Retirement: when and why?

The language of healthcare and how it shapes practice

Photographs in therapy: a key to the unconscious
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• Increase the availability of trained and supervised counsellors
• Maintain and raise standards of training and practice
• Provide support for counsellors and those using counselling skills, and opportunities for their continual professional development
• Respond to requests for information and advice on matters relating to counselling
• Represent counselling at national and international levels.

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When is the right time to retire – 60 or 90? This is a subject to which readers regularly return in letters and articles. For many, counselling is a second career, and if you’ve only just finished training in your early 50s you will barely have got into your stride before it might be considered time to stop. Thinking about work has evolved in recent years as we understand more about what it gives us, and this may be particularly pronounced with counselling and psychotherapy. Some people may simply need to continue working to pay the mortgage but, with the current lack of paid work, others may feel that they should make way for younger therapists.

There is no clear guidance about when to retire, apart from advice on fitness to practise. Health issues are regularly cited as a reason to stop practising, and memory problems – no longer being able to find the right word at the right time, as Mary Russell and Val Simanowitz found when they interviewed a group of therapists about their decisions to retire.

One reason therapists might choose to retire is to escape from a particular culture, perhaps in an organisational setting. The focus of the article by Rosemary Rizq is the language of healthcare – a lexicon created by what she calls the evidence-based movement – which we have all now adopted. Examples are ‘NICE-compliant interventions’, ‘patient wellbeing’ and ‘payment by results’. Rosemary compares this language to Orwell’s Newspeak and explores its tendency to narrow our range of thought, to eliminate feeling and, most significantly, to reduce the idea of relationship in mental health services. ‘They have already forced us into using certain words,’ she says, ‘already involved us in a... particular vocabulary. It’s already infiltrated our minds, our behaviour. We are already compromised.’

In an interview with Colin Feltham on our website (www.therapytoday.net), Rosemary further contextualises these developments and discusses what, if anything, we can do about it. We would like to hear your views.

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BACP register gains accreditation

The BACP Register has become the first register to be awarded accreditation under the Professional Standards Authority’s accreditation scheme for unregulated health and social care occupations. The Authority is an independent body, accountable to Parliament.

The Accreditation of Voluntary Registers (AVR) scheme was set up by the Department of Health to provide assurance on the standards of voluntary registers of health and social care occupations.

All full members of BACP are being invited to join the register by meeting the standards and signing the Terms and Conditions for registration. Many members will become eligible by successfully taking the Certificate of Proficiency.

BACP is currently rolling out a national Certificate of Proficiency programme to enable eligible members to complete the assessment at a centre local to them (see BACP News on p49). Registered members will be able to use the Authority’s accredited register quality mark to show that they are on an accredited register.

The voluntary registration scheme was launched in the House of Commons last month. BACP Chief Executive Laurie Clarke said: ‘This new safeguard provides a vital standard of service to help people select the very best counsellor or psychotherapist for them.’

Care and Support Minister Norman Lamb said: ‘The scheme will give people faith in the staff they employ, enhance the reputation of practitioners and raise standards across the board.’

Payday loan debtline calls rise

Calls to the National Debtline service for help with payday loans shot up by 94 per cent in 2012, debt charity the Money Advice Trust has revealed.

Last year the debtline took 20,013 calls for help with payday loans, nearly double the 10,301 calls received in 2011. In 2007, when the financial crisis began, the service took just 465 calls for advice about payday loans.

The Money Advice Trust says that in January alone National Debtline was taking calls for help with payday loans every seven minutes during the hours its phone lines were open.

National Debtline advisers are currently getting calls at a rate of 100 per day from people needing help with payday loan debts. Some callers have taken out as many as 80 payday loans.

The Money Advice Trust wants the Office of Fair Trading (OFT) to make use of its new powers to suspend consumer credit licences with immediate effect where it identifies persistent bad practice.

Joanna Elson, Chief Executive of the Money Advice Trust, said: ‘Payday loans have come from nowhere to be one of the most common debt problems people face. We hear from thousands of people each year who have been lured money when it was clearly not the right option for them. Borrowing on this scale can have serious ramifications if not dealt with properly.’

Bereaved children need stability

Losing a parent in childhood can cause lifelong emotional damage if the child and family don’t get adequate support, new research shows.

The study, conducted by researchers at the University of Liverpool and published in the Journal of the Royal Society of Medicine, found that low self-esteem, loneliness, isolation and inability to express feelings can persist through adulthood and into old age.

The research found that bereaved children often suffer disruption, instability and lack of continuity in their lives after a parent dies. The researchers say it can make it harder for the child to adjust to their parent’s death and increases stress if the family moves home after the death, separating them from family and friendship networks. Long periods of disruption and unstable living arrangements make bereaved children more likely to experience emotional difficulties, insecurity and loneliness in adulthood.

Bereaved children should remain in their existing social networks, live in the same area, go to the same school and maintain the same friendships.

‘Our research suggests that if the social network addresses the necessary “mothering or fathering” then a child does not appear to be affected in adult life,’ lead researcher Professor Mari Lloyd-Williams said.
Relate calls for ‘male-friendly’ support

Relationship counselling services should be more ‘male friendly’, Relate says in a new report published with the Men’s Health Forum. The report, Try to See It My Way, says men and women have different experiences of and react differently to major life events such as work and finance-related problems. They often don’t realise that their relationship is in trouble. Men also have different expectations of counselling; they go to counselling to solve problems, while women see it as a chance to talk about difficulties and review what’s happening in the relationship.

The report says that men are at greater risk of suicide in the aftermath of a relationship breakup and are less likely to have a network of friends to support them. They also tend to make less use of counselling and psychotherapy services; just 36 per cent of IAPT referrals are male, and only 44 per cent of Relate’s clients.

The report says policymakers and service providers across health, education and social care need to deliver services in a more ‘male-friendly’ way and that personal, social, health and economic education (PSHE) should include sex and relationships education and should be offered to all young people as a statutory requirement.

More people access NHS-funded therapy

Access to NHS-funded therapy has increased in the past two decades, research published in the British Journal of Psychiatry shows. The UK-wide study of uptake of psychotherapy treatments for common mental disorders from 1991 to 2009 shows that more people on lower incomes have been able to access psychotherapy, particularly in the last five years of the survey period.

Two per cent of the quarter of the population (26 per cent) who reported having a mental health problem had accessed therapy over the 18-year period. Of these, 77.5 per cent were treated by publicly funded services and 21.3 per cent in the private sector. The less affluent people receiving therapy tended to have more severe mental health problems, showing that talking treatments are reaching the people who need it most, the researchers say.

New self-harm campaign

Four young people’s charities have launched a national campaign to raise awareness of self-harm.

Self-harm is estimated to affect one in 12 young people in the UK. Calls to ChildLine from young people who self-harm have risen by 167 per cent in the past two years and children as young as 13 are now seeking its help.

The charities, ChildLine, YouthNet, Selfharm.co.uk and YoungMinds, hope that the public awareness campaign will help to reduce the stigma attached to self-harming that prevents many young people from asking for help.

Older therapists cry more, new research shows

Older, more experienced therapists cry more often during therapy sessions, new research published in Psychotherapy journal shows.

In the US study of 684 qualified and trainee therapists, 72 per cent reported crying in sessions with their clients. Older therapists with more experience cried more in client sessions than more recently qualified practitioners, but cried less often in their daily life.

Psychodynamic therapists reported slightly higher rates of crying in therapy than cognitive behavioural therapists, but similar rates of crying in daily life. There was no different in in-session crying rates between male and female therapists but the women cried more often in daily life.

The researchers say that experienced therapists may feel more confident about allowing themselves to experience these emotions when working with clients.
In practice

Are we worthy of their trust?

Rachel Freeth

‘I’ve told you a lot about myself but I still don’t trust you.’ Joanne had indeed just told me a lot about herself, including some of the despair and suicidal thoughts that had led to her referral to my outpatient clinic.

Like a number of young adults I see, Joanne’s desire to live and persevere in a threatening world seemed fragile, along with her sense of identity. She had also, like many, described a story of abuse, neglect and abandonment in her early years and numerous unstable relationships subsequently. She had been profoundly let down by care-givers and those in positions of power. It is no wonder she struggled to trust people.

It is not unusual for me to encounter people who find it very hard to trust helpers. It is rare, however, that anyone expresses a lack of trust in me as directly and firmly as this. It was a powerful moment. And, while I welcomed her honesty and her highlighting something of how she perceived me, I also felt profoundly challenged.

This experience also opened up for me many questions about the nature of trust, particularly in the context of helping relationships. It has since occurred to me that we so often talk about trust as the bedrock of the therapeutic relationship or helping alliance but we rarely engage in in-depth exploration of what trust actually involves and consists of – psychologically, socially, philosophically and morally.

We tend to assume we know what it is we are talking about. Yet coming up with a satisfactory definition of trust, or conceptual framework, is no easy task.

‘Do we consider what we need to do or how we need to be with our clients to make us more likely to be perceived as trustworthy?’

It has also occurred to me that we tend to talk about trust almost as a physical ‘thing’ – as something that a person either has or has not got. To me it makes more sense to refer to degrees of trust (while resisting attempts to quantify it), and as something that exists as a process, subject to fluctuations throughout the course of a relationship, or even throughout a conversation. It seems to me that Joanne might have had at least a fragment of trust in order to tell me something of her story, as well as to declare she didn’t trust me.

I have also become aware of how our professional discourse about trust and its importance in the helping relationship frequently focuses almost exclusively on the client. We talk about it as the client’s problem, about whether they are able to give us their trust, referring to the developmental and environmental factors creating distrust. But I wonder whether we talk enough about our own trustworthiness and what enhances or impairs it. Do we consider what we need to do or how we need to be with our clients to make us more likely to be perceived and experienced as trustworthy?

For me this is not about adopting particular communication techniques. It is deeper than this. I think my trustworthiness has something to do with my character, my beliefs and values. It relates to what I want for my client and what I want from our encounter. It concerns my feelings towards my client. Am I warmly disposed towards them and are my intentions essentially good ones? Am I willing to do everything I can to facilitate the best possible outcome for my client or will I just go through the motions?

Of course the client also comes with questions, many of which may be unspoken. When Joanne said she didn’t trust me, her perception of my trustworthiness could have been influenced by much more than my demeanour, attitudes and whether I listened attentively. She may have had questions about my competence, about whether I could actually help, and how. Could she trust me to deliver what she wanted and expected?

There is an important issue here, particularly for those of us who work in organisations. Our practice is influenced and at times constrained by the resources available – for example, time or number of sessions. Clients’ trust in us to deliver what they want in terms of outcomes will be inevitably influenced by what it is possible to deliver. This needs careful discussion and negotiation right at the outset of any therapeutic process.

I wasn’t all that surprised when Joanne did not attend for her next appointment, and I probably won’t see her again. I am nevertheless grateful to her for stimulating in me an enquiry into the nature of trust and for prompting me to think more about my own trustworthiness and what influences it, as well as how, for many people, trusting others is a tall order. ■
The person I want to be

Jeff Johnson

I led a criminal lifestyle for many years, involved in drugs and violence, football violence and things like that. I got the opportunity to sell some gear, some crack. Then I started taking it myself and I ended up subsidising my own use with selling it and everything got out of control. I made mistakes and I got caught.

In a way I’m glad I came to prison. It’s changed my life, this sentence. If I’d stayed out and hadn’t got caught, I’d have been a bigger dealer and would have been deeper into it all and f**k knows what would have happened. I would have lost my kids, lost my job, lost who knows what. I know what kind of attitude I had then.

I’d tried counselling before and fed them shit, told them what I thought they wanted to hear. This time it was different. I was ready for it. It was a window of opportunity and I went for it.

I wanted to find myself, to find who I was. It sounds stupid, but it’s true. I didn’t know who the real me was. I was aggressive and manipulative. I think I wanted someone to tell me I wasn’t as bad as I thought I was. To understand where I was coming from and to show me a different way than what my dad had taught me. The idea of the inner child – that I had a scared little child inside that lashes out to keep me safe… I dunno… I just wanted to sort my head out. Family, kids, relationships, and the other side, the violence. My dark side. The Shadow, my counsellor called it.

I clicked with my counsellor straight away.

I couldn’t have done it otherwise. There was something about him being my sensible side. It sounds stupid when I say it, but it’s like my dad was my aggressive side and he was my other side.

It was like having a best friend to talk to, helping me to find the proper way to deal with things. I knew I had all that in me, it was just putting it all to work. Helping me to deal with the little child inside. It just made so much sense to me, the way he would say things. The first few sessions it was like he just listened. He wasn’t judgmental, not at all. I could tell he was kind, friendly, caring.

An adult influence on my life. It brought out a side to me I didn’t think I was able to be. My adult I suppose. I’ve changed my attitude, my ideas. I’ve changed into the person I wanted to be.

Everything’s good at the moment – my relationship with my close friends, with my kids and my parents. I’ve learnt how to respond to things in a way that feels more real to me. I forgive my dad for what he did. He used to really beat me and my brother and lock us in a cupboard. I now realise he was trying to make us tough so we’d survive. I can see that now. I forgave him for my sake, not for his. I can’t undo things but I can change my way of thinking about it. I don’t need to punish myself for what he did. I don’t need to prove anything to him either. We’re actually getting on alright over the phone. It’s like my mum and dad have picked up on the changes in me. I’ve always punished myself for things that happened; blamed myself somehow. It was my fault. Now I know that’s not true.

I would never have got here without the counselling. It let me see everything in a different light. I was used to being a certain way. I was scared to change. I didn’t even know I could change. Counselling made me look inside me. It gave me the tools to become an adult, a better person, a better dad. I can feel my emotions and accept them. I can cry. I can feel happy. And proud. I’m proud of what I’ve done, what I’ve achieved, what I can do. Proud of me. And it doesn’t bother me what other people think about me. I know I’m going to be able to cope with my emotions.

Now I can think of things before they happen, before I do them. That comes through paying attention and listening to myself. I used to think all the bad things happen to me. When I look back, I was pathetic, looking to justify why I was taking drugs and all the rest. I was a violent, aggressive bully.

It’s not like that anymore. Life’s for living. I’ve got my kids, I’m a dad, there’ll be new friends. I remember this thing the counsellor said when we were talking about change and the point of it. He said, ‘If you change yourself, you change the world.’ I’m gonna get that tattooed on me when I get out.

‘I remember this thing the counsellor said… “If you change yourself, you change the world.” I’m gonna get that tattooed on me when I get out’

Interview by Lee Partis.
In training

Resources for all

Mel Perry

“The smartphone and all the software we can access, for free, allow us to tailor our training to our preferred way of learning.”

Counselling Association Podcast series. Aimed at students in particular, it takes you through the basics of many approaches, including Gestalt, Adler and existentialism, explores supervision and visits ethical issues such as confidentiality. The episodes are about 50 minutes long – perfect for a commute, a walk or the gym.

Early on I felt that I really needed to see some counselling in action. There are plenty of role-plays to view online and these are of some use, but I had to make a trip back in time to 1965 to find what I wanted. Gloria came to my rescue.

As I’m sure many of you will know, Gloria is an American client who volunteered to be filmed in sessions with various luminaries in the psychotherapy profession. Search YouTube for ‘Gloria, Rogers, Ellis and Perls’. Watching each of these masters in turn and how they conducted their first sessions with Gloria was illuminating, despite the contrived circumstances.

Perhaps surprisingly, I found other helpful examples of therapy in action in the US television series In Treatment. The show follows (fictional) psychoanalyst Paul Weston through his week as he conducts sessions with a range of different clients. The Guardian has described the show as ‘very superior TV’, and other reviewers agree that it is well researched. Watching it has given me a greater understanding of the psychoanalytic process and it’s reassuring to find that I can recognise many of the techniques and concepts at play. It’s an HBO production so it has a good pedigree and for me falls nicely into the class of edu-tainment.

Facebook also has something to offer. Take a look at the fb page ‘counsellingresource.com’. If you click on ‘like’ some chunky little bites with links come up on your newsfeed – it’s one way to feel less guilty about using Facebook. It also links to the counsellingresource.com webpage, which is international and accredited by the Health on the Net Foundation. It has something for everyone, such as ‘A Common Sense Guide to the Unconscious Mind’ or ‘Working Through Post-Traumatic Stress’, which has been particularly useful for me as this is an issue with which I am working on one of my placements.

And there are, of course, the emerging approaches to therapy. As students, we should be open to new ideas. See what you think about the YouTube ‘bob newhart stop it’ clip – how to ‘do’ therapy in less than five minutes.

So my thanks to all those who have embraced the Berners-Lee spirit and have shared their ideas freely with the world. Check out Dolores E Brien’s article ‘Archetypes of the Internet’ (see www.voidspace.org.uk/psychology/archetypes_internet.shtml): ‘On the Internet new myths are being formed, hitherto ignored archetypes are coming into their own, and new adventures for the psyche await us.’

In training

Mel Perry

“‘This is for everyone,’ Tim Berners-Lee tweeted on the stage at the opening ceremony of last summer’s Olympics. One of my heroes, he’s widely acknowledged as the inventor of the worldwide web and he gave it to us for nothing. Nearly 25 years later we can access the ‘hive mind’ and freely share our ideas, thoughts and feelings. Whether you’re in a Bolivian internet cafe, in Australia or in desperate need, someone, somewhere will have a voice and a view, however minority or niche the topic. Our profession is no different. Whether you’re in a Bolivian internet cafe, in Australia or in desperate need, someone, somewhere will have a voice and a view, however minority or niche the topic. Our profession is no different.

Like the Freudian iceberg, I am conscious of only some resources, from trusted sites, that have really helped me so far as a trainee. I know that other members will have found some gems so I’ve created a community page on the BACP members’ website, called ‘InTraining resources’, and it would be a Berners-Lee act if readers were to contribute to it.

At the start of my course I had a book list – a good list – but that was it. So I began searching the online resources at my fingertips. The internet, the smartphone and all the software we can access, for free, are incredibly powerful software we can access, for free, are incredibly powerful. Nearly 25 years later we can access the ‘hive mind’ and freely share our ideas, thoughts and feelings.

We all access education in different ways and for the auditory learners among us there are podcasts, downloadable on your computer or for your smartphone/mp3 player. There are many to choose from. One of the best I’ve found is the ACA (American Counselling Association) Podcast series. Aimed at students in particular, it takes you through the basics of many approaches, including Gestalt, Adler and existentialism, explores supervision and visits ethical issues such as confidentiality. The episodes are about 50 minutes long – perfect for a commute, a walk or the gym.

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The researcher

Damn my curiosity

Barry McInnes

The 1988 British film Sliding Doors follows the story of Helen Quilley, a young woman fired from her job in PR. On her journey home, as she is about to catch her tube train, the story splits into two parallel universes. In one, she just catches her train. In the other, the train doors close just before she can board, leaving her on the platform. This split second moment shapes the separate destinies that are explored in the rest of the film.

I sometimes wonder how different my therapeutic journey might have been had I not become involved in measurement. I imagine that, in a parallel universe, I might be arguing, as many in our professions do, that measurement is simplistic, reductionist and antithetical; that the notion of measuring therapy is antithetical to its very nature.

My own ‘sliding doors’ moment came in 1994, when (as previously related in this column) I was appointed Head of Counselling for the Royal College of Nursing (RCN). Had the service been restricted to providing counselling, it’s questionable whether we would have adopted outcome measurement. As fate would have it, the remit of the service included promoting the development of staff counselling services in the wider NHS – an argument that required a credible evidence base to support it. That single fact, probably more than any other, has shaped much of my professional life since.

I have great sympathy for any service required to implement routine outcome measurement. Now services must learn in the course of a year or two what we at the RCN had a luxurious three or four years to absorb. The principles are easy enough, but it’s the planning and execution that are often the downfall of service efforts to incorporate measurement. Why? Mostly it’s because they fail to appreciate the scale of the cultural challenge but it’s also because, having written their policy and procedures, they assume everyone will follow them. We’re therapists, for goodness sake – we subvert rules we don’t like.

I’m no different, and I would be lying if I told you that I bought fully into measurement from the start. I didn’t – that required a particular moment of epiphany.

For the first two years of using the CORE System we and our clients generated our data in paper form. The forms piled up on my desk until they reached paper avalanche risk – usually after six or seven months. They were then sent to the Psychological Therapies Research Centre at Leeds University to be processed. Some weeks would pass, and our data would return in the form of a 25-page summary. Contained within was a vast array of tables summarising our clients’ journeys through the service – from assessment to completion, and how many improved. I soon learned to turn to the back page, read the overall rate of improvement, and set it to one side. By now the data were at least nine months out of date and I may as well have papered the walls with the rest of the report.

