Chronic pain and self-acceptance

Is tomorrow’s therapist a smartphone app?

Accepting the ‘other’ within
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Correlation doesn’t mean causation. The correlation between the unremitting rise in mental health-related benefits claims and the steep increase in antidepressant prescriptions across the developed world (see News p4) is a case in point. Could the antidepressants themselves be exacerbating the problem? How come so few people recover from depression and come off the drugs? Why, if the drugs work, aren’t the people prescribed them back at work, working, too?

There is statistical evidence from long-term studies that people who aren’t prescribed antidepressants do recover, with time, and that they stay recovered. It’s also interesting to hear Joanna Moncrieff’s suggestion about emotional as well as chemical dependency on the pills; the message that we have a brain disorder that requires drug treatment has a profoundly disempowering effect, she argues. Why else do we continue to take the pills when they appear not to help?

Kim Patel (pp10–15) lives with medically incurable chronic back pain. She knows what it is like to find your mental and physical horizons closing in as the pain limits what you can do.

In proposing that the solution lies in accepting this drastically altered concept of herself, she is in no way suggesting the pain is ‘all in her mind’. She is simply pointing out the physiological truth that ‘pain perception resides in the brain, so it follows that the brain is where treatment [by which she means talking therapies, not medication] should be targeted’.

Continuing with this mind/body theme, we have Lisa Jenner’s fascinating article (pp28–30) on the costs to the therapist of that quintessential, person-centred counselling tool, empathy. Why do so many people in the caring professions suffer burnout? A recent article in the New Scientist (‘How sharing another’s pain can make you sick’, 11 May 2016) offers an answer: emerging research suggests that regarding someone else’s pain with compassion, with the Buddhist concept of loving kindness, having a ‘feeling for, not with the other’, is protective of the therapist’s sense of self. But then Rogers knew that when he distinguished between what he called the ‘as if’ condition and the ‘state of identification’.

Catherine Jackson
Acting Editor

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‘My aim is to combine science and the human, evoking positive emotions and enjoyment using multimedia... I’m adding heart to art to science’
Tuvi Orbach (p8)

‘When the objectified other chooses not to remain invisible, we are left facing our own shadow. This is the cost... in understanding difference’
Dwight Turner (p16)

“BACP members want to know that their professional body champions their professionalism.”
Well, not this one, he doesn’t’
Letters (p37)
School counselling standards ‘variable’

Standards of skills, qualifications and training in school counselling are variable and inconsistent, a report from the IPPR thinktank says. It says counsellors should be suitably qualified and receive specialisation training before they can work in schools, and it wants to see an onsite school counsellor or other mental health practitioner present in every secondary school on at least one day a week.

The report, Education, Education, Mental Health, says: ‘Nowhere is the crisis in children and young people’s mental health felt more acutely than in our secondary schools, which increasingly find themselves on the frontline.’ It says secondary schools should be placed at the heart of early intervention provision for children and young people to identify and prevent low-level mental health problems developing into severe mental illness.

But, it says, the quality of school counselling provision in particular is variable and inconsistent. It says schools cannot be sure that the counsellors they contract are suitably qualified and experienced. It wants the Government to set out a ‘road map towards making counselling a regulated profession, with a clear “specialist” route for working with children and young people in school settings’, including a national recruitment drive for school counsellors, an assessment of available training courses ‘with a view to raising the entry requirements in line with other professional qualifications regulated by the Health and Care Professions Council’, and the introduction of a ‘school-ready’ kitemark to demonstrate that a counsellor is suitably qualified and experienced to work with children, young people and families in a school setting.

BACP has challenged some of IPPR’s recommendations. ‘BACP has a government-approved voluntary register and we are confident that the standards we require for qualification and training are as high as those required by professions regulated by the HCPC, if not higher. The numbers on BACP’s register suggest there is a sizeable workforce available. However, we agree that counselling children requires specialist training, and we will be meeting with IPPR to talk further about their recommendations,’ a spokesperson said.

http://tinyurl.com/jhbfo3a

Antidepressants may be causing chronic depression, MPs told

Antidepressants may be fuelling the rise in the numbers of people who are unemployed and claiming benefits because of mental health problems, MPs on the All Party Parliamentary Group (APPG) for Prescribed Drug Dependence have been told.

These claims have risen to more than 1.1 million, alongside a 500 per cent increase in prescriptions for antidepressants to almost 60 million in England. The picture is similar in many other countries in the developed world. Yet benefit claims for other common health problems, such as musculo-skeletal conditions – are falling.

Speaking at an event in Westminster on 11 May arranged by the APPG to discuss concerns about the rising numbers of disability claims for mental illness in the UK, US health writer Robert Whitaker said that long-term follow-up studies show that up to 80 per cent of people with depression who take antidepressants remain depressed, yet 85 per cent of those who don’t take antidepressants are recovered and remain well at one year. ‘Drugs may be helpful for the short-term but maybe they increase progression of the disease in the long-term. They make you more vulnerable to depression,’ he said.

Joanna Moncrieff, senior lecturer at University College London and a practising consultant psychiatrist, disputed the belief that antidepressants work by reversing a chemical imbalance in the brain. ‘There is no evidence for this or even that there is a chemical imbalance associated with depression. It is a myth put about by drug companies,’ she said. She called for more research into the psychological effects of being prescribed antidepressants: ‘I think many people given a pill hear the message, “You have a problem with your brain, you need this drug to put it right,” and that has a profoundly disempowering effect. It sets people up to a lifetime of chronicity... Doctors need to look for alternatives.’

However, fellow consultant psychiatrist Alan Green warned against jumping to conclusions ‘based on soundbites’. The problem is not the over-prescribing of antidepressants so much as under-resourcing of good, holistic, multidisciplinary mental health care, he said. ‘We are spending the money but we are spending it on disability payments.’

http://prescribeddrug.org
Prisoners want counselling

Offenders say access to counsellors could help cut the risk of suicide in prisons.

Interviewed by the Howard Reform Trust and the Centre for Mental Health for a new report on Preventing Prison Suicide: perspectives from the inside, prisoners said that prisons need more staff, including counsellors with specialist skills in, for example, trauma, drug abuse and eating disorders, as well as training for all staff in relational skills such as being caring, non-judgmental and able to engage with prisoners and build up trust.

The report focuses on the views and experiences of current and former prisoners about what contributes to vulnerability and what increases or reduces their risk of suicide. It is one of a series of briefing papers by the two charities.

The last two years have seen a marked increase in the number of suicides in English and Welsh prisons, with 89 prisoners taking their own lives in both 2014 and 2015. This was the highest number of suicides since 2007.

Preventing Prison Suicide finds that relationships between staff and prisoners are key. Prisoners need to feel supported, cared for and able to confide in and trust staff. Prisoners reported that staff shortages, inexperience and lack of training can all increase the risk of suicide, the report says.

Prisoners described a culture where distress was often disbelieved or not responded to with compassion. One said: ‘[Suicidal prisoners] can’t cry for help because they are not the sort of person who can or, actually, who’s going to listen?’

Preventing Prison Suicide argues that prisons should be ‘enabling environments’, aiming to create a psychologically informed environment with an emphasis on the quality of relationships, and that prisons need more staff, with specialist skills, and better training in mental health awareness.

http://tinyurl.com/hm572zs

Call for tighter regulation

One in four counsellors and psychotherapists struck off their registers by BACP and UKCP are still practising, a new report from the campaign group Unsafe Spaces says.

The report, Why the Lack of Regulation in Counselling and Psychotherapy is Endangering Vulnerable People, is based on a survey of withdrawal of membership notices posted on the BACP and UKCP websites over the past 10 years. Internet searches revealed that nearly one in four of those struck off by BACP or UKCP were still advertising their services. In the case of UKCP, every single member struck off its register in the past five years was continuing to advertise their services as psychotherapists, including those barred for very serious allegations, including serious sexual misconduct.

Unsafe Spaces wants the professional titles ‘counsellor’, ‘psychotherapist’ and ‘coach’ to be protected in law and subject to statutory regulation, so that no one can use these titles if they aren’t registered. BACP and UKCP have both adopted the Professional Standards Authority’s voluntary registration system, which does not have this power.

Phil Dore of Unsafe Spaces said: ‘It is clear that, from a safeguarding perspective, the current system of accredited registration is a complete failure. It is simply not effective at removing rogue practitioners from the counselling and psychotherapy professions.’

http://tinyurl.com/hhkbcf7

Magic of mushrooms for treating depression

Magic mushrooms are safe to use in treating depression and can be beneficial, a small-scale pilot study by researchers at Imperial College London has found. The study, funded by the Medical Research Council, aimed to establish if psilocybin, the psychedelic compound in magic mushrooms, can be safely administered, with appropriate support, to people with treatment-resistant depression.

Twelve people (six men and six women, aged 30–64) with moderate to severe treatment-resistant depression were given psilocybin in two dosing sessions, seven days apart, and followed up at one, two, three and five weeks after the second dose.

No serious unexpected side effects were reported and all patients showed some decrease in symptoms of depression for at least three weeks. For seven, the improvement continued for three months after the treatment, and five remained in remission after three months. Senior researcher Professor David Nutt said the study showed that psilocybin was safe and could be of benefit for treatment-resistant depression. Lead researcher Dr Robin Carhart-Harris warned: ‘I wouldn’t want members of the public thinking they can treat their own depression by picking their own magic mushrooms. That could be risky.’

http://tinyurl.com/ktxzarc

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Can software ever replace the therapist?

