Asian could sense what was circling in the air relating to cultural and ethnic issues. I just feel, when I look back, that if this discomfort and fear is not addressed during training, how can therapists relate to clients experiencing these issues and, most of all, challenge their own prejudices?

Political correctness has also made discussion of cultural differences difficult and confusing. It is as though there are these unspoken rules about what you can and can’t say or do unless you’re of this or that ethnicity. Society is all jumbled up about what is accepted and acceptable, which stops people questioning and talking about these issues and learning from each other and from their own mistakes.

Research study
Part of the course was a research project, involving a piece of original research and a dissertation. I knew exactly what I wanted to do: I was going to focus on issues relating to the black community and their culture. But my course tutors’ response was discouraging: ‘Your proposal is too big, you need to reduce it or do something else.’ I was disappointed but I refused to be put off. My epic assignment was important to me. I was passionate about it, my heritage, my identity and who I am as a black person in Britain.

I had a re-think. What reactions have I had personally when telling people about my training? What have I experienced on my counselling placements with clients and colleagues? I looked within, to my own experience of growing up in the black community and the values and beliefs relating to my cultural identity that were drummed into me by my grandparents and extended family members. I not only connect to the individuality of their birthplace – the West Indies; I am also strongly linked to my roots, ‘Africa’, and have educated myself about its history, global legacy, oppression, the communal family and power hierarchies, which I was constantly reminded of in my childhood. It was drilled into me by my relatives to work hard, get an education, do well; I was taught to be suspicious of people outside the family circle who might ask questions. I think many people from the black community will recognise this.

My research question evolved after reading a Joseph Rowntree Foundation study2 on the low uptake of therapy by black people in Britain and the low number of BAC clients entering IAPT counselling and psychological therapy services.3 What was happening here?

Not only are BAC (and other ethnic
Race

minority) people reluctant or unable to access IAPT services; a higher proportion drop out of therapy too, for reasons that are not explored. These unexplored reasons are what inspired my final research question: ‘An investigation on how the values and beliefs of black African Caribbean clients affect the counselling relationship.’

For ethical reasons I was not allowed to interview clients, which was another disappointment, but I was allowed to invite qualified therapists to participate in my project. While researching the literature, I struggled to find the voices of therapists working with black clients from the Caribbean community.

My literature review produced a lot of evidence on attitudes to counselling among the black community. Although much of it is quite old and a lot comes from the US, I could relate to much of what it describes. Some people in the black community see counselling as a last resort and there is a taboo, not just about counselling and telling others your business but also about being seen to have a mental health problem. Growing up, I learned to keep personal things to myself, and especially not to confide in anyone in authority. If I needed to talk to anyone about problems, I would go to one of the elders – a wise community member, a grandparent, aunt or the church pastor. This robust older generation of black people knew how to communicate, and they still do. They were not afraid to speak their minds. I found them so vocal in sharing things and always so open and willing to engage when I needed to talk. We’d discuss issues in an environment of delicious food, music, dominoes and other traditional features of black culture. This was my therapy.

Before I trained I always thought of counselling and therapy as a white middle-class profession, especially given how few therapeutic services are tailored to a black client group and how few black therapists there are. During my training and since, I have found that black clients often don’t know what to expect from therapy. If they see a black counsellor, they expect to be judged, or they are worried about telling their business to someone who might know their family or community. They are wary of those from a black background who are aware of black issues, come from the black community and are likely to be upfront in challenging them, getting to the nitty-gritty on how they view themselves and why they behave and want to be seen as they do. But, on the other hand, they think that white counsellors will not understand where they are coming from and the issues affecting black people today, which can be difficult if they are exploring painful issues and trying to be open and relate to and trust others who are not from the black community. These fears too are reflected in the literature that I researched.

Themes from the interviews

For my project I recruited five qualified therapists who were working at agencies where I was doing my training. They were four females and one male. One was white British, one white Irish, two were black African Caribbean and one was mixed black African Caribbean. All had experience of working with BAC clients. They practised in a range of modalities, including person-centred, psychodynamic and CBT/integrative.

The interviews were a semi-structured discussion about how they worked with this client group and if and how the values and beliefs of their BAC clients influenced how they delivered therapy. Interestingly, when I analysed the themes arising from the interviews they were very similar for all five therapists. The impacts of race on the therapist relationship included difficulty engaging, trust, security, shared language, transference, countertransference, challenging assumptions, collusions and sessions ending early and unexpectedly.

Interestingly, too, the black and white therapists had diametrically opposite views about collusion: the BAC therapists reported that non-BAC therapists thought there was a risk they would collude with their BAC clients, while the white and Irish interviewees said that BAC therapists thought they would collude with their BAC clients.

I wasn’t surprised to hear how often black clients were reluctant to engage with therapists and requested to work with white counsellors. The reasons offered by the interviewees were similar: ‘I believe that BAC clients should be encouraged to work with counsellors from the same background. We understand where they are coming from and they know this and this can be challenging for them, which is probably why they ask not to be seen by a black counsellor – they want a white counsellor who may not challenge their blackness and way of being, which is more comfortable for them.’

But the interviewees also described how BAC clients would seek a black therapist or counsellor because they wanted someone they felt would understand their family history and community and would revert to talking patois: ‘There was one female client and she would talk in slang quite fast and I just could not understand this, so I would ask her to explain what this word means as I had no idea. It did cause problems at times, [she would get] anxious and frustrated; however I would always clarify this meaning with her and explore what it represented to her.’

Some of the black therapists experienced black clients deliberately challenging them, whether through fear of being judged or to test or check out the ‘blackness’ of their therapist or (as I also found in my placements) wanting ‘Political correctness has made discussion of cultural differences difficult... Society is all jumbled up about what is acceptable, which stops people talking about these issues’
to prove something, perhaps about academic or social status: ‘I remember counselling one client and they would get irate with me sometimes. I think they did not realise how good I was going to be in the helping process... This client was testing me; he wanted to see what I could do and he did not like it, so we explored this in counselling and how he felt about working with a BAC counsellor who was good at their job. This was an interesting relationship. I felt his belief system impacted on our relationship, he had never expected it and neither did I.’

Both of the white therapists were aware of the cultural differences and power dynamics in the room, and of the importance of white therapists working with that: ‘I was different to them, me being white and them black... they saw me as a person in power and thought that I was telling them what to do, rather than helping them get better.’

I was deeply inspired by one interviewee whose way of working is steeped in black customs and cultural history. Much of what we explored in our interview reflected what was reported in the literature, but it made more sense when she described why black people behave and act in certain ways, based on their values, beliefs and the knotted strands of their identity: ‘Black people in general... are seen as inferior beings and not able to hold superior positions in society. “You’re no good... you’re not intelligent... you can’t organise... You can’t work together... you do nothin’...’ which I think contributes to how they perceive they should act and behave in society, with me. Everybody has a sense of their spirit... to have that cool sense of our own goodness, to allow people to grow and be that goodness is connected to our sense of worth. If they can engage with themselves... they can understand themselves more.’

We discussed in depth the differences between ‘defence mechanisms’ and ‘cultural defences’. She explained: ‘Counsellors need to recognise these when engaging with these clients... to work effectively with them in overcoming barriers relating to trust... which can lead to transference and expectations of them as a counsellor and their client’s perceived values and beliefs of what counselling means to them. I know and understand where my clients are coming from. They don’t want to talk outside of the family – the community. They have cultural defences activated from power, authority, oppression, racism, and they have a manipulated identity that has been adopted from the Eurocentric white norm frame to that from the African frame, that originated in the homeland.’

She also described how she has adapted her psychodynamic approach so it works better for BAC clients: ‘I use a model that works for them and relates to them, working with any form of oppression, issues around power, the power hierarchy and the power structure of that relationship. During the counselling process, I tend to re-evaluate the traditional ways of working with clients, gaining an insight into their internalised model of being and thinking as a black person, which I see implanted from their values and beliefs, what they’ve been through. And the process of looking at yourself... that internalised inferior position that can divide the relationship in general.’

Cross’s model of black psychology – the four stages of ‘nigrescence’ – provides the framework for her work:

1. **pre-encounter**, where the BAC person takes a Eurocentric view of the world, and rejects their black identity in an attempt to fit in with the white culture
2. **encounter**, where something happens to change the BAC person’s Eurocentric view and they experience mismatch between what they think and feel and what a white person might think and feel
3. **immersion–emersion**, where the BAC person immerses themselves in their cultural heritage and history
4. **internalisation**, when the BAC person becomes more consciously comfortable and confident in their black identity and sense of self, way of being and their relationships with others who are similar and different from themselves.

I also explored with my interviewees why they think so few black people access counselling, and why so many drop out. Mostly, their reasons came down to distrust: not liking to talk to outsiders; the client’s own beliefs that counselling is a weakness, the wish to keep their affairs private, which is from their upbringing and traditional conventions in the black community; their experiences of racism and oppression, and especially a distrust of white-dominated organisations.

### Cultivating the inner self

My aim, when working with black clients, is to help them to cultivate their inner self and celebrate who they are. I understand where they are coming from, that their personal and cultural histories explain much of why they are the way they are. I too am engaged in that battle to establish the identity that comes from within. When people move to another culture they are often required to deny their own culture, values and beliefs, and they lose the sense of who they are as a person, which in turn affects how they relate to others and interferes with how others relate to them. Sadly there are no British models of black psychology to help untangle internalised black issues and guide clients to reconnect to their inner identity and to their BAC culture and its values and beliefs.

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**References**


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Carleen Robinson is a person-centred therapist and sexual assault referral crisis worker. She can be contacted at arabianomad1998@outlook.com
I have been rescuing people for as long as I can remember. My mother was my first ‘rescue’ and I would have done anything to make her happy. It was a mission that would inevitably fail; no child can rescue an adult from their own misery. This didn’t deter me, however, and I later went on to try to rescue all of my peers. Other children would actually book appointments to secure some of my lunch hour so they could cry on my shoulder. I was in demand – all because I could listen.

Thinking back, it is not surprising that I am now training to be a counsellor. Indeed, I am sure many counsellors have a rescuing tendency. This isn’t a bad thing. In fact, if recognised, the motivation to rescue can be harnessed to offer a nurturing environment where our clients can learn to rescue themselves. My aim in this article is to explore that critical difference between rescuing and counselling.

What is rescuing?

Does being a counsellor help ease your feelings of insignificance and powerlessness? Does helping clients give you a sense of purpose? Do you become deeply distressed when clients reject your help? Do you sometimes keep things from your supervisor because, even though your actions might not be standard practice, you consider them to be in the best interests of your client?

If you answered ‘yes’ to any of these questions, then you could be confusing counselling with rescuing.

So, what exactly typifies a counsellor who takes on the role of rescuer in a counselling relationship? I’ve looked at the literature and discussed these issues with my fellow counselling trainees, some of whom have kindly agreed to share their thoughts here. These, I think, are some of the key features.

For the rescuing counsellor, their primary motivation to become a counsellor is entwined with the long-standing need to rescue others; they believe this is what counsellors are supposed to do. Counselling clients is an automatic extension of their desire to save others; it is the identity they assume as counsellor. They don’t want to admit that, deep inside, they feel insignificant and emotionally powerless. They’ve realised this from childhood but have always denied it. It makes them feel good to save others, because it gives them a sense (albeit false) of omnipotence and power.

They think they know what’s best for the client – after all, they have the theoretical knowledge and skills to prove it. They get along well with clients who are compliant and see it as a sign that therapy is going well. They regard non-compliant clients as wayward children who, in time, will see the error of their ways and succumb to their guidance.

They never challenge their client, partly because they don’t want to alienate them or cause them emotional distress. The counsellor needs the client to help them complete their rescue mission. They often give clients advice, and see them as victims of their circumstances rather than as independent decision makers. As one fellow trainee admitted: ‘I don’t know if it’s a rescuing thing within me but it has been a learning curve not to tell options.’

The rescuer counsellor will go to extreme lengths to try to fix their client’s problems and protect them against discomfort and pain – making
themselves available to a client seven days a week, 24 hours a day – even if it means transgressing ethical boundaries. They believe their actions are justified because they are motivated by a sense of what is good for the client, and will resist or fight against supervisors who think otherwise.

Their ability to get clients to trust and confide in them is quite refined. Indeed, others can learn from them how to create a warm, welcoming and empathic environment very quickly. Touching or hugging clients is quite natural for them and they don’t see it as a problem in terms of maintaining professional, ethical boundaries. When clients reject their help they find it deeply distressing. It signals that they aren’t as capable as they thought they were and that they have failed in their mission or ‘calling’ to rescue.

Recognising the rescuer within
There are two types of rescuing counsellor. For one, being a rescuer has been part of their character since early development. Others can find themselves compelled by their client into taking on the role, even though being a rescuer is not typical of their personality make-up.

The counsellor who can recognise that the client needs them to play the role of a rescuer is generally in a better position to deal with the phenomenon. If they are conscious of a client’s projections, the counsellor can maintain an awareness of boundaries and make deliberate decisions about how to go forward in counselling. The danger – in so far as the counselling process is concerned – lies with counsellors who don’t recognise that they are adopting the role of rescuer with a client: it is who they are and part of their personality. Indeed, there can be huge amounts of denial about having ‘white knight syndrome’ – after all, acknowledging this means a lot of self-development is needed.

So, how do we recognise ourselves as rescuers in the context of a therapeutic relationship? Counsellors who don the cape of rescuer are typically likely to be good at making eye contact and creating a warm, trusting, emotional environment, and don’t shy away from touching or hugging clients. They are likely to sit close to the client and hardly ever criticise or make negative comments about the client or the client’s actions. They are completely on the side of the client and will never challenge them, no matter how irrational or self-defeating the client’s behaviours. Even when the rescuing counsellor becomes aware that a client is taking advantage of them and is abusing their desire to help them, they are likely to continue to find justifications to maintain the relationship.

Counsellors who rescue will do anything for clients; they will even see them outside counselling sessions if the client needs them. It’s also not uncommon for the rescuing counsellor to give their private telephone number to a client. Some may even help their clients with chores, such as going shopping on their behalf, or settle their bills. However, not once will the rescuing counsellor challenge the client or prompt the client to begin to make personal and behavioural changes. Indeed, it is the nature of their emotional involvement with a client that can quickly cause them to lose objectivity in the relationship.

The counselling profession, by definition, involves the impulse to help and support those who seek psychological therapy. It is the ideal environment in which the impulse to rescue someone from their personal troubles can flourish. It could be argued that most, if not all, counsellors offer therapeutic support to others because doing so makes them feel good. There is nothing wrong with this, since it is the primary motive behind all healing professions, and also the underlying motivation for all kinds of occupations.

Even so, most counsellors understand from their training that it is not their task to save clients from whatever brings them to therapy, whether clients come because of problematic relationships, addictions or low self-esteem or because their life feels meaningless. Professional, experienced, effective counsellors offer, or make clients aware of, the choices available to them so that clients can decide whether to pursue them or not. However the counsellor who sets out to deliver a client from emotional troubles and misery makes decisions on behalf of the client, or unwittingly compels the client to pursue options that they have already chosen for them. As another fellow trainee pointed out to me, ‘The true rescue is allowing the client to rescue themselves.’