‘At a stroke we could explore our data, on our terms, for our clients, in real time and we were the first to know how we were doing’

In 2001 we became an early adopter of CORE-PC. Described as ‘a researcher in a box’, CORE-PC transformed our relationship with our data. At a stroke we brought it in-house. Suddenly we could explore our data, on our terms, for our clients, in real time. Each therapist had access to their own and service level data and we were the first to know how we were doing. We began asking searching questions of our data, and of ourselves.

As a service manager I found this both exhilarating and terrifying; exhilarating because suddenly I had the kind of data at my fingertips that we needed to make our case for NHS staff counselling; terrifying because I realised what I should have known all along – namely that, as therapists, we are not all the same.

Beneath the service level data I was suddenly able to see the individual contributions of each of the therapists on my team – me included.

Before this moment I’d believed that outcomes were the domain of the therapist/supervisor dyad, and pretty sacrosanct at that. Damn my curiosity, because all that changed in a moment, and the face of the person who was really responsible for outcomes in my service was reflecting back to me from my computer screen. I recall feeling slightly sick.

Being a service manager carries that responsibility. I’ve written about the challenges this raises elsewhere,1 Avoid management and avoid outcome measurement if you can; once you have opened Pandora’s Box, there is no ethical way back. ■

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Reference

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Some crusades need to be fought

Anger is a natural response to bereavement – but is it helpful when it’s channelled into a campaign for truth or justice? Catherine Jackson investigates

Illustration by Annabel Wright

Julie Bailey rarely allows herself to relax. If she does, the memories come flooding back, and she really doesn’t want to go there.

‘There’ is the ward in Stafford General Hospital where her mother, Bella, died in 2007 – one of the hundreds of elderly, hapless victims of the failures in standards of care and leadership in the now infamous Mid-Staffordshire NHS Foundation Trust. Julie, a founder member of the patient and family group Cure the NHS, has been campaigning with fellow bereaved relatives for five years to get a full public inquiry into what went wrong at the hospital in the years 2005 to 2008 and why so many patients died before anyone in authority took any action.

‘I haven’t grieved for my mother,’ Julie says, bluntly. ‘I try not to think about her. She comes into my mind and I have to block it and then it comes over me when I least expect it, when I let my guard down. Then I’m back on the ward with mum again. It’s been over five years and I can’t think of a moment when I was happy since she died.’

Jim Swire was propelled into the media and political limelight when a bomb blew Pan Am Flight 103 out of the sky over the Scottish town of Lockerbie on 21 December 1988. His daughter, Flora, was among the 259 passengers and crew who died and Swire, at the time a GP, has spent the past 25 years fighting for the truth about what happened to be revealed by the UK and Scottish governments.

‘I don’t remember much about the initial few days or weeks. I was extricated from the numbness and horror by anger and I have been driven by that anger ever since – anger at the deep incompetence in the establishment, here and in the US, and the realisation that our government hasn’t looked after its citizens and is hell bent on concealing the way the disaster was allowed to happen,’ he says.

Linda Hurcombe’s daughter Caitlin took her own life in 1998. Caitlin wasn’t depressed, Hurcombe says, but had asked her GP to prescribe her an SSRI antidepressant; she’d read about them in a magazine when she was visiting the US (where direct advertising to the public is allowed) and had heard that they helped you lose weight. Hurcombe says the drug’s side effects – emotional numbness combined with a gnawing restlessness – played a part in compelling a young woman with no previous suicidal tendencies to hang herself.

Driven to act
Hurcombe threw herself into the international campaign to force the pharmaceutical industry to come clean about the dangerous side effects of these new, allegedly wonder-drugs, particularly for young people. ‘My prime motivation was to prevent it happening to other people. I didn’t want anyone else to have to feel like I did,’ she says. ‘I knew that nothing would help me, so I decided to carry on in the only way I could, using my skills, which were in campaigning and writing. I knew nothing about SSRIs then but there was a point when it turned from a personal tragedy into an international iniquity and I would say I was galvanised.’ A writer and college lecturer by profession, she wrote Losing a Child, a book for fellow bereaved parents about living with that loss.

Jim Swire says he needed to act; he couldn’t sit with his grief. ‘This was my way of coping and it still is. It’s how I survive and will remain so until the powers that be cough up the truth,’ he says. And in all he does he is guided, he hopes, by a sense of what Flora would have considered right. A medical student, she was about to take up a postgraduate place at Cambridge to finish her studies in neurology. ‘I needed to behave in a way of which Flora would have been proud, to find the truth but also to behave honestly. But it has been difficult to say how much has been justifiable,’ he admits frankly. ‘My wife, Jane, realised early on I was going to have to do this, but that didn’t give me carte blanche to lay about me to the detriment of my family and others.’

‘His way wasn’t my way,’ Jane Swire says. ‘I don’t have that drive. I just tried to keep going for everyone’s sake. I wasn’t anxious to discover the how. I think it was helpful for him, but it wasn’t my way of coping. What has kept me going is, at its most basic, that not to would have been worse, wouldn’t it? We have two surviving children who have a future and we have grandchildren. I just tried to cope and to do the best for the family that we have left.’

Julie Bailey says she was primarily driven by guilt. ‘I feel terribly guilty about what happened. We all do. My guilt is that I let it happen. I feel it happened under my nose and I couldn’t do anything about it. I colluded with the staff. I made friends with them and tried to get favours that way. I feel now I could have put a stop to it and perhaps Mum would have been alive today. If I’d been as strong then as I am now, I might have been able to do something to stop it.’

She says the campaign saved her. ‘It allowed me to focus on something else. I would be in a very bad place if I hadn’t
had the campaign. Something took over me when I lost Mum. I couldn’t sit down. I just kept walking, walking.’ When she tried and failed to get the hospital or any other organisation to do something to help the elderly patients left behind on her mother’s ward, she realised she had to act. ‘I thought, I can be crushed or I can do something myself. It was anger. I had a mission for Mum to uncover what happened. I lost her on 8 November and by 20 December the campaign had been launched and I started to get letters from other people saying the same things had happened to their loved ones and I knew I had to be the strong one for all these other people, to get the truth out.’

Fear of grief
Colin Murray Parkes is a leading figure in the bereavement care world: a consultant psychiatrist, Life President of Cruse Bereavement Care and author of numerous papers on bereavement. This is, he believes, a natural response to untimely death, even if writ large. ‘Bereavement is a time of the most enormous psychological pain we can ever experience. It’s natural to think, “Who did it?” And where the bereavement is culpable, it is understandable that people will seize on that as something they have got to put right.’

As a consultant psychiatrist at the Royal London Hospital, he found himself often called on to help deal with complaints from people who felt their loved one had died due to failures in their care. He describes one client, whose sister had died in the hospital. ‘Her case hadn’t been handled well. Nobody had listened. She received a fair amount of defensive aggression and was made to feel like an unreasonable child. She arrived clutching a letter from the Ombudsman in response to her complaint. She hadn’t been able to open it. We talked about what it might say and she said, “But he might agree with me and that would be the end of the line. There would be nowhere else to go.” And she burst into tears. I think she realised at this point that what she wanted was her sister back. She had been afraid to grieve; she feared that if she started grieving she would lose her sister all over again and her anger helped her to avoid the grief. When she did start to grieve, the anger diminished and she was able to start getting on with her life.

‘That is why anger can be an alternative to grieving: as long as we have a crusade, the person lives on and we are keeping his memory alive by fighting for a cause.’

But that is not to say that fighting for truth and justice is always a pathological response to bereavement, Murray Parkes emphasises. ‘There are some crusades that really need to be fought. There were occasions when a client decided to drop their case and I rather wished they hadn’t. They had drawn attention to a problem that probably ought to be put right and my therapy had reduced their anger so they didn’t go ahead with their complaint. But it was their decision to make, not mine.’

Sue Marshall, a psychotherapist who specialises in bereavement and is a supervisor and trainer for her local branch of Cruse, agrees. ‘Anger is common in bereavement and it can potentially be a healthy response to death,’ she says. ‘If people have a very obvious focus for their anger, that can be quite therapeutic. Anger is quite energising. It gives people a sense of doing something; they can’t bring the person back to life but they can channel their anger into raising money for hospital equipment, say, or campaigning to raise awareness of road danger.’

Channelling anger
June Allan argues that counsellors have to have an eye to the wider, social context of the person’s life; their anger may be a very understandable response to an unbearable and unjust situation.

Linda Hurcombe set up the Caitlin’s Kickstart Award, which funds local young people to go to college and is now in its 12th year. ‘That’s about continuity and community commitment to our youngsters. I am very proud of that, seeing young people go on into higher education and have opportunities they might not otherwise have,’ she says.

Jim Swire believes ‘something “bad can itself be “good” in that it may also become something in which you can invest worthwhile effort that may benefit others. It then becomes a positive “good” which can be dedicated with honour to the memory of the one you’ve lost’.

But the anger may also be about fear, Sue Marshall points out. ‘We find it hard to see ourselves as victims of fate, to accept that things happen to us that are outside our control. If a death is sudden or unexpected, we want an explanation. That is at the heart of bereavement. But if there is no resolution, if you can’t get answers to your questions or your concerns are unresolved, that is when a desire to seek justice may become pathological. And for some it may be a way of holding onto the person: “If I stop I would be letting him go, I would be moving away into a life of which he is not part” – and that may be too terrible to imagine.’
individuals who believe they have experienced grave injustices.’

Damien McNally’s father was murdered in The Troubles in Northern Ireland, when he was just a baby. Very recently he learned that someone was being investigated for the murder. McNally was first a client and then a member of the board of directors of Wave, a charity that offers both counselling and advocacy to people bereaved in The Troubles, across all religions and communities. He grew up in the shadow of his father’s unsolved death and chose to research the experiences of people like him, who were bereaved in childhood and adolescence during the Troubles, for his Masters degree. ‘You can’t deal with this therapeutically, in isolation from its context,’ McNally argues. ‘I went through counselling and I found it very useful but then you have to go out into the world again. It was only when I did my research that I realised that the fact no one had been brought to justice for the deaths was such a big issue with so many people like me. Their questions had never been answered.’

June Allen argues: ‘The organisations and institutions have to be held to account on behalf of the bereaved people affected, so that it’s not just left to the individual bereaved, who is already burdened. They need to be linked up with others with similar concerns and experiences, if they wish, to foster collective action and energy.’

INQUEST is a charity that supports bereaved families through the inquest process when a loved one has died in the custody of the state – in mental hospital, police custody or prison. ‘We see people who have suffered a double traumatisation, by the death and then by the investigation process. A lot of the families are experiencing complicated grief and shock and are wanting answers to their questions,’ says co-director Helen Shaw. And it can be a major problem for families when their legitimate anger about poor treatment or failure of care is mistaken for the anger of grief. ‘Obviously the two are inter-related, but these families have legitimate anger; it isn’t a symptom of their grief.’ Not all counsellors understand this, she says. ‘We need a network of grief counsellors with this experience and expertise, just as we have a network of expert lawyers.’

Simply being with others who have suffered the same loss can of itself be tremendously affirming when all around are people suggesting that maybe you aren’t in your right mind; that it is the grief that is driving your demands for truth and justice; that you should ‘let it go’. ‘There’s no doubt in the world that meeting other bereaved parents made all the difference,’ Linda Hurcombe says. She travelled to the US to meet a group of other parents whose children had taken their own lives after being prescribed SSRIs. ‘You are encouraged to feel that you are a mad, bereaved parent. I hadn’t lost my intelligence and skills, my sense of balance; I’d lost my daughter,’ Hurcombe points out. ‘We met with the other families and that was difficult but the good thing is you don’t have to explain: you know where you all are. You just reach out and give a hug,’ says Jane Swire.

For Julie Bailey, the solidarity of the Cure the NHS group is a huge part of what keeps her going. She too felt that the hospital dismissed her response as that of a grieving relative, not as a serious issue that needed answers: ‘We are a really close-knit group. We have never fallen out. We have just put our heads down and gone for the same thing.’

Moving on?

McNally wants his father’s death investigated and the suspect brought to justice, if possible. But there is a tremendous pressure in Northern Ireland now to ‘move on’, he says. ‘People here are living in two different worlds. There are people like me, my mother, my sister and other family members, still wanting to know what happened, and there’s people who are saying you must forget about the past and move on.’

Linda Hurcombe talks about ‘moving with’, not moving on: ‘My view of life is that you carry with you all the events that have happened to you. I sometimes wonder about people who choose the “letting go and moving on” way of dealing with tragedies; what happens to the experience? Do they remember their dreams? Caitlin comes into my dreams these days and she is in a good place. I feel blessed by that.’

Jim Swire says he has tried several times to step away from his pursuit for truth; it just hasn’t been possible. ‘It finishes when I am satisfied that the establishments of England and Scotland have been reasonably honest about what they know about what really happened and have passed that information to the public.’ Asked if he can imagine a life without his crusade, he says quite simply: ‘We desperately miss her. The one thing above everything else would be a campaign that would result in her miraculously appearing, but that’s not possible and this is the only way I have been able to muddle through.’

Julie Bailey thought her campaign was close to being over, only to be ‘kicked in the stomach’ by the decision by Robert Francis, Chair of the Mid-Staffs inquiry, that no one should be held personally to account for what happened. She says she can’t step away now; she owes it to her mother, herself and to the other bereaved relatives in Cure the NHS. ‘We have all put our grieving on hold to focus on doing what is needed. If I stopped now the grief would just rush in. It will only end when we get accountability and we are certain that other loved ones will not have to suffer like ours did.’

How would Sue Marshall respond to someone who was making this kind of choice? ‘I would ask them what it gives them, what are they hoping for, what would their desired outcome be, is it realistic – and what if you don’t get it?’ she says.
Retirement or renaissance?
With no formal retirement age, how, when and why do counsellors reach the decision to stop practising? By Mary Russell and Val Simanowitz

Illustration by Annabel Wright

Stimulated by an article by Sally Sugg and a colleague in the September 2011 issue of Therapy Today, we decided that we would like to go into more depth about certain aspects of the retirement process, especially as one of us is now facing some of these dilemmas herself.

We were particularly interested in how existential ideas relating to meaning, death, freedom and isolation affected people’s decisions to retire and also how these issues came up in practitioners’ lives post-retirement. We also wondered how practitioners experienced this last transition, whether they saw it as clear cut, and whether they believed they had received sufficient support and encouragement both from other practitioners and from their professional organisations.

We interviewed eight counsellors/psychotherapists aged between 60 and 92, who had either already retired or who had severely cut down their workload. We followed BACP guidelines on confidentiality, giving the participants the right to be anonymous (some chose to do this and others did not) and to erase any personal material before the article appeared in print.

The professions of counselling and psychotherapy have increased exponentially over the last 30 years; BACP membership currently nears some 40,000. At the same time an increasing number of us (over 6,000 in BACP alone) are practising beyond the age of 60 and face some of the dilemmas that confront people in other professions about when, if and how to retire.

This is a period of transition and, because the nature of our profession allows practitioners to continue to work long beyond the current normal retirement age (some even into their 80s and 90s), the change can take place more gently and gradually. Several of the practitioners we spoke to had continued with private practice after working for an organisation in either a counselling or other role. Some also continued to contribute to the profession in various ways after they had ended private client work.

The possibility of continuing work, particularly part-time work, also gives rise to many questions: not least the fitness to practise of such practitioners. We are at the early stages of understanding the many social, cultural and political implications of living and working longer, particularly when work opportunities for both counsellors and their clients are rapidly decreasing.

The responses from interviewees were moving, surprising and very varied. Tensions and polarities between conflicting values were often evident. We can draw no general conclusions but useful themes emerged.


**Existential issues**

There was a particular focus on the influence of existential philosophical concepts, such as meaning/meaninglessness, freedom, isolation and death. There was often a tension between freedom and commitment, between the wish to work and the wish to be available to support friends and family. The subject of death was either embraced or avoided as too painful.

Julia (68, formerly a person-centred practitioner, and trainer, retired at 60) had felt a strong need for freedom and thought that the imminent approach of death had helped focus on what she would do for the rest of her life. Her approach concurred with Heidegger’s view that the only way to live authentically and fully is by understanding every moment as an irreversible step taking us closer to our death. Annette (82, retired at 80) continued to use her counselling skills to support friends and relatives and could now give more practical support. Theresa (64, formerly a counsellor in the NHS) spoke of becoming aware of the fragility of her life after an illness and of being influenced by the resignation of disenchanted others to resign from the health service herself. Eve (70, retired at 65) decided that, at this stage of her life, the choice to have more freedom and flexibility was appropriate. Pauline (92, retired at 90 and a well-known pioneer, supervisor, trainer and writer) wanted ‘more time to be rather than be constrained by a timetable – time to explore what I wanted to do before I died’.

**Loss and leaving work**

Interviewees discussed the loss of the contribution work had made to their lives, and also what they had gained, particularly in their own personal development.

Although in general interviewees were ready to withdraw from the professional therapeutic relationship, several reflected ruefully on the loss of that specific and elusive yet inimitable quality of relationship that pertains to therapeutic work. This quality may be what many of us long for because of its absence in our childhood or in other areas of our lives, or its significance may be linked to an unattainable quest. Nadia (82, an analytic therapist, supervisor and lecturer, retired at 80 after a long preparation period) thought it was, perhaps, ‘a wish to expiate our guilt at not being able to heal our parents’. She had been ‘helping others’ since the age of 12, possibly, she thought, in a reaction to the coldness and repression of her own family culture.

Julia traced her chosen career back to her need for her life to have a purpose and to be there for other people and thence to the fact that she was born deaf and only recovered her hearing at the age of seven. From then on she loved to be with others and had always worked in institutions or groups with people. So the prospect of retirement brought with it fears of losing touch with the world and she mourned the loss of the in-depth therapeutic relationship. It was only since retirement and further therapy that she had been able to allow herself to access that grief at a deeper level.

Annette’s sense of independence and self-worth had been partially linked to work. Pauline missed the support group that had helped her make the decision to retire. However she had felt relief at stopping client work; she no longer felt the need for new challenges. Theresa missed being part of a team and was now concerned about the lack of structure in her day. She worried that, when winter comes, ‘living in woodland on a grey November day can be quite depressing’.

Alison (82, a former writer, who trained in her 50s, despite losing her husband during her training, and then practised, trained and supervised until the age of 80) felt she had less intimacy and less engagement with the world following retirement. She commented poignantly: ‘I no longer feel necessary in the world.’ However she was also enjoying the freedom of ‘just being’.

Nadia was relieved when retirement finally came, after many years of preparation. She wondered if her decision then to embark on a PhD was a way of fending off retirement and having to think about herself, perhaps linked to a lifelong pattern of ‘salvation through good works’. She missed the stimulus of being an academic tutor, but derived at least partial compensation from the contacts she was making through her research. Eve had noted the social assumptions attached to employment status: those who did not work were ‘of less value and possibly less interesting’, she felt.

**The decision to retire**

Interviewees reported a range of events, thoughts and feelings that led them to consider retirement. Some were aware of using concepts from their therapeutic models to inform their decision. Of those using a person-centred approach, Julia’s decision had been influenced by the concept of ‘felt sense’, which was connected to her need for a break and led eventually to her giving up all paid work. Alison too thought that this had helped her clarify her thoughts before her retirement decision. Similarly, psychoanalytic practitioners spoke of the clarification and support they gained from their model. Nadia felt able to trust her own unconscious.

‘Eve’s retirement came from a dislike of what was happening in the NHS and her belief that “internal changes... did not enhance or support an effective service for patient needs”’
For her the idea of retirement emerged gradually, and the idea of doing a PhD also came this way, after 25 years of thinking ‘maybe I’ll write’. Eve referred to the psychoanalytic concepts of boundaries and commitment but also viewed her retirement through a Buddhist lens. Having had psychoanalysis, she felt ‘comfortable in myself and about my decision, especially reflected in the Buddhist idea of the natural cycle of life and death’. Practically, the demands of psychoanalytic therapy to be available to clients up to three times a week did not fit well with a wish for more freedom and other roles, including grandparent.