As the NHS seeks to expand access to talking therapies within limited resources, digital technology could provide the solution, writes Bina Convey

The huge challenge of meeting public need and demand for psychological therapies within already overstretched resources may seem like a mission impossible, but digital innovations are already playing a transformative role. Could they be the answer to making therapy more widely available?

NHS England has been tasked with increasing the treatment capacity of IAPT services over the next five years from 15 to 25 per cent of adults with mild to moderate anxiety and depression, and providing mental health care to at least 70,000 more children and young people. Part of this plan is the greater use of non-face-to-face services, and the Department of Health is supporting a number of trials and pilots to develop digital alternatives to the traditional face-to-face appointment with the therapist or psychologist in the clinic or counselling room.

One way to meet the rising demand within budgetary constraints is to cut the human element from the equation, much as supermarkets have introduced customer self-checkouts to cut their wage bills. Yet a report published in the British Medical Journal last year suggests this may be a false trail. Contrary to a body of studies demonstrating the effectiveness of online therapy, the REACT trial, the largest of its kind, found computerised CBT (cCBT) to be of little or no benefit, and its authors concluded it was an inefficient use of resources. The main problem was low engagement with the commonly prescribed Beating the Blues and MoodGYM programmes; participants in the trial said they wanted more direct support from a human therapist.

The need for the human element is something of which those developing computerised systems are well aware. ‘These types of interventions don’t have the same positive effect without human interaction. For the client, knowing someone is there, checking in on their progress, adds accountability and responsibility,’ says Derek Richards, Director of Clinical Research and Innovation at SilverCloud. SilverCloud, born out of a seven-year research project at Trinity College, Dublin, offers 40-minute CBT-based modules supplemented with asynchronous text messages from a clinician. The average user will recover within 4.8 sessions (as measured by clinical scales such as GAD-7), but the drop-out rate is 75 per cent. Richards takes the pragmatic view that the programme is not designed as a stand-alone system and some clients may need a higher intensity of human intervention: ‘It’s not a panacea. It’s one step in care. My view is that SilverCloud or any other application is not a fix for everything,’ he says.

Around 2,000 people sign up to the SilverCloud system each year through the Berkshire Healthcare NHS Trust IAPT service. Judith Chapman, Clinical Director of Talking Therapies at Berkshire IAPT, says it was the therapists who needed more persuading of its benefits, not the public: ‘The bigger challenge was for the workforce to know that it’s not a lesser treatment and it’s working.’ But Berkshire IAPT is also trialling a new one-to-one online therapy programme, staffed by 10 therapists, using a platform provided by IESO Digital Health. This provides a secure chat room where therapists use CBT with their clients at a designated time slot. Chapman points out that cost-efficiencies include not having to employ a receptionist or provide a private and suitable counselling room, and that therapists can work alongside each other in an open-plan office.

She agrees that computerised therapy is not for everyone; it’s not suitable for people with complex needs, social problems and addictions, for example. However, for others online therapy can remove barriers to finding support. Men – notoriously hard to persuade to seek counselling – seem to prefer the online option: Berkshire IAPT reports a 50/50 ratio of men to women accessing online support, compared with 35/65 among those who have face-to-face therapy.

Removing barriers to access has been a selling point for Big White Wall (BWW), an online platform developed in partnership with the Tavistock and Portman NHS Foundation Trust. BWW offers facilitated online peer support through group and one-to-one chats, where users are anonymised. This sits alongside psycho-education and creative activities such as posting imagery and words on a virtual wall. The benefits derive from the 24/7 access, says BWW Service Manager Ian Toman. ‘BWW offers estimated savings based mainly on reducing unplanned care – we’re available when other services may be less accessible. Two thirds of our log-ins are out of hours. We complement existing services and add capacity where there might be a need out of hours, or at home, or for people who don’t want to engage with existing services.’

Yet, while popular with the NHS and universities, this award-winning platform has encountered a growing demand for human presence. Feedback from NHS commissioners and individual members led to the addition of a LiveTherapy option in 2012. The service is not yet available to all users, but BWW is recruiting more BACP and/or BABCP registered therapists this year to expand it.

Digital youth
Young people are the most likely client group to welcome digital therapy, and they are also the group for whom improved access is very much needed. Youth Access, which represents a national network of 170 youth information, advice and counselling...
Tuvi Orbach, creator of Beating the Blues, tells Catherine Jackson about his latest venture

Beating the Blues (BtB) was one of the first computerised CBT (cCBT) applications in the UK, and rapidly became the most widely used for treatment for anxiety and depression, thanks to its endorsement by NICE in its 2006 guidance on cCBT. It helped to have randomised controlled trial (RCT) evidence for its effectiveness, which put it ahead of rival packages, and NICE recommended it to GPs to make available in their surgeries.

Tuvi Orbach, who developed BtB and founded Ultrasis, the company that still produces it, now chairs a charity, MindLife UK, and is working with a number of leading psychologists on a third wave CBT-based computer package called iFitForLife that he says offers revolutionary new elements that are missing from BtB and other computerised CBT applications.

‘Beating the Blues was highly advanced in its time but when we developed it people didn’t have mobile multimedia devices. It was designed to be like meeting your psychologist in his clinic once a week.’ BtB too has evolved to include gentler, less mechanistic approaches such as mindfulness and Acceptance and Commitment Therapy (ACT), he points out.

While BtB was designed to replace the psychologist, Orbach now believes the most effective therapy should combine real human interaction with an interactive self-help app. ‘The connection with a human therapist is important to create a relationship that offers understanding, sympathy, empathy and compassion, and to personalise interventions to the unique needs of the client,’ he says. Interactive multimedia can add to this by providing 24/7 self-help information, engaging evidence-based interventions, easy to use assessments and exercises to carry out between sessions. The combination of a human with a personalised interactive application would enable healthcare providers, and clients, to achieve the best outcome and get the most out of the money they spend on treatment, he argues.

iFitForLife combines a number of elements to make up a comprehensive package that Orbach says any qualified therapist can use, and adapt, to meet their individual clients’ needs: a digital platform that allows communication between the therapist and client, alongside and following face-to-face appointments; a multimedia self-help app that can include any evidence-based therapy, intervention, assessment and education, from CBT and motivational interviewing through to person-centred counselling; flexibility so it can be personalised and customised to each client’s needs by their therapist, in consultation with the system’s expert advisory panel, and a comprehensive set of tools to assess and evaluate the client’s progress. The system will also allow therapists to talk to each other, to share experience and learning, and allow clients to do the same with each other.

Importantly, engaging with iFitForLife will be fun, Orbach says. ‘Therapy should be enjoyable. You need to make the therapy so people will love doing it. My aim is to combine science and the human, evoking positive emotions and enjoyment using multimedia – just like Adele’s voice can move people when they listen to her on their mobile.’

Orbach argues that iFitForLife could solve the problem of achieving universal access to an unlimited choice of evidence-based psychological therapies in primary care: GPs and IAPT providers could refer clients to any registered, qualified practitioner across the UK, who would use iFitForLife, alongside and tailored to their modality and to their individual clients’ needs.

He is currently adapting the iFitForLife concept to a specialist iFitForWork application. He believes this could achieve the Department for Work and Pension’s ambition to get more unemployed people with mental health problems back into work, without the toll of suicides among those wrongly deemed able to work.

Orbach argues that therapists collaborating with job centres will be able to use iFitForWork to assess a client’s work readiness, identify areas where they need more help, and only then introduce self-help programmes that will build and strengthen their motivation and resilience to enter the job market.

‘Many unemployed people are not ready for return to work; many aren’t even considering it. If they’re not ready to be helped back into work, then it’s a waste of time trying to push them into it,’ he explains. ‘What you need are sensitive tools to allow you to identify those who are ready for work and those who are not, to find out what the specific barriers are for each individual and work on them, using a range of CBT, motivational interviews and other methods.’

Readers of Therapy Today can trial iFitForWork at demo.iFitForWork.org or, for more information about the project, email therapy@mindlife.net
The human element to therapy cannot be replaced... Computers can be useful to educate in a self-help type of approach. However, this is very different to the relational element that is the catalyst for change.

The digital revolution has undoubtedly made counselling accessible to people with mobility problems and others whose disabilities make it hard for them to leave their home. Person-centred counsellor and private practitioner Helen Rutherford, who has a progressive disability herself, uses instant chat, email and video/audio platforms.

Online interventions, she says, give the client a greater sense of autonomy, but human connection is a vital component. ‘I feel the human element to therapy cannot be replaced. Computers can be useful to educate in a self-help type of approach. However, this is very different to the relational element that is the catalyst for change. An advanced empathetic understanding is key to the development of the relationship I have with my clients. Offering that level of understanding allows clients not to feel isolated and alone in their experiences. If there was no human involved this would surely feed into that element of isolation some clients feel,’ she says.

Rutherford finds that the written word provides additional material for reflection, for both therapist and client, but new skills are needed. ‘You need to have an awareness and understanding of miscommunication, the safety of the client and any fantasy that the client may bring into the session.’

Assistive technology, such as speech recognition systems for people with cerebral palsy, will become an invaluable tool in accessible therapy, Rutherford believes: ‘It is early days but I hope that assistive technology and therapy can be combined to support many more people.’