Typically, rescuing counsellors come to the profession with the impulse to rescue already awakened and acted upon long before they even considered training to be a counsellor. This is not to deny that the profession, by its very nature, has the propensity to turn otherwise well-meaning, non-rescuing individuals into the rescuing type. After all, counselling is inevitably going to appeal to people who are motivated to reduce others’ distress. The important point to keep in mind is that effective counsellors help clients solve their problems by clarifying and exploring options. The rescuing counsellor, by contrast, takes on the client’s issues and wants to solve them on their behalf. They want to protect clients against anything that might bring them pain, even if the client’s own behaviours and choices are responsible for their misery. As a fellow trainee counsellor admitted, with great honesty: ‘I was a terrible rescuer when I first started my training. I wanted nothing more than to make everything better for my client, all stemming from my own inability to be uncomfortable and my wish to get through the pain to the “good part”. I had to learn that there is room for growth in pain and that experiencing it in a safe and controlled environment helps it to not come back.’

It’s plausible to assume that the effective counsellor operates from a desire to help, and that doing so makes them feel significant. In fact, the need to rescue is motivated by an underlying, and often unacknowledged, profound sense of powerlessness. Counsellors who want to rescue clients mean well, but they often end up bringing more emotional harm to clients, and are rarely aware of doing so – primarily because they are trapped inside their own pathology to save others. The rescuing counsellor reduces their own sense of powerlessness while unintentionally increasing the powerlessness of clients.

Consequences for clients
Counsellors who attempt to rescue clients and protect them from the painful consequences of their actions inadvertently encourage them to abdicate responsibility for their lives. Emotionally immature clients in particular don’t get the opportunity to make progress since someone else – the mothering counsellor – assumes almost all responsibility for their actions. Hence, in this situation the help-seeker doesn’t feel the necessity to try to change aspects of their actions that are problematic. When clients aren’t challenged by counsellors to reflect on how they might be contributing to their own problems, it can help to entrench and strengthen the client’s rationalisations and denials, which are part of the reason why they came for therapy in the first place.

A rescuing counsellor also makes it easier for a client to continue to externalise the sources of their troubles.
‘The danger lies with counsellors who don’t recognise that they are adopting the role of rescuer with a client... indeed, there can be huge amounts of denial about having “white knight syndrome”’

Clients will continue to blame others, including the counsellor, for the things that go wrong in their lives. Since they don’t have to reflect on their own actions and take responsibility for them, they don’t feel the need to change. If they pursue a particular path of action, as maybe suggested by the counsellor, they can always blame the counsellor if it doesn’t turn out right. In short, counsellors who rescue clients help to infantilise them; psychologically, their clients remain like children who don’t feel the need to grow up.

Counsellors – indeed anyone – who habitually want to save others tend to believe they are capable enough to undertake these rescue missions. They convince themselves that they are emotionally stronger than those who seek their help. To the extent that this personal philosophy guides their actions and attitudes, rescuer counsellors never stop to reflect on the hidden sense of powerlessness that underlies their impulse to rescue. Many hate to admit that their attempts to save others are indirect efforts to save themselves from awareness of their own emotional issues. This is where self-awareness is fundamental, as a fellow trainee said: ‘The need to rescue comes from my own need to feel useful and be “the good guy”, so recognising that wanting to rescue was very self-centred and often not very helpful to the client helped me learn how it is important for me to be aware of it. By being aware I can step back from it.’

Consequences for counselling
There are consequences too for the counselling process. In counselling, the rescuer typically adopts a maternal stance, which puts the client into the role of compliant child. Since they believe that what they are doing is best for the client (their child), the values and ethics of the profession are pushed into the background, often unconsciously. These counsellors may even ignore supervision or lie to supervisors to protect their rescuing role; they believe that, because they are acting in the best interests of the client, their actions are justified.

Eventually, the counselling relationship becomes one in which the client develops a dependency on the counsellor. This is no longer a relationship of two autonomous adults but one in which an all-knowing, well-meaning mothering figure counsels a troubled child. Clients who resist this role are often abandoned by the counsellor or made to feel guilty for being disobedient – again, often unconsciously. Some counsellors may even reveal more of their own personal history in an effort to convince the client that they understand what the client is going through, based on their own experience. It doesn’t enter the rescuing counsellor’s mind that their efforts to provoke an empathic response from clients might lead to crossing professional and ethical boundaries.

In many, if not most instances the relationship takes a disastrous turn for both – the counsellor ends up feeling burnt out and the relationship has to end; the client feels abandoned and possibly worse off than before. The thin line between counselling and rescuing is one of many reasons why supervision and personal therapy are fundamental for counsellors. Both will help the counsellor realise – and this is going to be a great challenge for the rescuing counsellor – that what they are doing is not in the best interests of clients or their own best interests.

Personal therapy in particular will help rescuers gain an awareness of the fact that they can’t ignore the need to take care of themselves any longer.5

Am I able to put my rescuing tendencies aside when I take up my counselling role? For me, letting go of my rescuing tendency completely would be like having a personality transplant. Instead, I attempt to remain self-aware and use supervision to ensure that I keep the client at the centre of the therapeutic process – even if, as one of my fellow students confessed, I need to ‘sit on my hands to keep quiet instead of rescuing’. ■

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References
Why make research so hard to do?

Stacey Goldman describes the numerous hurdles and hoops she has had to negotiate in order to conduct her research study.

Counsellors and psychotherapists are often reticent about engaging with research; very few acknowledge its importance to the development of their practice. However, given the current pressure on counsellors to prove that what they do is effective, research has become ever more necessary.

Research into counselling and psychotherapy tends to be undertaken by researchers based in universities and working with academic teams who have the resources to carry out large studies with the targeted population. From my experience the lone counsellor undertaking research is a rarity, and this article may explain some of the possible reasons for this.

I would describe myself as an integrative counsellor, although I was initially trained in the person-centred approach. I work as an independent counsellor and supervisor. As part of my ongoing CPD requirements I attended a conference on anxiety in 2005 and was concerned to hear the keynote speaker advise the audience to ‘retrain in CBT or leave the profession’. I was stunned by this comment but it prompted me to consider how I might obtain evidence that would demonstrate the effectiveness of the type of therapy I deliver in my everyday practice.

I registered to undertake a professional doctorate, and this is when the problems began.

I enrolled at the University of Salford. My supervisory team has been and is extremely helpful, but neither my main supervisor nor my co-supervisor are practising counsellors and I have had to seek out other counsellors across the country who are working at doctoral level in order to get peer support. Further, as the only counsellor in my cohort of students, my thinking was challenged by nurses and social workers, who came from a background that differed not only in terms of epistemology (I was grounded firmly in qualitative approaches to research whereas they looked to more quantitative methodologies) but also in terms of the lenses (subjective versus objective) through which we viewed the world. All of my early drafts of writing were returned with comments asking me to remove the bias and I had to constantly rephrase what I wanted to say. At the same time I had to learn to be judgmental in critiquing the material I read and adapt my writing to meet the strictures of academic work.

Recruitment difficulties

In addition to the above, I also had to adapt the aim of my study. Employee assistance providers (EAPs) refused to give permission for their clients to be involved in any research, but asking my own private clients to participate was fraught with ethical difficulties too. Therapists are advised not to do research with their own clients on ethical grounds as combining the roles of therapist and researcher could be considered a conflict of interest. Primarily the conflict concerns whether clients can be seen to have freely given their consent to participate and to be able to speak honestly, as they may worry that they will offend or upset their therapist and that this could have an impact on their therapy.

However, there are differing views on this. I sought the advice of two leading academics. One told me that, provided there is an informed consent procedure in place, it is good practice – and common – for practitioners to ask clients what they find useful or helpful in psychotherapy. The other advised that there may be a blurring of roles if the therapist is researching her/his own clients, and to do so raises questions about how truthful clients are able to be about what is going on for them.

Given these contrasting opinions, I decided to change the focus of the study to a consideration of the views of clients of other counsellors. However, colleagues declined to be involved, citing worries about damage to the therapeutic relationship and concerns about a third party involvement in the normal counselling dyad. There was also some apprehension about being judged in their practice. The fear of being criticised has been identified as a major barrier to participation in research.

It was only when Counselling for Depression (CfD) was added to the IAPT programme that I was able to finalise the focus of my research and recruit participants. The CfD counsellors were interested in being part of a research study as it had the potential to supply them with feedback on how their clients perceived this approach to therapy and their work with them. The counsellors were hoping the research would provide evidence that their way of working with their clients was effective. This was not the study that I originally envisaged, but I was still able to focus on the clients’ views of how they experienced their therapy.

So I changed the aims of my study again, to explore how CfD is being experienced by clients and whether they consider this approach effective.
in meeting their needs. The objectives of the study became:

1. to explore the client’s experience of receiving CfD therapy
2. to explore the client’s views of helpful and unhelpful aspects of this therapy
3. to discover what clients mean by ‘effective’ therapy.

It is a qualitative study using interpretative phenomenological analysis (IPA), which is an approach best suited to capturing these kinds of individual, subjective opinions. Clients receiving CfD were asked to complete a Helpful Aspect of Therapy (HAT) questionnaire after each counselling session and to take part in a semi-structured interview when they had completed their therapy. These data were then analysed to identify recurrent themes.

Getting approval

As CfD was part of the IAPT programme I had to obtain ethical approval not just from the university but also from the NHS, through the Integrated Research Application System (IRAS). This was extremely challenging and took almost a year. Perhaps when you’re working in a team there’s a helpful camaraderie that supports you when you’re asked to repeat the same point on numerous occasions or get lost in the bureaucracy of filling out forms. For the lone researcher only grit and determination keeps you going through the initial 78 questions, followed by further sections involving another 76 questions. There is a huge amount of guidance provided to help you complete the form but when I came up against problems, the guidance didn’t seem to cover them!

Then, having gone through this process, I found the clinical leads in the NHS trusts I worked with didn’t seem to understand how to use the form. Some thought they had to complete a part of it themselves but then found they were not registered to do so; some wanted the form signed; some accepted it unsigned, and some did not ask for it at all!

Once the IRAS form was eventually completed and submitted I had to attend an interview with the National Research Ethics Board. But even when ethical approval was finally granted, the process was not over. Each individual NHS trust has its own research and development process, with further pages of questions to be completed, and I had to have a Criminal Record Bureau (CBR, now Disclosure and Barring Service (DBS)) check and an occupational health check before a research passport could be granted. It was no easy task and could be considered disproportionate when all I wanted was to ask a client to fill in a form after their sessions and attend a one-hour interview once they had completed their therapy.

Recruiting participants

Getting approval for the study was a major achievement, but the problems did not stop there. Finding IAPT services with trained and practising CfD counsellors was difficult. As CfD was a new approach to therapy, not every IAPT service offered the model. I rang around the services listed in the IAPT directory. People were busy and said they would call back, but then did not return my calls. I sent emails but they weren’t acknowledged. I attended a meeting to try to find counsellors who were practising the model. The developers and trainers of CfD came but only one practitioner, who could not participate in the study as she was having to re-apply for her own job the following month.

Even when I managed to find counsellors who had completed the CfD training there was no guarantee that they were actually practising it. I attended a monthly meeting of one IAPT team where four counsellors had completed the CfD training but was told the model did not exist and that it was merely ‘a badge’ to get counselling accepted into IAPT. Further, unlike other trusts that accepted the paperwork for the study printed on university stationery, this particular trust’s research and development department wanted all the paperwork to be printed out on its own headed paper before I even attended the meeting. So this was all wasted and had to be re-cycled. Thankfully their view was not shared by the other IAPT services that did commit to the study.

‘Not everyone has the determination to push through the hurdles in their way. When the profession needs research to provide urgently needed evidence, could the process not be made a little easier?’
The study has been designed to interfere as little as possible with the therapeutic relationship between the counsellors and their participating clients. However this has brought its own problems. To protect the therapeutic relationship I felt it was necessary to ask the counsellors to recruit suitable participants for me and to introduce the study to their clients. I am thus distant from my participants and very much in the background. I am also very much in the dark in terms of the recruitment process. I do not know who has agreed to participate until I receive the consent form from the counsellor and I have no way of knowing if a person has chosen to withdraw unless they tell me. I am torn between wanting to know what is going on and not wanting to bother the counsellors too much when they are all already busy.

Being a lone researcher is hard, even with all the wonderful support I have had. If I were setting up this project today, without a doubt I would do it differently; knowing this is part of the learning journey of the professional doctorate. Hindsight is a wonderful learning tool and it would also be useful to have stronger batteries in the crystal ball! But, joking apart, I do think simplifying the ethical approval process might remove some of the more challenging hoops and encourage more people to engage in research. Why is it made so difficult to interview half a dozen participants for a research project?6 Could the process not be simplified? My degree will take five years; three and a half have already been taken up with planning the project and getting it approved; the final year will be spent writing it up. This leaves me six months to meet participants and obtain the data – the precious raison d’être of the whole piece of work. Not everyone can take five years out of their life to focus on research. Not everyone has the determination to push through the hoops and hurdles in their way. When the profession needs research to provide urgently needed evidence, could the process not be made a little easier?

Carrying out research as a lone practitioner is not easy but it is possible. We are constantly asked to provide evidence that counselling and our way of working is effective. We know it is; we see the evidence of this every day in our clients as personal changes occur and their confidence grows. But it is not enough to ‘know it’, we have to ‘show it’, and we have to find ways of doing so that convey this understanding to those who judge us.

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References
How I became a therapist

Myira Khan

I was being approached more and more by Muslim men and women asking for counselling.

I started counselling training when I was 28. At first it was just out of academic interest. I had a job in a university research department studying young adult and children’s attitudes to climate change and felt I wanted to do something outside my work that was just for me. I enrolled on a 10-week introduction to counselling course at Leicester University and enjoyed it so much that I decided to do the two-year certificate.

My first degree was in psychology but I was most interested in animal behaviour so I wrote my dissertation on gorillas – I spent nine fascinating months at London Zoo observing the two gorilla families there. I went on to do an MSc in Conservation Biology and studied lions in East Africa for my thesis research. In a way, the counselling course brought me full circle, back to human behaviour.

Having completed the counselling certificate, I continued on to do the diploma. It was only then, when I started working with clients, that I thought I might actually be able to do this as a job.

I found the diploma course really challenging. I was fine with the theory; it was the personal development work that challenged me – having to dig deep to find and understand my sense of self and identity. My job and academic work had always been my identity; now I was having to get the rest of me up to speed with the intellectual me. I realised that to be able to genuinely ‘be’ with another human you have to be able to be fully present as yourself. That was hard!

After qualifying I worked as a counsellor for 22 months in an independent counselling service. I also started offering a few hours a week at SAFE, a domestic violence charity in Leicester. I was being approached more and more by Muslim men and women asking for counselling. There was a clear demand and need for it and so I made the leap and decided to branch out and work for myself. Interestingly my first three private clients were all Muslim men.

I set up the Muslim Counsellor & Psychotherapist Network in April 2013, soon after I qualified. It stemmed from my own experience. I was the only Asian woman and the only Muslim on my courses throughout all my five years of studying counselling. I thought, surely I can’t be the only one? I would have really welcomed some support and advice from others who had been through the training. So I set up the Network to provide a forum for peer support and networking and to reach out to Muslim students and trainees, to give them support and guidance. I’m aiming to offer formal mentoring in the future.

I was ecstatic when I got my first member – he was a Muslim counsellor in the US. We currently have over 270 members worldwide – they are spread throughout the UK, Middle East, India, Pakistan and the US and Canada. But this is just the tip of the iceberg – they have found us via LinkedIn and social media and word of mouth. When we have a proper website we hope to recruit many more. We’ve also widened the membership to include psychologists, psychiatrists and counselling psychologists, in response to demand.

Another of my aims is to break down the stigma around mental health in the Muslim and BME communities and get recognition for counselling/talking therapies as a valid, reputable profession. A greater diversity of BME counsellors and of religious beliefs in the profession would make it a more accessible career option for people from these communities. It would also help people from these communities feel confident that they would get support that is sensitive to their cultural and faith needs.