Life circumstances generally played an important part in the retirement decision. Eve described an ongoing internal process over a period of five years, the seeds of which were germinated by different factors in her life. Her retirement from the NHS came from a dislike of what was happening in the health service and her belief that ‘internal changes, such as increased record keeping, did not support or support an effective service for patient needs’. She was also influenced by her husband’s change of career and the birth of their first grandchild. Theresa began to feel that her own age and those of her clients were beginning to converge: ‘Working in a dementia service where patients were of similar age to myself and suffering the consequences of ill health, anxiety and aging was a component of my decision to retire, alongside the bureaucratic difficulties.’

Belle (64, retired at 60), who was born and brought up in France and whose family were French civil servants, thought her decision to retire was influenced by this culture where it was taken for granted that you retired at 60. She remembered her father telling her that she would probably only be able to do such demanding work for 10 years before she burned out.

**Life after retirement**

Several of the interviewees had reduced their hours of paid work with an organisation or individual client work but continued to contribute to the profession. Eve spent four years as a member of a committee that organised and ran advanced training for experienced psychotherapists. She said she would ideally like to continue to be involved in some kind of work with a social purpose where she could use her skills. Annette (a former actress, who trained late in life) found that she had not wholly taken on the identity of counsellor and that, once retired, her identity as an actress re-emerged more strongly. Pauline continued to offer supervision; she wanted ‘something to get up for’. She also works as an editor and facilitates some workshops. Nadia is in the final year of her doctorate.

**Practical considerations**

None of the group spoke of finance as a primary consideration, although the changes did have some effects, both positive and negative. Annette was pleased to lose the financial obligations of professional body membership, insurance etc and that her counselling room would now be freed up for other purposes. Nadia had been able to move house after she had retired from private practice. Eve felt that, by retiring, she had given up her financial independence but she had been able to rent out the premises she previously used for psychotherapy, to provide some income.

For some interviewees, health considerations (not always their own) played an important part in their decision to retire, and in their life subsequently.

‘Julia... mourned the loss of the in-depth therapeutic relationship. It was only since retirement and further therapy that she had been able to allow herself to access that grief’
clients who were coming to the end of therapy. She had decided to retire as she was worried that her short-term memory was deteriorating. She sometimes struggled to find the appropriate word at the right time and felt this ability was essential in her work so took the decision to retire because she felt it was in the best interests of her clients and supervisees. Nadia, as a psychoanalytic practitioner, started planning her retirement four years in advance, and gave all her clients 18 months’ notice.

Support
Interviewees were asked if they would have welcomed more support from family, friends, and groups or from their professional organisation before and after taking their retirement.

Several would have welcomed more support, and felt that their professional organisation showed little interest in supporting its members through this transition. Julia felt it would have been helpful to have joined a group where she could have talked through the personal, emotional and developmental aspects of retirement. Annette had taken a course called ‘One year to live: facing issues relevant to end of life’, which she had found useful.

Theresa phoned BACP for advice about maintaining her accreditation/payment of subscriptions and found their response confusing. She suggested that professional organisations could offer workshops for people to discuss their hopes, fears and feelings about retirement, and especially issues of competence and health. Nadia had not found it helpful to talk to friends and family about her decision; she felt they tended to have their own agenda. She would have liked a group or workshop to explore the issues of retirement. Nadia and Theresa said that their interview was the first time they had been able to talk about these issues in depth.

Conclusions
Clearly there is a need for further research and thinking in the areas touched on here. A bigger sample, and one that included men, would allow a broader discussion of the issues. At present this research does not, to the best of our knowledge, exist.

In response to our interviewees’ comments, we would like to make the following suggestions as to what BACP could do to support retiring members.

BACP could draw on the skills and experience of its retired members to contribute to its work in an advisory capacity. An information sheet addressing ethical issues and possibilities would be useful. Several practitioners mentioned a wish for a support group; BACP could encourage members to set these up, either locally or online.

Currently BACP does not have specialist provision for members whose retirement is related to age; for example, there is no listing of these members. Information about how an accredited member (of any age) who is no longer practising can maintain their accreditation would be helpful.

Finally, briefer forms of counselling, therapy and coaching may be an option for this age group, both to provide and receive, when the commitment to longer-term work no longer feels appropriate.

Carl Rogers, still a practitioner at the age of 78, reflected on how much he had enjoyed the previous 10 years. He had been able to ‘open myself to new ideas, new feelings, new risks,’ he wrote. ‘Increasingly I discover that being alive involves taking a chance, acting on less than certainty, engaging with life. All this brings change and for me the process of change is life. I realise that if I were stable and steady and static it would be living death.’ We believe that BACP needs to think seriously about what it offers members at this important point of transition to help them ‘engage with life’ so their later years can be a time of renaissance rather than retirement.

All names have been changed to protect interviewees’ identities and all interviewees have given permission to be quoted. Additional interviews were conducted by Sally Sugg.

Mary Russell is an accredited counsellor working integratively in private practice and for an adult education college. Previously she was a student services manager in adult education. She is in her 60s and her interests include the changes that older members of society will continue to lead. Please email bluewater@maryruss.co.uk

Val Simanowitz is a person-centred BACP accredited counsellor and supervisor, now semi-retired and practising part-time. She has previously worked with survivors of domestic violence, young asylum seekers and in a young people’s drop-in centre. She was course director of a BACP accredited diploma in counselling at Lewisham College for 10 years and co-authored Personality Development (Open University Press).

References

‘Nadia wondered if her decision to embark on a PhD was a way of fending off retirement and having to think about herself, perhaps linked to a lifelong pattern of “salvation through good works”’
Talking point
Why men don’t talk

How do we get men into the counselling room? Maybe by going out to meet them on their own ground, says Colin Penning

The British Library, in partnership with the BBC, is engaged in an ambitious long-term project to record ordinary people in intimate conversations. The Listening Project invites two people to talk about meaningful personal matters they may never have properly discussed before. Excerpts from the conversations are broadcast regularly on BBC radio.

In October 2012 a 15-minute compilation was given over entirely to conversations between pairs of men. It was introduced by the presenter with the words: ‘I don’t think you can hear any reticence, emotional handicaps or crippling inability to communicate caused solely by chromosome formation.’

The message was clear: the listener could expect to hear emotional openness and honesty. The underlying implication was equally clear: this will be unusual.

Of course, this remark was made light-heartedly. But the fact that it was made at all tells us plainly what many people think about men’s emotional literacy and ability to articulate their feelings. The question then is, do these assumptions about men reflect a stereotype or a reality? This was the question that Relate and the Men’s Health Forum set out to explore in their new report *Try to See it My Way*.

We know that men are more reluctant than women to seek support and advice when relationships run into difficulties. Far fewer men use telephone advice and helpline services. We also know that men are less likely to access counselling services generally. Men make up just 36 per cent of referrals to the Improving Access to Psychological Therapies (IAPT) programme. They are also under-represented in relationship support services: just 44 per cent of Relate’s clients are men.

So why can’t (or won’t) men seek help for emotional problems? The first and most obvious answer is that men are socialised not to admit to vulnerability, which is a prerequisite of securing help. The second is that maybe we aren’t offering the kind of support that men can relate to and that they find helpful.

The report suggests work is a key factor. Men’s tendency to work longer hours can cause relationship problems and conflicts around the life–work balance; financial difficulties can increase pressure on the man, who is often still the primary breadwinner in the family.

One of the key findings of the report is that men and women have very different approaches to communication. Insights generated by two focus groups of Relate counsellors found that men have a tendency to want to ‘solve problems’ while women want to discuss change and understand why things have happened. So men are coming to counselling with unrealistic expectations.

But the Relate counsellors told us that men may have become more open to the idea of relationship counselling in recent years. And they told us there may be things we can do to reach out to and engage men in taking better care of their own emotional health.

Our report makes a series of recommendations. Some are to national Government around raising men’s awareness of the importance of emotional health and making personal, social and health education a statutory requirement in schools.

But the Department of Health and counselling providers need to be thinking of ways to encourage men to seek help for emotional and relationship issues, whether through the IAPT programme or from voluntary sector or independent providers.

Counselling providers need to explore less formal, more practical and solution-focused approaches to relationship support that may be more acceptable to men, such as relationship coaching. They could take services out of traditional counselling settings and deliver them online and in community settings and workplaces, at times that fit men’s schedules.

They could market their services better, in more male-friendly ways. And they need to recognise the importance of partners, relatives, friends and employers in encouraging men to access relationship support.

And, as data is always important, they should ensure the information they record on uptake, exit and outcomes is broken down by gender. How else can we be sure that what we are offering is reaching men and delivering positive outcomes?

Our report doesn’t provide all the answers because we haven’t got them. It asks a lot of questions and we hope researchers and counsellors will engage with these questions. Enabling men to talk will be a core message in our mental health themed Men’s Health Week in June (you can find out more at www.menshealthforum.org.uk).

Colin Penning is External Affairs Officer at Men’s Health Forum.
The language of healthcare

Rosemary Rizq warns that the language we use to describe and report what we do can begin to dictate how we work with our clients

Illustration by Annabel Wright

I want to start by telling you about a recent experience in an NHS service. This service became an expanded IAPT service some years ago and moved into rather smart new premises. Its staff now enjoy a pleasant reception area, an open-plan office with plenty of desks and telephones and use of a large number of individual clinical rooms.

Each of these rooms is equipped with a whiteboard on the wall, for use by therapists and their clients during sessions. On this particular day, as I walked past a room, I noticed a phrase written on the whiteboard. It said: ‘Dysfunctional thought: my husband is dead.’

I’m not really concerned at this point with the finer points of what appears to be a particularly telling piece of cognitive behavioural therapy. I just want to share with you my response as a human being – which was simply one of baffled incredulity. Is the client’s thought, ‘My husband is dead’, really dysfunctional? As a (presumably) bereaved client, should she really not think about the fact that her husband is dead? Should she not remember her husband, not feel loss, sadness, grief or fury? Should she not remember that this was probably the most significant relationship in her life? Perhaps she shouldn’t be making her therapist feel uncomfortable by grieving? Perhaps she should just get over it: get back to work, become a productive, preferably employed member of society? (Indeed, according to the new DSM-5 criteria, if the grieving spouse has not got rid of her ‘dysfunctional thought’ within two weeks, her doctor will now be able to diagnose a major depressive disorder and treat her with drugs.)

It was at this point that I started to think seriously about the language and terminology that are increasingly deployed in our public services. And the more I thought about it, the clearer it became to me that there is a vocabulary out there, a lexicon created largely by the evidence-based movement (or perhaps the evidence-based regime), that is now essential, if not obligatory, for those working in the health professions.

We’re all familiar with this language. I suspect we’re all using it. Let me give you some typical examples: patient choice and patient wellbeing; competence frameworks; evidence-based interventions; risk assessment, world class commissioning, best practice or positive practice; outcome-led services, payment by results; and even ‘NICE-compliant therapies’.

The problem I have with these by now very familiar terms is that they have been welded together into a discourse that has become the only language available to health professionals and academics working in the public sector. It’s a language that is taken extremely seriously. It’s a language that is required, certainly within academic circles, in order to get papers published, to win promotion and to get grant applications approved. It’s also a language used by managers and commissioners in the NHS to get funding for services. Most of all, it’s a language that is applied to those people who are referred to us for psychological help, to label their problems, prescribe the appropriate ‘interventions’ and define the desired ‘outcomes’. It’s a language that I think we can safely say defines success. Richard Rorty,
‘There is a vocabulary out there, a lexicon created largely by the evidence-based movement, that is now essential for those working in the health professions’

the philosopher, might call it a ‘final vocabulary’. Deleuze might call it the language of ‘royal science’. It’s a language that establishes and reproduces invariant laws; one that polices the legitimacy of knowledge and ensures its disciplinary boundaries are maintained. It’s a language, in short, that defines the basis of its own authority.

This language is irresistibly reminiscent of Orwell’s Newspeak, the ‘official’ language in his dystopian novel 1984: the only language, says Orwell, where the vocabulary is deliberately reduced to improve efficiency and effectiveness, with appalling consequences. ‘Don’t you see the whole aim of Newspeak is to narrow the range of thought? In the end we shall make thoughtcrime literally impossible, because there will be no words in which to express it. Every concept that can ever be needed will be expressed by exactly one word, with its meaning rigidly defined and all its subsidiary meanings rubbed out and forgotten... every year, fewer and fewer words, and the range of consciousness always a little smaller.’

Along with David Holmes and his colleagues, I want to suggest that the evidence-based regime has created a kind of ‘scientific Newspeak’. And this scientific Newspeak, which has, I think, reached an apotheosis in the IAPT programme, is one that also reduces the range of consciousness; one that deliberately and progressively eliminates any reference to feelings or relationships. Indeed, in the example I gave you just now, even remembering the existence of a meaningful relationship seems to be ‘dysfunctional’.

To apply Orwell’s term, it is ‘ungood’ perhaps; thoughtcrime, certainly.

Dispensing with suffering

Let me give you another example of the scientific Newspeak currently being fed to the public. Here is an excerpt from the NHS leaflet called ‘Which talking therapy for depression?’

‘If you have depression or are worried you might have, you need good information to make the right choice about different kinds of help. This booklet tells you about the range of evidence-based talking therapies that are approved by the National Institute for Health and Clinical Excellence (NICE) for treating adults with depression. It aims to give you the information you need, help you ask the right questions and decide which therapy suits you. These therapies have been shown to be at least as effective in treating depression as flu vaccines are in preventing flu, beta-blockers in treating high blood pressure or surgery in removing cataracts – and they can be safer and more effective in the long term than prescribed drugs. So you can choose these therapies with confidence.’

There are lots of things we could say about this piece of scientific Newspeak. The language is unashamedly medical – treating depression is exactly like treating flu; there’s a clear implication that therapy has been proved to be effective – indeed, as effective as surgery for cataracts – and they can be safer and more effective in the long term than prescribed drugs. But what is really interesting – and for me perhaps most disturbing – is the version of care that this language, this discourse, embodies. It not only dispenses with any notion of suffering or vulnerability; it dispenses with any possibility of dependence on the health professional. It dispenses with the idea of relationship by converting suffering into a satisfying consumer activity: ‘You can decide which therapy suits you; you can choose with confidence.’

This disavowal of relationship, this refusal of the patient’s right to dependence on the clinician in favour of a consumer model emphasising choice for all, is now not only embedded within such scientific Newspeak; it is incarnated within a vast managerial and bureaucratic structure aimed at implementing a tightly regulated and highly standardised culture within IAPT services.

This organisational culture reflects new public management principles (the model that currently dominates our public services with its argument that the introduction of market principles will lead to greater cost-efficiency) and is designed to allow an unprecedented level of public and governmental surveillance and regulation. It includes, most controversially, the central requirement for all clinical staff to record multiple clinical outcome measures for each client contact. A wide range of clinical measures – including a psychiatric diagnosis, the centrepiece of evidence-based practice – is collected electronically, each session, via software systems monitored by service managers, and made available to a central IAPT administration, to be used for national and regional reporting purposes. In IAPT, it seems, Big Brother is well and truly watching us.

What does all this bureaucracy, this obsession with numbers, this preoccupation with so-called evidence actually mean? As a clinician – and, let me declare my colours, as a
We are in the business now of enhancing happiness and economic productivity – of creating “docile bodies” as Foucault might say – in a time of deepening austerity.

The perversion of care that I suggest is increasingly evident in some NHS services also involves turning a blind eye to the difficulties, limitations and realities involved in working with mental distress. The colossal IAPT targets (treating 900,000 people a year, with the target of 50 per cent ‘moving to recovery’), for example, disavow the painful reality, particularly in these days of austerity, that secondary care and specialist services have been cut, and that staffing and funding of existing services is severely limited. The overall aim to ‘improve economic productivity’ clearly disavows the fact that there are very few jobs out there for people to return to. The delivery of manualised, protocolised, evidence-based ‘treatments’ disavows our very real uncertainty about what works for a particular patient and what our patients think is important for them. These are all things that we know – and yet we are invited not to know – at one and the same time.

Instead of these uncertainties, instead of opening our eyes to a more realistic awareness of what is involved.

psychoanalytic clinician – it’s very hard not to think of all this bureaucracy, all this checking, auditing, regulating, measuring, assessing, evaluating and governance, as a defence, as warding off something. In fact, this massive emphasis on numbers and targets and so on – far in excess of what any other psychological practitioner has ever had to do – seems to me to bear a remarkable resemblance to the kinds of social defences identified by Isabel Menzies-Lyth, 60 years ago now, in her well-known study of nurses. The study looked at why so many young nurses were leaving one particular hospital. It identified a number of working practices – very strict routines, protocolised interventions, the identification of patients by number rather than by name – that Menzies-Lyth realised helped nurses defend against the enormous emotional difficulties in working with sick, dying and injured patients. But she also found that these same institutional practices so reduced nurses’ emotional investment in and satisfaction from relationships with their patients that they ended up leaving the profession.

I think it is precisely this notion of relationship that the bureaucracy and scientific Newspeak of the IAPT programme attempts to defend against. Rob Hinshelwood reminds us that mental health services are set up to act as containers for the unwanted anxiety of society; that mental health staff are implicitly tasked with ‘anxiety work’ – work that necessarily involves establishing and managing relationships and so presupposes emotional involvement. I think this anxiety work has been very successfully recast – by, among other things, the Government’s happiness agenda – as ‘wellbeing’ work. We are in the business now, as psychotherapists, of enhancing happiness and economic productivity – of creating ‘docile bodies’ as Foucault might say – in a time of deepening austerity.

To know and not to know
I have recently written about the ‘perversion of care’ implicit in this systematic disavowal of the significance of relationship within public sector services. The psychoanalytic view of perversion refers to individuals and organisations who ‘turn a blind eye’ to certain facts, thereby unconsciously misunderstanding or distorting the truth. This of course is Orwell’s own definition of ‘doublespeak’: ‘...to know and to not know, to be conscious of complete truthfulness while telling carefully constructed lies, to hold simultaneously two opinions which cancel out, knowing them to be contradictory and believing in both of them.’

Susan Long has written about the way in which perverse states of mind underpinned the collapse of Enron and other financial institutions during the banking crisis of 2008. There is, I think, in the NHS a perverse privileging of certain kind of evidence, inscribed in a certain kind of language, where attention to targets, outcomes, protocols and policies is consistently privileged over attention to the patient’s need for a confidential psychotherapeutic relationship with an experienced, consistent and thoughtful clinician. We might want to remember that, in Freud’s understanding of perversion, the fetish comes to substitute for what is felt to be a lack (of the phallus or the father). It masks a gap, an absence that cannot be symbolised. I think it’s not too much to say that the current levels of excitement, energy and financial investment generated by the evidence-based movement and incorporated within IAPT – these ‘technologies of representation’ as Michael Power calls them – undoubtedly constitute a fetish: that is, an attractive fabrication that serves to disavow what is felt to be a lack or absence of relating at its heart.

instead of opening our eyes to a more realistic awareness of what is involved
in caring for and managing those in distress, the range of our consciousness has indeed been reduced, as Orwell predicted. We have been sold – and many of us are now being forced to comply with – a very comforting, utopian alternative: a state-sponsored, totalitarian, one-size-fits-all medical model of clinical work that is sanctioned by results (PbR), where receipt of funding will be in part dependent on services being able to demonstrate that patients are achieving statistically measurable levels of change in their clinical scores (and, by implication, those whose scores do not improve will not be paid for and, presumably, will have to be discharged). And, while it is true that models other than CBT have recently been introduced in IAPT, albeit in very small numbers, the premise on which any IAPT-compliant model is based remains exactly the same: manualised, protocolised, standardised, homogenised and, I would say, well and truly compromised.

A compromise too far
I think Orwell’s Newspeak draws attention to the wider way in which hegemonic discourses disseminate throughout society, limit thinking, instil fear, and sponsor what Christopher Bollas calls a ‘fascist state of mind’ in people and in the services in which they work: in other words, a state of mind that maintains ideological conviction by eliminating all opposition. I want to suggest that the scientific Newspeak of the evidence-based movement has clearly become such a fascist discourse today, unable to question the basis of its claim to authority.

Like all totalitarian regimes, there is no clear location of power and no one person or source can be held responsible. The authority of the evidence-based regime is self-evident, incontrovertible; its supporters – in health services and universities up and down the country – are ‘just following orders’. And it’s become very clear to me that the main difficulty we face in public sector services today is the way in which politicians, managers and commissioners – those bureaucrats of desire or the ‘administrators of the unconscious’, as Adam Phillips calls them – have nonetheless already obliged us to participate in scientific Newspeak. They have have already forced us into using certain words, already involved us in a particular language and a particular vocabulary. It’s already infiltrated our minds, our behaviour. We are already compromised.