The jury remains out as to whether digital therapy is as clinically effective as face-to-face therapy with a human therapist, which also raises questions about its cost-effectiveness. Health economist and researcher Simon Leigh of Lifecode Solutions has a special interest in the quality control of mental health applications. He believes that platforms using algorithms – a step-by-step approach to which cognitive behavioural therapy (CBT) is ideally suited – can vastly reduce waiting lists and save money. But, he warns, they also carry a significant risk.

‘The potential to save money is there [in these systems] and the best way they can do that is not to be constrained by a human being,’ he says. But the most extreme version, where there is no interaction with a skilled therapist, whether through messages or in an online conversation, carries the danger that the user will either not use it at all or there will be no monitoring of how that person is progressing, he warns.

The economic argument may look good on paper but it fails to add up if the service is ineffective. John Nuttall, Professor of Integrative Psychotherapy at Regent’s University, London and Chair of the third sector service West London Centre for Counselling (WLCC), contests the reliability and depth of therapy that can be obtained from computerised systems, and particularly the quality of tick-box computerised assessments. ‘Research shows that psychotherapy effectiveness is about the relationship that builds between two people, and that starts in the assessment. The depth of a presenting problem is not always clear via a computer or over the phone, or ticking boxes on a screen. This does not indicate the underlying issues causing depression or anxiety and assessors don’t get a feel for the origins of the distress,’ he says. The very ethos of psychotherapy is at stake, in Nuttall’s view. ‘We have to be careful to put systems in place that fulfil cost-effective objectives,’ he agrees. ‘This is something that the profession wishes to deliver. But this does not mean sacrificing the clinical process and outcome to achieve spurious low-cost delivery.’

References
Chronic pain and the self
I am ‘medically unexplained’. I have chronic pain and doctors have been unable to provide a pathological explanation for why it hurts and spasms, even though they can see inside my back by way of ‘sexy’ imaging (my husband’s term). Because there is no evidence of a bulging disc or some other physical cause, I am given a ‘diagnosis’ of ‘medically unexplained symptoms’ (MUS, or sometimes MUES). And I am not alone. Many people have very painful long-term health conditions (LTHCs), such as fibromyalgia, chronic fatigue and irritable bowel syndrome, which also all go into the MUS cookpot, along with medically unexplained chronic pain.

MUS featured in the DSM-IV-TR,¹ as a ‘somatoform disorder’, so I (technically) had a psychiatric diagnosis for my chronic pain. Whoop, whoop! In DSM-5² somatoform disorders have become ‘somatic symptom disorders’, defined as ‘characterized by somatic symptoms that are either very distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings and behaviors regarding those symptoms’.² For the record, as a person-centred counsellor, I consider such labels and diagnoses to be red herrings.

All pain is real, and pain is whatever the patient says it is – to borrow a mantra from my former nursing profession. In 1965 the gate control theory of pain,³ for the first time, acknowledged the importance of physiological, social, behavioural and psychological influences and demonstrated the role of emotions in pain amplification and meaning. Memory and neural networks in the brain have also been shown to maintain pain,⁴ and we now know that the limbic system in the brain, when exposed to stress and pain experiences, sensitises the nervous system to be pre-disposed towards pain.⁵

Pain is ‘an unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage’,⁶ which suggests that tissue damage is neither necessary nor sufficient for pain to exist. Acute pain is useful; it alerts us to potential or actual tissue damage so we can stop whatever it is we are doing, limit further damage and begin recovery. Usually pain abates
Chronic pain

with healing (where healing is possible, of course). However, for some people pain persists beyond tissue healing; in nursing terminology, pain is deemed to have become chronic when it persists for three months or more.

Chronic pain has no useful qualities; it causes considerable emotional distress and impairs social and occupational functioning. Its cause is largely irrelevant – in my own experience as a nurse (specialising in pain management) and as a counsellor, people with chronic pain, with or without a pathological diagnosis, share similar physiology, thoughts, feelings and behaviours. (What a diagnosis might mean to the individual is outside the scope of this article.)

Although the medical professions and the public may be more sympathetic these days towards the concept of a mind/body connection, the Descartian split persists, largely unchallenged, in the medical model of healthcare. But human beings are not compartmentalised like this. Illness, disease and injury are not solely physical, behavioural, emotional or psychological. Like eddies, they may appear to be distinct from the rest of the stream but they are indissolubly part of the whole. In health (and non-health), we are the sum of all our parts.

Chronic pain and recovery

Using both my former nursing head and my current counsellor head, I have reflected on how I have changed since I became ‘medically unexplained’, and why. I wanted to better understand why I ‘recovered’ (another label) when others have not and, indeed, may become why. I wanted to better understand why I became ‘medically unexplained’, and reflected on how I have changed since my counsellor head, I have brought my own experiences and those of others with whom I’ve worked. I’ll explain the process here, using two fictional, composite clients drawn from my own experiences and those of others with whom I’ve worked.

Based on my personal experience and observations in my professional work, I believe that the self-concept changes with the onset of chronic pain (and LTHCs) and continues to do so throughout the chronic pain/LTHC journey, and the person’s life. Recovery, as I have defined it above, depends on whether the person accepts or rejects their changed self. I’ll explain the process here, using two fictional, composite clients drawn from my own experiences and those of others with whom I’ve worked.

Saffron’s pre-pain self was strong, capable, independent, school assistant, wife, mother, sexually experimental and sexually active. Then she was involved in a car accident and diagnosed with ‘spinal problems’. Saffron’s early pain self-concept was damaged/broken, pain, school assistant, wife, mother, sexually

‘Human beings are not compartmentalised like this. Illness, disease and injury are not solely physical, behavioural, emotional or psychological... In health (and non-health), we are the sum of all our parts’
limited. She attempted to carry on as she had before the accident (despite the pain) but was eventually unable to continue working (due to pain).

Saffron actively sought a surgical cure for her pain; she had many operations, without success, and her use of pain medication (including opiates) rapidly increased. Her husband left his job to become her carer, as she had difficulty walking and struggled to manage their three children. Saffron’s depression worsened and she experienced increasingly intrusive, catastrophising thoughts. Her self-concept changed to include disabled (she is a Blue Badge holder and uses a mobility scooter), useless, helpless, burden, (largely) sexually inactive, wife, mother, broken, unfixable. She was awaiting further spinal surgery when she finally agreed to her husband’s suggestion that she ‘talk to someone’.

Louise’s pre-pain self-concept included teacher, strong, independent, wife, mother, capable, sexually active, dancer. In the previous year, Louise and her husband had experienced marital difficulties and had moved house. She woke one day with back pain, which was later diagnosed as ‘medically unexplained’. She tried to carry on at home and at work, but quickly found it impossible, because of the pain (or anticipated pain). She gave up trying to do the household chores and left her job. Then her husband moved out. Her early pain self-concept was useless, burden, hopeless, helpless, lonely, and alone, with catastrophising thoughts and the belief that the pain would never change or go away. Despite medication, Pilates, physiotherapy and acupuncture (for the pain), Louise was unable to drive, use a knife and fork or even hug her child. Her self-concept was broken, useless, helpless, burden, dependent, non-productive, lonely, alone, never teach or work again, drowning in pain. She began to take antidepressants.

Her mobility became increasingly restricted, and Louise could see she was heading towards a wheelchair. She decided she didn’t want to go there. She began working with her pain, taking small steps towards performing household activities, and as she did so she noticed how her thoughts and emotions influenced her experience of the intensity of the pain, and vice versa. She began to use this awareness of the mind/body connection to guide what she did.

Her self-concept changed gradually; it now incorporated determined, trying, strong, trying to find balance, productive in small ways, hopeful. She found ways to address her loneliness. Through self-directed pacing of activities and graded exposure to exercise, she was able to move more, without an increase in pain. With her GP’s support, she began to withdraw from her pain medication and antidepressants. (With chronic pain, medication is of limited use in reducing/ameliorating the perception of pain.) Her self-concept now included independent, strong, with pain and OK, wife, mother, and friend.

### How I work with chronic pain

I divide the chronic pain and LTHC journey into three phases (see Figure 1 over page). In the first phase we move from pre-pain/injury to injury/pain, and non-acceptance of the pain. We are looking for a cure for the pain and the pain controls us and our choices. It is a vicious cycle of fear, depression, anxiety, avoidance of activity that might cause pain, catastrophising and a revolving door of health professionals and/or alternative/complementary health practitioners in our attempts to ameliorate pain. Our self-concept is enmeshed in pain, and, like Saffron, we can become ‘stuck’ in this cycle, which may lead to disability, due to fear-avoidance of activity and social isolation.

Louise too was ‘stuck’ in phase one, but she didn’t want to be this version of herself. To move into taking control of her pain, she began a process of accepting her pain and accepting a self-concept of living in/with pain (phase two). My experience suggests there is some oscillation between these two phases of non-acceptance and growing acceptance, which can continue for some time. It is possible too to get ‘stuck’ in this oscillation phase. If the journey continues, the oscillation becomes less pronounced and finally stops, leading to a sense of integrated mind-body wellbeing (phase three). We realise that a cure for the pain is unlikely and we start to work with the pain. We may drop back into phase two if we experience a pain flare-up or a change in our LTHC, but this is generally only temporary. Thus the self-concept changes through the experience of chronic pain or LTHC, but the changed self-concept may also be the catalyst and motivator for recovery and regained wellbeing.