Alongside my counselling and the Network, I volunteer as a counsellor one day a week and teach a one-year Certificate in Counselling Skills course. I feel I am only just getting started in my work and with these various projects but the impact has already been positive for so many people. My current Network project is a conference in April in Leicester on ‘Muslim Women in Today’s Society’. It will address issues that Muslim women face, including domestic violence, mental health and issues of honour and shame. It’s open to all interested professionals.

It would have been very easy to put my head down and just do private practice and not engage with these wider societal issues. I feel we have to talk about these issues and engage with people and be visible. My motto is ‘Be good and do good’, both individually for my clients and at community and national and international levels with the Network.

I feel very blessed and fortunate to be able to do this job.

‘I was the only Asian woman and the only Muslim on my courses throughout all my five years of studying counselling. I thought, surely I can’t be the only one?’

Myira Khan is one of ten ‘Mental Health Heroes’ awarded by Deputy Prime Minister Nick Clegg last month for their work to challenge the stigma around mental illness (see BACP News, p48). For details of the conference, go to www.kubepublishing.com
In May last year 183 counsellors and psychotherapists from 15 countries gathered in Victoria, Canada for the 2014 Conference of the International Association for Counselling (IAC). The previous year’s conference took place thousands of miles away in Istanbul, but both events shared one striking characteristic. Speaking to delegates at both conferences, whether they were practitioners, researchers, university professors or students, what stood out was a resolute desire to connect with therapists from other backgrounds, to look beyond their own backyards.

In short, they all possessed an international mindset.

This raises some interesting questions. Are the attendees of such international conferences representative of a generally internationally-minded counselling profession? Who counsels internationally? And why are some counsellors, but not others, motivated to work and think internationally? In this article a range of counselling professionals whose work involves an international focus offer their perspectives, reflecting on the factors that have influenced their international orientation and how working internationally has affected them personally and professionally. The article also considers the benefits and challenges that working internationally can present.

Counselling internationally is a broad term that can cover various methods of working. These include, but are not limited to, short-term counselling abroad, such as supporting humanitarian projects in areas of need after natural disasters or during war or conflict; counselling outside your country of origin on a long-term basis; having an international clientele within your home country, and working virtually with clients around the world, using communication technology. This article explores a selection of scenarios.

**Influences and motivations**

Dione Mifsud, Head of the Department of Counselling at the University of Malta and President of the IAC, sees the desire to expand professional horizons cross-culturally as a key influence on counsellors who choose to work internationally: ‘Counselling by its very nature celebrates differences, and counsellors generally enjoy working with diversity,’ he says. ‘They may have been trained in cross-cultural competency, be interested in different cultural contexts and have already experienced counselling international clients in their own country. They may also be moved to give their “share” towards social justice, solidarity and human rights by working in a context that presents itself as lacking in these values.’

Beverley Costa exemplifies many of those characteristics. Her exposure to cross-cultural influences began early in life, growing up in a bicultural, bilingual family: ‘We had two different cultures at home and I lived in England, which was a totally separate culture again. These external influences shaped the way I have lived, the decisions I have made, the relationships I have formed. In my own personal therapy, training and professional life I have always tried to look outwards as well as inwards and have tried to respect, value and act on the pull I feel towards the international context,’ she explains.

‘When I trained as a counsellor, the modalities focused on an individual-centred worldview, with very little effort made to incorporate other kinds. In my family I was used to a collective-centred one. In cultures with an individual-centred worldview, coping strategies that fall outside of that view can be seen as dysfunctional. But they are not; they are simply about prioritising the effective functioning and harmony of the group.’ Beverley’s response was to set up Mothertongue, a UK-based multi-ethnic counselling service that offers culturally and linguistically sensitive counselling to people from black and minority ethnic communities, delivered in their preferred language.

Last year Mothertongue extended its reach beyond the UK to provide online mentoring support to clinical workers in North Africa. ‘I heard about the number of refugees in North Africa coming from countries like Syria. The news made me think long and hard about any way in which Mothertongue could be of assistance in the humanitarian crisis of mass migration by refugees. My family have a refugee history so it had a personal resonance,’ Beverley says. She set up a buddying and training scheme, with experienced mental health specialists across the UK providing *pro bono* peer support and training via Skype to psychosocial workers in a refugee camp. The camp workers were themselves asylum seekers who had received basic initial training.

‘The project offered a space for reflection so that the psychosocial workers, many of whom had had their own deeply affecting experiences of displacement and loss, could feel robust enough to sit alongside those they were helping who were consumed by grief, fear, distrust and uncertainty. Although all conversations were conducted over the internet, it felt very powerful to have the face-to-face contact,’ she adds.

Counsellor-coach and former Chair of BACP Coaching, Jo Birch has lived and worked in multicultural environments in the UK and all around the world. Most recently she spent nine months coaching hospital managers in Mongolia.

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**Counsellors without borders**

*Jacqui Gray* talks to counsellors who have chosen to work internationally about the special challenges it brings and what they have learned
Jo’s decision to operate in an international context is very much internally driven: ‘I have always wanted to work internationally, but it has also been a case of being open to opportunities and following them up,’ she says. ‘I find the challenges satisfying, such as working out what I am seeing only through my cultural lens and what multiple cultural factors are influencing this person, the situation, this moment between us. Often I am working with people who are living and working outside of their original cultural location, who have lived in a second culture for a long time or who have moved around the globe to multiple locations. Many work in global organisations and there is the culture of the organisation to notice as well. It’s not a case of my culture/their culture – it’s much more complex than that – and I love being in that place of uncertainty, enquiry and not-knowing.’

George MacDonald, a therapist/coach in private practice, spent 15 years working internationally in his previous career as a manager and management consultant, mostly living and working abroad with global clients. The research focus of his counselling doctorate is culture as a resource. ‘I have found that counsellors have a natural interest in difference, and I suspect that they have an above average interest in nationality, ethnicity and religions. However, their training does little to engage this interest and, unless they seek out cultural difference in their practice or exercise the choice to work abroad, I suspect that this intrinsic interest is likely to be ignored or suppressed,’ he says.

George believes that some of the personal factors that motivate individuals to become counsellors may also encourage them to work internationally, such as the feeling of being an outsider, the desire to understand the essence of humanity and the wish to make things better. ‘Working internationally or globally provides real opportunities to help individuals and organisations struggling with issues of difference,’ he says. ‘Perhaps by representing difference it is possible to help clients hold up to scrutiny aspects of their culture and life that could not otherwise be expressed.’

The third culture counsellor
One group experiencing difference on a daily basis are those who identify as ‘third culture’.1 ‘Third culture kids’ (TCKs) and ‘adult third culture kids’ (ATCKs) are people who are growing up or have grown up outside their parents’ culture – for example, in a culture(s) to which their parents have relocated to work – and as a result have developed a third, uniquely international outlook. Experience in counsellor education has taught Dione Mifsud that ATCKs can be very interested in counselling internationally themselves. ‘This may be because they have already experienced working within and outside the culture of their home country and are quite comfortable with interconnecting, to the point that they can live with and within difference, rather than “gaze”, observe and study it,’ he suggests.

Josh Sandoz, a licensed mental health counsellor in private practice in Seattle, US, is an ATCK. Born in South Korea to foreign missionary parents, he grew up as part of an international community and attended school with students from over 50 different nations. He now works with adolescent and adult third culture kids, including children of immigrants or missionary parents, international students and others with mixed cultural heritage and expats returning to the US after living abroad.

The TCK upbringing, he says, brings unique challenges: ‘One of the most profound issues is the sometimes overwhelming amount of grief and loss that has played such a significant part in the development of the TCK. There are also often many underlying questions about identity and belonging as many TCKs feel multiple loyalties to various groups, people and places,’ he explains. ‘When the experience of change becomes so highly normalised, as it does for many TCKs who grew up highly mobile, the urge to make change for the sake of change can become increasingly disruptive in adult life.’

Josh describes his own lifelong sense of cultural ambiguity as a TCK: ‘I don’t think I can remember a time before I knew how to eat with chopsticks. Experiencing myself as “at home” as a foreigner in Seoul and as a “hidden immigrant” when visiting my passport country, the US, it’s not uncommon for me to find myself wondering to this day, “What is going on here?” It’s a question that I’ve found gets me into no end of adventure and is quite useful in the therapeutic process as well.’

He has no doubt that his TCK background has influenced his desire to counsel internationally mobile clients: ‘Well before pursuing my graduate studies in counselling psychology, I began wrestling with many questions around my own identity. It was a natural part of growing up and a way of processing an internationally mobile childhood. As part of that work I attended and later became involved with helping to lead transition seminars.

for TCKs entering high school or university in North America. These experiences became part of shaping my interest in making myself available to others who are wrestling with their own TCK-related questions. As a direct response to client need, Josh set up the International Therapist Directory,3 a comprehensive online global listing of professional mental health therapists who define them as having an expertise in TCKs and international expat experiences. ‘A huge reason for creating the directory was to identify others who think similarly. If its growth is any indication, the number of counsellors working with this international mindset is growing all the time,’ he says.

**Working abroad long term**

While for ATCK counsellors the dilemma is often about working out where ‘home’ actually is, for counsellors who grew up in their passport country and have moved to live and work abroad long term, it can be more a question of how they fit back into a culture to which they may no longer feel attached. Psychotherapist Marja Kuzmanic was raised in Slovenia, trained as a psychotherapist in the UK and now lives and practises in the Netherlands, where she specialises in counselling international expat clients. She says: ‘Living in different countries, my attitude to life changed so much that I somehow didn’t completely fit back into where I originally came from. The Netherlands, which is much more open and international than Slovenia, fits my international outlook on life and the world much better. Cross-cultural adjustment is something I have been going through personally; I have been concerned with questions such as, where and what is “home”? Where do I come from? And where do I want to spend my life?’

Hazel McClure, Head of Counselling at an international school in Kuala Lumpur, Malaysia, has worked overseas for the past 18 years. Born in Northern Ireland, she trained originally as an art therapist; her shift to an international counselling career came about indirectly, after she qualified as a teacher. Hazel wanted to see more of the world and that led her to take up teaching posts at international schools. She was teaching at a school in Kuwait during a period of build-up to possible military action against Iraq. She witnessed the increasing distress of the pupils, some of whom had lived through the 1990 invasion, and took on a temporary counsellor role as a crisis response measure. This developed into a remit to set up a permanent counselling service at the school.

While Hazel has found the international experience very positive, she admits there can be negative consequences when working away from one’s passport country for an extended period, including maintaining a connection to both personal and professional roots. ‘I’ve come to realise, for example, that while my somewhat specialised skill set is valuable in international settings, my exposure to UK developments in the field of counselling, and particularly in working with children and young people, needs updating. I do worry from time to time that this might create barriers to my working back in the UK in the future,’ she says.

She has also had to adapt to different cultural views of counselling in the countries where she has worked: ‘Counselling in Asia is still developing and, as it begins to emerge as a profession, local concepts and understandings of counselling are in transition. Many people expect seeing a counsellor to consist of consulting an expert to get advice; others would never dream of seeking support, fearful of implied stigma in doing so,’ she explains.

Overall, Hazel has no regrets about choosing to counsel internationally: ‘It has been a mind-opening, culturally rich experience and I have gained a friendship group spanning continents and languages. I definitely see counselling in a much wider context now. I have become more of a global thinker – I identify now more closely with the international community than with any other. I still see Northern Ireland as my home country but I feel a bit of a stranger these days when I visit. I really do feel I could make anywhere my home now.’

**The virtual counsellor**

Digital technology has provided an increasing number of counsellors with a route to working internationally. But Kate Anthony, co-founder of the Online Therapy Institute and a leading international trainer of practitioners and organisations in online therapy, has some words of warning. Working virtually and internationally brings an additional cultural challenge, she points out: ‘In addition to traditional geographically-based cultures, we have a whole new culture in Cyberspace itself – that of Cyberculture.5 One of my early motivations in my career was experiencing a face-to-face therapist who told me my relationship with someone online wasn’t “real”. His complete inability to empathise with how society functions now in a digital world rendered

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him totally unable to connect at a relational depth. I didn’t go back.’

Ethically and legally, it isn’t straightforward either, she cautions: ‘Ethically we have a responsibility to adhere to our professional organisations’ guidelines or statements. The BACP Ethical Framework currently acknowledges that modern technologies (and I include the telephone in that) are used and that practitioners move between traditional ways of working and using distance tools. It notes that practitioners are “therefore required to consider what constitutes good practice in different settings”.6

‘Legally, it’s a minefield – particularly when crossing borders into countries – or, in the US, states with different laws. The US has strict laws such as the Health Insurance Portability and Accountability Act, which covers using third parties, such as Skype, to conduct therapy at a distance. Skype isn’t HIPAA compliant and so is unsuitable for therapeutic work.’ We have no such legal requirements here and it’s stunning how many practitioners think that Skyping over the Atlantic or elsewhere is acceptable. It’s not – privacy is hugely compromised even though Skype is encrypted. Skype quite cheerfully says it is not suitable for mental health practice, but I see these laws being broken every day, for therapy, coaching and also for supervision.’

International training
An issue central to counselling ethically, effectively, safely and sensitively internationally is training. Dione Mifsud sums up the challenge: ‘Where the IAC is concerned, there has been a conscious decision to support people suffering the results of living in areas of conflict, those suffering from the devastation following natural disasters, and in general people suffering from discrimination and lack of social justice. This development immediately raises longstanding issues around ethics and standards, especially whether qualifications in multicultural or transcultural counselling are enough to bridge any cultural divide or lack of tacit understanding of the nuances and issues that may exist in different places and cultures,’ he says.

Sue Pattison, Lecturer in Education and Counselling at Newcastle University, has worked extensively with counsellor training institutions both in the UK and abroad. She believes we need to train counsellors to have an awareness of and willingness to include and work with diversity generally. ‘Students do need to know that counselling in other international arenas is not necessarily the same as in the UK. Generally students can find the cultural element of their training challenging; it can shake their pre-existing foundations,’ she says.

‘Ideally, truly international counsellor training would be based on a core curriculum that could accommodate the diversity of backgrounds of the students taking the training’

The enthusiasm for connecting with others that was so evident at the IAC conferences is echoed in the international outlooks of the practitioners who have contributed to this article. In focusing their therapeutic gaze outwards and embracing otherness and difference, what many appear to have found along the way is actually a sense of togetherness and a new dimension of challenge, excitement and satisfaction in their therapeutic work.

Dione Mifsud believes an international focus is almost obligatory in our increasingly globalised world, and argues that counselling’s professional bodies must recognise this: ‘For me, thinking internationally is now a requirement and only inward-looking individuals and organisations can afford the luxury of not engaging with the concept,’ he says. ‘Counsellors living in multicultural societies have had to adapt their practices to deal with differences in mindsets. Once they can engage in this truly “empathic” exercise they can be flexible in their approaches and more aware of their own cultural biases, values and assumptions. They can appreciate the different cultural backgrounds of their clients better and are better able to respond through appropriate approaches and techniques.

‘Organisations too need to be able to share, listen to, understand, respect and be open to learn. We have so much to learn from each other, and counselling can be a much better profession when we can appreciate how helpers in different countries have enabled their clients to deal with endemic issues in a way that makes sense. We should adopt a respectful and learning attitude rather than barge ahead with a one-size-fits-all solution. We are at a point where there can be a global meeting of counsellors and organisations, and we need to address it in the right way.’

Jacqui Gray is International Editor of Therapy Today.