Indeed, as the new structures of the NHS develop and emerge, including PbR, I think the compromises will be too much for many practitioners. At a meeting of counsellors and psychotherapists in my service recently there was a long and, I think, desperately sad discussion about the likelihood of practitioners feeling compelled to manipulate clinical outcome scores in order to avoid the professional and ethical dilemmas of having to prematurely discharge their patients. ‘Whenever there is fear,’ said William Edwards Deming, the economist responsible for the rise of Japan’s post-war economy, ‘you will get wrong figures’. Or, as Orwell knew, you will get doublethink.

The physicist Michael Polanyi has written: ‘So long as we use a certain language, all questions that we can ask will have to be formulated in it and will thereby confirm the theory of the universe which is implied in the vocabulary and structure of the language.’ My hope is that we can together start to imagine, create, organise and sustain an alternative vision for mental health services: one where the question of what constitutes evidence is rather less important than who or what decides what constitutes evidence; one where the notion of ‘relationship’ is no longer considered ‘thoughtcrime’.

This article is the text of a talk given at a conference on the future of counselling and psychotherapy organised by the Alliance for Counselling and Psychotherapy in December 2012.

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Therapy Today.net
Visit our website (www.therapytoday.net) to read Colin Feltham ‘in conversation’ with Rosemary Rizq.
Despite their shared ethnic and cultural background, Canada and the UK have very different experiences in the evolution of their counselling and psychotherapy professions. The Canadian Counselling and Psychotherapy Association (CCPA) is the national voice of counselling and psychotherapy in Canada. As a non-statutory self-regulating body, it has much in common with BACP, which it regards as its ‘sister organisation’. As sisters, we share multiple resources, meet up with each other at many conferences around the world, and discuss events that potentially have an impact on our members and the people they serve.

Geographically, the two nations could not be more dissimilar. Canada’s vast and diverse terrain spans tundra and permafrost, mountains and plains across some 10 million square kilometres; the UK covers just 240,000 square kilometres. Some 41 British Isles could comfortably fit into Canada’s land mass. Yet, at 61.9 million, the UK’s population is nearly double that of Canada, at 33.9 million. Canada has over 40 times more space and less than half the population of the UK.

Canada is the world’s second largest country. It extends over six time zones. It contains four of the ‘most liveable cities’ in the top 20 of the world, but is still predominantly a place of small towns and villages. The population tends to cluster in the south along the border with the US, and people living here have a very different sense of Canada than those in the north and in remote areas. In the south, major motorways, airports and electronic highways connect people. Elsewhere, many Canadian communities are accessible only by air or by ice road (temporary motorways created by packing snow on frozen lakes and rivers) in the winter.

Like the UK, Canada receives approximately 23,000 asylum seekers per year and its refugee population ranks 18th in the world (the UK ranks 10th). The age distribution of our populations is the same: approximately 17 per cent of our people are under 15, and about 20 per cent are seniors. Our divorce rates, number of hospital beds and access to doctors are almost identical to the UK. Our counsellors work with many clients who face similar developmental and displacement, migration or oppression-related issues.

Canada has always had two official languages: English and French. Many indigenous languages (including those of the Métis, Inuit and First Nations) are also spoken. Like the UK, its major cities are also becoming far more cosmopolitan, due to immigration, which is also changing the language profile. Cluster communities, signage and services reflect specific nationalities, such as Chinese, Korean, Indian, Pakistani, Philippine and Ukrainian.

The Canadian accent sounds more American than British, and Canadians in the south are heavily influenced by US culture through the media and the North American Free Trade Agreement (NAFTA). But Canadians differ substantially from Americans in key respects. Canada is quite distinct in its culture, languages, government structures and educational systems. Canada’s approach to governance is much closer to the UK model, and our preference for a ‘mosaic’ as opposed to ‘melting pot’ approach to social integration is more closely aligned with UK policies. Historically recognised as mediators, Canadians tend to seek out strategies that address the needs of the many without impinging on the needs of the few.

Statutory regulation

While BACP and CCPA share identical objectives for achieving effective standards of practice and education of the profession, our very different national governance structures have led us down strikingly different pathways towards these goals.

The Canadian government system is simultaneously federal and provincial/territorial. Because of our extensive history of diversity, a culture of respect for ‘other’ emerged early in the nation, resulting in a recognition that the people who know their region best are best situated to govern it. Today, the 10 provinces and three territories in Canada are individually responsible for activities related to education and health (including mental health and counselling) within their borders. CCPA has been involved in promoting regulation for the profession at the provincial level since 2003, with funding from the Government of Canada.

Unlike the UK, there is no national statutory register or government-imposed national regulatory standard for education and health-related professions. Statutory regulation of these professions is a provincial/territorial matter, and so varies greatly, depending on where the counsellor lives and works. A nationwide Agreement on Internal Trade (AIT) is intended to assist the recognition of regulated professionals as they move between jurisdictions.

Only three of the 10 provinces have introduced statutory regulation related to counselling/psychotherapy. The province of Quebec has statutory legislation dating back almost 50 years. Most recently, Nova Scotia introduced legislation in 2011 and Ontario is in the final stages of forming a provincial Professional Regulatory College that may begin accepting applications this year. This leaves the majority of provinces and all three territories in Canada without any statutory regulation, although New Brunswick, Prince Edward Island and British Columbia are currently in discussion with their governments on the issue. This situation is likely to remain for quite some time.

Lorna Martin offers a brief overview of the regulatory systems that govern counselling in Canada today, and the unifying role of its professional association

Counselling in Canada
Diversity of the profession
Practitioners in counselling and psychotherapy in Canada use more than 70 different titles, 12 of which are formally recognised in at least one province, and some in more than one. A national survey conducted by CCPA found a clear preference for three: registered psychotherapist, counselling therapist and clinical counsellor.

Most Canadian counsellors and psychotherapists are in paid employment, either working in private practice or in public and private institutions, agencies and organisations. Like the UK, Canadian counsellors are an eclectic group who have often taken multiple and varied pathways to their profession. Unlike the UK, however, there are no levels of certification. Regulated counsellors/psychotherapists in Canada and professionals seeking certification through CCPA must hold a Master's level qualification or competency level.

The role of CCPA
In the absence of national statutory regulation, the profession of counselling has regulated itself through CCPA for more than 45 years. Through its national standard and scope of practice, definition and code of ethics, CCPA provides a certification process that is recognised across the country, together with a formal complaints process and ethics review board. CCPA has also developed an accreditation process for educational institutions offering programmes of study in counselling. Known as the Council on Accreditation of Counsellor Education Programs (CACEP), the process is similar to BACP's process for accrediting courses but with a focus solely on Master's level degree programmes within universities in the Association for Universities and Colleges of Canada (AUCC). CCPA has also taken a lead in providing continuing education for

‘Canada and the UK share a cultural heritage and professional commitment to setting appropriate standards of care and educating the public and employers’
counselling professionals. It supports the development of new generations of counsellors through a student programme, welcomes collaborative projects with like-minded associations and engages in a variety of high profile research and development activities focused on the profession. This role is very similar to the objectives and activities of BACP.

**National dialogue and development**

Between 2006 and 2010, CCPA, with funding from the Government of Canada, assembled a pan-Canadian team to address issues of professional convergence and alignment in counselling and psychotherapy-related titles, definitions and scopes of practice. This resulted in a series of symposia that increased information and resource sharing, informed decision-making and continued collaboration across the country. Outputs include a nationally validated definition and scope of practice for the profession and a national entry-to-practice competency profile.

From 2011 CCPA began intensive work with provincial regulatory colleges to enhance the flow of information and understanding across jurisdictions. Commonly known as the Pathways Project, the focus of the ongoing dialogue is to recognise the uniqueness of each college’s requirements while simultaneously appreciating the similarities and alignments, with the goal ultimately of facilitating the mobility of counsellors across provinces. With a highly mobile society and increasing immigration, it is essential that an understanding is reached between all regulators on employability and protection of the public. These discussions and developments support the intergovernmental AIT.

CCPA is also in the final stages of developing a national standard entry-to-practice assessment in both official languages. With the assistance of the Government of Canada’s Foreign Credential Program, this online, simulation-based assessment is taken at secure test centres under the supervision of accredited proctors. It also includes a self-assessment component that can be taken at home or in the office. The purpose of this tool is to provide an assessment to Canadian, foreign or alternatively trained practitioners that is recognised nationally so they can demonstrate to the public and employers that they have met the national standard in Canada. The assessment will be offered to Canadian regulators for their use as part of their registration processes within their colleges.

CCPA has established an extensive national dialogue network to promote understanding of the role of professional counsellors and psychotherapists in the continuum of healthcare and increase our influence on the decisions of public policy makers, researchers, and employers. As the national voice of counselling in Canada, CCPA is committed to extensive outreach globally, both formally through international conferences and informally through ongoing dialogue and collaborative ventures.

Different though our countries are, Canada and the UK share a cultural heritage and professional commitment to setting appropriate standards of care and educating the public and employers about the value our profession brings to the health and welfare of our peoples. And while Canada may be equal in size to continental Europe and have a population less than three times that of the city of London, we share identical patterns of immigration and demographic diversity.

Across all of Canada, whether one lives in the northern land of the midnight sun or the northern temperate zone in the south, professional counsellors assist people with mental health concerns ranging from ADHD and learning disabilities to marriage counselling, from eating disorders to stress, and from depression and anger to grief and infertility. Weight management and body image, addiction, Aboriginal issues, family counselling, career development and management are just some of the concerns that clients bring to our professionals. None of these concerns are geographically dependent.

But perhaps the most striking similarity between the UK and Canada is the role of our professional associations. Both BACP and CCPA strive to provide educational opportunities, research, resources and certification of members wherever they may reside in our countries. Both associations have dedicated staff committed to quality assurance and anticipating the needs of our members and the people they serve. Counselling and psychotherapy are noble professions, focused on bettering the lives of others. BACP and CCPA have focused themselves on bettering the professional lives of our members.

Lorna Martin is the 2011–2013 President of the Canadian Counselling and Psychotherapy Association. Formerly a provincial government consultant, she has extensive experience in curriculum and assessment development, publications, public speaking and counselling. Her doctorate in education follows studies in educational psychology and counselling. She is a Canadian Certified Counsellor and a contributing editor of the forthcoming Canadian Counselling and Psychotherapy Experience: Ethics-based Issues and Cases.

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3. The proceedings of the annual National Symposium on Inter-Provincial/Territorial Mobility within the Counselling Profession are published in a series of ‘As Was Said’ reports, available from the CCPA website at www.ccpa-accp.ca

‘A culture of respect for “other” emerged early in the nation, resulting in a recognition that the people who know their region best are best situated to govern it’
Photographs in therapy

For some time now I’ve noticed a trend among my clients of bringing personal photographs to sessions, without any prompting or suggestion. These have struck me as natural, organic actions, offering potential for self-exploration and healing, and have prompted me to conduct personal research on the topic. Personally, I feel more connected with clients after one of these sessions. Looking at photographs together is an intimate experience that amplifies and enhances qualities in our relationship and often deepens trust and rapport.

Perhaps due to their accessibility and social ubiquity, photographs seem to offer a way for clients to develop relationship, both with themselves and with me. Roland Barthes write: ‘A photograph is always invisible, it is not it that we see’. I think this hints at the unknown, the seen and the unseen. Visual dichotomy between the known and the unknown, the seen and the unseen. A photograph’s imagery represents a photograph’s power to activate inner places, things), yet is also symbolic of unconscious material hovering on the threshold of consciousness. I find photographs to sessions, without any prompting or suggestion. These have struck me as natural, organic actions, offering potential for self-exploration and healing, and have prompted me to conduct personal research on the topic.

Historically, the use of photographs in therapy was developed by health professionals in North America in the 1970s, and eventually the term ‘phototherapy’ was coined. Phototherapy is not a psychotherapeutic modality; rather, it is a series of techniques that any therapist can use where the photograph is a tool and efficacy of the intervention is reliant on the skills of the practitioner.

Linda Berman and Judy Weiser have helpfully detailed some specific techniques of phototherapy. The underlying principle is that the use of visual imagery such as a photograph helps bypass cognitive filters such as rationalisation, verbalisation and other protective defences and thereby gives easier access to the unconscious. The process helps clients recognise and articulate feelings, tap into creativity, and become more self-aware. It also provides opportunities to work through and explore transference, resistance and conflicts.

A photograph encourages the client to enter into a mindful, perceptive state where they become conscious of what is occurring through their senses, moment by moment. From my own experience of client work, it’s not specific technique that matters so much as the client’s ability to attain a perceptive state when engaging with a photograph. A perceptive state means that experience is anchored in the mind, in the body and in the present moment. This state resonates with Siegel’s description of mindful awareness as a kind of ‘intrapersonal attunement’ that promotes self-love, openness, and acceptance. To relate to a photograph with perception bridges the gap between past and present and initiates transformative experience through a meeting of body, heart and mind in the ‘now’.

A mindful, perceptive state is made easier with a photograph because of the visual dichotomy between the known and the unknown, the seen and the unseen. It is as if the photograph becomes both a magnet and visual springboard, offering access to one’s inner world. A photograph’s imagery represents conscious signifiers in life (people, places, things), yet is also symbolic of unconscious material hovering on the threshold of consciousness. I find clients are often drawn to a particular photograph without knowing why, only to discover its significance and meaning when the time is right, at their own pace. If the photograph carries an attraction or emotional charge for someone, it must have deeper personal meaning. Even if the meaning is initially unknown, the photograph acts as a catalyst that helps it emerge.

Photograph as catalyst

I have experienced firsthand how a photograph acts as a catalyst in a session, particularly in the contexts of grief and loss. A client’s girlfriend had died of a drug overdose nine months earlier. He had found her body, and was plagued by distressing images and intrusive thoughts that her overdose may not have been accidental. Several months into therapy he brought in photos of her taken over a 10-year period. Looking at the earlier photographs he described the ‘light’ in her eyes that first attracted him, and how this light had dimmed through addiction. The last photograph was taken a few weeks before she died. He now described the illness he saw in the picture, how he could barely recognise the woman he loved.

This triggered a series of repressed memories of the day he found her body and initiated a catharsis of horror, terror and shock. The recalling of submerged details and feelings produced a physiological re-experiencing and release (shaking, sweating, elevated heart rate), as well as a psychological one (the terror and shock). He reported that, following this experience, the intrusive images and thoughts ceased.

The photograph can be a powerful therapeutic tool that can open a window directly onto the unconscious and deepen trust and rapport, writes Laura Prins.
A colleague who frequently works with bereavement encourages clients to bring photographs of the deceased to sessions. He describes how one client carefully places a photograph in sight between them during each session, and how another puts a photograph in a chair and dialogues with the deceased. Using photographs in this way honours the dead and allows space for grief, communication and remembrance. If we see photographs as attempts to capture the permanence in an impermanent situation, we gain a deeper understanding of their potential role in addressing grief and loss.

**Transitional object**

This notion reflects Susan Sontag’s interpretation of photographs as *memento mori* – objects that invite participation in the mortality and vulnerability of a person or thing. The western world tends to either ignore death or hurry it along when it occurs; we prefer the grieving process to remain secret and out of sight. Bodies are quickly removed and burial or cremation occurs soon after; there is little time to process the loss. Photographs may be all that is left to honour and remember the deceased.

I think the photograph has a very important role as a transitional object that provides psychological comfort and supports development of the self; for example, during the grieving process. Another client, a man going through a messy and painful divorce, thought often of suicide. He used a photograph of his wallet, it functioned as talisman for them in times of distress. Kept in his wallet, it functioned as talisman for strength and became emblematic of his growing sense of purpose to protect and care for his children. In our therapeutic work we used this photograph as a resource to strengthen his sense of self and reinforce qualities such as courage and compassion.

Bollas writes about the phenomenon of ‘transformational objects’ – the searching for objects identified with a metamorphosis of self. He believes the infant has knowledge of mother as transformational experience, not just as object. Thus, a transformational object differs from the transitional object in that the object becomes ‘known’ as a recurrent state of being rather than as a direct representation of something else. I think a photograph has the potential to operate as both: as a direct representation of something or someone, and also as symbol of a person’s urge for self-transformation. A photograph brought to therapy may represent the client’s desire for transformation and metamorphosis; exploration of the photograph in therapy becomes a way of connecting with and realising that drive.

**Sight and seeing**

When working with photographs, it seems important to remember the distinction between sight and perception, or seeing and *seeing*. Sight is a sensory faculty; perception is the application of conscious awareness to sensory faculties. Therefore, sight is but a dimension of perception. Photographer Dorothea Lange touched on this difference: ‘This benefit of seeing... can come only if you pause a while, extricate yourself from the maddening mob of quick impressions ceaselessly battering us all our lives, and look thoughtfully at a quiet image... the viewer must be willing to pause, to look again, to meditate.’

Here Lange provides instruction on perception: look thoughtfully, pause, look again, meditate. In contemplating her statement, it seems she is describing ‘respect’, a word originating from the Latin *re*-meaning ‘back’ (as in repeat) and *specere*, meaning ‘to look’ (as in spectator). Taken together, these root words mean ‘to look again’, or ‘to notice with attention’. Lange’s statement subtly equates the act of perception with respect. Working therapeutically with a photograph can therefore be understood as an act of self-respect, where one gives attention and focus to one’s inner world through (self)-consciousness and (self)-reflection. The use of a photograph acts as a catalyst to this self-perception, or self-respect. In this case, seeing is not believing; perceiving is believing.

Another of my clients, divorced for over 15 years, found herself having to care full-time for her dying ex-husband, and struggled under the weight and pressure of this task. She came to therapy seeking emotional support for her exhaustion and pain. Early on she brought in her wedding photos, taken in Sri Lanka over 40 years ago, and abruptly threw them across the table in front of us. I watched them skid across the surface and land in a heap on the floor. I picked one up. In the picture she was dressed in her wedding sari, 19 years old, stunningly beautiful, fresh. I handed her the photograph. ‘What do you see?’ I asked. At first she wouldn’t look at the photo but when she finally did, the atmosphere in the room changed.

‘Perhaps due to their accessibility and social ubiquity, photographs seem to offer a way for clients to develop relationship’
‘Sadness. Devastation. I knew it then,’ she said. ‘On my wedding day I knew this marriage would be painful, and I see that in the photograph.’

This moment opened a window of understanding onto her dismissal of self and the underlying pain she carried. A door also opened relationally between us, allowing us to broach a lifelong theme of rejection and abandonment, of never feeling loved. If we consider working therapeutically with a photograph to be an act of self-respect, the importance of this intervention for some clients is clear. My client had resisted giving attention to her inner world, understandably, to avoid facing grief and pain originating in the past. Despite her initial desire to push herself and the feelings aside, the photograph challenged her resistance. It acted as catalyst in breaking down this barrier and creating space for perception, or self-respect.

Lost and regained

I’ve found that a photograph’s influence in therapy extends to finding and retrieving ‘lost’ aspects of self. Perceptive connection with a photograph often culminates in a deep recognition that helps a client consciously re-inhabit that aspect of their self and reclaim and re-integrate it back into their personality. One client who was working through a difficult childhood brought in numerous photographs of himself and his family for us to look through together. I found one picture of him taken at age four particularly arresting, but kept this to myself. Surprisingly, when I asked which photograph attracted him most, he chose that picture. His face in the photo held an angelic innocence and purity of expression that resonated with both of us. Spending time with this photograph initiated a grieving process that ultimately led to reunion with and reclamation of his four-year-old self.

As a therapist, my role is that of guide and witness. I provide a safe space to explore and encourage a mindful, perceptive state. I am also a vessel and receptor for transference. Because a photograph encourages access to the unconscious, there seems to be greater potential for the activation of transference and re-enactment situations, for amplified relationship. I don’t care to remember the time I was caught unawares by a client’s powerful transference. My response was clumsy and I realised I had responded to his photograph exactly as his mother. I saw that in the photograph. ‘The most fundamental harm we can do to ourselves, is to remain ignorant by not having the courage and the respect to look at ourselves honestly and gently.”

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References

‘A photograph helps bypass cognitive filters such as rationalisation, verbalisation and other protective defences’
Dilemmas

‘I killed a lot of people’

This month’s dilemma

Robert is an experienced counsellor in private practice. A new client, Antonia, comes to see him. She comes from a country which, 10 years ago, experienced violent upheavals, but the issues she brings have to do with problems in her marriage. Her husband is a drinker and serial adulterer.