Pain perception resides in the brain, so it follows that the brain is where treatment should be targeted. Cognitive behavioural therapy (CBT) has had only variable success in treating chronic pain, with high drop-out and relapse rates. Indeed, Craig suggests CBT does not sufficiently recognise the role of emotions in chronic pain.

‘I certainly experienced a sense of disconnection from my back, and would speak about it as it were a separate entity (‘My back won’t let me do...’). Today I feel that reintegration or reunion; my back is once more part of me’
very little research into the effectiveness of the person-centred approach (PCA) with chronic pain, and a growing body of evidence for the helpfulness of mindfulness-based approaches.14

I believe we can harness the same neuroplasticity that entrenches maladaptive coping in response to pain (such as avoidance of movement) to improve our physical functioning and reduce pain (through graded exposure to exercise, for example). My own recovery began from a conscious decision to reject my pain-self (disabled) and embrace a pain-self (active), and (re)construct my behaviours, thoughts and the environment to bridge that gap between the undesired and desired self-concepts.9

I became more aware of my mind/body connection, and began to work with these insights, learning and testing out activities to see what I could do. With no knowledge of mindfulness or CBT, I intuitively (and compassionately) developed my own DIY versions, on my own, which I think was instrumental in my recovery.

I now offer my own model of pain management counselling, which blends the person-centred approach with mindfulness, self-compassion, neuroscience and CBT, and my nursing and personal knowledge of pain management. Since chronic pain is biopsychosocial, its management needs to include all those aspects. This was the approach I used with myself (intuitively and unknowingly), and that I now offer my clients. My biggest challenge with clients (and healthcare colleagues) is to educate them in and get them to accept the mind/body connection and the need to let go of ‘fixing’ through interventions.

So with Saffron, who is stuck in phase one, I might explore issues around (in no particular order):

- loss/grief
- self (old me, current me and desired me)
- the meaning of pain (pain as punishment?)
- thoughts
- fears
- expectations
- movement (talking around, and doing)
- pacing activities and setting baselines, and why and how
- primary suffering (the pain) and secondary suffering (the stuff we pile on top of the pain, such as thoughts, negative self-talk etc)
- sex (eg what are the most comfortable positions)
- education in the mind/body connection, chronic pain mechanisms as different to acute pain, the ‘virtual body’ and homunculus, pain/condition flare-ups and how to manage them, acceptance and resistance to pain/condition.

‘It is vital that Saffron is able to hear and feel that the counsellor believes her pain is real, because it is real. Ultimately my aim is to help Saffron to accept her pain and gain insight and self-awareness about herself and her pain’
The list is not exhaustive. It is vital that Saffron is able to hear and feel that the counsellor believes her pain is real, because it is real. Ultimately the aim of my work is to help Saffron to accept her pain and gain insight and self-awareness about herself and her pain. Acceptance of the mind/body connection and its influence on pain is essential and empowering, as Saffron is then able to appreciate that she can directly influence her pain experiences. Experimentally, she will be challenged by movement and activity (it was a source of terror for me). Education around boom and bust cycles, pacing and slowly building activity levels is essential. We are giving Saffron the tools to manage her own daily rhythm.

Through using her body and her growing self-awareness, she will come to understand that all pain is influenced by thoughts and feelings and behaviours, and will develop an acceptance of the pain, softening her resistance to it. (New) movements may increase her pain (she will be using muscles that haven’t been used for a while); this is expected with anyone taking up new activities (even if, in Saffron’s case, it is the washing up, rather than lifting weights in a gym). Mindful awareness may be helpful in this process.

Throughout, it is essential that we never forget that it can be terrifying (and lonely) to be challenging yourself in all these ways – physically, emotionally, cognitively and behaviourally.

From the evidence I have gained through reflection and my own counselling practice, I believe that the self-concept, rather than the actualising tendency, is the prime motivator of change – both with chronic pain and counselling more generally. What informs my counselling work is, in Rogers’ words, my belief in ‘individuals [having] within themselves vast resources for self-understanding and for altering self-concept, basic attitudes, and self-directed behaviour’.

For the counsellor, I believe that a sound knowledge of pain physiology (chronic and acute), and pain management theory and practice is essential. However, even without this knowledge, the counsellor can still help the client to explore their self-concept and losses and facilitate acceptance of their chronic pain, alongside introducing behavioural changes.

I believe that psychological approaches should be introduced much earlier in chronic pain management (rather than as a last resort when medical/surgical interventions fail). This would lessen the likelihood of pain chronicity and encourage the psychological flexibility necessary for the person to cope with and adapt to change. This model, based around the changing self-concept, may prompt other healthcare practitioners to suggest their clients with chronic pain and long-term health conditions seek psychological treatment earlier in the course of their journey.

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References
As a minority black, male transpersonal psychotherapist in the world of counselling and psychotherapy, I am always interested to read about difference from the perspectives of those who identify as other. Whatever form they take, from podcasts to academic articles, these writings have been important both in mirroring an understanding of my own experience of being an outsider living in the UK and now also in forming the backbone to my PhD studies in using creative techniques to understand the unconscious process involved in being the other. The words of these many disparate authors present a unique vision on psychotherapy that challenges the white, male, heteronormative perspective often presented in the literature, and offer a more participatory understanding of human nature.

I was therefore pleased to read Nicola Codner’s well-written and widely researched article on ‘Mixed race identity and counselling’ in the December 2015

Therapy Today; and her call for a broader understanding of what it means to be mixed race – a call that is particularly relevant, given the multicultural world more and more of us inhabit.

I had a very different response to William Johnston’s letter, two months later in the February 2016 letters pages, where he presents in the very first paragraph his weariness at there being another article on difference in Therapy Today. It is not the aim of this article to add to this debate; nor is it my place to criticise Johnston’s letter, as his opinion is as important as anyone’s in this ongoing discussion about difference. My aim here is to explore what these two pieces of writing exemplify for me: just how difficult it is for us to discuss difference as we attempt to understand this incredibly complex subject. I also want to explore the further issue that, even though our understanding of difference and diversity is governed by the various laws and strictures that society has put in place over the past
50 years or more, in the world of psychotherapy our deeper understanding of the unconscious experience of being seen as different or the other, together with what it might mean unconsciously for us when we encounter the other, still lags some good way behind thinking in the political sphere.

**Eurocentric approaches to difference**

Johnston’s letter raises an important point in highlighting a possible beginning in our understanding of difference – that we identify self not just by who we are but also by who we are not. Yet his idea is nothing new; such notions in the West stretch back centuries. Hegel, for example, centres much of his writing around this subject/other paradigm, recognising that the other needs the subject as much as vice versa and that they identify each other by what they believe they are not.

Psychotherapeutically, even the most basic Lacanian approach allows us to recognise that there is a detrimental psychological impact on the other from not being witnessed by the subject. Also, this lens then logically recognises the selfishness of the subject as it forms its own identity: it has no responsibility for the other, doesn’t need to recognise the other, and will even go to great lengths to undermine the humanity of the other in order to maintain its dominance and therefore its identity.

In addition, from a Western perspective, this constant need to identify oneself via the mirror of the other is rooted in the earliest of childhood experience, as Weil and Piaget explain. Their argument is that, when growing up, we all form groups and ostracise the other at various times in our formative years, in an attempt to understand who we are. This supposition in turn allows a less Eurocentric approach to understanding difference, because it moves us away from a purely object-relations approach to understanding difference, and this in turn allows a less Eurocentric understanding of the importance of engaging with difference.

The influences on my working with difference are manifold, with a good number coming from around the globe. For example, the African spiritual philosophy of Ubuntu speaks strongly of the interconnectedness of all things, echoing ideas from Maori culture, the Brahma Kumaris traditions and many others. The philosophies here speak in varying ways of the responsibility that I have for the other, as the other has for me, while recognising that I am as much the other as they are me, and that my identity is tied up in my mirror image.

Such influences are therefore a departure from the more power-based, psychodynamic understanding of our relationship to the other, and speak from a more settled and secure sense of egoic self, and one that does not need the constant narcissistic reassertion of its own identity.

But these ideas are present too in some streams of Western philosophy. The theologian Martin Buber raised this idea from a more European perspective. His thinking, born from his wartime experiences, proposes two types of relationship: an I-It relationship, which in the context of this article fits with the idea that the other is used in service of the subject, and an I-Thou relationship of mutuality. Although some of these
‘Many of us hide as much as possible in groups, so that we can avoid the deep wellspring of pain that comes from being an outsider. It is also why... so many of us sacrifice our identity in order to fit in with the majority’

ideas hold a somewhat idealised vision of humanity, in comparison with a more psychodynamic perspective, they allow more possibility of moving beyond external power dynamics in the formation of a sense of self, towards a personal recognition of the impact that being the other has on all of us. This is what an egoic approach to difference protects us from – the pain of being the other, the recognition that we have all been objectified, judged, rejected, abused, beaten, or (far, far worse) just deemed as other, or threatening. This, more relational and more transpersonal vision of the other then challenges or softens this power dynamic and allows me to recognise that I am not just identified by the other, but that I am actually the other, and vice versa. So that which I see and fear over there is actually just a reflection of that which I may be unwilling to acknowledge in myself.