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1. www.mothertongue.org.uk
2. Sociologist and anthropologist Dr Ruth Hill Useem is widely regarded as the founder of TCK research and is credited with introducing the concepts of ‘third culture’ and ‘third culture kid’. For more details, visit www.tckworld.com
3. www.internationaltherapistdirectory.com
4. www.onlinetherapyinstitute.com
Beneath his rather prosaic painting of a tobacco pipe, the surrealist artist René Magritte wrote the caption: ‘Ceci n’est pas une pipe’ – ‘This is not a pipe’. This defiant contradiction of what is clearly the case challenges our certainty, inviting us to look again, to re-view, and to recognise that a painting of a pipe and the actual object are not the same thing. In common with the philosopher Wittgenstein, Magritte believed that pictures and words are merely symbols that may or may not resemble which they are intended to represent. What we express outwardly can only ever be a version, a re-presentation, of our internal experience of an object, a person, a place or an event. This, for me, is a vivid metaphor for counselling interactions and interventions, meanings and interpretations etc: in other words, a re-presentation of the session.

Supervision provides a space in which the supervisor and supervisee can stand back and reflect together on these transformed re-presentations, allowing the supervisee to explore and process (to look again and re-view) their own experience of and with the client. Hence the gallery analogy: in supervision we’re not just looking at the client’s artwork through the therapist’s experience and interpretation of it, we are also looking at the therapist’s artwork created in response to it.

Maclagan describes what is brought to supervision as ‘the history of a story’, ‘the echo of a report’, with the supervisor occupying a ‘postponed or second-hand’ perspective. This is not at all a detached view through binoculars at a distant individual shrouded in mist; this ‘separated position’ can open up vistas of insight and understanding that are perhaps only possible through the process of re-viewing – that is, looking again from outside the therapeutic space.

Cycles of transformation

The analogy with the viewing of artwork is useful but it falls short in that this is usually a linear experience, very rarely engaging the original artist with any re-experiencing based on the viewer’s opinions. An artist expresses something of their internal experience by painting a picture, someone looks at it and is in some way transformed by the experience, and it ends there. Thoughts may be shared with other viewers but generally not with the artist, whose internal experience is therefore transformed only through the process of creating and reflecting on their own work. There is rarely a direct feedback loop. When a client enters the world of psychological therapy however (as when a therapist enters into supervision), there is an implicit request for another’s viewpoint, a second opinion, a desire to engage in a dialogue of experience and meaning, usually with some agreed aim in mind such as improving emotional or psychological wellbeing. Both parties are, implicitly or explicitly, hoping for change of some sort – a transformation.

Contrary to the adage that you can’t teach an old dog new tricks, the field of neuroscience suggests that significant changes can be made in this way. Memory is remade in the telling and what has been laid down in the brain (including patterns of thought and behaviour) can be changed through the feedback loop of talking, reflecting and reprocessing. Thus, on a biological level, counselling/psychotherapy is about helping clients to lay down new and different neural pathways through the process of telling, exploring and re-experiencing in the context of a good therapeutic relationship.

In the model proposed below (figure 1) there are two interlinking cycles: the upper one relates to the therapeutic process, the lower one to the supervisory process. Both cycles mirror one another, alternating between internal and external processes – from that which is experienced to that which is reported. The client first externalises his/her experiences by transforming them into words (client report); the therapist has an experience of the client and his/her painted narrative (counsellor’s internal experience), and responds to it (counsellor intervention, shared exploration), which impacts on the client’s internal landscape and creates a new or
modified experience (client’s internal experience), and so on. A similar cycle occurs in supervision. The crucial linking point is where the experience of the supervisee is transformed through supervision and feeds directly back into the client work – hence the figure of eight configuration. Each step, as well as each circuit of this dual cycle, involves re-presentations and transformations that are cumulative, and all have a direct link back to the client.

**Transformative supervision in action**

As with therapy, the role of supervisor requires us to manage both the conscious and the unconscious, the seen and the unseen, the presented and the re-presented. By creating a safe space for supervisees to reflect on their clients and the therapeutic work, and by embracing all that emerges as potentially valuable, new and different responses to the client will emerge and transformation will take place. The therapist’s below-conscious experience of a client is not at the forefront of awareness; like peripheral vision, it needs a sideways glance to bring it into focus. By watching and listening from a bystander perspective, the supervisor can encourage the therapist to look again, to broaden their field of view, and in so doing allow new content and new meaning to emerge.

Holding the frame in supervision can be a significant challenge, however, as the complexity of the re-presented therapeutic work vies with the complex unconscious processes that are an ever-present part of the triadic relationship between supervisor, supervisee and the ‘not present’ client. Packwood cautions that holding this triadic encounter safe requires supervisory wisdom and the ability to detach from the turmoil, taking an open and reflective stance and encouraging the supervisee(s) also to step back and reflect. By doing this we engage both our conscious and unconscious minds (or, in the language of neuroscience, both the left and right hemispheres of the brain) – an essential way into material that might otherwise go unnoticed. How this material is labelled, interpreted and used will depend largely on the theoretical modality(s) of those present in the supervision; a shared therapeutic vocabulary is essential.

Maintaining a position of what Freud called ‘hovering attention’ and Bion termed ‘reverie’ is a key supervisory skill for this type of working and is perhaps similar to the quasi-meditative state employed in the more modern concept of ‘mindfulness’ – a kind of unfocused contemplation. Put simply, it is about attending differently in order to bring into awareness things that might otherwise go unnoticed and experiencing...
‘What the counsellor sees is not the client’s lived experience but rather their transformed version of it... What the supervisor sees is neither the client nor the therapy session but a representation of both’

References
Conference Announcement

BACP 21st Annual Research Conference

‘Understanding professional practice: the role of research’
15 & 16 May 2015, East Midlands Conference Centre, Nottingham

We are delighted to welcome the University of Nottingham as co-hosts for the 2015 conference

Pre-conference workshop
Thursday evening 14 May 2015 6.00–7.30pm with
Professor John Norcross
‘Changeology: tailoring the stages of change to the individual client’

Keynote speakers
Friday 15 May – Professor John Norcross
(University of Scranton)
‘Creating a new therapy for each client: where practice & research converge’
Saturday 16 May – Professor Glenys Parry
(University of Sheffield)
‘First do no harm: how to make therapy safe as well as effective’

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This month’s dilemma

Brenda works from home as a counsellor in private practice. Two years ago she met Emma for an initial assessment session. Emma wanted support to help her leave her husband, who had been emotionally and physically abusive towards her throughout their eight-year relationship. Emma also told Brenda about her history of mental ill health since childhood, including diagnoses of borderline personality disorder and bipolar disorder. She also disclosed that her husband had once violently date-raped a woman he met in a bar and covered it up to avoid arrest.

Following the initial assessment, Emma does not get back in touch. Two years on, Brenda receives an enquiry from a prospective client. During the initial assessment session she becomes aware that he is Emma’s husband. What should she do?

Please note that opinions expressed in these responses are those of the writers alone and not necessarily those of the column editor or of BACP.

Breaking confidentiality

Guy Westoby
Person-centred counsellor and BACP Private Practice Executive Committee member

Brenda will feel more confident handling an assessment of this kind if she has a good appreciation of her position with regards to confidentiality and the law. As counsellors we are trusted with clients’ confidences and, quite rightly, could be sued if we break them without good reason. In law there are a few situations in which we must break a confidence and inform the authorities, some circumstances when we may be required by a court to divulge information, and other situations where we may break a confidence if it is in the public interest to do so. The different situations are outlined in BACP Information Sheet G2 and this is a good starting point in determining when we might need to voluntarily break a confidence.

From the information supplied it strikes me that Brenda should do nothing about her suspicions about the potential client because he has not confessed a crime to her and she could be wrong about his identity. If during the assessment (or later during therapy) he were to disclose that he had committed rape, then she may inform the police, as rape is a serious crime, and she would be protected by law for breaking his confidence. Her decision to do so would probably be a very difficult one and taken with the support of her supervisor, as she would need to balance the client’s right to confidentiality with her responsibility to society.

Having established whether or not Brenda has any legal obligations with regards to this client, she may now determine whether or not she feels able to work with him. First, does she feel safe and comfortable working with him in her home and does she have a safety plan? Does she feel that her assessment session with Emma has compromised her ability to offer the potential client an impartial therapeutic relationship? If she feels she is biased or feels unsafe, she should refer him elsewhere.

When to say no

Nikki Schuster
Counselling Manager at Renew and MBACP (Accred) therapist, trainer and supervisor

When working therapeutically in any community it is inevitable that we may find ourselves meeting clients who have family members or friends with whom we have previously worked. I wonder if Brenda has thought about this and whether she has a personal policy in this regard? It may be that in some circumstances Brenda works comfortably in this way; indeed, she had just one assessment session with the previous client. However, this dilemma highlights the need to look at each situation as it arises.

Regardless of orientation, our ethical principles remain the same. Can Brenda offer these principles to the current client, given the content of the assessment that so readily comes to mind two years later? I was struck that most of the detail in the dilemma is about that previous session. We have no detail about Emma’s husband, not even his name, and it is he sitting before Brenda now. Nor have we any sense of why he has come to counselling. I wonder if this shows us that it would be impossible for Brenda to set aside

‘Saying no to a client can be challenging, especially when it is because of a conflict of interest or beyond our competence... Knowing our limits can be a lesson hard learned’
Emma’s story to allow her to provide the new client with fair and impartial treatment and the provision of an adequate service.

Considering the impactful content of Emma’s session, I wonder if Brenda feels safe with this current client? Is she competent and experienced in working with perpetrators of domestic violence and can she manage the notion that he may have date-raped a woman? Again we need to consider that the client may not be coming to counselling to address any of this and, as stated already, would Brenda be able to set this knowledge aside?

While Emma’s story is shocking, it is her truth and perhaps not the husband’s. If it were true that he is violent, will working with this client mean Brenda will have to keep secrets? Would she tell the current client of her relationship with Emma? So many questions arise from this dilemma.

How much does he know?

Clive Lees
Child counsellor, Registered Member MBACP

In the first instance, Brenda should ask the husband how he happened to choose her as a counsellor with whom he might potentially work. He might reveal immediately that he chose Brenda because he knew that Emma had also once consulted her, in which case Brenda can reply that she cannot comment on whether or not someone has been a client. But, by bringing into the open that he knows that she knows Emma, Brenda can be comfortable that this fact is no longer a secret; were it to be revealed well into therapy, it could seriously undermine the therapeutic relationship.

However, if the husband makes no such revelation, Brenda would be well advised to find a plausible reason for explaining that she cannot be his counsellor. She cannot reveal that Emma was once her client but, equally, taking on the husband as a client with this ‘secret’ in the background would not be ethical.

Does Brenda also need to consider Emma? She certainly has to keep the relationship confidential, including its existence, but beyond that I think her responsibility to Emma is minimal. Emma did not get back in touch after the initial assessment, so Brenda has no contract with her and therefore no ongoing obligation to her.

Clive’s full response can be read online at www.therapytoday.net

Impossible position

Mandy Pitts
BACP student member

This seems fairly straightforward to me. Brenda should not agree to become this man’s counsellor. It is unclear whether he is still married to Emma; Emma may even have recommended Brenda to him but, even if that were the case, it would not be appropriate to see him.

The fact that Brenda saw Emma, even though it was only once for an initial assessment session, means that information was disclosed about her prospective client. In a way the nature of this information doesn’t change Brenda’s position but, considering the specific things disclosed, it is even more imperative that she does not become his counsellor. Unless he brings it up himself, there is no way for Brenda to find out whether he is aware of her meeting with Emma and, if he is, if Emma told him what she disclosed to Brenda.

This puts Brenda in an impossible position because she is aware of things that he may not want her to know. If he were to tell Brenda about them, the version of events from his perspective could be very different to Emma’s. Brenda could find herself involuntarily stuck between the couple, even if Emma is no longer with her husband.

Being aware of Emma’s disclosure gives Brenda second-hand knowledge before the counselling even starts. If he were not to mention the things Emma recounted, Brenda would still have this information and may well find herself unable to remain objective, even privately, due to her prior knowledge. This will hinder any attempt at a therapeutic relationship with him.
Brenda should tell the client that she is unable to be his counsellor. Confidentiality prevents her revealing the real reason and if he demands an explanation I think in this case it would be justifiable to say something like she doesn’t think she would be the most suitable counsellor for him, or she doesn’t have the right experience to suit his needs. Emma’s confidentiality needs to be protected, even if it means Brenda has to bend the truth.

**Holding a secret**

**Michael Kallenbach**  
**Couples counsellor in private practice**

It appears that, two years after her initial session with Brenda, Emma may not have been able to leave her husband as she had intended to do. It is unclear why he has come to Brenda seeking therapy, but obviously he must have his own, very different set of problems he wants to sort out. And perhaps Emma has threatened to leave him and he wants to work on his relationship with her. I imagine Emma gave him Brenda’s name and contact details, telling him that she was the counsellor whom she saw two years previously and he might want to contact her to get some help on his own.

It must have been quite a shock for Brenda – although she can’t show it in the room – when the penny dropped that it was Emma’s husband sitting in front of her. Brenda was very much aware of Emma’s history with her husband, her mental health problems and anything else she discussed during that initial session two years ago. Brenda is now faced with the dilemma of holding the secret about Emma and the marriage she so desperately wanted to exit when she came for help.

I can only hope that Brenda has discussed this situation in detail in supervision. In terms of client confidentiality, Brenda would not be able to say that she saw Emma or disclose any dealings with former clients, even though Emma only saw Brenda on one occasion. If an assessment session is just that – an opportunity for both client and therapist to explore whether they might like to work together – Brenda somehow needs to tell Emma’s husband that it would not be a good idea for them to work together and she certainly should not take him on as a new client.

If the husband has told Brenda during the session that his wife recommended her as a therapist after seeing her once, that will make it easier. But if not, she will have to come up with something to explain why she isn’t able to work with him. Brenda cannot risk breaching Emma’s confidentiality so she would have to perhaps say that she doesn’t have time to take on new clients at the moment and she could recommend a suitable colleague for him to see.

**Personal safety issues**

**Lesley Ludlow**  
**Senior accredited counsellor and supervisor in training in private practice**

This is a tricky one. It would be interesting to find out what issues Emma’s husband presented with, to see if they matched Emma’s story. However, there seem to be enough matches for Brenda to realise that she is assessing Emma’s husband. If Emma were a current client, this would be a clear case of conflict of interest and Brenda would be able to refer Emma’s husband to someone else. But Emma only attended the assessment, so the contract/counsellor contract was not developed.

There are two issues here: Emma’s version of her husband and her husband’s version of himself. How close are the two stories? Does his story disclose the level of emotional and physical abuse and the date rape? Or is it completely different? The difficulty here is that Brenda will already have knowledge and experience of him through Emma’s eyes, which will inevitably cloud her experience of being with him.

The date rape issue stands out; if it isn’t disclosed it will be difficult for Brenda to work with him, as she has prior knowledge of it. However there must be occasions where counsellors work with clients who have been in the news but the issues never get discussed in the session. I guess the main issue would be for Brenda to decide how she experiences being with the client. She would need to conduct a thorough assessment to be able to make a judgment on whether she could work with him and whether she presents a risk of violence.

I wonder how he forms relationships and what his experience of being with Emma is like? That will provide Brenda with information about the type of relationship she is likely to have with him. If there were a history of violence then Brenda would need to consider her own personal safety, given that she is in private practice.

**April’s dilemma**

Val is a training therapist at a counselling institute where she also facilitates experiential groups for trainee counsellors. Steve, a trainee in a group that has recently come to an end, had shared in the group his experience of being emotionally abused by his father as a child. Val has since heard from Steve who has explained that a situation has arisen with his current training therapist, Mike. Steve tells Val that Mike had encouraged him to participate in a retreat he was leading. Steve was reluctant but Mike persuaded him, saying he thought it would support the work they were doing in therapy. Steve has recently returned from the retreat and found the experience troubling. He doesn’t want to return for further sessions with Mike and, having had a positive experience of Val from the experiential group, wants her to be his training therapist instead.