At the end of her fourth session Antonia mentions, almost in passing, that she was involved in the fighting in her country and that she was captured and tortured. She adds: ‘I did well in the war; I killed a lot of people, so it’s OK.’

After Antonia has left, Robert finds himself reeling, to the point where he can barely think straight. It is clear to Robert that Antonia’s war experiences cannot be swept to one side and that he will find it well nigh impossible to work with her. Above all, Robert recognises that he is completely out of his depth, and does not want to see Antonia again. What should Robert do?

The views expressed in these responses are not necessarily those of BACP.

Julia Segal

Counsellor

It is difficult to know whether Robert’s reaction is no more than an immediate panic that will subside as he considers the situation, or whether he has some good reason for being unable to work with his client. Is his panic simply an immediate countertransference reaction: an expression of an anxiety that the client may be hiding – that, once a war is over, admitting to killing people makes you a pariah?

This is a dilemma faced by many traumatised clients and returnees from any war; they cannot talk about what they have seen or done, except to each other – if then. Robert’s reaction may be a perfectly normal initial horror at the thought of killing, in a time of peace.

Clients often present us with situations that we find horrifying in one way or another. Antonia took four weeks before she told Robert. Perhaps by doing it in this way she was testing the water: testing whether Robert can bear to stay with her and hear her talk about it, whether he will simply dismiss it as of no consequence, or whether he will say that she is now beyond the pale. Perhaps she knows, in some sense, that his first reaction would be horror – which is why she waited until the relationship was established before disclosing. Robert’s reaction in this sense is helpful; he may be feeling both Antonia’s own reaction, 10 years on, to her behaviour in the heat of war, and also the feelings that other people around her experience when they find out.

Personally I would want to explore with Antonia, at a pace she chooses, her experience and her feelings about it. She has already spoken volumes through the timing and delivery. Robert, as her counsellor, has an opportunity, and perhaps a responsibility, to offer to help her to bear her knowledge of her experience and what it did to her.

This will not be pleasant: torture leaves long-term scars and the feelings that have not been processed can be evoked in the therapist. Antonia has perhaps told Robert because she senses he could help her to find a better way of dealing with the aftermath of her war than by living with a serial adulterer and alcoholic.

Counsellors are not asked to judge or condone, but to understand. I would expect an experienced counsellor such as Robert to be able to set about trying to understand both his own and Antonia’s experience. I would also expect him to be careful; he is probably reluctant to re-evoke Antonia’s experiences, which is right. He needs to let her determine the pace, as she has done up to now.

Understanding Robert’s feeling that he cannot work with Antonia is essential. This needs to be explored with his supervisor, and possibly in his own therapy. Because there is already an agreement to continue, and they have worked together for four weeks, he cannot simply stop seeing her. He has to understand both his own reaction and (as much as he can) what Antonia is doing and saying.

Tim Branson

NHS psychological therapist, specialist counsellor and BACP senior accredited clinical supervisor

As Robert is an experienced counsellor in private practice, I am a little surprised that Antonia’s revelation has thrown him so much. Surely her evolving presentation is typical of many clients who have suffered various traumas?

How many of our clients sit down in the first session and treat us to a full, insightful resumé of the myriad facets of their presenting issues?

We know that Antonia comes from a country where there were ‘violent upheavals’. She has stated concerns about her relationship with an abusive man. She served in the {perhaps para-} military, and has killed. She endured further complex trauma in her capture and (undefined) torture. Her way of making sense of the situation seems to be by justifying her violent behaviour as ‘OK’ (in terms of her beliefs about her role as a fighter).

Robert is considering how he might ‘sweep aside’ part of his client’s presentation, hence giving more value to some other part of what she has already brought to the sessions. Robert has perhaps had a violent countertransference in not wanting to see Antonia again.

Just as important as ‘appreciating the variety
of human experience and culture, we find the BACP Ethical Framework requires of the counsellor that [Robert] ‘effectively deploys the skills and knowledge needed to do what is required for his client’. Indeed, BACP declares that ‘all clients are entitled to good standards of practice and care’, and demands ‘competently delivered services’ from practitioners who constantly reflect on ‘the limitations of their training and experience’.

If Robert feels out of his depth, then clearly that is a matter for him to discuss in supervision, where it may be resolved. Perhaps some focused work might help him consider his violent reaction in terms of projected identification, or reframe his view of the client’s needs, so enabling him to be more reflexive about how to hold her. But perhaps the ethical dilemma here is whether or not he is operating beyond his competency. If so, then would he be acting ethically to appropriately refer her to another therapist more able to help with her clearly potentially complex needs?

The question is then how he should handle any transition. Handled clumsily, Antonia might conclude that her issues are too extreme for anyone to help with or that she is too damaged to have even a counsellor sit with her – potentially wrecking any hope of effective therapy.

If Robert is uncomfortable working with this client then all credit to him for bravely acting in her best interest – and his last service to her might be a thoughtful referral, and a healthy ending and handover.

Fauzia Gaba
BACP accredited counsellor/psychotherapist in private practice and clinical assessor

Clients arrive in counselling armed with an array of presenting problems. In this case the primary issue is the client’s need to address her feelings around her husband’s alcoholism and his serial adultery.

Antonia’s revelations that she was not only taken prisoner during the war and tortured but was herself involved in killing many people is material of a highly sensitive and complicated nature and appears to have deeply burdened Robert and left him in a state of anxiety.

Having carried out a personal assessment on his client, he would already be aware that she comes from a country ravaged by violent upheavals. I am perplexed as to why Antonia’s revelation seems to have shocked him to the extent that he feels he cannot work with it. Her disclosure may be regarded as a secondary issue but the fact that it has been voiced quite early on is indicative of how long she has repressed the enormity of her difficulty in this area and that she has been holding onto it until she is able to find someone she can finally trust.

War pushes the human spirit to the limit and, while we do not know the details or circumstances of Antonia’s involvement, it is possible that she has experienced feelings of extreme loss, pain, isolation, aggression, guilt, shame, hopelessness, humiliation and helplessness, to name a few. Her husband’s behaviour could have unconsciously evoked flashbacks of her torture. She may be a victim or survivor of abuse.

If Robert severs the alliance at this point, it will have negative implications in that he may project onto his client the idea of the ‘persecutor’ and the absent, abandoning parent. There might be a re-enactment of the war experience for the client rather than the healing experience for which she probably longs. The client is damaged and possibly to survive her losses she has shut down emotionally. She may be caught between rage and rigidity and this might also be her first experience of sharing her disclosure.

Inherent in this dilemma are the counsellor’s own prejudices toward his client’s actions. However, he has to step back and look at her role in the war within a context. We do not know if she was coerced to take life, if it was self-defence or if she found herself caught up in a collective group fervour to seek compensation for the deaths of people she has lost herself.

Robert should immediately seek guidance from his supervisor, where he can explore the gravity of his feelings. If he still feels inadequate and adamant that he can’t work with Antonia, he should refer her on to a counsellor who can deal with this client competently.

‘Handled clumsily, Antonia might conclude that her issues are too extreme to have even a counsellor sit with her’

Next month’s dilemma
Carole has been seeing Bianca, a woman in her mid-40s, over the last few weeks. Bianca wanted to discuss issues around the break-up of her last relationship, which had lasted five years but ended around a year ago. Bianca prides herself on speaking her mind, which often involves being highly critical of people in and out of her life.

Carole is increasingly struggling with this, as Bianca tends to be highly critical of many people, and in particular has regularly expressed racist and homophobic views. Carole is herself Jewish and is increasingly uncomfortable with Bianca’s presentation. But, as Bianca is such a new client, Carole is reluctant to challenge her too early in the relationship and is in any case rather afraid of her possible reaction.

What are the issues inherent in this dilemma and what should Carole do?
Email your responses (500 words max) to Heather Dale at hjdale@gmail.com before 28 March. Readers are welcome to send in their dilemmas to be considered for publication, although these will not be answered personally.
A voice for counselling

Colin Feltham interviews John McLeod, academic, researcher, counsellor and recently retired Emeritus Professor at the University of Abertay, Dundee

Colin: You’re one of the most prominent academics in counselling in the UK, with an extensive involvement in the field. Can you remind us how you came to be attracted to the person-centred approach and how you got into counselling practice?
John: As with many in the world of counselling, my interest emerged from needing to deal with my own problems. Although I had a stable and loving family, as an adolescent and young adult I had many self-doubts and difficulties in forming close relationships. Some of these difficulties probably arose from being exposed to different ‘worlds’, and not feeling I belonged in any of them. I lived in India until I was six, because of my father’s job, and then attended a school in Dundee, where I had little sense of what the rules were. Later, I was the first member of my extended family to attend university. Quite a lot of what troubled me was probably also about growing up in the 50s and 60s, a time of massive cultural change.

Almost immediately on arriving at Edinburgh University in 1969, I began trying different therapeutic and spiritual approaches, and I also read my way through Jung, Freud and others. I shifted from a maths degree to psychology. I did a PhD on people who took part in meditation courses and person-centred encounter groups, using qualitative methods to collect data on their experiences. I got a research job at Oxford University, then a lecturing job at Wolverhampton Polytechnic.

During this time I continued, off and on, as a client in different forms of therapy. About 10 years after my PhD, I began to think I could offer something back by becoming a counsellor. This had to be person-centred training because, first, I had got to know Dave Mearns, Brian Thorne and Elke Lambers during my PhD, and second, it was the only therapy approach consistent with my political and social values. I don’t see myself as a ‘master therapist’; I don’t possess the emotional receptivity and interpersonal courage that are hallmarks of the best therapists. As a counsellor, I think I’m resourceful, I care about my clients and am committed to doing my best for them.

Colin: I believe you were a ‘natural’ academic psychologist too – is that what led you to become so deeply involved in the development of counselling research?
John: After completing counsellor training, I got a job teaching on the Masters in Counselling programme at Keele University, where students came from a range of disciplinary backgrounds and some were quite hostile to quantitative psychological research. I had to get up to speed quickly – the ideas that I then developed at that time about bridging the gap between research and practice were published in Doing Counselling Research (Sage, first edition 1994). I then became involved in organising research events and supervising large numbers of Masters and PhD studies.

Colin: My impression is that, in spite of the push to get more counsellors to be research savvy and to raise the research profile of the humanistic and psychodynamic therapies, this remains problematics.
John: Several factors are pertinent here. There is a significant amount of research into humanistic/experiential and psychodynamic therapies. The new edition of the Handbook of Psychotherapy and Behavior Change, edited by Michael Lambert and due out very soon, includes major reviews of research in these areas. From my perspective, what’s missing is research on counselling. Counselling, by my definition, is a flexible, front-line, community-based form of therapy that is grounded in the formation of a helping relationship rather than on a specific model. Thus understood, counselling is hard to investigate, and to get funding to investigate. Nevertheless, I am confident it’s possible to develop a research tradition consistent with the values and practices of counselling.

A major problem here is that counselling training has often been based in further education colleges or independent institutes that have no need to promote research, or in income-generating university programmes where staff are required to devote their time to teaching. Also, few university counselling programmes employ enough staff to enable a vibrant research environment to develop. This is unfortunately getting worse as leading university centres of counselling research, in Durham, Bristol, Roehampton and elsewhere, are closing or being scaled back.

A further key factor has been that counselling training has tended to be organised around ‘schools’ of therapy. It may have been necessary in the early years to build training and practice around the ideas and methods of key founding figures, but those days are long gone. I suggest that authentic research, where the researcher follows the knowledge trail wherever it goes, produces evidence for the interconnectedness and value of all therapy approaches. It would be better
to forget about studies comparing the effectiveness of different approaches and channel our efforts into using research tools to do better by clients.

Resistance to research is a perfectly reasonable response to the failure to publish research that really makes a difference. I haven’t seen any evidence that therapy carried out today is more effective than therapy carried out in the 1960s. For instance, survival rates for certain cancers or for heart disease are much better now than in the past. This kind of evidence isn’t forthcoming in counselling and psychotherapy. Statistics on the prevalence of anxiety and depression don’t present a picture of a population that year on year is becoming psychologically better adjusted.

Colin: You’ve researched client experiences and views quite a bit – how far can the findings alter counselling practice itself?

John: I’d rather say that practitioners can use research knowledge as a resource that can help them alter their practice. There has been a lot of research into what clients find helpful and unhelpful and what they would prefer to happen or not happen in therapy. This research has found that there are many different kinds of helpful change processes and therapeutic experience. Therapists who focus only on a limited set of change processes will find that what they are offering is ideal for some clients and almost completely irrelevant and unhelpful for others. Good therapists are willing to adapt their skills and knowledge to what works for each individual client.

A related, narrower research area consists of work by Michael Lambert, Scott Miller, Rolf Sundet and their colleagues on the use of brief client feedback questionnaires in therapy. Such instruments produce important information on the process and outcome of therapy for both client and therapist. They can be regarded as ‘conversational tools’, allowing therapist and client to reflect on their work together. There is evidence that thoughtful and appropriate use of these methods leads to better outcomes. On the whole, clients believe the feedback procedures are helpful.

Colin: In addition to your books Counselling Skills (now in its second edition) and An Introduction to Counselling (a fifth edition will be published in August), you’ve written a lot on research methods, narrative therapy and pluralistic therapy. Do you see these as all linking or are you pulled in different directions?

John: One of the enjoyable aspects of adopting a pluralistic stance is that it encourages ‘either/or’ statements and questions to be reframed as ‘both/and’. All these interests are linked in my personal quest to understand things I find important. But they’ve also pulled me in different directions. It’s been stressful to keep on top of the ever-expanding research and theoretical literature: something most people in academic jobs find hard.

Pluralism represents an underlying theme in all my work. Being an author of textbooks for more than 20 years and needing to produce new editions every few years constantly re-acquaints me with the richness of the counselling literature.

Another key theme has been the significance of culture, society and history. Counsellors and psychotherapists are really only appropriating, adapting and re-cycling ideas and practices that already exist within our culture. What we describe as theories of therapy are cultural discourses that permeate the way we talk and think. What we regard as valid or invalid methods of research and inquiry are similarly socially constructed.

Colin: What major progress have you seen since the early days and what do you think are the key challenges ahead for the profession?

John: I think counselling is in crisis because of funding cuts and the pressure to conform to standards of evidence-based practice that aren’t appropriate to our work. Counselling is a flexible, front-line, non-stigmatising service, operated by practitioners who are largely selected on the basis of life experience and their ability to relate to others. The public like and trust counselling and most counselling agencies have long waiting lists. But there are too many unpaid and under-employed counsellors. I worry that the identity of ‘counsellor’, as a distinct professional role, is under threat. There are many who see counselling training as just a first step towards what they regard as the higher status roles of psychotherapists or psychologists. The counselling profession seems fragmented and lacking a voice. Counselling agencies are closing. These factors constitute a strong argument that counselling needs to build an evidence base consistent with its distinctive values, practices and mission.

Colin: I wonder what impact you consider cultural changes have had on counselling since its heyday in the 1970s?

John: In the 1970s a lot of what was happening was creative, experimental and slightly mad. No profession, career structure or ethical codes existed. Inevitably, organisations or social movements become routinised. This has happened to counselling and has partly been for the good. Present-day counsellors have a more realistic idea of what can be achieved through weekly one-hour conversations. At the same time, I find huge optimism in many students, who have discovered that counselling can make a difference to them and to their clients. But I’m not confident this optimism is being channelled within the profession. In my view, there is not enough entrepreneurial activity going on in the counselling world in the form of social enterprises, collectives and innovative services.

Britain has become more culturally and ethnically diverse but the counselling profession hasn’t kept pace with these developments. Information technology makes it easier for users of counselling to learn about different therapeutic and healing practices, and about what is relevant to them. The counselling profession hasn’t fully grasped the implications of this knowledge explosion.

A range of factors like the banking collapse, climate change, an ageing population and peak oil mean that the amount of taxpayer funding for counselling will gradually diminish. We’ll find ourselves moving away from psychotherapeutic services offered by highly trained specialist therapists and needing to develop some sort of collectivist, community-based ‘barefoot doctor’ service. This could be a worthwhile direction, away from therapy models based on self-contained individualism, and a recovery of mutual aid traditions.

Colin: You recently retired from the University of Abertay. What is your working pattern like now and what plans do you have?

John: I see clients, do some supervision, and run occasional workshops. I have a part-time appointment at the University of Oslo with a research team carrying out extremely interesting work. I remain involved with the counselling programme at Abertay. I write a lot, and am constantly behind deadline on the delivery of books, articles and chapters. I’d like to slow down a bit, but am finding that hard. I tell myself that becoming a grandparent, I hope at some point in the not too distant future, will help me to re-evaluate my priorities.

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How I became a therapist
Lucy Beresford

Lucy Beresford changed career when she realised she was desperate to be made redundant from her job in banking.

In a way, I have always been analysing things. My first love at school was English literature and then I went on to study it at university. I have had a novel and several short stories published and recorded for radio, and I review fiction for a number of national publications. So I have always enjoyed analysing text or character or reading stories.

I remember when I first went into therapy myself, being struck by how stimulating this world of personal analysis was. It was like I was the story now, and I was trying to make sense of myself. I had just discovered that I wasn’t about to be made redundant. The bank I worked for had been taken over by another one and I was hoping to be made redundant. I was, feeling upset because I’d been offered a new job. And the therapist asked, ‘What kind of career is it, where you are hoping to be made redundant?’

That one perceptive sentence made me realise how much I had begun to lean away from financial services and towards psychotherapy and fresh study and new beginnings. This was the new chapter in my story.

It seems to me that this is the most crucial aspect of therapy. We tell ourselves stories to make sense of our lives. Whether it is a story of how we found the perfect cake recipe or had a run-in with a traffic warden, whether it is a tale of a personality clash at work or an ongoing feud in the family, we weave anecdotes and scenes together to make sense of what has happened, or is happening, to tell someone else, or ourselves.

Some people are very good at telling stories. They can tell wickedly funny jokes at parties or they have wonderful imaginations. We are not all born with the same skills and yet we all of us have something to say and we all of us hope in some way to be heard. And again, not all of us can find someone to listen to us or, more importantly, to listen to us without prejudice or without letting their own agenda get in the way.

This for me is what a therapist provides. We listen. We are there. So active listening is a really important part of the therapeutic process. I had one clinical supervisor who would ask the class why we assumed that our patients or clients told us the truth. ‘It doesn’t matter,’ he would say, ‘What matters is that they tell us something.’

I think this is right. What matters is that, by coming to therapy or not coming, or coming on the wrong day, by paying or by ‘forgetting’ to pay, by screaming, crying or remaining silent, our patients or clients are telling us something of their world, something they might not be able to articulate.

One satisfying aspect of being a therapist is doing ourselves out of a job. It is that incredible moment, after perhaps many months or years with a client, where the two of us discuss the possibility of an ending. This powerful moment can carry with it – if the timing feels right – a sense for therapists that this is why we do what we do. So that our clients can feel ready to think about going out into the big wide world on their own. For some clients, it can feel like a no-brainer, an appropriate next step. For others it is more scary, but always there is the prospect of change and renewal.

I have so many heroes from the world of people who write about therapy but I am drawn most to those whose case studies could have been written by the best fiction writers (which, given issues of confidentiality, they in some way are...). So, whether it is pretty much all of Freud or Yalom in Demystifying Therapy, or Oliver Sachs in The Man Who Mistook His Wife For a Hat, or RD Laing in Sanity, Madness and the Family, I feel I delve into my patients lives as if they were a new book waiting to be read.

‘Whether it is a tale of a personality clash at work or an ongoing feud in the family, we weave anecdotes and scenes together to make sense of what has happened’

Perpetual beginners

A heartfelt thank you to Paul Gordon for his beautifully written eulogy of Merleau-Ponty (‘A philosophy of wonder’, Therapy Today, February 2013). He was ‘the best of all phenomenologists’, according to Paul Ricoeur, in spite of being strangely ignored by the generation of great minds that followed, from Foucault to Derrida.

In spite of the fact, it must be added, that his work does not figure prominently in the curricula of contemporary existential/phenomenological psychotherapy and counselling. This might have to do with the fact that Merleau-Ponty presents a view of human existence as essentially dialectical and ambiguous, not reducible to a definitive meaning, hence not so easily packaged into a neat formula.

Gordon mentions four key areas where Merleau-Ponty’s contribution is vital to therapists. I would like to suggest a couple more.