Towards individuation
I should add here that I do not in any way consider it to be an easy process to recognise one’s own experience as different and work with it. It is not. Sitting with all the moments when the majority has attacked your sense of self in a way that has led to a form of exclusion is an incredibly difficult and painful experience, whether this occurred in childhood interactions with peers or in being marginalised into one of the more traditional politicised categories. This is one of the reasons why so many of us hide as much as possible in groups, so that we can avoid the deep wellspring of pain that comes from being an outsider. It is also why, at times, so many of us sacrifice our identity in order to fit in with the majority, or why those who have themselves been marginalised then subsequently choose to marginalise others in turn.

Even with his own prejudices and racism, Jung11 recognised that the shadow was the other. My own understanding builds on this idea, seeing an appreciation of our own sense of otherness as a route towards individuation and realising that, the more we consider our own sense of outsiderness, the less we need others to mirror our sense of egoic self. The relational allows for an intrapsychic exploration of what it is to be the other and a consideration of how this internalised/unconscious other helps our identity, thereby separating us from the narcissistic objectification of the interpersonal other that we use for our own needs.

This is a hugely important point. In my own work, for example, I have found myself working with a good number of clients and supervisees who, for one reason or another, have felt excluded in their course, placement or workplace. What has helped me here is the work I have done, and will continue to do, on my own sense of otherness. This work has given me a greater empathy for the experiences I hear about on such a regular basis. This empathy has in turn enabled me to work with difference in many forms, prompting me to ask questions of myself and learn more about the cultural, gender-based and other differences that separate me from the people who sit across from me in my consulting room. It is this work on my own sense of outsidersness that has also encouraged me, as other, to lecture students at all levels and of all experiences, to demonstrate that these experiences can be put to good use if accessed and held.

This is why the move from a more traditional, object relations experience of being other to one that is more relational is so hugely important – because the other then may be able to allow themselves to be seen perhaps for the very first time.

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References
Dyslexia

Sarah Olds explains how undiagnosed dyslexia can affect a child and young adult’s self-esteem, and how this can present in counselling. Illustration by David Doran

Undiagnosed dyslexia

Maya is a fictitious client presenting issues typical of the students with undiagnosed dyslexia whom I have met as a university counsellor. Life is challenging enough at university for those who already know they are dyslexic and who come armed with an array of coping strategies and support packages. But for those who don’t understand the source of their difficulties, the situation can feel insurmountable.

Dyslexia does not simply mean difficulties with reading and spelling. It is now understood to cover a wide range of learning issues and to encompass visual and auditory processing skills and memory capacity. It can be very hard to identify these difficulties in childhood, as children naturally develop their own coping strategies to circumvent problems. Often, though, when a student reaches Higher Education and the intellectual demands of their studies increase, their coping mechanisms become inadequate. Wading through large amounts of written text can be overwhelming for a dyslexic student who struggles to decipher and retain meaning, as can trying to express coherent opinions in seminars, since thinking out loud presents enormous difficulties. Even Freshers’ Week can be problematic – many people with dyslexia struggle to remember the names of new acquaintances and may therefore suffer from a degree of social anxiety.

Lectures pose a particular challenge for a student with dyslexia. Listening and writing simultaneously, while attempting also to grasp the concepts being explained (and not get distracted by surrounding conversations), is like trying to drive with your foot on the brake and the accelerator. The brain can feel as if it’s seizing up through information overload. Even if a dyslexic student manages to produce pages of notes from a lecture, they may have no actual memory of what was discussed. This might only come afterwards, after hours of poring over their notes. Overwhelmed by information, they may find themselves incapable of organising their thoughts on paper or concentrating long enough to construct an argument. Panic sets in. Many become caught up in a perpetual cycle of perfectionism and procrastination, fuelled by feelings of shame and anxiety, and begin to question the legitimacy of their place at university. As in Maya’s case, self-punishment and depression can often follow.

I muddled through my own academic journey without realising that I was dyslexic, but with a strong feeling of not being as quick as my peers, so I’m particularly sensitive to signs of undiagnosed dyslexia in others. It has been my experience that a significant proportion of students presenting with depression and anxiety have an undiagnosed specific learning difficulty (SpLD), such as dyslexia or dyspraxia. In general, the distinction is that dyslexia
A child with dyslexia often has lower self-esteem than their peers. I would argue that the school system is currently designed in such a way that anyone whose learning style does not fit with the testing system can begin to feel shame about their academic performance from an early age. Research has shown that many children with dyslexia – both identified and non-identified – are targeted by bullies, who sense and exploit areas of academic weakness. A child with dyslexia who blushes when asked a question in class and is later teased in the playground, or who earns exasperated sighs from the teacher when they have yet again forgotten a recent instruction, might well internalise negative self-beliefs.

It can take someone with dyslexia up to 10 times longer than someone with no dyslexic traits to master a new skill. Applied to the classroom situation, it is easy to see how the associated frustration and embarrassment can have an enormous impact on self-esteem. Girls with dyslexia tend to internalise their distress, often becoming shy and introverted, while boys may use avoidance and distraction as coping mechanisms. Adults with dyslexia often remember being on the receiving end of bullying behaviour from teachers – belittling, shaming, and deliberate humiliation – with a resulting impact akin to trauma. And this treatment is not limited to those who have been recognised as dyslexic; there is evidence that dealing with an undiagnosed dyslexic child at school can trigger intrapersonal conflict in the teacher. Forty years later I still vividly recall a teacher who seemed to take great pleasure in telling the class I was lazy and backward because it took me so much longer than my peers to learn to read aloud. No one suspected that I might have dyslexia. Fortunately, attitudes do seem to be shifting, but only in the last five to 10 years, and many young adults currently in Higher Education are likely to be still scarred by their school experiences.

### Difference and dysfunction

Widely held assumptions about the ‘normal’ learning process contribute to the feelings of inadequacy and shame experienced by a child with dyslexia. Some have recognised this, and there has been some resistance to diagnosing a child’s learning differences, for fear of labelling them as ‘not normal’ – a fear that is bound up in the negative language associated with dyslexia.

Indeed, the ‘dys’ part of ‘dyslexia’ implies that something that should be there is missing – that the brain is malfunctioning in some way. The psychiatric diagnostic manual DSM-5 defines SpLDs as a list of ‘deficits’. So suggesting to a child or young adult that they might be dyslexic can create or validate painful, negative self-beliefs, when actually what they have is not a deficit but a different way of learning. Recently, the apparently more positive concept of ‘neurodiversity’ has been introduced, yet it is still contrasted negatively with ‘neuronormality’. It is not hard to see how a child’s self-concept would suffer from the weight of negative vocabulary associated with being dyslexic. It comes as no surprise that dyslexia (both recognised and unrecognised) is often ‘in the mix’ when clients present with depression.

So what do we do when we suspect undiagnosed dyslexia? In the university where I work, the usual process would be to signpost the student to Academic Support for assessment and advice and, if appropriate, to an educational psychologist for further evaluation. This raises the fundamental question as to whether it is part of my remit, as a university counsellor, to highlight difficulties that might be educational.

‘The school system is currently designed in such a way that anyone whose learning style does not fit with the testing system can begin to feel shame about their academic performance from an early age’
rather than emotional or psychological in origin. As a person-centred practitioner, my approach is essentially non-directive. How does this fit with directing a student towards an assessment that will test out my theory? Ethically, is raising my concerns in my client’s best interest?

Most of the time, on reflection, it feels congruent to do so, although the decision is never straightforward. I tread very carefully, mindful of the likely impact on the therapeutic alliance: is the client able to hear what I am about to say? Are there any relevant cultural issues? Dyslexia is still seen as a weakness in many parts of the world; parental aspirations and expectations can intensify the emotional distress experienced by an ‘undiagnosed’ international student with dyslexia who is experiencing academic difficulties. It would be unthinkable for some of these students to tell their parents they are dyslexic, and so they battle on, attempting to hide what has become a shameful secret.

Sadly, and ironically, many of the undiagnosed dyslexic students who might benefit from counselling never make it that far because of the impact of the dyslexia on their lives. They might forget about the appointment or get the date and time wrong, since poor organisational and memory skills are yet another spanner in the workings of the dyslexic mind. Even if they do make it, they might struggle to engage with their counsellor. Grande and Bayne suggest that the dyslexic tendency to flit rapidly from one idea to the next creates a potential barrier to therapist empathy, and could be misinterpreted as defensive. This surprises me, as both a dyslexic client and a therapist to dyslexic clients. If we are to meet each client as a unique individual, why does it matter how their world is constructed? In any client, differences in processing style are a part of ‘who they are and how they think’.

Even as I write this, I am increasingly uncomfortable with my use of the terminology of difference, and all that it implies. Do we need to develop a different vocabulary that validates and empowers those who do not learn in the standard way, instead of undermining and belittling them?

Working with dyslexia

Clearly, identifying an underlying learning issue does not automatically mean that the client’s depression and anxiety will evaporate; there may be other contributing factors, or the low self-esteem and depression may not be related to the client’s dyslexia at all. Could the dyslexia, with its accompanying impact on self-esteem, have shaped the client’s personality in such a way that they become more prone to depression? We can never know this, and many of the characteristics typical of dyslexia – poor concentration, poor organisational skills and a tendency to over-analyse – can also be symptoms of depression and anxiety in both the dyslexic and non-dyslexic population.