What should Val do?

*Please email your responses (500 words maximum) to John Daniel at dilemmas@bacp.co.uk by 26 March 2015. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but they will not be answered personally.*
Towards radical social evolutionism

I have always valued Therapy Today for being a place of well-balanced dialogue around wide-ranging issues salient to counselling practitioners. The Letters and Dilemmas sections allow ‘ordinary members’ to get their views included, which maintains some degree of power balance among the ‘louder’ voices featured in the articles. The inclusion of the new ‘Your views’ section serves to enhance the dialogue further and I heartily welcome it.

In the spirit of dialogue I would like to respectfully respond to Mick Cooper’s article in the February 2015 issue. ‘Social change from the counselling room’ sounds good on paper but let’s be honest, we have a tremendous amount of work to do if we are to transform the counselling profession from its current state of obdurate middle-class conservatism to one of radical social evolutionism.

This long and difficult process would need to be wrought on several fronts, starting first with our sense of professional identity, which is shaped by job markets and education structures that offer pathways to prestige by serving state-driven demand for practitioners who willingly mop up the staggering emotional fall-out of our economically and socially unequal society.

One client at a time. It is a blindingly inefficient way of ‘doing good’. And yet we soldier on, because no one is demanding a change in the way practitioners are educated. Our training is neither designed nor designated to work on weeding out the socio-cultural roots of emotional unwellness, such as discrimination, poverty, isolation, injustice, violence and abuse. Finding ways to challenge political processes is ‘not our job’ and, in any case, there is only so much politics can do to trammel our society’s overall value of the pursuit of individual self-interest.

If we were educated to be not simply practitioners (and I do not denigrate the complex skills of practice) but also researchers, social change agents and social entrepreneurs then we might stand a chance of taking the next two big steps forward in doing our bit to promote social justice: changing our theories of wellbeing, and evolving the therapy employment market. Our humanistic theories of change, rooted as they are in the ‘actualisation of the individual’, are outdated and androcentric. Models based on relational-cultural wellbeing are probably better suited to the needs of contemporary British localised-yet-multicultural society, and community psychology a preferable approach over individual psychology. Relational-cultural models pave the way for us to update how we conceive, organise and finance therapeutic services, making better use of the power of grassroots and non-professional social groups and networks to innovate and action locally relevant mental health solutions.

Don’t get me wrong – there will always be a place for personal therapy but, to amplify sentiments expressed recently in Therapy Today, the market is saturated with over-professionalised providers of expensive one-to-one therapy at a time when we really need to be fostering therapeutically-minded activists who can simultaneously promote sustainable community services AND devise and deliver more efficient models of social change.

Social change won’t happen from our cosy consulting rooms. We need to get out and do more, and I am afraid that idea will be met with resistance for decades to come.

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REFERENCES:

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Higher wants and basic needs

While I was interested by the premise of his article, Mick Cooper lost me by about a third of the way through (‘Social change from the counselling room’, Therapy Today, February 2015). He seemed to me to be taking a very convoluted route towards something that really does not have to be all that complicated.

I particularly noticed the total absence of the word ‘needs’. I assume that, when he talks about ‘higher wants’, what he really means is basic needs. If so, then why not say so?

Our needs as human beings are remarkably few; wants, on the other hand – the illusory creation of needs – are the very basis of capitalism and, accordingly, of much of the misery at the core of social injustice. Capitalism thrives on our addiction to things, and this addiction is so prevalent that even those of us who know that we are addicted can find it difficult to break free of all those very wants that distance us from our basic needs and thus generate yet more wants.

If relationship lies at the heart of counselling, and also at the heart of human needs, then how I am with my clients is going to be far more important than any number of techniques that allow me to define hierarchies of wants or to categorise whose wants should top any particular political or social agenda.

This does not mean that social injustice should be ignored, but I regard it as much more subversive, through the fulfilment of relationship, to encourage clients to be free of wants than to struggle for some illusory equality where we can mostly have most of our wants more or less satisfied at least some of the time or more or less attain some sort of status and respectability. I just cannot see the point.

Respect vs respectability, for me, sums up to a remarkable extent the difference between tinkering with social norms and making true change possible. It is arguable, I think, that self-respect is a basic human need. Our present Government is notable for doing everything it can to deprive the poor – and not just the poor – of self-respect
while promoting fatuous concepts of respectability and status. It is a poisonous ideology that undermines everyone. They have even stated officially that, if they win the next election, unemployment will become a criminal offence, punishable (without trial) by community service. The unemployed and the poor will be removed further than at any time since the 19th century from any established standard of respectability. If I can inculcate a sense of self-respect in my clients — whether rich or poor — that allows them to treat respectability with the scorn that it properly deserves, then I believe that I shall have achieved something worthwhile — an internal revolution in thinking that can, over time, effect an external revolution in society as a whole.

William Johnston

Ayahuasca is not an ‘easy ride’

Many thanks to Fiona Goodwin for her article on ayahuasca and the Temple of the Way of Light (TOTWOL) (‘Healing with plant medicine’, Therapy Today, February 2015). I attended one of their 12-day retreats last year and I would agree with most of what Fiona says about the place and the people. I have a great deal of respect for the work at TOTWOL and its partner organisation Alianza Arkana, which campaigns for justice for indigenous peoples and protection of the rain forest. However, I do have some reservations about their approach to therapy and especially the structure of their 12-day retreats.

The explicit assumption at TOTWOL is that ayahuasca will always give you exactly what you need and all you need to do is surrender to it. I find this simplistic and potentially harmful. I believe that ayahuasca has great therapeutic potential but it is not a miracle cure-all and it is certainly not an easy ride.

There are vast cultural differences between the shamanic healing approach used by the Shipibo shamans and models of therapy that we use. I trust this works well in the Shipibo cultural context, where it has been used for thousands of years. I am sceptical, though, about transferring this way of working to groups of non-indigenous people without careful consideration of the cultural differences. At TOTWOL there are non-indigenous facilitators who recognise this to a degree but they are not therapists. I think we could find ways of working that would incorporate the teachings of the shamans and those of psychotherapy in a very powerful way but we all need to be open to learning from each other, and I didn’t feel that was acknowledged at TOTWOL.

The 12-day retreat is structured so that participants undergo seven ayahuasca ceremonies in nine days. This is a truly gruelling schedule and allows no space for the processing and integration of the often profound and dramatic experiences that occur in each ceremony. I was there with my partner, who is a trained body psychotherapist and very talented aspiring plant spirit healer herself. Over the nine days she recovered a string of extreme, traumatic childhood memories, which a less experienced person could easily have found overwhelming and retraumatising. There was neither space nor encouragement between ceremonies to work with what the ayahuasca uncovered. We tried to get this across to the main facilitator (who was North American, not Shipibo) and he listened politely but I had no sense that it made any difference. Of course, there is the choice to opt out but that is not really the point and the facilitators tend to discourage this anyway. Undoubtedly a great many people have benefited from this work in its current form.

Our contention is that a great many more could benefit more effectively and safely from a creative integration of the shamanic and psychotherapeutic approaches to healing.

I would not want to discourage anyone from trying ayahuasca, at TOTWOL or at one of the many other retreat centres in Peru and other parts of the world, including Europe. The rewards can be great but they do not come for free and without risk. Such is life.

On a final note, ayahuasca is not the only substance out there with powerful psychospiritual healing properties. To name just a few: iboga from the West African Bwiti tradition (or its pharmaceutical analogue, ibogaine) is being used with great success to treat substance addictions; trials with MDMA-assisted psychotherapy for PTSD look very promising; on my own therapeutic journey San Pedro, the ‘cactus of vision’ (huachuma in Peru), has been the most powerful healing agent.

Thanks again to Fiona for opening up the space in Therapy Today for discussion of this fascinating and important subject.

John Masters
Registered Member MBACP (Snr Acccred)

There are vast cultural differences between the shamanic healing approach used by the Shipibo shamans and models of therapy that we use

High praise for February issue

In my opinion, February's edition of Therapy Today is the best yet. As a student counsellor, I have found previous issues a little heavy going and disheartening, with what felt like honest but negative outlooks on the future of counselling and finding work. This edition was a joy to read.

Linda Cundy’s article on attachment and digital communication was interesting and up to date. It hit home for me not only as a counsellor but as a parent and as someone who had a relationship breakdown due in part to a partner’s near constant use of a mobile phone or console. When we can relate to something we are better able to use it in our work, and this article struck the right balance between personal and professional issues.

‘Healing with plant medicine’ was incredibly moving. I cried as I read Fiona’s story. Not everyone will have the luxury of being able to travel and experience such things as she did, but it did raise, for me, some interesting ideas about how meditation can be used alongside counselling as a way...
of opening up another realm of personal understanding – a way to make sense of the seemingly bizarre images we can see when in an altered or more peaceful state of mind.

‘Post-qualification paths to expertise’ was most informative and pleasingly factual without being negative. The lack of formal pathways can feel quite daunting and confusing, and this article reassures me that, with hard work and faith in my capabilities, I will find my own way. This leads me on to the Dilemmas section – which, if I’m honest, I usually skim read. This month I found the feedback very valuable and it reminded me that the BACP publications are, of course, a valuable source of ongoing learning and personal and professional development that some new practitioners could miss out on.

I normally don’t read the ‘How I became a therapist’ section at all but this month found myself drawn into James Lamper’s story as I am a big believer in holistic therapy, treating the body and the mind and addressing diet. Food is such an important part of everyone’s life and can be used to prevent and cure illness. I am always interested in what people eat as it can show how much interest and care they take of themselves. Many sources do not like to go near weight or diet and see it as a separate entity but Therapy Today has touched upon it a few times of late.

Thank you.

Corey Williams

The marketplace will decide

Counselling in private practice is a business in a competitive market. Employment operates in a market. I have recently qualified as a counsellor and am, as I write, launching my counselling practice. I have been intrigued by the amount of reference in correspondence and articles in the various BACP publications on the challenges of private practice and securing employment, usually referencing the over-supply of counsellors and the need for some form of control over voluntary work. There are calls for the supply of counsellors to be controlled. There are suggestions that there should be a cap on voluntary hours.

Taking the former first, I can only imagine that those calling for a control on the supply of counsellors feel that it is appropriate for the profession to somehow interfere with the free market of training courses. The academic institutions may have something to say on that subject. I also wonder how those who advocate some form of quota would have felt had they been prevented from training. Who should qualify for the restricted places? And how do we ensure that our clients end up with the best counsellors in practice? Surely the marketplace is the best way of determining who should and should not make it as counsellors?

In terms of the latter, I wonder why voluntary organisations that ask for voluntary help and those who provide it, also voluntarily (albeit while also saying that they are forced into that position by the absence of paid work), should not be able to do so?

Perhaps what makes me scratch my head the most is that, if my training was anything to go by, counsellors have been through courses and years of rigorous personal therapy that above all else has taught us to be autonomous – to take responsibility for ourselves and our worlds. Yet it seems that the underlying theme of the concerns is to bemoan the absence of anyone else taking responsibility for the difficulties newly qualified counsellors may have in attracting enough (or any) clients or finding paid posts and to ask someone else to do something about it for them.

Counselling is no different to any other business or market. The better counsellors in the business and marketplace of counselling will survive and there will be those who do not. The marketplace will decide.

‘Counselling is no different to any other business or market. The better counsellors in the business and marketplace of counselling will survive’

Perhaps I should add that I have also grown my own professional practice (in another sector) and managed a number of other businesses. I hope, but I do not yet know, that I will be able to help those who need my help as much as I once needed that of my own counsellor. I also invite your readers to communicate with me via my website if they would like some guidance for their business.

David Sherborn-Hoare
MNCS (Acc); email david@cheltenhamcounsellor.co.uk; visit www.cheltenhamcounsellor.co.uk

Right to choose or policy diktat?

In the February Dilemmas article (‘Suicide – the client’s right to choose’) the issue of how counsellors might respond to a suicidal client was discussed. The contributors highlighted the possible options and the issues we need to consider when counselling someone who is suicidal. However, for those of us who counsel in agency settings there is an additional consideration: what is the policy of the agency we work for? What does it expect us to do? And what would we do if we disagree with it?

In her response to the dilemma Judy Stafford stated that she had given consideration to this question when in training and concluded that she would act according to her beliefs, which were, at the time, to do what she could to keep the person alive.

I would argue that many of us do not give this issue enough consideration; that there is a tendency to passively comply with policy because we are grateful for the job or the placement or, as Andrew Reeves states in his book Counselling Suicidal Clients, a ‘switching off’ when issues of policy are raised.

However, if we stop and think about it, it is clear that agency policy on suicide will impact on us as counsellors, will affect the counselling relationship and could be a matter of life or death for the client. I believe it is important that we give this issue due consideration and that policy makers’ attention is drawn to the

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Roslyn Byfield’s article (‘Don’t rush come to you’ Counselling at University of Chester. Third-year student studying MA Clinical Counselling at University of Chester. Email 1124531@chester.ac.uk

‘I would recommend a business studies course over an accreditation course for any counsellor thinking of starting their own business’

but at times I felt ill equipped to work with them. The training that I had was not enough. Part of my business strategy was to be able to market/promote myself as a specialist in a certain area. I decided to specialise in couple therapy and took a postgraduate diploma in creative couple work. It was at this point that I realised how much more I had to learn and that what I had learnt on my diploma course barely scratched the surface. Over the next two years I grew as a person and as a counsellor and my business continued to grow.

If you decide to set up your own private practice, you need to include networking in your business strategy. Networking with other counsellors is very important. You can provide each other with support and referrals.

I am not the person or the counsellor that I was in 2009, but I had to start somewhere. I now have a thriving counselling practice. My business has gone through many evolutions and has achieved critical mass, allowing it to be self sustaining.

I set up my practice straight out of training. If I had undertaken the accreditation process I am not sure if or how that would have made me a more suitable candidate to have my own practice. Perhaps Roslyn Byfield is advocating increasing the amount of placement hours that should be undertaken before a counsellor embarks on private practice. I think that would be a good point for BACP to debate. Counselling training as we all know is so diverse and varies greatly, with some courses being far better than others. It is my view that if you have had good training, have undertaken and continue to undertake personal therapy, continue your CPD and have a good business and marketing strategy, the work will come to you.

Karen Brewster
MBACP

‘Suffocating’ ethical framework

During the 1960s and 70s, in among the erupting tower blocks and throughout our parks, children’s playgrounds spread, made out of concrete, mild steel and the remnants of Victorian swing frames. Children were flung from the rotating witch’s hat or tipped onto stone encrusted mud from the rickety see-saw. Some were seriously injured. There were limited safety regulations about children’s play. There was no ethical framework for counselling.

In the 80s and early 90s risk was ‘designed out’ of playgrounds. New spaces of bland, unchallenging, risk-free and non-developmental play appeared. Children were not involved in the design of these spaces. They still got injured but now on building sites and roads and other areas that offered more excitement than the dull and overly simplified areas that the health and safety officers thought at the time were a good idea.

The decades surrounding the new millennium saw an element of risk being ‘designed back in’ to play spaces, providing exciting, challenging and ‘safe enough’ areas for children to be children. Zip wires, four person see-saws, six metre high rope pyramids, pirate ship climbing walls – such fun! Children still get hurt, just not as badly. They learn dexterity, they learn to hold on and have courage, they learn autonomy and self-reliance and they learn to wait their turn, play with others and, in essence, grow. Children’s play has once again become all about children.