First, as a critical admirer of Freud, Merleau-Ponty understood the creative side of the unconscious, something that psychoanalysis (and psychodynamic counselling), for complex reasons, decided to ignore but that is being redressed in the work of Christopher Bollas. The recognition of this latent element forever hidden from consciousness in any endeavour (including, Merleau-Ponty adds, his own version of phenomenology) is a humbling reminder at those times when I feel, rather smugly, that I have understood my client’s predicament and the right course of action.

Second, for Merleau-Ponty truth is created by ‘taking the risk of communicating’: ‘communiquer dans le risque’. Truth in therapy does not exist prior to the meeting between client and therapist. It is not revealed, but it emerges from the encounter. Strictly speaking, he says, there is no ‘truth’ but instead a ‘going further’. This is not because he is a relativist, but because he understands the limitations and, as vividly emphasised in Paul Gordon’s article, the situatedness of our condition. Experience being always more vast than our self-construct, we need to approach our work, Merleau-Ponty says, as ‘perpetual beginners’.

Absolute objectivity is an illusion. We keep marvelling at the mystery of the world from a necessarily limited perspective. Or, as he so beautifully puts it: ‘Our body is in the world as the heart is in the organism.’

Manu Bazzano
Psychotherapist, supervisor and trainer

Data that mislead

Experienced, well-trained counsellors and psychotherapists know that many clients feel they need to please or placate their counsellors/therapists and I wonder how much all the ‘evidence’ being gathered to prove the effectiveness of CBT and other short-term interventions takes this into account? I suspect it doesn’t – which means the outcomes being reported are skewed and will therefore skew the conclusions reached by the number counters. Here is one example.

I have a friend who accessed CBT counselling through her GP. My friend is in her early 60s and her life has been marred by two tragedies: the first being the loss of her husband in an accident in his 40s and then, a year later, the death of her 18-year-old daughter. She coped with these bereavements with amazing fortitude. Her remaining child has been wildly dysfunctional in response to her own losses and creates many kinds of havoc in her own life and that of her mother. There are grandchildren involved and my friend is a loving and tenacious mother and grandmother, trying to help contain and support them and her daughter. All this takes a huge toll on her energies and makes her own life difficult to manage at times, due to the day-to-day unpredictability.

She was allocated to a young woman CBT counsellor in her 20s who was ‘very nice’ but visibly nervous. She had a few sessions but then felt that this was not helpful to her as she felt protective towards the young woman and unable to communicate her distress.

When asked to fill out the outcomes forms she did not tell the truth but was kind, complimentary and generous, feeling the counsellor needed some affirmation and positive feedback. Another layer of obligation and responsibility.

What will her feedback form tell the researchers, I wonder? We are constantly being told that our objections to ‘industrial counselling’ are because we are defensive dinosaurs.
I fear that what is being measured and how it is being measured will distort how counselling is funded and how different types of therapy are seen. This surely can’t be in anyone’s interests.

_Name withheld_

**Genuine and grounded**

I was heartened to read the interview with Mike Shooter and so glad that he is our new President. He seems such a genuine person and really grounded on the subject of mental health. The interview was free from the trite phrases sometimes used by your interviewees. It was refreshing to read that he actually believes in God.

I also thought the letter you published ‘Let’s work together for survival’ (Letters, _Therapy Today_, February 2013) was informative and valuable.

_Clare Whittle_

**What the IAPT data really tell us**

I write in response to Barry McInnes’ column, ‘Let the data do the talking’ (‘The researcher’, _Therapy Today_, February 2013).

Having recently managed a psychological therapy service through the transition to IAPT myself, I believe that the IAPT data are a much more reliable indicator of the state of an organisation’s data collection systems than they are of the numbers of people accessing or receiving psychological therapy.

The wide variations between primary care trusts’ access and recovery rates may simply reflect a wide range in the method and accuracy of the data collection.

I would predict a year-on-year improvement in the data, but this will reflect IT departments getting to grips with how to record relevant activity, clinicians becoming better trained, service managers monitoring clinicians’ use of the systems, and senior managers becoming more canny about which people they include in the reports.

It will have little to do with enhancing people’s experiences of services.

_Isabel Gibbard_

**Breath of wisdom**

What a delight to read Colin Feltham’s interview with Michael Jacobs (Therapy Today, February 2013). Three strong breaths of fresh air hit me: Michael is the first author I’ve noticed who realises that book prices are way beyond what most of us can afford if we need to buy more than one. So I’d like to offer him sincere thanks for taking material out of his fourth edition and referencing it instead, to keep the cost down.

The second gust of wind came with the realisation that this is the book we especially need to understand if, as applies to many of us, we move into integration with coaching or add coaching to our repertoire. Michael’s second response to Colin, where he summarises the essence of his book, is the perfect summary of what all of us need to keep in mind, whichever model or discipline we work within.

Third, Michael declares that he works with individual differences and not with the commonalities that provide the basis for research. Hurrah – someone of standing within the profession knows what matters on the shop floor.

Many of us have limited money to spend on books, we ignore psychodynamic thinking at our peril, and we always need to ignore commonalities by and large, lest we miss something really important to the client in front of us.

Thank you Michael. Old you may be; ‘past it’ you are not.

_Eleanor Patrick_

MBACP (Accred) and editor of BACP Children and Young People

**A division for clients?**

For some time now I have sought to promote the enfranchising of clients in our Association. It began at the Fellows meeting in 2011, when we were invited to suggest directions and projects that BACP might consider for the future. When I compare what BACP has done in relation to the recipients of counselling and psychotherapy with what I have experienced in the mental health services, I am struck by how professionally self-absorbed we are.

NHS patients and service users of charities such as Mind, Rethink, Richmond Fellowship, Sane and the Mental Health Foundation have places by right in the governing of mental health services and research. They contribute to professional training, serve as expert patients, as advocates, as members of clinical ethics committees, and on NHS trust boards.

In most cases the results of this involvement have been much appreciated by professionals as well as patients. ‘It is crucial for the future integrity of research that mental health service users are actively and equitably involved in every aspect of the research process.’ In Somerset the mental health foundation trust carried out extensive research on mental health, religion and spirituality with service users as researchers. The results of this work have helped shape and deliver spiritual and pastoral care throughout the trust.

I asked at the Fellows meeting what aims BACP had to bring clients from the edge to the centre of our organisation and its committees and working parties. Other Fellows pointed out that most counsellors and psychotherapists have been clients at some point in time and in many of their trainings. I recognise this, but it is very different to be on both sides of the divide – client and counsellor, and whatever ‘client’ experience we counsellors have had, it is not something that we often address in Therapy Today and other journals.

I really value and enjoy ‘In the client’s chair’ in _Therapy Today_ but that seems to be the only regular voice of the client we hear.
I realise that many clients have more than enough to do and would not want to be active in our affairs, but some I am sure would, just as patients have done in the NHS.

Reading Amanda Hawkins’ column ‘So much to talk about’ (‘From the Chair’, Therapy Today, November 2012), I was struck by how often ‘professional’ issues and interests appeared compared with those of clients. She writes: ‘As our strategic thinking starts to fall away from matters to do with registration, there has been time and space to focus on other issues.’

My plea to her and to our leadership is please to make the client perspective one of those other issues. We are not an Association for professionals (a trade’s union). We are an Association for counselling and psychotherapy, which values above all the relationships at the heart of our work. It would be good and timely to make that relationship more equitable in the work and research of BACP and all its divisions and committees.

Thinking of how different interest groups have developed in BACP, I wonder if a division for clients might be a good way to begin? I would be delighted to hear what other members think and even more to hear what other members think and expect.

在我工作的例子中，我与一个叫做 Step Forward in Bethnal Green, 我正在日益越来越的关注的一群人, 那个局中的模式问题，以及在那个领域中的需求。主要问题是一个信息和选择问题，它们提出了年轻人群中的承诺，对年轻人群他们可以感到更好，以及在探索他们的破灭或破碎的时候。

As a counsellor working with young people for an organisation called Step Forward in Bethnal Green, I have become increasingly concerned by a number of patterns that have been emerging for some time. The main issue is a lack of information and choice offered to young people when they seek help. This is by no means only an issue affecting young people; my work years ago with older people was very similar because most services in the NHS are not able to give enough time to understand a person’s unique situation and suggest options that would be best for them. Often cost is also an issue, although I think some creative solutions could be found to address such constraints. Most importantly, people must be able to make and be responsible for an informed decision about their own health and wellbeing, which they cannot do in a state of deferential ignorance.

Another issue is that medication or therapy is often not reviewed so that opportunities for alternative interventions are missed, but too soon is the chance for professional reflection on what treatment is or is not successful, in what situations and why. This will increasingly need to be a component of local commissioning boards, yet in so many places it seems completely absent.

Some young people I have worked with have been very depressed and unable to really be in touch with their feelings. The therapy then becomes a place to hold that young person until they are able to feel better, rather than explore their broken or fragmented inner worlds. Sometimes I have suggested clients discuss their medication with their GP – that they ask them for a guaranteed 10 minutes to ask questions about, for example, the possibility of reducing the dosage and what this may mean. Nearly always this has achieved very dramatic results. One of my clients cried with joy in a session as she described how she could feel again after so many months of a kind of numbness and sluggishness and that, even with her dose of medication halved, it was still enough to hold her depression at bay but without removing or seriously diminishing all feeling states.

I would seriously welcome the idea of more joined-up working and discussions on how health professionals can work together in improving the information and choices available for individuals who are in psychological distress. We all need to learn from each other rather than create professional barriers and I believe the benefits could be truly revolutionary.

Alena Dierickx

Sexist and belittling

We would like to object to the editorial title given to Anne Power’s review of the 10th anniversary edition of our book Sex, Love and the Dangers of Intimacy published in the February issue of Therapy Today.

Entitling her review ‘Straight talking’ feels like a slur; while we appreciate that every good sub-editor loves to find a cheeky pun for a title, in this case it is one in extremely bad taste and rude. At best, it is tabloid.

We feel sure that an analogous one would rightly not have been made on a review of a book on homosexual relations. Nor has a similar comment been made anywhere else in the reviews to the original book printed elsewhere.

As it is, the title does not refer to any hint in the review that it is a book full of ‘straight talking’, which would have been OK. Instead, it focuses
We know that exclusively on heterosexual approached this subject from relationship. I quote: from our own man-woman about what we had learned book', that we were writing book, entitled 'About this component.'

The title chosen by the editor raises very important questions: should heterosexual couples be mocked or shamed for being who they are, for being interested in the specific dynamics that occur when men and women attempt intimacy? It goes against the whole tenure of the book, which tries to support couples who may be feeling that they have failed at this difficult project.

Do Therapy Today readers believe that it makes no difference in a couple if they are the same or different sex? Do we really believe that equality in gender relations – which we all want, no doubt – eradicates the difference between the sexes? Would we all want our parental couples who created us through their sexuality described as 'straights'? Do we feel we can never comment on 'mainstream' issues without reference to the 'margins'? Helena Lovendal-Duffell Director/Founder, The Centre for Gender Psychology

Counselling isolated older clients

I was extremely interested to read the article ‘Growing old happily’ in the November 2012 edition of Therapy Today, which was passed to me by my colleague. She leads the year-long pilot counselling service that we have introduced at our befriending charity, which supports housebound and isolated clients in the London Borough of Ealing. The majority of our clients are older people: 86 per cent are aged over 75 years and, to be accepted as a client, they will be experiencing the debilitating effects that severe loneliness can have.

Our premise for setting up our counselling service came as a response to the needs of our clients; we realised that some required more than the befriending service we offer, which is delivered by trained volunteers. We believed that, for some clients, the option to participate in counselling would enable them to go on to fully benefit from the befriending service and would equally help to ensure that volunteers would not be put in the position where they were dealing with clients and situations that were beyond their responsibilities or capabilities.

In order to set up our new service we carried out research to see what other counselling services were available to housebound clients and to find out how they worked. However we found very little on offer for this very vulnerable and isolated client group. Working along BACP guidelines, we have devised our own service, which is carried out one day a week by my colleague, who is a qualified counsellor. She has extensive experience of working with housebound clients in her role as Volunteer Manager and felt able to manage the process of delivering counselling in the home setting.

As we have a long-established understanding of supporting our client group, having been in existence since 1994, we knew that our approach to informing them about the new service needed to be extremely well managed. We have simply advised clients that the service is available and asked them to contact us for a chat and our easy-to-read leaflet, should they be interested in learning more. While we thought that our service was needed by the client group, we did not know whether or not clients would actually want the service; however there has been an excellent take-up. Clients are initially offered six sessions, but this can be extended if it is deemed appropriate.

We sought local council funding and private funding from charitable sources for this project as we believed that this would enable us to design the service to best fit our clients’ needs without being constrained by prescriptive monitoring and reporting. The project budget includes running costs, along with costs for monthly supervision, training and insurance. For the purposes of the pilot, our clients have not been charged; however we have discussed whether or not we should be asking for a voluntary donation and it was extremely interesting to read Helen Cooke’s opinion of this in the article.
Letters

Language concerns

I write to express my concern at the extraordinary statement highlighted in Lysanne Sizoo’s article ‘Counselling in a cold climate’ (Therapy Today, October 2012): ‘Research suggests that a therapist who works in a language other than her native tongue might have a reduced ability to be fully present, affecting the depth of the therapeutic relationship.’ We are further informed that counsellors at Ms Sizoo’s centre are requested to work only in their mother tongue.

Given that so many of the pioneers of psychotherapy in the UK and the US have been émigrés working in a language other than their native tongue (I leave readers of this journal to compile their own lists), the statement seems more than a trifle controversial. I can also say with some confidence, on the basis of some 35 years’ experience of working as a colleague and supervisor with many therapists who have been working in a language other than their native tongue, that I have seen nothing to substantiate it. Perhaps unsurprisingly, neither of the studies cited as an example of this ‘research’ have been published.

But worse than being simply strange, the claim implicitly casts an unwarranted slur on the work of virtually all therapists working in languages other than their native tongue, including many of my own colleagues and supervisees. Moreover, while it is worrying enough that Lysanne Sizoo runs her counselling centre according to this rather prejudicial notion, the highlighting of it by your journal – unless of course it was intended to provoke just such a response as this – raises serious concerns about a lack of awareness of xenophobic themes in the social unconscious of some parts of the counselling and psychotherapy profession.

Dick Blackwell
Group analyst and Director, Centre for Psychotherapy and Human Rights

Where are the adolescents?

Trudi Dargan’s detailed review of Attachment Therapy with Adolescents and Adults: theory and practice post-Bowlby (Therapy Today, November 2012) omits an important fact: the index contains just one reference to adolescence and the case material and illustrations focus exclusively on caregiving and care-seeking as seen through adult eyes.

As a therapist who works with children and adolescents, I was surprised and disappointed – a case of the authors not really doing what is claimed ‘on the tin’.

Jon Blend
MBACP, UKCP, CQSW

Keeping debt from the door

I have been prompted to write by the article ‘Recess ion depression’ (Therapy Today, December 2012). The statistics make for interesting reading. I only have to turn on the radio, television or open a newspaper and they are saying the same thing. I only have to go to the city and see many young and old living homeless on the streets. The lack of finance and jobs, which impacts on relationships, has always been there and yes, I agree it is much worse due to the economic climate.

I sensed from the article that counsellors may be exempt from this reality of depression and recession. When clients can’t afford to come to therapy it has a knock-on effect on the therapist in private practice.

Therapy Today has 26 pages of training and only one page with a couple of jobs. Surely someone has noticed this. Maybe this is an area to look at: where are the statistics for counsellors? How many have found employment that can support their training and their family?

My training has been the most rewarding gift I have given myself. But the reality is, in this economic climate, I could not support a family on my earnings.

In the final paragraph Mora Maclean suggests ‘personal development work around these issues is crucial if a counsellor is going to be able to offer a genuinely empathic and prizing relationship of any depth to clients’. I find this quite offensive.

My counselling diploma and further training included much work around these areas. Also I often witnessed how my mother would have to keep the debt collector from the door. I am sure all of us who entered the counselling profession did so because of our personal experience, genuine empathic nature, and a desire to support the poor, deprived and those who are suffering.

Name withheld
Getting to know their ways

Gender in the therapy hour: voices of female clinicians working with men

The 12 North American contributors to this book, who describe themselves as ‘fourth wave’ feminists, recognise the particular difficulties men have in using talking therapies. Here they explore the ways in which gender socialisation shapes and constrains attitudes and behaviours and discuss how to make therapy more male-friendly and promote ‘compassion for the suffering of men’. I read it with very mixed reactions.

The book is in three sections: ‘Core treatment issues’, ‘Different modalities’ and ‘Different populations’. It values self-reflection, both in the contributors and in the writing process itself, and each author includes an extensive personal account with their chapter, some of which I found fascinating. This, along with the abundance of case material (which thankfully includes a generous proportion of ‘failures’ as well as ‘successes’) makes it an easy book with which to engage.

The book has much to recommend it – so why my mixed reaction? On the one hand, I agree with the overall argument that effective therapy requires the therapist to communicate with the client in their own language or style, especially in the early stages. Getting alongside our clients, seeing things through their eyes, is the everyday reality of most therapists’ work, whatever the client’s gender. I might not go so far as some of the authors, who seem happy to talk about sport, crack jokes and offer firm handshakes, but I am with them in their attempt to engage with the client’s version of reality and their sensitivity to issues of vulnerability and shame.

I also agree that we need to be thoughtful and self-reflexive around our gendered interactions, and that we have to make an effort to step aside from our own gendered version to engage with the other. So at one level I have no problem with arguments that we ‘need to understand how our socialization as women and our own history with men may interfere with working most effectively with our male clients’ and ‘strive to be compassionate and non-judgmental’ when male clients ‘sexualise us, threaten us, or shut us out’ (p16).

But on another level I am aware of an undercurrent of my own anger. This sounds too much like the traditional female role of servicing men, and very little to do with challenging inequalities or privilege. ‘You get to know their ways and work round them,’ as my grandmother would say.

If we are concerned for social justice, what part does compassion for the ‘oppressors’ have to play? What role, if any, does psychotherapy and psychology have in challenging the privileged structures of power in society? These are the sorts of questions that I wish the book had addressed directly, and I was drawn to those chapters that looked in greater depth at the difficulties of balancing empathy with challenge. Here I found a more sophisticated analysis of the complexities of power in society.

This is a book that challenges and provokes. I closed it thinking that, although its content left me at times dissatisfied, it was an excellent stimulus to self-reflection!

Chris Rose is a group psychotherapist and writer

Existential dialogues

Existential therapy: legacy, vibrancy and dialogue

This excellent book, an edited collection of 15 articles, certainly lives up to its subtitle. Its contributors, all existential practitioners, encompass the ‘legacy’ of the movement, from its inception over 50 years ago with May’s book Existence, published in 1958. The writers also cover the ongoing, ‘vibrant’ debate about the nature of existence and how the discussions and developments in thinking relate to our therapeutic practice (often illustrated by examples). There are also transcripts of a number of ‘dialogues’ between leading thinkers in the field, in the UK, Europe and the US.

I found myself surprised by how accessible and engaging most of the articles were in seeking to explain the complex thinking of Hegel, Heidegger, Sartre, Levinas et al. That said, there were times when I felt the writers were over-emphasising very insubstantial points.

I particularly appreciated the debate between four practitioners on the impact of Yalom’s existential book about facing death, Staring at the Sun. I was moved by the poignant contribution

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Dreams and meaning

**Dreams and the person-centered approach: cherishing the client experiencing**
Andrea Koch
PCCS Books, 2012
135pp, £13.99
ISBN 978-1906254476
Reviewed by Mary Martin

I have not explored my vivid dreams in therapy so I was very curious about the content of this book and how I might be influenced both personally and professionally.

Koch has coined a new word to describe working with dreams – ‘dreamsensing’ (pxiii). She begins by locating ‘dreamsensing’ within person-centred theory and discusses this in relation to the many authors cited (Rogers, Gendlin, Schmid et al). Subsequent chapters focus on practice. Koch presents three different person-centred approaches to working through her own dreams: relational person-centred, focusing and structural. The reader is invited to witness three sessions and become acquainted with how ‘dreamsensing’ can bring into awareness previously unknown aspects of oneself. Further insight from a client’s perspective is offered in the closing summaries of each of the three sessions.

The text continues with a comparison of the various theoretical approaches, to help practitioners choose which would be most appropriate. Koch concludes by presenting her hopes for the future: dreams are undervalued in person-centred training and practice; ‘affirmative action’ is needed in person-centred theory, training and therapy to win greater recognition of their relevance (p26).