As with any therapeutic intervention, careful thought has to be given to the student’s readiness to be given a ‘label’; ideally space will be available to allow them to explore what a diagnosis means to them. A client’s immediate reaction is often one of relief, as they finally begin to understand what makes them tick. They may then become angry with the teachers or parents who misunderstood their difficulties or failed to spot the signs. There may also be disbelief; the client might reject the idea of dyslexia altogether, due to deeply entrenched preconceptions about what this might mean. For some, coming to terms with this new knowledge might look rather like grief, as they first deny, then begin to accept their new reality, and finally integrate it into their self-concept.

Overall, however, diagnosis tends to be followed by forward movement in therapy. By suggesting that a young adult may be struggling due to underlying learning differences, we are offering an alternative understanding of what is going on at a time when feelings of self-doubt and inadequacy might otherwise become deeply entrenched and irreparably damage their educational prospects. And we are also enabling these clients to recognise their own capacity for resilience, as they begin to realise that their academic struggle does not come from personal weakness and that they’ve done very well indeed to get this far.

Crucially, many of these students will begin to recognise that ‘dyslexia is not a disability – it’s a gift’. People with dyslexia are often highly creative, due to the strong influence from the right side of the brain. I have discovered that my own ‘gift’ is the ability to store information and imagery as a kind of mental photobook. I keep client notes as an ethical requirement, but I don’t usually need to look at them to recall details of previous sessions.

It has been suggested that students who are unaware of their dyslexia ‘have undergone the emotional confusion of knowing they are bright but having a faulty vehicle for expressing this in ways that our education system values’. However, you need only do a quick head-count of famous people with dyslexia – Einstein, Leonardo Da Vinci, Edison and Beethoven, to name but a few – to see that the vehicle is not faulty at all; it is just wired differently, and as a society we are all the richer for it.

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References


When East marries West

Sara Hitchens explores the challenges presented by East–West intercultural marriage

The subject of intercultural marriage has been dear to my heart since the day I was born, to an English mother and Pakistani father. Now, living and working as a counsellor in Tokyo, I often see the world through the eyes of clients negotiating intercultural relationships. This has given me plenty of food for thought; it is an interesting phenomenon that, when you are exposed to another culture, you find yourself learning as much, if not more, about your own. Perhaps this is part of the joy of living in a foreign country... and of marrying someone from a different culture.

First, it is never as simple as saying someone is ‘British’ or ‘American’ or even ‘Japanese’. We all now tend to be a complex mix of backgrounds, depending on our exposure to our parents’ cultures, where we have been educated and where we choose to live. In Japan, perhaps more than many other countries, people perceive being truly Japanese as being mono-ethnic. Recently, Ariana Miyamoto (the child of a Japanese woman and an African-American man) was crowned Miss Universe Japan, leading to a vigorous discussion in the media. Apparently, reporters asked her, ‘What part of you is most like a Japanese?’ to which she replied, ‘But I am a Japanese.’

Ariana is one of a growing number of multi-ethnic Japanese, known as hafu, in a country where around one in every 50 babies born in 2012 had one non-Japanese parent. And the fact that she was chosen as Miss Universe Japan suggests that opinion is shifting towards an acceptance of more diversity.

Also, of course, all marriages are intercultural. Every family has its own unique culture – its own pattern of beliefs, values and behaviours – and every couple has to negotiate differing attitudes to gender roles, child rearing, money etc. Sometimes, these differences can be greater – or smaller – than those between people from different countries.

So, with the caveat that ‘culture’ is too complex to encapsulate, I am going to discuss here some of the differences that keep cropping up in conversations with clients, colleagues and friends about East-West marriages in Japan.

A traditional marriage in Japan

I have been particularly struck by the difference between the traditional Japanese concept of ‘marriage’ and the Western one. Before marriage, when the couple is ‘going out’ together, there seems to be more cultural agreement between Western and traditional Japanese values: it’s all about getting to know each other, having fun, and enjoying a sexual relationship. Much has been written about the fact that young people in Japan have stopped having sex; you only have to google ‘Japanese young people and sex’ and a long list of articles will appear.

However, in my experience of working with clients in intercultural pre-marriage relationships, this has yet to come up as an issue. In fact, I often wonder whether there is something about the exotic ‘other’ that lights the erotic fires for both sexes and, unencumbered by guilt-laden attitudes to sex, Japanese men and women may actually be more liberated than their Western partners.

However, once the couple is married and children come along, some of the more traditional Japanese family values are often triggered. The role of ‘mother’ is particularly strong in Japanese society, and children are the focus of the family unit, taking precedence over the couple relationship. So, in some families, the husband moves out of the bedroom, leaving the mother to sleep with the children, sometimes for many years. This can be a nasty shock for a Western husband, particularly if sex has been an important part of the relationship for him.

Traditionally, marriage in Japan has been less about attachment and self-fulfilment and more about being a practical parenting team. Couples call each other Okasan (Mother) and Otosan (Father), and socialising is done as a family rather than as a couple, so there is very little demand for babysitters. Each parent provides for the needs of their offspring in clearly delineated ways. Motherhood in Japan tends to be a full-time job. Seventy per cent of women withdraw from the labour market after they have children, to focus on their new ‘duties’. The Japanese obento, or lunchbox, prepared for nursery age children, epitomises the time and energy devoted to motherhood, with books and blogs devoted to the subject.

I know of professional women who have been driven to tears by the level of social expectation around getting up early to prepare a spectacular packed lunch for school.

The father tends to be the provider – the ‘salaryman’, working long hours, including obligatory after-work drinking. Sometimes the after-hours socialising will include visits to fuzoku, or sex industry establishments. Curiously, the word fuzoku can be translated both as ‘sex business’ and as ‘everyday culture’, which is a telling conflation. Although prostitution (defined as vaginal sex) is illegal, the business thrives in Tokyo, and I can’t help thinking that this is in some way connected to the absence of sex in some traditional marriages. One Japanese wife explained to me that there is often an implicit understanding that men fulfil their physical needs outside the home, but only as long as there is no threat to the family unit. It must be done discretely, so that the wife is not embarrassed. Affairs in the workplace are not acceptable.

For non-Japanese husbands and wives, these traditional values can be challenging, particularly if there is a lack of real awareness about them before marriage. This can happen, as the values tend to be unspoken, like so many things in Japan. Non-Japanese men can feel...
American values meet Japanese customs

I received a phone call from a Japanese woman called Tomoko, asking for an urgent appointment. She had just discovered that her husband, Kenji, also Japanese, regularly visited hostess bars and strip clubs. When we met, she described how she had confronted him but, to add insult to injury, he was angry with her for having looked at the messages on his smartphone! He did not apologise or show remorse or beg forgiveness. Instead, he insisted that he was a good husband because he provided well for her and their two-year-old child, spent time with them at weekends, organised holidays, and would never think of leaving them.

Tomoko was distraught: this was not the man she’d married; how could he treat her like this? It was the most fundamental betrayal of trust; how could they possibly stay married? Her emotions veered from anger to intense sadness, back to outrage and then bewildered tears.

My first task was to hold her emotionally and to acknowledge all her complex feelings of loss: the loss of the husband and marriage she thought she had. I suggested she take time to think and not make a decision in the current turmoil. We met weekly and talked about her marriage to Kenji, and about their respective families and cultural models for relationships.

It emerged that, although Tomoko was ethnically Japanese, she had moved to the US with her parents when she was six years old, and had only returned to Japan after college. So her values were American, including those about fidelity in relationships. Kenji, who seemed very Westernised because he had gone to an American school in Tokyo, had in fact lived all his life in Japan. So his values were more Japanese; also, he worked in a Japanese company, where after-work drinking in bars was part of the culture.

As we talked and I was able to describe her relationship with Kenji from my external viewpoint, Tomoko realised that she had mistakenly assumed that their cultural norms around sex and fidelity were the same. She had seen an Americanised man and assumed his values were American; Kenji had seen a woman who was ethnically Japanese and assumed her values were Japanese. It was a misunderstanding that had taken four years – and the pressures of parenthood – to surface. Tomoko tested the thesis by talking to Japanese friends, reporting back that they did not seem to think her husband was so bad; he had only done what other men did!

The next phase of our work focused on whether Tomoko could continue to love – and remain married – to this ‘more Japanese’ man. With a clearer understanding of their problem, she was able to explain to him where she was coming from culturally. For his part, Kenji very much wanted to stay married and was prepared to compromise. He would continue to go to the bars with his work colleagues but would not participate as he had done previously. He still did not see anything wrong with his previous behaviour, but understood that her upbringing meant that she did.

Sexually and emotionally neglected by their wives, who are living their devotion through their dedication to their children. Non-Japanese women can feel rejected and betrayed if their Japanese husbands go along with the after-work hostess culture, whereas the husband may feel that it is ‘just sex’ and find it difficult to understand his wife’s response.

East–West conflict

Under Japanese law, parents cannot share legal custody of the children when an intercultural marriage breaks down. If a foreign citizen is married to a Japanese citizen and their child has Japanese nationality (or is a dual citizen), then Japanese law applies. In almost all cases, custody is granted to the mother, and she controls how much or how little the other parent can see the child, if at all. It is impossible to say how many dual-citizenship children are prevented from seeing their foreign parent when international marriages break down, but it is a significant issue in Japan. It is argued that not allowing dual custody is in the best interest of the child, as it reduces the potential for conflict, and conflict avoidance is a key Japanese value. Yet, to the non-Japanese parent it makes little sense and appears to go against the parent’s right to see their own child.