The existing BACP Ethical Framework does this for me. It helps create a space for me to practise in a reflective and autonomous way. It promotes growth in me on my journey, maintaining a direction of ongoing development grounded in well thought out principles, morals and values. I feel supported enough by the framework that allows me to make mistakes and take responsibility to repair any damage. Like those children of the new millennium, out of the framework I learn dexterity as a professional; I learn to hold on and be courageous; I learn to be autonomous.
eight clinical trials of GET (n=1518) representing. The positivity of the existing framework allows my clients to take control, to be autonomous within a container that is spacious and flexible and facilitates growth. The negative narrative I perceive in the proposed narrative I perceive in the proposed changes requires me to take away some of that control from my client. It is enforcing a level of representation onto my client while ignoring me, the counsellor, the very person I thought my organisation was supposed to be representing.

Pete Smallwood
Registered counsellor

Activity and chronic fatigue syndrome

In the February 2015 edition of Therapy Today (News, p6) there is a short report on exercise and CFS. Uncritically your report states, ‘Both [CBT aimed at increasing patients activity and GET (graded exercise therapy)] have been shown to be beneficial to people with CFS.’ The evidence base does not support this bold assertion.

In a recent Cochrane Review of the eight clinical trials of GET (n=1518) 85 per cent of the patients (n=1287) were recruited into five of these trials based on one symptom – fatigue. This is a common symptom of many health problems, including major depression, making generalisation of the findings problematic. The high percentage of patients included in these trials with elevated levels of distress perhaps indicating a depressive state, which may be their primary condition, confounds the results. Exercise, through behavioural activation programmes, has a moderately positive impact on patients with depression. It is unclear whether the modest improvement seen in some of these trials can be accounted for by an improvement in low mood caused by depression. Moreover, where there are data, there is a high usage of antidepressants in patients included in trials. Three further trials used the CDC4 CFS criteria (n=231). While these criteria purport to be more selective, they do not necessarily include patients whose primary difficulties include post-exertion weakness and debility beyond broadly defined fatigue and other general symptoms, that could be attributed to CFS or major depression.

There is also an issue with lack of evidence of patients’ fidelity to exercise programmes using objective measures. Without using monitoring devices such as actimeters or pedometers to track daily activity levels, we have no accurate way of assessing whether an increase in activity occurred and whether this helps. Black and McCully’s study demonstrates the difficulties CFS patients face when trying to increase activity and concluded that they were exercise intolerant, unable to sustain activity targets.

Many patient surveys from across the world report numerous instances of harm and worsening of symptoms from taking part in exercise programmes. For a summary of the difficulties and limitations of the reporting of harms, in and outside of clinical trials, and why these might be underestimated, please see Kindlon.

Joan Crawford
MA, MSc, CSci, MBPS, MBACP; Chair, Chester ME self help (MESH); humanistic counsellor, CBT therapist and trainee counselling psychologist

REFERENCES:

Correction

In our November 2014 issue we published a letter about people with medically unexplained symptoms (MUS), ‘Don’t label the undiagnosed patient’. This was mistakenly attributed to C Aikin-Sneath. We have been asked by Catherine Aikin-Sneath to make it clear that she is not the author of the letter. The initial on the signature was clear that she is not the author of the letter. The initial on the signature was clearly marked ‘Aikin-Sneath’. We have been asked by Catherine Aikin-Sneath to make it clear that she is not the author of the letter. The initial on the signature was clear that she is not the author of the letter. The initial on the signature was clearly marked ‘Aikin-Sneath’.

Contact us

We welcome your letters. Letters that are not published in the journal may be published online on the Therapy Today website – TherapyToday.net – subject to editorial discretion. Please email the Editor at therapytoday@bacp.co.uk

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Counselling in the digital age

Love in the age of the internet: attachment in the digital era
Linda Cundy (ed)
Karnac, 2015, 204pp, £24.99
ISBN 978-1782201465
Reviewed by Jane Cooper

A profound change has happened in my lifetime and I can identify with Linda Cundy’s starting point in this fascinating book. As a counsellor, I am a ‘digital immigrant’, working predominantly with clients born in the last decades of the 20th century, the ‘digital natives’. I found this book readable, enlightening and thought provoking.

With the help of three moving case studies and excellent chapters on sexual addiction and couples, Cundy and colleagues explore the dialectic between the digital revolution and attachment behaviour and the implications of this for our work as counsellors and psychotherapists. Drawing on observation in the consulting room and a small piece of research with colleagues, the contributors broadly suggest that those with a preoccupied attachment style use technology to feel connected, whereas the avoidantly attached feel reassured by its remoteness.

In particular I would recommend the chapter on surviving as a psychotherapist in the 21st century. Here Cundy considers the use of websites to promote your private practice and issues of availability, boundaries and the therapeutic frame. She does not shy away from the thorny question of whether it is ethical for a clinician to Google a client. In a wonderfully accessible passage on ‘Skypotherapy’, she suggests that Freud, who was listening for resistance and interpreting defences, would have tried it but Winnicott, who used the countertransference to tap into early relational ways of being, would not have felt able to access this information remotely (p113).

Although it does not shrink from exploring the dangers of the digital era, such as instant gratification and the erosion of boundaries, this is at heart an optimistic and encouraging text. I was particularly taken by the analogy with blindness: ‘Just as those who lose their sight take time to reacquaint themselves with their world and learn to see it anew,’ we digital immigrants might use this book both to understand the world of our clients and to ‘begin again in another (digital) medium to build up our expertise’ (p129). Jane Cooper is a counsellor and supervisor

Women and problem gambling

Working with women’s groups for problem gambling
Liz Karter
ISBN 978-0415899622
Reviewed by Michele Head

Liz Karter’s book makes a refreshing read in the often-neglected field of problem gambling. It not only outlines the issues for women affected by gambling; it also provides a much-needed account from an attachment perspective in a field (addictions) that is generally dominated by a CBT discourse.

The book follows a group of women attending meetings for one year, tracking their progress, the difficulties in group dynamics and how these tie in with both theory and their histories. The account is insightful and reflective, and includes how the therapist is perceived and transference and boundary issues. These are tackled with a rare warmth and transparency; indeed the whole tone of the book seems to reflect the style of the therapist and her empathy with the women with whom she works.

Karter’s premise is that ‘everything is about relationship... our relationship with others and our relationship with ourselves’ (p1). Problem gambling is seen as a form of self-soothing and escapism from difficult internal and external realities. The treatment therefore focuses on awareness of internal states – of fears from the past that become obstacles to relating to others in a healthy way and are repeated and worked through in the group dynamics. The focus is on the underlying causes of gambling, rather than symptom reduction alone. That said, an impressive 84 per cent of participants from several similar groups reported remaining free from gambling at one year follow-up.

This book is relevant to those interested in integrative/attachment-based work and in group processes, not solely to those working in the field of gambling, or even addictions. The author’s musings early in the book about social networking and its similarities with gambling in terms of impeding true and supportive relationships seemed initially tangential. By the end, however, I found myself applying what was written not only to society as a whole but also to both personal and professional relationships and appreciating the importance of prioritising healthy forms of inter-relating across a wide range of presenting difficulties. Michele Head is a clinical psychologist

Perspectives on emotional trauma

Understanding and healing emotional trauma: conversations with pioneering clinicians and researchers
Daniela F Sieff
ISBN 978-0415720847
Reviewed by Chris Rose

Daniela Sieff has taken on the enormous task of examining trauma from three broad perspectives – psychodynamic, neurobiological and evolutionary. She has then added to the challenge by her choice of method that, although described as ‘conversation’, turns out to be mainly
questions and answers. Most of those interviews are well-established authors, condensing years of their own thinking and research into the confines of one chapter. The result is often didactic and repetitive, as each author introduces his or her own understanding of trauma, or explains yet again the various forms of attachment and the importance of attunement.

Despite this, I found myself impressed by Sieff’s endeavour. Described as ‘an independent writer and scholar’, she has created a valuable resource that contains thought-provoking material. The psychodynamic perspective is largely Jungian and members of other tribes will have to adapt and translate as they read. Both psyche and soma are included; the body is not only highlighted in Tina Stromsted’s chapter but retains a presence throughout. I enjoyed Marion Woodman’s use of her own personal experiences to describe the internal ‘Death Mother’, bringing a welcome intimacy to the discussion.

In the neurobiology section Allan Schore presents a concentrated overview of the relationship between emotional environment and brain development, emphasising the role of non-verbal right brain attunement in therapy as well as child care.

The book sends a consistent message that healing does not mean damage can be reversed but that, through body work, therapy and journaling, it is possible to make more of the unconscious conscious, develop emotional security and lead a richer life.

The final section on evolution brings refreshing new material to challenge our assumptions about attachment and appropriate maternal behaviour. James Chisholm emphasises that there is no ‘normal’ pattern of attachment; it is always shaped by the environment and risk, and we should not assume that our Western models have universal applicability. The focus on the individual gives way here to the sociopolitical, cultural context, where inequality is revealed as a key factor. Those at the bottom of any hierarchy have less control over their own lives, live with greater risks and invest accordingly.

I would recommend this book on the basis of this section alone, but there are

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Fifty shades of mild eroticism

Julie Sale is unimpressed by Fifty Shades of Grey

For those of you who have deliberately or accidentally missed the Fifty Shades phenomenon, the film (and book on which it is based) tells the story of Christian Grey, a young billionaire entrepreneur, and his relationship with Anastasia Steele, a college graduate. The X-rated aspect of the story is that Grey’s sexual taste is for dominance and submission. Much has been written on the BDSM (bondage and discipline, dominance and submission, sadism and masochism) aspect of the film. But the chance to break taboos or to educate is lost in the film’s inaccurate portrayal of BDSM – particularly its lack of emphasis on safety and consent. Of significant concern is that Grey’s proclivity for dominance is explained as stemming from an abusive past, which is simply not evidenced as a predictor for BDSM preferences.

Some commentators are alarmed by the similarities between Grey’s behaviour and domestic abuse. At points in the film Anastasia is stalked, isolated, intimidated and controlled. Personally, I think the lack of emotional tension in the film and its limited character development reduces any sense of threat in these scenes.

For me, this film presents the author’s heterosexual female fantasy of BDSM, woven around a classic Mills and Boon-style redemptive ‘love’ story aimed at a heterosexual female demographic. In the two showings of the film I attended, the audience was easily over 80 per cent female. Like all erotica, the focus is on fantasy over reality.

If the point of this film is to increase female arousal, which as a psychosexual psychotherapist I would generally be in favour of, then it does a reasonable job. The sexual scenes are artistically shot, mostly focusing on the face or body of Anastasia (Dakota Johnson). Genitalia are discretely avoided, although pubic hairs get the occasional look-in. As an experience of mild, visual erotica, the film may impact positively on the viewer’s sex life, if only while they are watching it.

However the film falls flat as a rounded piece of cinema. The decision to make this the first in a trilogy, like the books, left the film without enough story to link the erotic scenes together. Once Anastasia’s virginity has been ‘addressed’, the dialogue reduces and the connection between the characters is emotionally unconvincing, which makes, quite frankly, for a boring film. The most compelling scenes are in the last 10 minutes, where the action and emotion is troubling. But would I sit through a sequel just to see this storyline developed? Probably not.

Julie Sale is a psychosexual psychotherapist and director of a counselling centre.


If you would like to review a new film, concert, exhibition or event that you think has special resonance for counsellors and psychotherapists, please email Chris Rose, Reviews Editor, at reviews@bacp.co.uk
many other nuggets concealed within – a book not to be taken in one sitting but offering rich pickings.  

Chris Rose is a group psychotherapist and author

The therapeutic relationship

The therapeutic relationship handbook: theory and practice  
Divine Charura, Stephen Paul (eds)  
ISBN 978-0335264827  
Reviewed by Els van Ooijen

The therapeutic relationship stands out as a key concept in the many different models of counselling and psychotherapy. This book examines it from four perspectives: modality-specific, cross-modality/integrative, group and couples and mental health. It also includes a more general section on diversity, spirituality, online work and neuroscience. Each section has four to six brief chapters that convey the essence of their topics, aided by helpful case studies.

In the first section individual therapy is discussed from psychodynamic, cognitive behavioural, existential and person-centred perspectives. Interestingly, the current ‘relational turn’ in psychoanalysis is not mentioned in Alayarian’s helpful chapter on the psychoanalytic conceptualisation of the therapeutic relationship. The centrality of relationship in human flourishing is, however, given ample attention in the second section on integrative, creative and coaching therapies, by Gilbert and Evans and by Charlesworth and Nicholson. A sensitive chapter by Fisher demonstrates the power of the non-verbal in expressive arts therapies.

In the third section Paul and Charura argue that, for groups, ‘cohesiveness is the therapeutic relationship’ (p293), whereas Burghgraef and Charura point out the importance of attending to the complex dynamics that occur when working with people from various cultural and social contexts.

Section 4 contains particularly helpful contributions on working with people with learning difficulties (by Nadirshaw), and dissociative identity disorder (by Ringrose). Refreshing offerings by Read, Hipolito, Nunes and Brites and Majumder discuss the negative impact of the current focus on targets, diagnosis and treatment guidelines on therapeutic relationships.

In the final section Lago and Watson argue that ‘micro-aggressions can easily be repeated’ in transcultural therapy (p249); Paul and West emphasise the importance of self-knowledge when focusing on spiritual or religious issues; Wright highlights the importance of training before embarking on online therapy, and Uphoff provides a thoughtful discussion on the implications of neuroscience for the therapeutic relationship.

This attractively presented textbook would be a useful addition to the library of any counselling or psychotherapy course. Its concise chapters constitute an excellent introduction to the many facets of the therapeutic relationship.  

Dr Els van Ooijen is a relational-integrative psychotherapist, supervisor and author

Parent and child predicaments

Attachment and family therapy  
Patricia Crittenden, Rudi Dallos, Andrea Landini, Kasia Kozlowska  
ISBN 978-0335235902  
Reviewed by Anne Power

I was pleased to read a book offering an integration of attachment and systemic theory and, on the whole, my hopes were met. Attachment theory has informed my practice for 20 years but this book has deepened my understanding of different strategies. Some of the passages that describe and explain the interactions between parent and child are superb: descriptions so illuminating that they seemed as clear as the video footage upon which many are based.

At times I would have preferred less jargon – the authors are not sparing in their use of technical language. However what I found highly useful was the detailed explication of the subgroups in the avoidant and ambivalent categories. These subgroups are named and described in various contexts and illustrated in parents and children of different ages. I particularly appreciated the book’s clarity on the predicament of the ambivalent child who keeps asking for attention without feeling soothed by the parent’s efforts to respond because ‘their real need, that of knowing that their parents are in control and able to...’

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*Figure taken from Google Analytics. 44,931 unique visits between 1 May to 31 May 2014.
to evaluate and meet their children’s needs, is unfulfilled’ (p77).

The book is well structured; each chapter covers a particular phase of development, from new-born to school-age, looking at how children adapt to the limitations of their parents. Each chapter offers a vivid eyewitness depiction of a family in trouble and the efforts of professionals to help them. The authors then critique the treatment offered and make sense of the children’s interactions with parents and therapists.

My concern about the book is that the authors write as though they are offering brand new theory, and they have coined new acronyms to go with this. This aspect of the book was unconvincing. What I found of benefit were the presentation and development of basic attachment theory examined through a systemic lens. As a couple therapist I appreciated how the authors repeatedly focus the reader’s attention on the family as an organisation and how systemic process impacts on the individuals involved.

The book would be valuable for those working in children’s services but would also be very informative for all general counsellors and therapists who want to understand family constellations and sibling relationships.