This stimulating book gives plentiful food for thought long after you have closed its pages. I have been persuaded to work with my own dreams since reading it and would recommend it to practitioners and educators as a stimulating, useful and enjoyable read.

Mary Martin is a person-centred counsellor

Did the Buddha get it wrong?

**Mindfulness and the art of managing anger**
Mike Fisher
Leaping Hare Press, 2012
143pp, £7.99
ISBN 978-1908005304
Reviewed by Manu Bazzano

This slim self-help volume is a good old-fashioned anger management tool, spiced up with the now obligatory allusions to neuroscience and, of course, ample references to a predominant buzzword, mindfulness.

The author – a counsellor, anger management consultant and founder of BAAM (the British Association of Anger Management) – means every word he writes. He ‘has been there’, walked the terrain and managed to control his own anger. Anger management, he reminds us, is not repression; it is more a matter of understanding, of awareness, of considerate yet direct expression, and of compassionate detachment.

Fisher offers Gandhi, Malcolm X and Mandela as three exemplars of the application of anger to achieve positive change. The author’s own anger has been channelled through occasional moral tirades against social media, profile pages, online marketing and networking platforms, all sternly chastised as ‘modern-day vanity board’ (p27).

At times the sermonising extends to his own client group, who are found guilty of ‘worshipping the wrong God’ (p39) and of lacking humility, which ‘prevents them from experiencing meaning in their lives’ (ibid).

These types of angry people are ‘highly opinionated, arrogant with a self-serving skewed morality, have a distorted value system and an unethical framework’ (pp39–40), Fisher opines, before gracefully conceding in the next disarming paragraph, ‘I can say this because I am talking about myself.’

As a fellow Dharma practitioner prone to self-righteous indignation, I see the author’s congruent stance and captivating sincerity as the very best things about the book. I particularly liked his admission of having used meditation and Buddhist philosophy as ‘yet another way to escape’ and a means to avoid confronting emotional pain and suffering (p41).

But things get a little fuzzy when, drawing variously on
unreferenced sayings of the Buddha, the hyped-up platitudes of Eckhart Tolle and the managerial lingo of mindfulness based stress reduction, the reader is summarily told that suffering is an option and happiness is a choice.

Did the Buddha get it wrong, I wonder, when he affirmed in his first discourse, Setting in Motion the Wheel of the Dharma (Dharmacakra Pravartana Sūtra), that life itself is suffering, anguish and dissatisfaction? Obviously he knew nothing of mindfulness-based stress reduction.

Manu Bazzano is a psychotherapist in private practice, trainer and ordained Zen Buddhist monk

Battle of the siblings

Person-centred therapy and CBT: siblings not rivals
Roger Casemore and Jeremy Tudway
Sage, 2012
192pp, £23.99
ISBN 978-0857023392
Reviewed by Adrian Pepper

Person-centred therapist Roger Casemore and cognitive behavioural therapist Jeremy Tudway here engage in metaphorical battle about the relative merits of the two mainstays of current counselling and psychotherapeutic practice: the person-centred approach (PCA) and cognitive behavioural therapy (CBT).

Together and alternately, they compare and contrast the underlying philosophies, theories and practices of each approach in a noble attempt to resolve the hostility and criticisms voiced by each side in the ongoing debate for supremacy.

The book opens with the misunderstandings, conflicts, prejudices and disrespect associated with each approach. Then two chapters set out the basic philosophies of PCA and CBT and their histories and divergence. Chapter four draws on the works of founding fathers Carl Rogers, Albert Ellis and other authorities to further illustrate the dissonances and to demonstrate that the mutual criticism is not new: these two have been battling it out for superiority from very early on.

In chapter five, each author illustrates how he works with his clients, to demonstrate how the different processes can reach the same end. Chapter six recasts from a PCA perspective the use of formulations and assessments associated with CBT to demonstrate how PCA therapists can incorporate this approach without betraying the values of their own modality. Chapter seven helps PCA and CBT therapists to identify the differences between therapy and therapeutic education. This will be an uncomfortable chapter for all therapists who consider that they deliver pure counselling every time they meet a client.

In chapter eight, the authors reflect on 14 areas of similarity and difference that they recognise between PCA and CBT. Then the final chapter gives voice to seven experienced therapists who have completed a course related to this book and who reflect on what they learned and how it influenced their counselling practice.

The authors finish with reflections on their own work together on the book and the course. And their conclusion? PCA and CBT do not need to be rivals: each offers something to someone and they are in fact allies (or siblings) in the quest to find the best and most appropriate ways to help the client recover control of a life and emotions gone awry.

Sadly, in the real world, IAPT rather upsets this cosy reconciliation with its favouring of manualised procedures delivered in six sessions. That said, I do recommend this book to experienced counsellors who are interested in extending their skills to both PCA and CBT want a better and detailed understanding of the principles and processes of either.

Adrian Pepper is in private practice as a counsellor, psychotherapist and supervisor

Creative grief work

Techniques of grief therapy: creative practices for counselling the bereaved
Robert A Neimeyer
Routledge, 2012
388pp, £28.99
ISBN 978-0415807258
Reviewed by Brenda Mallon

Robert Neimeyer is a practitioner as well as a professor of psychology at the University of Memphis. Most people involved in bereavement counselling will have come across his extensive publications. This is a dazzling addition to the literature on the practical application of therapeutic support for the bereaved.

It is a book for everyone working in bereavement, at whatever level of experience. Its 94 chapters offer a vast array of creative techniques to use with different age groups and in different settings. And there really is something for everyone; Neimeyer has gathered here some of the most significant contributors to grief counselling in the 21st century.

The book is organised thematically: working with the body, transforming trauma, changing behaviour, finding meaning, renewing the bond, integrating the arts and grieving with others. It concludes with an often overlooked subject, ‘Healing the healer’, on how the healer takes care of themselves.

Each of the chapters identifies the clients for whom the technique is appropriate, gives a detailed description of the technique and a case example and winds up with some concluding comments. Anyone who has ever felt stuck with a client will find a way forward in the material collected here, which includes psychodynamic, cognitive-behavioural and experiential approaches.

Neimeyer’s aim was ‘to present a rich and representative smorgasbord’ (pxvii); the book does more. This is truly a banquet of ideas and techniques that will sustain us for a very long time.

Brenda Mallon is author of Death, Dying and Grief: working with adult bereavement (Sage, 2008)
Why they killed

**Understanding Dunblane and other massacres:** forensic studies of homicide, paedophilia and anorexia

Peter Aylward
Karnac Books, 2012
240pp, £23.99
ISBN 978-1780490946
Reviewed by Tracy King

Written from an overtly psychoanalytic perspective, the author brings to this book forensic experience from both his work as a psychoanalytic psychotherapist at Broadmoor high security hospital and his role as a Special Branch officer.

Aylward argues that killings such as the Dunblane shootings and the Soham murders, have to be regarded in the context of the perpetrator’s life and inter-generational history, of the perpetrator’s life and to be regarded in the context of exclusion. The question to manage early trauma and attempts by the perpetrator perversion are, in fact, of extreme violence or incomprehensible acts rehabilitated. Seemingly successfully treated and if the killers are ever to be

The author recognises the rage that a therapist may understandably feel towards someone who has committed a terrible, violent act that they do not understand. This is why he encourages them to triangulate the patient with their offence and their history; it provides, he says, a route to comprehension that may lessen the rage and create space for self-reflection so the therapist can continue to work therapeutically with the client.

This book will be more easily read by those familiar with the psychoanalytic framework and its terminology. The level of analysis makes it most appropriate for practising forensic professionals. But it is not a text or reference book; it is best read from cover to cover. Dipping in and out may risk losing the thread of the developing themes. **Tracy King is a chartered clinical psychologist working independently in forensic practice**

Ageing and depression

**Managing depression, growing older**

Kerrie Eyers, Gordon Parker and Henry Brodarty
Routledge, 2012
296pp, £19.99
ISBN 978-0415521512
Reviewed by Sarah Lewis

Perhaps surprisingly, given the topic, this is a really good read – accessible, informative and full of personal accounts as well as its more professional content. Practical but with a light touch, it combines humorous anecdotes and well-known quotes about growing old with what you need to know to diagnose and differentiate between the different types of depression – melancholic and non-melancholic – as they affect older people.

Each chapter contains a ‘Noteworthy’ summary, which is helpful for quick reference. The overall message is well made: depression is not an inevitable feature of ageing, and there is effective treatment that can help, whether medication, non-medical complementary treatments or talking therapies, or a combination.

The accounts by sufferers and their family members or carers are frank and accessible, making this a suitable resource for anyone affected by depression. Its discussion of talking treatments focuses primarily on CBT but there is some coverage of alternative non-medical treatments, such as music and art therapy.

Towards the end of the book, it turns to the needs of carers, stressing the importance of self-care. There are also pointers to further resources, but none specific; this is an Australian book for a worldwide audience.

I would recommend this book as very useful background reading for all counsellors. I learned much from it and will be returning to it for reference many times, I am sure. **Sarah Lewis is a person-centred counsellor and supervisor in private practice**
I’m proud of us all

BACP has come a very long way in just the past four weeks  
By Amanda Hawkins

Were you there? 6.30pm, 4 February, Queen Elizabeth II Conference Centre, London? Irvin Yalom and his son Victor were (virtually, that is), along with 900 flesh and blood members of BACP.

It was a fantastic evening, and Irvin kept us all enthralled, telling us stories from both real life and his fictional explorations. The buzz in the atrium before the event began was palpable. Some of that was about Yalom, but some of it was the sound of old friends and colleagues meeting up over a shared interest and a common focus. It felt very good to be together.

Irvin shared something of his new novel, he read us one of his new case studies (always a delight), and he also talked about his experiences of practice, both in the past and now. But for me the two best bits were witnessing his relationship with his son – the pride and the humour – and the way he took the time to answer questions that his audience of counsellors thought were important. How he answered them gave me reason to think that they were important to him too.

I came away from the evening with a grounding sense of continuity, which I find very reassuring in these times of change. The politics and the policy changes might whirl round us as a profession, but at the end of the day it’s the work that we do with a single individual that matters – it’s the relationship. It seems to be Irvin Yalom’s gift to us to remind us of this really important fact.

The BACP Summit that followed the next day was a different affair but just as important. I have to admit that I was a little nervous: how on earth would we follow the Yalom event? But I needn’t have worried: the discussion, discourse and debate throughout the day were both important and stimulating.

The aim of the summit was to explore in the widest possible sense the future of the counselling profession in the 21st century. We assembled a wide range of speakers and panellists to set the scene and offer expert commentary on what we felt were the main areas of debate.

We discussed the future of ethics, professionalism, the importance of technological advances in the world of therapy and the relevance of research. But this wasn’t just about experts holding forth. The audience included a wide range of stakeholders, BACP senior executives and non-executives, and counsellors working at the coal face too. All engaged in lively debate, with immensely valuable and challenging contributions coming both from the platform and from the floor.

Laurie Clarke’s closing words spoke for me too. ‘I am gobsmacked,’ he said. ‘I feel massively optimistic about the profession in the 21st century. It’s become clear to me we are in a fantastic space.’

This was a very different event from the conferences we have run in the past, which tend to be CPD-focused. Our aim was to glean ideas to inform BACP’s strategic planning process. We came away with a wealth of material to feed into our future planning. Here, I felt, was a mature profession taking control of its own agenda.

I toyed with the idea of not talking about registration this month, but how could I not? Because on 13 February Laurie Clarke, our Chief Executive, Sally Aldridge, BACP Registrar, and I, as Chair, travelled to Westminster to attend the launch of the Accredited Voluntary Register scheme. As I’m sure you’ll appreciate, it was for us a hugely significant stage in a very long journey. We were the first register to be accredited, and we believe we have set a very high standard for others to follow. We now have a register that will be available to the public, that is externally scrutinised, that is endorsed by the Government and sits within its legislative framework for professional regulation. It is such an achievement. I am tempted to just stand in the sun for a moment and appreciate where we have got to.

However, while we now have the recognition, we also need to live up to the task. Being publically and externally scrutinised means that we have to make sure our house is in order, and that we remain accountable to and for our profession and the clients we serve. The journey continues.

Pride is not a quality that I have associated with counselling in the UK. Yet it was pride in the profession that prompted me to invite Yalom to speak to us. And, standing in the Great Hall in Westminster on 13 February, I again felt proud – proud of all those who went before me, who got us to this point, and all of you who actively contribute to the profession on a daily basis. It was a moment that I will remember for a long time.

From the Chair
Making a difference

Dani Singer is editor of University & College Counselling, the recently retitled journal of the BACP Universities & Colleges division (formerly AUCC).

How would you describe yourself and your professional background?
I started professional life as a social worker in London’s East End, and then moved into electronic journalism abroad, with a strong interest in photography. Back in the UK, after a couple of false starts, I trained as a psychotherapist and counsellor and have not looked back since (though my bank balance certainly has, with deep longing!).

Editing the journal allows me to combine both areas of interest. But, more importantly, it facilitates communication and collaboration with so many amazing and talented colleagues.

Who is the journal for?
The journal is primarily aimed at practitioners in further and higher education settings. This ranges from placement trainees and associate counsellors to highly experienced and often long-serving heads of services, as well as other colleagues concerned with student wellbeing such as tutors, mental health/disability advisers, chaplains, lecturers and educators.

What is in the journal?
Contributors range from neophyte counsellors to authors who are highly respected in their field. Recent content includes our Lead Advisor Patti Wallace’s report on her research on the impact of in-house counselling, in our November 2012 special issue; Teri Apter’s article on ‘Thresholders’; articles on recent developments in neuroscience and their impact on our clinical work, eating disorders (the subject of our March issue) and several takes on organisational dynamics.

Particular topics more often than not suggested by the membership include social anxiety, email security for counsellors, the (mis)use of the internet (including pornography), bullying as trauma, bereavement groups and self-care for therapists. In future issues we hope to explore difference and diversity, handling the pressures of austerity, being more visible/political and how to move from firefighting to driving real change in addressing mental health issues at a wider institutional level. All this in addition to our regular columns on research, divisional news, book reviews, legal concerns and updates from our Chair.

As editor, what have been your priorities?
Making a difference, staying relevant and attuned. I take as a starting point my own experience when I started as a part-time lone counsellor. The journal was an absolute lifeline. My bottom line has always been: what would be useful to the membership?

Are there any particular challenges for your journal?
As with many print media, one of the challenges is how to remain relevant, responsive and interactive (eg via letters to the editor) when the trend is towards instant access via Jicsmails. Another is negotiating the finer points of what is and is not publishable (not always as obvious as one might think!).

Are you actively looking for readers to contribute articles?
As editor, I am always (heavily underlined) eager and looking both for topic ideas – the journal is always hungry and wanting more – and for contributors, particularly from our membership. If anyone reading this feels inspired, please do contact me; I would be delighted to provide help, encouragement and support.

What has given you greatest satisfaction in the role?
Positive feedback naturally is very gratifying. Best of all perhaps is when an article or opinion generates real thought, controversy and debate, as this suggests that we have hit on a live issue that really matters.

Could you sum up in three words what you hope the journal provides for readers?
Questions, explorations and discoveries (QED). ■

You can email Dani Singer at d.singer@ram.ac.uk

About the division
BACP Universities & Colleges is a specialist division of BACP. It is the leading forum for those involved in the management and delivery of counselling services in further and higher education. For further information about joining the division, please email julie.camfield@bacp.co.uk

‘When an article or opinion generates real thought, controversy and debate, this suggests that we have hit on a live issue’
Certificate of Proficiency assessments

The first Certificate of Proficiency assessment events are now underway and BACP will be adding to the itinerary of dates across the UK.

The Certificate of Proficiency is a computer-based assessment that gives eligible members a way onto the BACP Register of Counsellors & Psychotherapists.

The Certificate of Proficiency will be your route to registration if you hold MBACP membership but aren’t BACP-accredited and haven’t done a BACP-accredited course.

BACP has a dedicated site for the register and the Certificate of Proficiency assessment. The site is at http://wam.bacp.co.uk/wam/RegisterEligStart.aspx. Members can visit the site to check their eligibility status and book onto the Certificate of Proficiency assessment events.

BACP has now added the locations on the map to the itinerary (see right). Once the venues are confirmed you will be able to book online at www.bacp.co.uk/events/conferences.php

Further information on the Certificate of Proficiency assessment can be found on the BACP Register website at www.bacpregister.co.uk/prospective/CoP.php

Shortlisted entries for BACP 2012 awards

Due to lack of space in last month’s issue, we couldn’t report the shortlisted entries for the BACP 2012 awards.

Runner up for the Adapting Services award was Saheliya Counselling Service, based in Edinburgh. Saheliya offers counselling and support to black and minority ethnic women who have experienced sexual, cultural, religious and racial violence, victims of torture, trafficking and sexual violence in war, refugees and asylum-seekers and women who are persecuted because they are considered ‘impure’ after sexual abuse or divorce, or who are lesbian or bisexual.

Three entries were shortlisted for the Communicating the Benefits award. The Armada Project in St Albans was shortlisted for its multi-media approach to communicating the benefits of counselling, with a focus on male clients. The project uses its website (www.armada-counselling.co.uk) and Twitter to provide information about the counselling process, its costs, and links to self-help articles, websites and news on mental health issues.

Washington Mind’s website (www.wellbeinginfo.org) aims to promote good mental health and wellbeing by giving information about common mental health problems, self-help tips, a jargon buster and information about local support and wellbeing services. It includes a page on talking therapies and referral pathways for local counselling services. They have also produced a range of promotional materials, such as postcards, key rings, pens, business cards and mouse mats, with information about their services.

University of Dhaka, Bangladesh, was shortlisted for its work to promote access to counselling and awareness of mental health and wellbeing among its students. It publishes a bi-annual newsletter and a website with information about mental health and organises an annual mental health and school counsellor week, when students wear blue ribbons to signify positive mental health.

Apologies to the Hospice in the Weald, which we reported in last month’s BACP News as being in Maidstone, Kent. The joint winner of the BACP Improving Access to Counselling and Psychotherapy – Adapting Services award is based at Pembury, near Tunbridge Wells, in Kent.

BACP student conference

A record-breaking 400 trainee counsellors/psychotherapists attended the 2013 BACP student event in London on 23 February.

The annual event offers a full day’s choice of workshops and drop-in taster sessions. It is a unique opportunity for student counsellors to find out about career options, get advice on jobs and setting up in independent practice, learn about potential training and career pathways and discuss professional development issues, as well as meet up with students from other institutions and courses.

This year’s event was the first to include an exhibition area. The exhibition drew 30 exhibitors, including publishers and training organisations.
Coaching network groups

The BACP Coaching division is looking for members who would like to set up a coaching network group in their locality.

Over 25 per cent of the BACP Coaching membership responded to a survey about the existing coaching network groups. The feedback was extremely positive:

- 91 per cent of members think that coaching network group meetings are important as a way of making connections, contributing to their own learning and feeling supported by colleagues.
- 95 per cent of members who attended a network group meeting found it useful and there was a request for more network groups so that people do not have to travel more than 30–60 minutes to attend.

A quarter of members did not know that there were local coaching network meetings, so publicising the meetings more widely is a priority.

BACP Coaching has launched a recruitment drive to invite more members to set up a coaching network in their area. There is a particular need in the South East, North East, Midlands and Wales.

If you are interested in becoming a BACP Coaching network group leader and would like further information, please email the BACP Coaching Executive Specialist for Networks, Trish Turner, at dr.trish.turner@gmail.com

BACP Private Practice event

A record 150 attendees packed the BACP Private Practice conference in London on 9 February to discuss ‘Depression: what’s therapy got to do with it?’. The conference turn-out was 50 per cent up on previous years.

Psychoanalyst and author Darian Leader, whose books include The New Black: Mourning, Melancholia and Depression and What Is Madness?, opened the day with an exploration of current thinking on the aetiology and treatment of depression. He highlighted the apparent ‘explosion’ in the clinical diagnosis of depression and pointed to a similar phenomenon in diagnoses of bi-polar disorder in primary care in recent years. Is this a genuine increase in prevalence, or simply the product of skilful marketing by the pharmaceutical industry, he asked?

Benjamin Fry’s closing keynote presentation focused on somatic experiencing, a novel approach to treating trauma-related depression, developed in the US. He described how it saved his life when he experienced a total psychological collapse in 2008 and psychotherapy could not help. Somatic experiencing focuses on the body and works at the level of the reptilian and mammalian brain, not the cognitive brain, using techniques such as EMDR and body psychotherapy.