Of course, there is an element of generalisation here. Roles are changing in Japan; fewer people are getting married than before and, of those who do, fewer are having children, which could be seen in some part as a rejection of the traditional roles that I have described earlier.

There will, of course, be conflict in any relationship, whether intercultural or not; the longevity of any marriage depends very much on communication and problem solving. So, when working with couples it is worth knowing some of the key differences between Japanese and Western approaches.

The typical Western approach is to acknowledge there is a problem and talk it through, however difficult and uncomfortable that might be. In Japan, the virtue is in avoiding conflict and instead striving for wa, or harmony. This concept of wa is central, and as an adjective is used to describe anything that is Japanese in style, such as washi (Japanese paper), washoku (Japanese cuisine), and washtsu (a Japanese-style room). It links to the Zen idea of living in harmony with the natural world, which then extends to harmony in relationships and social groups. It is more important than any individual interest. So, when there is conflict, a Japanese person will typically stay silent and, as one wife said to me, wait for the issue ‘to blow away in the wind’. Resolution of conflict inevitably takes more time, but the ‘wait and see’ approach is seen as less risky, because, once you have said something, you cannot take it back. Even when there is communication, the pursuit of wa leads to a style that is indirect, non-verbal and very context dependent. It’s about picking up on subtle hints, tone of voice, unfinished sentences, facial expressions, body language, and just knowing what is the ‘correct’ (socially considerate) thing to do. There is an often-used expression, kuki yomenai, which means someone who ‘cannot read the air’ – that is, someone who is socially awkward. In couple relationships, things become even more implicit. Many Japanese partners do not feel comfortable saying things like ‘I love you’, because it is too direct. A friend explained to me that, if you need to say ‘I love you’, there must be something wrong with the relationship; when you have a relationship of mutual trust – shintaikei – things are understood and don’t need to be said. An extreme example of this is the film Hadaka no Shima (Naked Island), which depicts the relationships within a family and contains no dialogue at all!
There will, of course, be conflict in all relationships, whether intercultural or not; the longevity of any marriage depends very much on communication and problem solving.’

Gary Chapman, in The Five Love Languages, describes how people with different personalities express love in different ways. I think the same could be said about different cultures. In the West there is an emphasis on words of affirmation, with ‘love you’ being one of the most popular. There is also an emphasis on spending quality time together, with couples continuing to have date nights, even after they have children. By contrast, in Japan there is more of a focus on acts of service, especially thoughtful acts that pre-empt a need. For example, a husband will notice that his wife is using the computer and will spontaneously refill the paper tray, or a wife will make sure that there is rice in the cooker so that her husband can eat immediately when he gets back, hungry, from work.

Successful intercultural marriages

I see many successful intercultural marriages in Japan. Statistically, just under 40 per cent end in divorce.8 So what makes the difference? It is a question that I’ve asked a lot of people, often non-Japanese married to Japanese, and these are the answers that have come up most frequently.

The first is respect for the other’s culture, which is not at all the same as saying that you have to like everything about it. That wouldn’t be possible, just as it is not possible to like everything about another person. But, as in a healthy relationship, you focus on the positive rather than the negative. So, in terms of your partner’s wider culture, you need genuinely to appreciate the strengths. Happily married non-Japanese spouses tend to say how much they value the close-knit co-operation of Japanese society, the safety and cleanliness, the pride in work and honesty, the respect shown to older people, the many gestures of kindness etc. Respect also entails being prepared to spend time learning about and understanding your spouse’s culture, learning the language, both spoken and unspoken, and being prepared to participate in and enjoy the social rituals.

Successful intercultural couples tend also to be very committed to the marriage and determined to make it work, whatever the hardships encountered along the way. As one wife said, ‘A successful marriage lasts forever, but the meaning attached to the relationship changes with time.’ She added that couples should expect tough times in a marriage and not expect to be happy all the time: ‘It is a long road, and perhaps even more so now that we live longer.’

But perhaps the word that comes up most often is ‘flexibility’ – the flexibility to adapt to one’s partner. One Western woman, happily married for 30 years, explained that she had ‘toned down’ her confrontational style in arguments, knowing that her Japanese husband found it difficult; moreover, the rice was always ready in the cooker. For his part, her husband made an effort to say ‘I love you’, although he tended to send postcards, which he found easier than having to actually say the words.

Flexibility can often be demanded in very profound ways: the flexibility to live in a country which is not your own or to allow your children to be brought up in a different language from your mother tongue. As one woman said to me, ‘I had to come to terms with the fact that my children would be foreigners.’

Some of these reflections are specific to a Japanese context, but many are relevant wherever cultures meet and people fall in love, be it in Kyoto, Cape Town or Cardiff. It seems to me that, when people of different cultures come together, there is a risk of dissonance, leading to misunderstanding and unhappiness, but there is also an opportunity to make this dissonance positive and creative – the very best of East and West.

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References

The high price of empathy

Empathy is much more than a purely emotional response – the effects are inscribed on the therapist’s body, as Lisa Jenner discovered.

In autumn 2014, close family and friends began to express concern about me. They pointed out several worrying symptoms and eventually persuaded me to talk to my GP. Various tests were run and came back all clear, ruling out anything purely physical. The GP and I agreed that the best-fit diagnosis was probably something ‘stress related’.

She asked me what I did and, on discovering I was a counsellor, nodded knowingly, as if that explained it all.

I, however, was stunned. How could this be? An experienced practitioner, I had run monthly stress management courses for a large organisation and now spent much of my working life helping individual clients understand stress. How could I, with all my knowledge of both stress and self-care, get so close to being debilitated by stress? And I was alarmingly close to that point. I needed to understand, so I took a four-month sabbatical to recover and started to try to find some answers.

Rethinking empathy

I have a keen interest in neuroscience and the brain-body connection so I first turned to Babette Rothschild’s book, Help for the Helper, on vicarious trauma, compassion fatigue and burnout. I wasn’t convinced that it would provide the answers I was looking for as I don’t work exclusively with trauma. Far from it. I work in a large public sector organisation and in a small private practice; my work covers a wide range of presenting issues, and includes trauma, but I don’t work with trauma day-in, day-out. So how could vicarious trauma be remotely relevant to me?

Reading Help for the Helper opened my eyes to the neurophysiology of empathy and to the relevance of vicarious trauma and compassion fatigue to all therapists.

The negative impact of counselling on the counsellor is often unconscious, as Rothschild explains. Many people, like me, career towards burnout without even noticing it. To understand why, we have to ask: ‘What is empathy?’

As counsellors we use empathy instinctively. It’s such an intrinsic part of how we work. The only consideration I had ever given to empathy in the past was to notice whether it was accurate or deep enough. I had never thought about what empathy actually is and how it works physiologically. However, Rothschild explains that empathy is far more than just a cognitive or psychological phenomenon; it is a highly integrated process involving both cognitive and somatic activity.

First, Rothschild describes how mirror neurons work. I’d heard about mirror neurons but didn’t know much about them and had never considered them in relation to my work. They were discovered by accident in the 1990s when researchers were trying to identify the specific neurons that fired when a monkey grasped a raisin. During a break in the experiment, while the monkey was still wired up to the brain monitors, a researcher absentmindedly reached for and picked up a raisin. The team were astonished to see that exactly the same neurons fired in the monkey’s brain when it watched the researcher grasp the raisin as when the monkey grasped the raisin itself: ‘The monkey’s neurons fired as if it had made the same movement itself.’

The existence of mirror neurons in humans remained unproven and controversial until 2010, when UCLA Professor of Neurosurgery Itzhak Fried reported the first direct recording of single mirror neurons in 21 people with epilepsy. There have since been a myriad studies that have deepened our understanding of the role of mirror neurons in empathy. Knowing about mirror neurons gave me my first appreciation of the fact that there is a real physical impact from empathising with my clients. Neurons reflecting what is going on for my traumatised client are actually firing in my brain too.

Second, Rothschild talks about automatic mimicry. Empathy is not only a psychological phenomenon but also a somatic one. Our bodies respond to other people’s bodies all the time. It turns out that people who are in close interaction with others spontaneously and unconsciously copy each other’s facial expressions and body postures. Rothschild quotes a study by Hess and Blairy (2001), who filmed people watching other people expressing various emotions. The subjects consistently and unconsciously mimicked the expressions they were watching. In another example quoted in Rothschild’s book, Dimberg (1982) showed that, even when pictures of emotional faces were flashed through so quickly that the observers didn’t consciously register them, they still mimicked the emotional expressions.

Rothschild also explains, that when facial expressions associated with particular emotions are copied, both people may experience the same feeling. She quotes studies showing, for example, that people rate humorous material as more amusing if they are made to artificially smile before viewing it. This is because our bodies contain two types of nerves, which send signals both from the brain to the body and from the body to the brain. This body-to-brain feedback system means that, when my
face adopts a particular expression, I feel the correlating emotion.

All emotions start as body sensations. For example, fear may be recognised by tension in the legs, a butterfly sensation in the stomach and sweaty palms. How many times do we ask clients who seem unsure of their emotions what they're feeling in their bodies or where they feel it?

**Mirroring**

But empathy is not just about me cognitively recognising the clues my body sends me about what I’m feeling when I mirror my clients. My central nervous system will actually experience changes: when I spontaneously and unconsciously mirror the visible aspects of my clients’ affect, such as facial expression and posture, there are corresponding invisible changes in aspects of my autonomic nervous system, such as heart rate and temperature.