Susie Orbach, one of the conference speakers, is quoted in Kate White’s introduction: ‘There is no such thing as a body; only a body in relationship with another body’ (p144). This shift towards an embracing of the body in psychotherapy, especially the body countertransference of the therapist, is reflected in this volume. It includes contributions from practitioners working in a range of modalities, from body psychotherapists Roz Carroll and Nick Totton to attachment-based psychoanalytic therapists Mark Linington and Orit Badouk Epstein.

The chapters explore a range of issues. Unsurprisingly, the impact of trauma on attachment relationships features significantly; anyone familiar with the work of Babette Rothschild will be aware of the link between attachment, trauma and the body. This is the theme of Pat Ogden’s chapter, ‘The Wisdom of the Body: lost and found’, which explores her work, combining both somatic and cognitive approaches, with a deeply traumatised young adult.

As might be expected from a book based on conference material, the contributions vary in tone and approach, dancing a fine line between the academic/theoretical and professional/practical. I was particularly drawn to Mark Linington’s chapter ‘The Body I Want’, describing issues arising in his work with a disabled man and the complex challenges of creating a healing, embodied relationship from an attachment perspective with a client with a troubled and traumatised body.

As a dance movement psychotherapist (DMP), I admit to being disappointed at the under-representation of my profession within this book. DMP is highly relevant to the investigation opened up here, especially in terms of examining the expressive, moving body in relationship to others. However this book marks a key shift from an emphasis purely on psychological development to one that views the development of the body as equally important to our understanding of the impact of attachment on who we are and how we form relationships.

Anne Power is an attachment-based psychotherapist

Embracing the body

Talking bodies
Kate White (ed) Karnac, 2014, 156pp, £17.99
ISBN 978-178220109
Reviewed by Diane Parker

This collection of papers from the 2012 John Bowlby Memorial Conference represents a gradual but significant shift in body therapy and mainstream psychotherapy towards a focus on the relevance of the body within the framework of attachment theory and relational psychoanalysis.

Diane Parker is a coach and dance movement psychotherapist and editor of Coaching Today

American Sniper
Warner Bros, 2015 (134 minutes)
Directed by Clint Eastwood
Reviewed by Julian Edge

‘Is there a point at which my responsibility to society exceeds my commitment to the individual client?’

The new politics of experience and the bitter herbs
Theodor Itten, Ron Roberts
PCCS Books, 2014, 281pp, £18
ISBN 978-1906254742
Reviewed by Colin Feltham

‘...written with much pertinent knowledge and some humour.’

H is for Hawk
Helen Macdonald
ISBN 978-0224097000
Reviewed by Lorna Swain

‘... a powerful reminder... that nature itself reflects life’s processes.’
We set off from the centre of Grasmere village in the Lake District to walk from Helm’s Crag. The snowcapped scenery was breathtaking. As we walked, sometimes through snow drifts up to two foot deep, it occurred to me just how blissfully happy I was and how insignificant many of life’s worries really seemed, for that moment. I then realised that there actually isn’t an evidence base for my improvement in mood; no RCT that had measured my experience with scientific accuracy. It somewhat ruined the moment.

Ah well, I thought, there’s always cooking – I so enjoy cooking, particularly on a wet Sunday afternoon with the kitchen to myself and a glass of red wine. Nope, no evidence base for that either; I might just as well have beans on toast. A beautiful sunset, maybe? Nope, no evidence for that either! It seems I have been nourishing my life on a set of experiences with absolutely no evidence to support them.

Don’t get me wrong, I am all for evidence. I edited Counselling and Psychotherapy Research for nearly six years; I do sincerely believe that we cannot work with clients simply on the basis that we quite like what we do and ‘it worked for me’. I also think that we need to be accountable to our clients for the therapy we offer and, wherever possible, ask questions about their experience of it and whether it is actually helping them. My problem with the ‘evidence base’ as it is currently articulated was brought into focus at the 2015 Psychological Therapies in the NHS conference I attended in February. It’s all ‘evidence this, evidence that’, but actually the criteria for what constitutes ‘evidence’ seem to me to be so narrow, so specific – so... well, scientific – that the experience of being or the process of doing really don’t count. It might feel good and help you think differently but, unless there’s an RCT to prove it, it won’t stack up to much. Qualitative research seems to be viewed like a slightly eccentric and socially awkward relative: we see them because we have to but we wouldn’t invite them round for tea. And case study methodology? Well, what can one person really tell us? (Quite a lot, actually.)

There seems to be a will among policy makers and the ‘really clever people’ to apply scientific principles – apparently unquestioningly – to the human condition; anything less than ‘science’ really isn’t good enough. Yet, ironically, I spoke to a prominent and influential medical consultant at that same conference and she said that the greatest advances in physical healthcare came through the process of imaginative thinking, of risk taking, of believing, of collaboration, of pushing boundaries – no RCTs anywhere to be seen. It seems that when physical medical practitioners take risks they are innovators, but when we try to do the same in the psychological therapies we are naïve and self-interested.

These are important debates, and we need to engage with them. Whether we work in the NHS, in education settings, in the third sector or independently; whether we work with children, young people or adults, we are operating in a culture where the type and strength of the evidence we can offer dictate not only the nature of the therapy we provide but, increasingly, whether we are funded to provide it at all. Alongside the push for greater choice for clients in the range of psychological therapies available on the NHS and speedier access to them, it seems that a dogmatic fidelity to a narrow evidence base is contributing to shutting doors, not opening them.

I hope BACP can continue to actively contribute to that debate and that we can achieve parity of esteem for the qualitative and individual in our lives. I hope that, come the spring, as I stroll along the riverbank marvelling at the bird song and the fragile flowers bursting into new life, I can trust that I really am feeling that good, even though science can’t capture the moment and explain it.
Meet the BACP Vice Presidents

Kim Hollis QC became a BACP Vice President in November last year

First, could you say a bit about who you are and what you do?
I am a Queen’s Counsel specialising in criminal work. I’ve worked in the Criminal Justice System for the last 36 years. I was the first Asian female Queen’s Counsel to be appointed when I was awarded the honour in 2002 at the age of 45. For the last 20 years I have worked with people charged with the most serious crimes, including serious sex crimes, infanticide, people trafficking, honour-based violence, forced marriage and more recently female genital mutilation. I am a qualified mediator as well and most recently I have volunteered and trained with the NSPCC as part of the ChildLine Schools Service.

What is your particular interest in counselling/psychotherapy?
I have a particular concern about women offenders. The long-term consequences of short-term prison sentences for women still need to be fully appreciated by government, including the long-term emotional harm caused by the breakup of a family when a mother is imprisoned. Counselling and psychotherapy in appropriate circumstances would help to significantly reduce repeat offending, in my view, as well as preventing escalation in the seriousness of offences.

What do you feel you bring to the role of Vice President of BACP?
My vast experience across the Criminal Justice System. I think that is largely why I was invited to take on the role. I know from attending the Social Justice Summit in Manchester that BACP is actively involved in this arena and I hope to be able to advise the Association on how to take this work forward.

Tell us a bit more about you – what are the three principles/beliefs that have guided you in your life and professional career?
First, to always try to be both professional as well as compassionate to my clients’ needs. The people I meet and represent are often bewildered and frightened and in need of professional, clear advice from someone they can trust. I also inherited a very positive attitude to life from my father and that has been one of my stalwarts – I am very much a ‘glass half full’ person. Every morning I believe that something really nice will happen today, however small, and it always does! I also believe that you have the power to achieve anything you want through hard work and determination. The journey may not be easy but if you want something enough and work hard enough you will get there in the end.

Who inspires you?
Mahatma Gandhi, and his words, ‘Be the change you want to see.’ This has inspired me from the outset of my career to strive to change the ‘Rumpole’ face of the Bar and why I chaired the Equality and Diversity Committee of the Bar’s General Council for many years. All you can do is ensure that a person is given an equal chance – after that, it’s up to them. I have spent my career working for equal chances for all.

What motivate you?
My family. My father always impressed on me that I should always try my best and if I did I would succeed. He was right.

What are the three greatest achievements in your life so far, and why are you proud of them?
My three greatest continuing achievements are my three sons, James, Oliver and Anthony. I am one of those embarrassing mothers who talks endlessly and in cringe-making detail about her offsprings’ achievements. I am also very proud to have been the first female Asian Queen’s Counsel in the UK. My grandfather was a lawyer and freedom fighter with Gandhi. He died young and I never knew him, but when I rang my aunt in India to tell her that I had been awarded QC she burst into tears. She said, ‘You have made your grandfather’s name.’ It was very moving.

And I am proud that I am able to make a positive and lasting change to perceptions of my chosen profession, in particular as far as diversity is concerned. Having practised at the Bar as a young Asian mother with children, I am able to act as a mentor and role model for others.

Are there other goals you still hope to achieve?
I’ve frequently been approached to consider a political career and have never been able to fit it in. I’d like to contribute more at a policy-making level, especially around diversity and equality issues, and help make change happen – not just talk about what I think ought to happen.

Do you have a message for BACP members?
I am honoured to have been appointed a Vice President of BACP. I hope I will get to know as many of you as possible. I am happy to help at any time.
Mental health hero member

BACP member Myira Khan has been picked from over 900 nominations as one of 10 regional ‘mental health heroes’ in England in a national campaign to promote mental health awareness led by Deputy Prime Minister Nick Clegg.

Myira, who is based in Leicester, was named mental health hero for the East Midlands region. She is the only counsellor among the 10 mental health heroes.

She was presented with the award at a ceremony in London last month to mark national Time To Talk Day.

Myira is a counsellor in private practice. She founded the Muslim Counsellor and Psychotherapist Network in April 2013 to promote counselling as a career for people from Muslim communities and to provide peer support to other Muslim counsellors and Muslim counselling students. She also campaigns to raise awareness of mental health stigma among South Asian communities.

Myira said: ‘I am really honoured and humbled to be receiving the award. I want to create easier and wider access to counselling services for our communities. Talking therapies and counselling need to be recognised and fully funded to ensure everyone can get access to services and the help they need when they need it.’

BACP Coaching

BACP Coaching has appointed Becky Wright as its new Executive Specialist for the Promotion of Therapists Who Coach.

A senior accredited member of BACP and longtime member of BACP Coaching, Becky is a director of Community Life Design CIC and leads New Leaf Life Design in Somerset, which delivers coaching, counselling and wellbeing EAPs locally.

Spend an evening with Irvin Yalom

BACP is offering members another chance to enjoy an evening with psychotherapist and writer Dr Irvin Yalom.

Dr Yalom will be speaking by live link from the US at the very popular OCTIA online therapy conference from the day for up to 30 days.

Access to all the filmed events is available online. The conference is on 28 March. Again this year, on 28 March.

The webcast includes the very popular OCTIA panel discussion and live chat with Dr Yalom, which includes an evening with Dr Yalom. Dr Yalom is speaking on post-traumatic growth; Dr James Davies on diagnostic labeling, Dr John Rowan on the transpersonal, and Dr Geoff Pelham on working with mood and emotion in coaching.

For full details of all the workshops and further information about the conference, please visit www.bacp.co.uk/events

2015 Practitioner’s Conference

The full programme for the BACP Practitioner’s Conference is now available online. The conference is on Friday 24 April at Weetwood Hall, Leeds.

As before, the conference programme follows eight concurrent themes. Four of the streams are tailored for members of the four participating divisions – BACP Healthcare, Workplace, Coaching, and Spirituality – and are for general covering self-care, business development, trauma and neuroscience. Delegates can follow one specialist theme or create their own programme by choosing workshops from across all eight streams.

Guest speakers include Professor Stephen Joseph on post-traumatic growth; Dr James Davies on diagnostic labeling, Dr John Rowan on the transpersonal, and Dr Geoff Pelham on working with mood and emotion in coaching.

For full details of all the workshops and further information about the conference, please visit www.bacp.co.uk/events

BACP Spirituality Executive

Keith Hackwood has been co-opted onto the BACP Spirituality Executive Committee.

Keith originally trained as a psychosynthesis therapist but has since been pursuing his interest in mindfulness. He has integrated into his studies many of the world’s religious wisdom traditions including Advaita Vedanta, Sufism, Kabbalah, the Western Hermetic Schools, indigenous shamanic traditions and Christian mysticism.

We look forward to his contribution to our work,” said BACP Spirituality Chair, Melody Cranbourne-Rosser.

BACP Private Practice networks

Executive member Julia Greer has taken over responsibility for co-ordinating the BACP Private Practice regional networking groups. There are currently 18 groups across all four nations of the UK.

Groups are currently thriving in Ashford (Middlesex), Banbury, Basingstoke, Belfast, Cambridge, Cheltenham, Dunstable, East London (Ilford), Edinburgh, Grays, Leeds, North Shields, Nottingham, Omagh, Peterborough, Redruth, and South London (Brixton). The inaugural meeting of the Cardiff group will take place on 20 March 2015.

Anyone interested in setting up a group in their area should contact Julia at juliagreer14@btinternet.com. Details of all divisional networking group meetings can be found on the BACP website at www.bacp.co.uk/events/network.php
BACP Private Practice Conference 2015

BACP Private Practice has confirmed the keynote speakers for its 2015 conference. Following up on the previous conferences on depression in 2013 and anxiety in 2014, the theme this year is 'Trauma: the challenge of our age'. The conference takes place at the Holiday Inn, Bloomsbury in central London on 19 September 2015 and the programme is tailored specifically for therapists working in private practice.

Mark Brayne, a trainer and psychotherapist in private practice specialising in trauma and PTSD, will give the opening keynote speech on the subject of trauma and journalism. Before training as a therapist he served for 30 years as foreign correspondent and senior editor for Reuters and the BBC World Service. He now works with journalists, mental health professionals and educators to develop a greater awareness of trauma among journalists and a better understanding of journalism among trauma professionals.

The closing keynote, ‘The power of spiritual support following trauma’, will be given by ordained Anglican priest Canon David Wilbraham, Force Chaplain with Thames Valley Police and leader of the National Association of Chaplains to the Police.

The workshop titles (subject to confirmation) include 'Working with women experiencing trauma diagnosed as borderline personality disorder' with Dr Gillian Proctor; 'Therapist as client: a personal perspective on dissociative identity disorder diagnosis as a result of trauma' with Katy Woodger; 'Veterans and trauma' with Margaret Chapman; 'Intergenerational trauma' with Haya Oakley; ‘Trauma following a major incident' with Noreen Tehrani; 'EMDR' with Derek Farrell; and 'Somatic trauma for the client and self-care for the trauma therapist' with Michael Gavin.

The conference costs £105 for BACP Private Practice members, £120 for BACP members, and £190 for non-members. For more details and to register, visit www.bacp.co.uk/events or call Customer Services on 01455 883300 or email bacp@bacp.co.uk

Counselling website prompts concern

On 25 February the BBC Radio 4 current affairs programme You and Yours featured a report on a company called commissioning gp. Presenter Winifred Robinson said: ‘More than a dozen counsellors and psychotherapists have been in touch with us about a company that cold-called them and persuaded them to be on a website. They were approached by a company called commissioning gp. The sales rep said they were setting up an online register that would be used by GPs looking for psychotherapists and counsellors when they were referring patients for talking therapies.’

The programme featured the comments of two counsellors who were contacted by people claiming to work for commissioning gp and who were very unhappy with the service they received.

BACP has had a number of concerned members get in touch after being approached by someone offering to list them on a directory for GPs. BACP is reminding members that the NHS has formal commissioning processes to enable GPs to refer patients for NHS-funded counselling. ‘It is our understanding that being on a directory is highly unlikely to be enough to secure NHS-funded referrals. GPs are also highly unlikely to use directories to make direct private referrals to counsellors as this would be considered a recommendation and there is no guarantee of quality of care,’ said BACP Chief Executive Hadyn Williams.