‘The human cognitive brain won’t let go of the trauma. So the treatment looks at how the body feels... Counselling and psychotherapy work with language but language is situated within the body and the body itself is the governor of the nervous system. The whole process works bottom up, not top down,’ Benjamin Fry explained.

BACP divisional membership grows

Over 200 members joined one of the seven BACP specialist divisions in January.

A total of 209 members joined a division, with BACP Private Practice recruiting the most, at 42 new members. Overall (including lapsed returners), BACP Workplace recruited nine members, BACP Private Practice 75, BACP Universities & Colleges (formerly the Association for University and College Counselling) 10, BACP Coaching 13, BACP Children & Young People 54, BACP Healthcare 19 and the Association for Pastoral and Spiritual Care and Counselling (APSCC) 29.

If you would like to join a BACP division, please contact Julie Camfield (BACP Divisional Officer) for further information at julie.camfield@bacp.co.uk

BACP launches new PDD programme

BACP Events has launched its 2013 programme of professional development days (PDD). The PDD programme was first introduced last year and proved very popular with members, with an 85 per cent take-up.

The aim of the PDD programme is to widen the range of continuing professional development opportunities available to BACP members. The all-day PDD events are for groups of just 25 people, and focus on very specific topics, enabling participants to explore issues in greater depth and intensity. This year’s programme includes Martin Hogg on ethical marketing, and on establishing an online presence; Carolyn Mumby on building a coaching approach; Peter Jenkins on counselling confidentiality and data protection, and on legal issues in therapeutic work with children and young people; Sally Despenser on looking after yourself, and on becoming a supervisor; Paula Hall on working with sex addiction; Gillie Jenkinson on working with former members of abusive groups and relationships; Guy Harrison on pastoral care and counselling, and David Hawley on working with gender identity.

For more details, visit the BACP Events webpages at www.bacp.co.uk/events
BACP CYP division conference

The 2013 conference of BACP Children & Young People, BACP’s largest division, is on 8 June in London.

Speakers booked for the event, titled ‘Working together and holding the difference’, include Aqualma Murray of I Am Woman; Safe Spaces, who design safe rooms and sleep places for children with special needs; Deborah Rogers, who will be presenting on pre-trial therapy for children, and Edith Bell, who will give a workshop on self-harm and safeguarding.

The conference is open to members and non-members. To register and for more information, please visit www.bacp.co.uk/events

Newly accredited counsellors/psychotherapists
Carol Aitken
Rosaleen Allen
Rosemary Andrews
Freda Anning
Sarah Appleton
Anne Ashton
Samuel Baker
Leo Barnard
Joseph Barnes
Janet Barrett
Julie Beaumont
Tracey Billham
Margaret Bracken
Christine Bridger
Kathryn Brown
Julie Castleman
Deborah Catherall
Anne Chilton
Angela Chrysafids
Joanne Clifford
Sarah Cochrane
Sharon Cook
Richard Cormell
Dawn Crighton
Rosemary Crockett
Natasha Curnock
Claire Curran
Stephen Davy
Hilary Day
Lorraine Ellison
Paul Emery
Stephanie Fishwick
Andrew Garman
Janet Giles
Jane Grant
Robert Green
Fiona Gribbin
Rafia Hanid
Susan Harness
Anne Harrison
Karen Harry
Peter Hingston
Linda Hobbs
Anne Hogg
Sarah Holland
Joyce Holmes
Carol Hughes
Aldine Iqbal
Leo Jameson
Maude Jenkins
Ellie Keavey
Chi Ko
Val Kohnner
Sharon Laird
Ann Lowton
Samantha Lucas
Cathryn Macleod
Caroline McWatters
Bernadette McDonagh
Laura Monk
Shane Morrow
Cathryn Munns
Kate Murphy
Amanda O’Brien
Susan Parry
Ila Patel
Ursula Pfeiffer
Joan Pye
Rosie Rangelova
June Rattray
Polly Ravenscroft
Sally Richmond
Evelyn Riddle
Gina Robbins
Catherine Sabatini
Hilary Seaberg
Rosa Sebastian
Nicola Shankland
Sarah Shatwell
David Shaw
James Sheehy
Robert Slater
Kate Smith
Jo Solomon
Anne Swindell
Sheila Symons
Linda Taylor
Amanda Trotman
Gill Turner
Emma Turrell
Helene Wander
Janet Way
Isabelle Yates

Newly senior accredited supervisors of groups
Wilf Hashimi
Gill Kaye
David Richards

Newly accredited counselling/psychotherapy service
University of Bradford/Bradford College Counselling Service

Successful counselling/psychotherapy service re-accreditation
Thurrock Mind Counselling & Groupwork Service

Members whose accreditation has been reinstated
Rosa Chillari
Ruth Clark

Members not renewing accreditation
Elizabeth Andrews
Lynn Baker
Moyra Birnie
Jane Cross
Allison Green
Nicholas Hall
Lynn Harris
Ann Haworth
Quito Hertz
Graham Huxstep
Margaret Kerlogue
Jenny Leslie
Marylyne Norton
Nathalie Ogden
Karen Osborne
Jennifer Perren
Patricia Pettit
Joan Rudnick
Eric Seddon
Angela Thomas
Val Tudor
Nicola Wilson
Sue Wood
Katherine Wyatt

All details listed are correct at the time of going to print.

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Universities & Colleges conference

The BACP Universities & Colleges division’s two-day conference takes place on 24–26 June, at the University of Sheffield. The packed programme of workshops includes Patti Wallace on applied research, Ali Zabarfi on language and culture, Robin Wiltshire on music therapy, Karen Tomlin on drama therapy and Julia Segal on chronic illness and disability.

To register your interest and for more information, please email Jessica Baxter at jessica.baxter@bacp.co.uk

Newly accredited counsellors/psychotherapists
Dennis Hughes
Vajra Lila
Sophie Livingstone
Jane Wilkins
Sarah Worley-James

Newly senior accredited counsellor/psychotherapist for children and young people
Gail Thornton

Newly senior accredited supervisors of individuals
Jay Clarke
Susan Cousins
Joy Cullwick
Clive Henderson
Gill Kaye

Patricia McIlroy
Sheila Mudadi-Billings
Julia Naish
Tanya Orr

University of Bradford/Bradford College Counselling Service

Thurrock Mind Counselling & Groupwork Service

Rosa Chillari
Ruth Clark

Elizabeth Andrews
Lynn Baker
Moyra Birnie
Jane Cross
Allison Green
Nicholas Hall
Lynn Harris
Ann Haworth
Quito Hertz
Graham Huxstep
Margaret Kerlogue
Jenny Leslie
Marylyne Norton
Nathalie Ogden
Karen Osborne
Jennifer Perren
Patricia Pettit
Joan Rudnick
Eric Seddon
Angela Thomas
Val Tudor
Nicola Wilson
Sue Wood
Katherine Wyatt

All details listed are correct at the time of going to print.
A number of interesting parliamentary debates have taken place in the past month, starting with the Countess of Mar in the House of Lords, who led a debate on chronic fatigue syndrome. During the exchanges, Lady Mar suggested the results of a trial into the effectiveness of CBT and GET (graded exercise therapy) treatments had been artificially inflated and called for the results to be re-analysed.

**Eating disorders**
In the Commons, Conservative MP Caroline Nokes instigated a debate on eating disorders, coinciding with eating disorders week. During the debate one MP called for a review of the guidance issued by the National Institute for Health and Clinical Excellence (NICE) on eating disorders.

**Suicide prevention**
William McCrea MP (DUP) introduced a debate highlighting the ‘major challenge for government and society’ posed by the number of suicides in the UK, particularly among young people. Stuart Andrew MP (Con) spoke of the importance of the suicide prevention strategy in targeting groups known to be vulnerable and stressed the importance of improving access to talking therapies.

The All-Party Parliamentary Suicide Prevention Group of MPs and Peers has called for all local authorities to be required by the Government to develop a suicide prevention plan led by the Director of Public Health or a senior member of the public health team. The plan should include provision for self-harm prevention and support for people who have been bereaved by suicide.

**War veterans**
A report published by the Commons Welsh Affairs Committee says public bodies need to do more to support Armed Forces veterans in Wales, particularly in the key areas of housing and health where there are currently problems with provision.

The report also raises concerns about standards of psychological support. It says some charities are ‘providing treatments for complex psychological issues that do not meet NICE guidelines’ and warns that the regulation of charities may be ‘insufficiently robust in this area’. It says the Charity Commission should insist that veterans’ charities offering medical, psychological or counselling services provide documentation from the relevant professional bodies to confirm that they have the appropriate endorsement for the services they offer and calls on the Cabinet Office to take this forward as a matter of urgency.

**School-based counselling**
In Scotland, Dr Richard Simpson MSP (Lab) asked what the Scottish Government made of the Welsh Government’s evaluation of its school-based counselling strategy. Responding for the Government, Minister for Learning Alasdair Allan MSP confirmed that Scottish Government officials met BACP in August 2012 to discuss the report’s findings and their relevance for Scotland. He went on to state that Education Scotland is now in discussion with BACP to identify how best to disseminate the findings to Scottish local authorities.

**Counselling courses**
Counselling was also the subject of parliamentary questions in the Northern Ireland Assembly. David McIlveen MLA (DUP) asked two questions relating to the number of counselling courses offered in Northern Ireland, and numbers graduating. (The response was eight courses offered at Queens University, the University of Ulster and the Open University, from which 902 students graduated in the past five years; and 31 in further education colleges, with 1,589 enrolments on courses that include counselling.)

**MPs’ mental health**
Finally, back to the House of Commons where, at a meeting on 11 February, the House of Commons Members Estimate Committee (MEC) approved limited funding for an assessment and referral service that will enable MPs to access secondary mental health care while in Westminster. This follows the passing of the Mental Health Discrimination Bill, which removes longstanding legislation that meant an MP had to stand down if s/he was treated under the Mental Health Act for more than six months. The long overdue reform also removes the ban on people with mental health problems from being company directors and from serving on a jury.

‘Lady Mar suggested that the results of a trial into the effectiveness of CBT and GET treatments had been artificially inflated’
Green light for Early Intervention Foundation

The Early Intervention Foundation (EIF) started work this month, following the final go-ahead from the Department for Education.

The contracts between the Early Intervention Foundation Consortium, of which BACP is a supporting organisation, and the DfE were signed last month. An independent Early Intervention Foundation was one of the recommendations of MP Graham Allen’s Early Intervention: the next steps report, published in 2011. The Foundation will be supported by the Consortium members until it is established as a charity in the summer.

The EIF is being set up to champion and support greater use of early intervention approaches. The aim of early intervention is to break the intergenerational cycles of dysfunction by identifying early signs of social problems and seeking to ensure that every baby, child and young person has the social and emotional skills they need to be able to fulfill their potential.

The EIF will initially focus its work in England and will:

• assess which programmes work – to determine both the best early interventions available and their relative value for money
• produce evidence-based, practical advice for local commissioners, service providers and potential investors to help them choose the best supports to meet the needs of children and families
• advocate for early intervention as a serious alternative to expensive and ineffective late intervention.

Graham Allen, who chairs the Foundation, said: ‘It is fantastic news that contracts have been signed. The Consortium will be working tirelessly to get the Foundation up and running.’

Public worried by long waits for counselling and therapy

A majority (85 per cent) of people surveyed by health insurer Aviva for its Health of the Nation report say they are worried that having to wait to have talking therapies would worsen any mental illness they have.

Nearly three quarters (73 per cent) also feel the Government and NHS are failing to do enough to tackle mental health problems, and more than half (51 per cent) say a period of two to three weeks is the maximum time they should be waiting for treatment following a referral.

The report also highlights GPs’ experiences and concerns about mental health provision and access to counselling and psychotherapy locally: 84 per cent of GPs in the survey complained about long waiting lists for talking therapies.

BACP is a member of the We Need to Talk coalition, which has called on the NHS in England to offer a full range of evidence-based psychological therapies to all who need them within 28 days of referral. The coalition emphasises the need for speedy access to appropriate interventions, and recognises the devastating impact on a person’s life from prolonged waiting times.

For further information about the coalition and its work, visit www.mind.org.uk

Welsh School Bill passed

As we go to press the Welsh Government’s School Standards and Organisation Bill is set to receive royal assent and become law.

The Bill will ensure that all secondary school children in Wales have a statutory right to school-based counselling. BACP has supported the Bill throughout its progression through the Assembly, stressing the important role school-based counselling can play for children and young people’s health and educational attainment.

It was BACP’s 2011 evaluation of the Welsh school-based counselling strategy that showed its popularity with students, parents and teachers.

Report raises concerns about care of child offenders

A joint report from the Prison Reform Trust and the charity YoungMinds reveals that high numbers of children with mental health needs and learning disabilities are getting caught up in the criminal justice system.

The report, Turning Young Lives Around, says that children who offend often have health, care and education needs that, if they are not met, can lead to a lifetime of ill health, unemployment and crime.

Some 25 per cent of children who offend have a low IQ; 60 per cent have communication difficulties, and half of these have poor or very poor communication skills; 43 per cent of those on community orders have mental health and care needs and prevalence of mental illness among those in custody is even higher.

The report says health and criminal justice services are still not working together well to ensure that these vulnerable children have access to the right support, despite recent improvements in mental health services for children. It sets out a blueprint for how the NHS and the Criminal Justice System can ensure better health and education provision to these vulnerable children and young people.

The full report can be downloaded from www.prisonreformtrust.org.uk

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CPR journal seeks editor

Andrew Reeves has announced his intention to step down from the editorship of Counselling and Psychotherapy Research (CPR), the BACP flagship research journal, after five-and-a-half years in post.

The position is advertised in the March issue of CPR. Andrew was appointed editor of CPR in January 2008 and has since made a number of important changes to the journal.

Throughout this time the journal has continued to be distributed as a member benefit to all BACP members, making it one of the widest distributed counselling and psychotherapy journals nationally and internationally. Around half the annual submissions to CPR now come from counsellors and psychotherapists working outside the UK and the journal has continued to make a strong contribution to the emerging evidence-base for counselling and psychotherapy, drawing on a range of approaches to research.

CPR has also expanded its electronic access. The journal now has its own website (www.cprjournal.com), a Twitter feed (@cprjournal) that provides regular updates of new research, links to articles and general research news, and a free quarterly e-bulletin giving details of forthcoming articles. More than 90,000 full articles were downloaded from the website last year.

CPR can be accessed online by BACP members for free via the BACP members’ area at www.bacp.co.uk

Further information about applying for the editor post can be found in the March issue of CPR.

Professional regulation special issue of the British Journal of Guidance and Counselling

BACP Registrar and Director of BACP Registers Dr Sally Aldridge has co-edited a special symposium issue of the British Journal of Guidance and Counselling with a focus on professional regulation: philosophy, policy and practice.

Dr Aldridge has co-edited the issue with Professor Rachel Mulvey, Associate Dean and Professor of Psychology at the University of East London.

The symposium issue contains articles covering a wide range of views and positions on regulation and regulatory models.

Waller and Guthrie consider statutory regulation in the Health Professions Council (HPC) but counsellors and psychotherapists were excluded by the change of government policy.

Cayton and Bilton present the Council for Healthcare Regulatory Excellence’s (CHRE) model of Right Touch Regulation (RTR) and the scheme to accredit voluntary registers.

House and Musgrave take a different view and propose a local model of professional accountability that, in their view, both protects the consumer and regulates the professional, while preserving the diversity and creativity of therapy.

Etienne comes from a different discipline and applies the economic theory of ‘homo economicus’ to professional regulation. He queries both the extent to which it has been successful in the first place and then how well it transfers to other occupational sectors.

Martin, Turcotte, Matte and Shepard appraise the progress of statutory regulation in Canada, which they depict as a mosaic that in itself reflects the varied cultures and contexts in which Canadian professionals practise.

By contrast, Hughes’ article, with a focus on the UK and particularly on England, conveys a sense of history in the making as it describes how the various careers working collectively to demonstrate the value of their contribution to society.

Further information about the journal’s content and abstracts, please visit www.tandfonline.com/toc/cbjg20/41/1

Research surgery

The BACP Research team has a regular research surgery to support BACP members who have a research dilemma, question or problem.

The research surgery will be via telephone with Andy Hill (Head of Research) and Dr Jo Pybis (Research Facilitator).

The 30-minute sessions are offered throughout the year and are available to any BACP member, whether you are new to research or an experienced researcher.

The next research surgery date is Wednesday 24 April.

To book a session, contact Stella Nichols in advance on 01455 883372 or email her on stella.nichols@bacp.co.uk.

Slots are limited so please book early in order to avoid disappointment.

Research workshop

Andy Fugard, from the CAMHS Outcome Research Consortium (CORC), will be running a workshop on ‘Practice research network: making routine outcome monitoring more manageable’ at the BACP Children and Young People annual conference in London on 8 June.

The workshop will be of interest to counsellors working with children and young people who wish to find out more about the use of electronic platforms (which are available at no cost) for the collection and analysis of outcome data.

For more details about this event, visit www.bacp.co.uk/events
Counselling for bullying

A recent study published in Child Care in Practice has found that school counselling is effective in supporting pupils who have been bullied.

Longitudinal data were collected on 202 pupils across 47 schools in Northern Ireland between September 2004 and December 2005. A total of 55 pupils (27.2 per cent) were referred to the school counselling service for help with issues relating to being bullied.

Participants completed the self-rated Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) and school counsellors determined ‘bullied/non-bullied’ status in accordance with Olweus’ (1994) definition.

The results showed that the intervention was successful in promoting positive change in the emotional health and wellbeing of both bullied and non-bullied pupils. However, this change was greatest in bullied pupils.

The study also found that the pupils with the highest levels of distress at the initial stages of counselling improved the quickest over time, suggesting that school-based counselling interventions are particularly effective for those who have elevated levels of distress when entering counselling.


BACP Professional Conduct Hearing

Findings, decision and sanction

Susan Wilburn
Reference no 622715
Doncaster DN4

The complaint against the above individual member was heard under BACP’s Professional Conduct Procedure 2010 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 it was unanimous in its decision that those findings amounted to serious professional malpractice on the grounds of incompetence, recklessness and providing professional services which fell well below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill. The Panel found such malpractice required the suspension of Ms Wilburn’s BACP accreditation.

Mitigation

Ms Wilburn admitted in her formal response that she was responsible for the failure to maintain appropriate boundaries in the counselling relationship and that she had been unwise in allowing extensive outside of counselling contact with her client through texting and phone. Ms Wilburn gave evidence of the following changes that she had made within her practice:

• she had reviewed her written client contract in light of this experience
• she had improved her record-keeping and case notes
• she intended to put in place further training in mental health issues.

Sanction

Within one month from the date of imposition of this sanction, which will run from the expiration of the appeal deadline, Ms Wilburn is required to provide a written submission which evidences her immediate reflection on, learning from and understanding of the issues raised in this complaint.

Additionally, in no less than six months and no more than 10 months from the date of imposition of this sanction, Ms Wilburn is required to provide a further written submission, countersigned by her supervisor, which evidences the following:

• the importance of boundary-keeping in counselling and psychotherapy
• the avoidance of fostering dependence in a counselling relationship
• keeping and recording case notes
• impact of dual roles in counselling and psychotherapy
• making risk assessments in work with clients
• differences in working in an agency setting and in private practice
• proper use of supervision as a means to monitoring professional competence.

Ms Wilburn will be required to appear for interview before a Sanction Panel within 12 months from the date of imposition of the sanction, to give further evidence of her sufficient learning from and understanding of the issues raised in this complaint.

Prior to appearing at an interview, and within 10 months from the date of imposition of the sanction, Ms Wilburn is required to provide written evidence from the training provider of enrolment and completion of formal training, of no less than 12 hours duration, in understanding mental health problems presenting in counselling and psychotherapy.

This evidence should be submitted to BACP and should include confirmation of Ms Wilburn’s attendance/satisfactory completion from the training provider.

These written submissions must be sent to the Registrar by the given deadlines and will be independently considered by a Sanction Panel.

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

Research conference

The 19th BACP Research Conference takes place on 10–11 May at The Forest of Arden Hotel, Meriden, near Birmingham.

The 2013 conference is co-hosted with the Irish Association for Counselling and Psychotherapy and is titled ‘Synergy in counselling and psychotherapy research’.

The brochure and booking form are now available and can be downloaded from the BACP website. Please visit www.bacp.co.uk/research