BACP has published a suite of information about the commissioning process, which members can download free from www.bacp.co.uk/commissioning/

Workplace practice guidance – experts needed

BACP’s Good Practice Guidance project needs volunteers to help review the materials it is producing on workplace counselling. If you have workplace expertise and would like to help, email Susan Dale, Good Practice Guidance Manager, at susan.dale@bacp.co.uk

Susan is also seeking volunteers for the focus groups on mental health and ethical decision making, to help decide the resources needed for these topic areas. Please email her if you think you can help with these too.

CPR journal

With the Counselling and Psychotherapy Research journal approaching its 15th year, we are pleased to announce that Wiley became the new publisher of CPR at the beginning of 2015.

After many productive years of working successfully with Taylor & Francis, we look forward to collaborating with Wiley in developing CPR in both international reach and quality. BACP members can access not just the current issue of CPR online but the entire back catalogue as well, free of charge. To do this, log into the Members’ Area via the BACP website homepage, select the second tab (BACP account), scroll down to the online resources sub-heading and select CPR Online. You will then be re-directed to a BACP webpage where you can click through to the Wiley Online Library and view all the CPR volumes back to 2001.

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Update on PhD studentship

You may remember that last year we sponsored Emma Broglia to undertake her PhD entitled: ‘A feasibility trial of the effectiveness and impact of counselling in universities and/or colleges of further education’ at the University of Sheffield.

This is an update on the progress of Emma’s project.

For many years counselling staff have faced a dramatic growth in the number of students seeking their services, many presenting with more advanced and often complex mental health problems. At the same time, university counselling centres have also started to adopt more innovative approaches into their services such as e-therapies – that is, using technology to facilitate therapy – in order to appeal to a wider demographic. At a time of increased demand and severity it is crucial to understand the effectiveness of counselling. Accordingly, BACP and the University of Sheffield have combined efforts to build an evidence base with the aim of supporting the development and effectiveness of student counselling services.

As a starting point, a new survey was last month distributed to members of BACP University and College Counselling. The survey aims to capture the main features and functions of the university and college counselling sector and to identify factors that impact on counselling services. This information will be used to address aspects of a feasibility trial for Emma’s PhD, which will be supervised by Professor Michael Barkham and Dr Abigail Millings.

In particular, the survey will provide information on the different pathways into receiving and maintaining counselling support. It will also capture difficulties experienced when gathering outcome data as well as information on the time points these outcome measures are administered.

The survey will provide an initial snapshot of some of the e-therapies already being used in the sector and information on how these and other online interactive support tools are viewed by counselling and therapeutic staff.

Emma will be posting regular updates on her research at www.bacp.co.uk/research/phd_opportunity/

Enquiry of the month

This month’s research enquiry asked: ‘What research has been conducted that has looked at self-care in counsellors?’ We searched our internal abstract database and google scholar (http://scholar.google.co.uk) using the terms ‘self-care’ and ‘counselling’.

Much of the published literature has focused on integrating mindfulness into therapist training to promote self-care. Shapiro and colleagues’ examined the effects of incorporating mindfulness-based stress reduction (MBSR) into therapist training and they found that participants reported significant reductions in stress, negative affect, rumination and state and trait anxiety. Participants also reported significant increases in positive affect and self-compassion and increases in mindfulness. Similarly, Christopher and Maris’ found that mindfulness training enhanced the physical and psychological wellbeing of trainees.

Both of these studies contribute to a wider body of knowledge about self-care in counsellors and may have implications for training.

If you have a research query, email research@bacp.co.uk

REFERENCES:

BACP funds exploratory study into dementia

The BACP Research department has funded an exploratory study looking at psychological support for people with dementia.

The study will be conducted by Kelly Birtwell, Senior Clinical Studies Officer with Manchester Health & Social Care Trust. It will be a small-scale, qualitative study that will use thematic analysis to explore the views of people with mild dementia about the current provision of psychological support, their attitudes to it and its acceptability.

The project has been funded through BACP’s Small Research Grant funding stream, which allocates grants worth up to £5,000 each. The study is expected to be completed by January 2016.

Further details of previous research funded through this funding stream can be found on the Research webpages at www.bacp.co.uk/research/resources/small_research_grant.php

Opportunities to take part in research

BACP members often ask us how they can get involved in research. Our research notice board (www.bacp.co.uk/research/Research_Notice_Board) promotes a wide range of members’ research studies where participants are needed, usually to complete a questionnaire or take part in an interview.

Please visit the noticeboard to see if there are any areas where you might be able to get involved. Members can also place their own notice for research participants by emailing Stella Nichols (Office Administrator in the BACP Research Department) at stella.nichols@bacp.co.uk
Early bird offer for Annual Research Conference 2015

We’re offering a special early bird rate to delegates who book their place at BACP’s Annual Research Conference before 27 March 2015. The conference is on 15–16 May 2015 at the East Midlands Conference Centre in Nottingham. This year’s theme is ‘Understanding Professional Practice: the role of research’ and the programme will be of interest to researchers, practitioners, students, academics and trainers from different backgrounds and traditions. Early bird day delegate rates are £110 for BACP members and £190 for non-members. Presenters pay a reduced rate of £90 per day.

To find out more about the research conference, please visit www.bacp.co.uk/events/conference.php?eventID=116080

Newly accredited counsellors/psychotherapists
Julie Adsetts
Lindsay Austin
Melanie Ayers
Jonathan Bailey
Lisa Barnard
Dot Barrow
Tracy Burns
Sue Burton
Alice Campbell
Susan Cappaert
Andrea Cauldwell
Jane Chapman
Stella Christou
Gala Connell
Lesley Cooper
Tina Cozens
Rhiannon Dalton
Marion Dunn
Gemma Ewins
Fiona Fellberg
Ria Foster
Jackie Gaze
Claire Gilkes
Alan Jones
Gina Laibinis
Ania Liro
Patricia McGill
Patricia McGurk
Kerry McNally
Stuart Melvin
Julie Nesbitt
Clare O’Brien
Patricia O’Malley-Boyd
April Parkins
Debbie Russell
Margaret Ryan
Allister Simmons
Tracey Smithers
Lesley Snowdon
Tom Taylor
Dola Twomey
Giulia Wiseman
Joan Worsock

Newly senior accredited counsellors/psychotherapists
Pauline Cuthbert
Rebecca Woods

Newly senior accredited counsellor/psychotherapist for children & young people
Sonia Mackenzie

Newly senior accredited supervisor of individuals
Dorothy Millar

Organisations with new service accreditations
Woman’s Trust
Xenzone Ltd

Organisations with successful service accreditation term renewals
● Counsel for LIFE
● CPF Counselling Croydon
● Employee Counselling Service (ECS)
● Mothertongue Counselling & Listening Service

Newly accredited courses
● Birkbeck, University of London: Foundation Degree in CBT and Psychodynamic Counselling
● University of South Wales (Carleon Campus, Newport): Postgraduate Diploma in Cognitive Behavioural Psychotherapy (CBP) and Postgraduate Diploma in Integrative Counselling and Psychotherapy

Newly accredited courses
Margie Bates
Jennifer Bell
Marion Bennett
Jillian Bentley
Gill Blades
Pat Bowen
Frances Bower
Anne Callander
Diana Charters
Peter Chadwick
Victoria Cole
Margaret Daniel
Bernadette Deegan
Linda Elliott
Susan Esau
Linda Fox
Pamela Gee
Carol Gibbons
Stephanie Gibbons
Rosemary Glover
Kay Green
Linda Green
Pamela Hargreaves
Valerie Hargreaves
Brian Harrington
Christine Hart
Amanda Haynes
Helen Hyndman
Stephen Ingham
Mary Jackson
Avril Jones
Marie Kane
Marian Kirby
Polly Klinefelter
Regine Lallah
Rachael Lang
Margaret Law-Homewood
Hui-Leng Lim
Mary Logan
Wendy Lynch
Christine North
Rosalind O’Kane
Sandra Panormo
Kathryn Pearce
Brigitte Pepper
Lynda Price
A Purton
Madeleine Richardson
Linda Riecken
Gill Roberts
Catheine Rowland
Valerie Saberton
Natalie Shah
Suzanne Simpson
Rachelle Son
Margaret Spencer
Linda Stone
Josephine Thomason
Margaret Tomlinson
Angelina Veiga
Alison Waines
Marie Ward
Jane Warman
Rosemary Williams
Stephen Wilson
Jane Wren
Mary Wright

Members whose accreditation has been reinstated
Dorothy Anderson-Scarlett
Lena Cromartie
Jim Flowers
Shereen Glean
Jean Selmes

Correction
It was published in the February 2015 Therapy Today that Rebecca Woods and Pauline Cuthbert gained their accredited status. Please note that Rebecca Woods gained accreditation in August 2004 and Pauline Cuthbert in May 2003; both have since gained their senior accreditation. These members are now listed in the relevant senior accredited category and we apologise for this error.
Around the Parliaments

The NHS continues to be at the top of the general election battle ground, with the major parties trading policy commitments, reactions and lots of political posturing at every opportunity.

With 100 days to go until the General Election, Labour Leader Ed Miliband emphasised the importance of early intervention: ‘When problems with mental health aren’t spotted early at school or work, they build up and people end up in hospital,’ he said. Labour would do more to ‘end the scandal of neglecting mental health by prioritising investment in young people and ensuring teachers are trained to spot problems early.’

Shadow Health Secretary Andy Burnham MP built on these comments later the same day with a speech to the King’s Fund in which he made several references to counselling. An NHS for the 21st century should be one ‘where people can find mental health support, such as counselling or therapy, as readily as medication’, he said, and he went on to confirm that Labour will amend the NHS Constitution to give patients the same right to counselling and therapy as they have currently to medical treatments.

UKIP too outlined their policies with 100 days to go. The 100 reasons to vote UKIP include a pledge to invest £3 billion more annually in the NHS; pay greater attention to elderly care across the country; end Private Finance Initiative (PFI) privatisation of the NHS, and introduce a Veteran’s Card to ensure ex-armed forces personnel can access help if they have mental health needs.

In the House of Lords, Labour peer Lord Ponsonby of Shulbrede led a debate where he asked the Government to address the shortcomings in mental health services for deaf people who use British sign language (BSL).

He explained specialised support was not available in most parts of the country and the result was ‘second rate’ and ‘sometimes dangerous’ service provision.

Over in the Commons, addressing an urgent question from shadow minister for Public Health Luciana Berger, Care Services and Support Minister Norman Lamb reported recent data on child and adolescent mental health services (CAMHS). ‘The Government are committed to improving CAMHS as part of our commitment to achieving parity of esteem between mental and physical health,’ he told MPs.

The House of Commons Health Select Committee received a response from the Government on its report on child and adolescent mental health and CAMHS. The Government confirmed that it is ‘working with experts in school counselling to prepare advice which is expected to be published in spring 2015 on securing high quality counselling’. This will include information on the wider benefits of counselling, what constitutes high quality counselling, and the different approaches that schools might adopt. Karen Cromarty, BACP Senior Lead Advisor for Children and Young People, has been representing the Association in these discussions.

Finally, a report from the House of Commons Home Affairs Committee found that the prevalence of people with mental health illness in the criminal justice system is too high.

Consultation on abortion in Northern Ireland

The Northern Ireland Department of Justice is consulting on a potential law change to allow abortion where the foetal condition is deemed incompatible with life.

In its response to the consultation, BACP has advised that, if the law were to change, in these situations the pregnant woman, partner and family should be offered counselling during the decision-making process as well as before and after the procedure.

We point out that a termination for foetal anomaly is a major life event that may have traumatic psychological effects for both women and men. Counselling can offer support during the mourning process, allow the expression of feelings and facilitate dialogue between the couple and help to prevent the onset of post-abortion depression.

Screening for depression in adults

BACP has backed the decision by the UK National Screening Committee not to recommend that all adults are routinely screened for depression. The Committee is currently consulting on its UK NSC Recommendation on Screening for Depression in Adults.

In our response BACP supports the committee’s call for more research into the impact of screening for depression on mortality, morbidity and longer-term outcomes, as well as the likely acceptability of screening programmes within a UK context. We agree that the current evidence base is not sufficient to support a recommendation for routine screening for depression.

However we have drawn the committee’s attention to other research findings that suggest routine screening for depression may be beneficial for sub-sets of the population known to be at increased risk of common mental disorders – such as patients receiving medical treatment in hospital and people with type 2 diabetes. We’ve also highlighted the NICE guidelines on depression in adults with a physical health problem, which recommend that practitioners should be alert to depression and should consider asking further screening questions.

We’ve also added to the research evidence listed in the Recommendation on the accuracy of screening tools and the potential impact of screening.
Health standards for children

BACP has welcomed the inclusion of positive mental health and emotional wellbeing in the health and social care standards outlined by Northern Ireland’s Department for Health, Social Services and Public Safety in its draft Service Framework: Children and Young People.

We welcome the inclusion of a range of services and departments in delivering the standards outlined in the document. But we have raised concerns about the performance indicators, which we feel are too general and do not identify specific professional groups. The framework should identify particular leads within each responsible organisation to ensure the standards are met.

We also call for greater emphasis on the role of schools and educational establishments in promoting children and young people’s mental health and wellbeing, such as the Counselling in Schools Service launched by the Department of Education. We point out that schools are where most school-age children spend much of their day. We argue that all secondary school children and young people in the UK should have access to professional, qualified counselling services in their school, delivered by qualified practitioners registered with an approved voluntary register accredited by the Professional Standards Authority.

We also query the document’s limited references to ethnic origin and religion and the barriers these can create for children and young people accessing services.

Withdrawal of membership
Karen Grant
Reference No: 534043
Brighton, BN1 8NH

The complaint against the above individual member was heard under BACP’s Professional Conduct Procedure and the Professional Conduct Panel considered the alleged breaches of the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy.

The Panel made a number of findings and the Panel was unanimous in its decision that, in view of the findings made, Ms Grant’s actions were of sufficient seriousness to merit withdrawal of her membership from BACP.

Full details of the decision can be found at http://www.bacp.co.uk/prof_conduct/notices/termination.php

BACP Professional Conduct Hearing
Findings, decision and sanction
Debbie Walker
Reference No: 571328
Herts, EN6

The complaint against the above individual member was heard under BACP’s Professional Conduct Procedure and the Professional Conduct Panel considered the alleged breaches of the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy.

The Panel made a number of findings and the Panel was unanimous in its decision to impose a sanction requiring Ms Walker to provide a written submission which evidences her immediate reflection on, learning from and understanding of, the issues raised in this complaint and a case study describing how she might have done things differently with regard to this case, given the client’s issues and the organisational constraints under which she was working.

Full details of the decision can be found at http://www.bacp.co.uk/prof_conduct/notices/hearings.php

Withdrawal of membership
Fiona Legh-Ellis
Reference No: 505641
Worthing, BN11 1PE

A sanction was imposed on Ms Legh-Ellis following a Professional Conduct Hearing.

Ms Legh-Ellis failed to comply with the sanction and consequently her membership of BACP was withdrawn. Any future application for membership of BACP will be considered under Article 12.3 of the Memorandum and Articles of the Association.

Have your say
BACP’s Public Affairs team regularly put together responses on a wide range of consultative documents produced by government departments and non-statutory bodies.

We welcome input from BACP members with relevant expertise in the topic areas.

If you’d like to have an input to our responses, please ring Anna Lewis on 01455 206381 or email her at anna.lewis@bacp.co.uk

You can find details of all our consultation responses on the BACP website at www.bacp.co.uk/policy