All this explains why conscious mirroring can be used deliberately to facilitate understanding of the client’s emotional state, although I have never consciously done this. It always felt too much like a ‘technique’ and even thinking about it disrupted my connection with the client. However, Rothschild believes that unconscious mirroring ‘may be a major factor underlying our risk for compassion fatigue, vicarious trauma, and burn-out’.

And it turns out that I do unconsciously mirror, and not just in the counselling room. My 16-year-old son was telling a story recently when he suddenly stopped mid-sentence and laughed at me. He turned to the others and said: ‘Don’t you think it’s hilarious when mum does that?’, and he proceeded to mimic me mimicking him. ‘You even do it when you’re watching TV, mum!’ he said. Since then, he has loved pointing out when I do this (as has the rest of the family), especially when I mimic someone on TV. It happens a lot... and I am oblivious to it.

As I expanded my research into facial and postural mimicry and its relationship with empathy, I discovered some startling facts. It turns out that facial mimicry is so important to empathy that, according to addiction medicine physician Paul Earley, citing a study by Neal and Chartrand (2011), empathy is actually impaired in people who have paralysing facial Botox injections.

Even if I don’t visibly appear to copy my client’s facial expression when empathising, invisible micro-movements in my facial muscles will occur (as long as I haven’t had Botox). ‘Set-related neurons’ (a bit like a mirror neuron network) will fire in my brain so that a simulation of my client’s facial expression will occur there, regardless of whether or not I actually made that expression myself.

Furthermore, neuroscientist Carl Marci has shown just how little difference there is in brain activity when an expression is visibly imitated or simply observed. In the same study he also demonstrated the effect of empathy on the central nervous system by simultaneously measuring activity in the eccrine sweat glands of clients and their therapists. This gland, he says, is a window to the central nervous system and can be used to measure arousal states. He mapped the clients’ arousal levels and those of their therapists on two graphs, layered on top of each other. When the client’s perception of therapist empathy was high, the two graphs were identical – ie there was perfect concordance between the arousal levels of the therapist and those of the client.

A synchronised dance

In other words, when empathic connection is high – when we are doing our job well – mirror neuron networks are firing in our brain, our postural and facial muscles are contracting to produce movement and micro-movements, and our central nervous systems are activated in the same pattern as our clients. Our bodies are literally locked in a synchronised dance, resonating perfectly with the emotional state of the distressed client in front of us... And with the next client... And the next. No wonder burnout is a risk.

Counsellors, like many practitioners in other caring professions, are usually in some way driven to work with people in need, and somewhere in our histories we got very skilled at attuning to the needs of others. Being a ‘good’ counsellor means honing those skills to perfection. I have always judged my own practice and each individual session by how empathically attuned to my client I was, without even noticing that I was tuning out interoceptive information – that is, information about what was going on...
in my own body. I didn’t even notice the signs of stress and overload before they overwhelmed me.

Rothschild calls this ‘exteroceptive bias’ – bias in favour of information from the external senses – and suggests that this is common in counsellors. She recommends that we view empathy as a continuum and that, rather than aiming for constantly deepening an empathic connection, as I was, we should instead be aware of the level of contact we choose in any moment. This was an extremely challenging concept for me to embrace, despite Rothschild’s convincing argument that working in this way is equally therapeutic.

Power and posture
When I tell other counsellors what I have learnt, the most common reaction is recognition; it seems to instinctively make sense to them, and they say it helps to explain physical sensations they have noticed too. A few challenge me and argue that the role of the counsellor is actually to ‘hold the pain’. I don’t intend to enter into a debate about the role of the counsellor, but I do want to point out that ‘holding the pain’ is not an abstract concept: in reality it’s a very physical one. Nothing brought this home to me quite as clearly as social psychologist Amy Cuddy’s TED Talk on how body language and our posture affects even our hormone levels.

We make sweeping judgments about others based on their body language and posture. But Cuddy showed that we are also influenced by our own body language. We naturally make ourselves bigger and take up more space when we are feeling powerful. We naturally close in, and make ourselves smaller, when we feel powerless. Cuddy wanted to look at what happens when you fake this. Specifically, can you fake feeling powerful until you actually feel more powerful? She wanted to see whether our bodies change our minds in the same way that our minds affect our bodies.

Her talk explains how powerful people report subjectively feeling more assertive, confident and optimistic. But physiologically there are also differences, specifically in the case of two hormones: testosterone, the dominance hormone, and cortisol, the stress hormone. Powerful people have high testosterone and low cortisol, and low power people the opposite. Cuddy and her team looked at the impact on those two hormones of adopting what she calls high power or low power poses. The experiment was simple; participants had a saliva swab taken to establish their individual baseline testosterone and cortisol levels. They then adopted either a high power pose (making yourself bigger – think of Wonder Woman, with your hands on hips) or a low power pose (making yourself smaller, crossing your arms and legs etc) for two minutes. Another saliva swab was taken at the end of the experiment. The difference was marked. In the high power posers, testosterone increased by 20 per cent and cortisol decreased by 25 per cent from their original base lines. In the people who adopted a low power pose, testosterone decreased by about 10 per cent and cortisol increased by 15 per cent.

I was astonished that something as simple as adopting a certain posture for just two minutes could have as much as a 20 or 25 per cent impact on our hormone levels. I wondered what impact more subtle postural shifts would have. If you apply this research to the notion of subconscious postural mimicry in empathy, it makes sense that even our hormone levels will change in response to our clients.

Self-care
As a result of my research, I am now much more attuned to the impact of my work. Having returned from sabbatical to working part time, self-care now takes place during sessions, not just outside of them. I’m working at consciously un-mirroring during sessions and at varying my level of empathic connection, although I admit to finding both extremely difficult in practice. Empathy is so innate, automatic and subconscious that controlling it feels a bit like trying to hold my breath. What’s easier for me so far is to actually notice if I feel somehow different after a client session. Sometimes, as I re-enter my own life, I can feel as if I have absorbed part of the client and am reacting a little more like them. I think this has always been true; I just never noticed before.

Reflecting on this, I was reminded of an athletic client I worked with a few years ago. At the time, I was training for a half marathon. One day I trained immediately after a session with this client and noticed that I ran significantly faster and with a very different running style, as if my body had taken on some of her muscle tone. I began to deliberately schedule my runs so they were immediately after sessions with her, without ever understanding why I ran faster. I now believe that it could be explained by subconscious postural mimicry.

Non-counsellors often assume that counsellors are taught how to not ‘take client material home’ with them. I definitely wasn’t. None of this was even touched on during my otherwise excellent training, mainly because much of the research I’ve referred to is so recent. Even if it had been covered, I wonder if, before my visit to the GP, I would have actually made the connection. Now I recognise that, while some of us do work in more extreme settings than others, we all work with trauma in some form and for all of us there is a neurophysiological impact of empathising with that trauma. I had to learn the hard way that it could happen to me.

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References
Radicalisation and the law

This month’s dilemma

Amira, an 18-year-old student, has self-referred to her university counselling service with anxiety. Following an initial assessment, she is offered six sessions of counselling with Duncan, who is in the second year of a person-centred training and has just started a placement with the service. Amira is one of five children. Her parents are observant but not rigorous Muslims, who are relaxed about their children’s Westernised lifestyle. Her grandparents came to England from Pakistan in the 1960s.

Amira is hesitant in the session and Duncan has a feeling she’s conflicted about sharing with him her real reason for coming to counselling. So, towards the end of the session, he explains that counselling is a safe and confidential space in which she can share anything that’s troubling her. Amira tells him she’s worried about her elder brother. Until recently, he smoked weed, drank alcohol and partied, but that all has stopped suddenly. He has started wearing Islamic clothing and has cut himself off from his old friends. He has a new group of friends and meets up with them frequently but is very secretive about the meetings. Amira says she is worried that he is being radicalised.

Duncan is panicked by Amira’s disclosure. He knows there are Government regulations on reporting concerns about radicalisation but can’t remember what he’s been taught on his course about confidentiality and the law. He is frightened about having to tell his supervisor, as he’s just begun his placement and wants to make a good impression. What should Duncan do? Please note that opinions expressed in these responses are those of the writers alone and do not necessarily reflect those of the column editor or the editor of Therapy Today, or BACP policy.

No evidence of risk

Peter Jenkins
Author of Counselling, Psychotherapy and the Law (2nd edition) (Sage, 2007)

There are a number of levels to try to unpick here. At the level of policy, Duncan is partly right that the situation has changed recently regarding government responses to the perceived problem of radicalisation. There is sector-specific advice for staff working in universities in England, Wales and Scotland (it doesn’t apply to Northern Ireland), which Duncan could download and discuss with his supervisor and the counselling service manager. Briefly, this is the Counter-Terrorism and Security (CTS) Act 2015. Under section 26, universities and other authorities – such as schools, the NHS, prisons etc – have a duty to ‘have due regard to need to prevent people from being drawn into terrorism’. This is part of the Government’s Prevent strategy, launched in 2011. It doesn’t translate into any new legal duties on universities, or counselling staff, to proactively report to the police people at perceived risk of radicalisation. Instead, it sets out a range of requirements for universities relating to external speaker events, IT policies, risk assessment and student unions.

However, universities do have a duty, under section 38 of the CTS Act 2015, to co-operate with local panels, set up under the related Channel programme, to respond to police requests for information. The assessment framework for vulnerability to being drawn into terrorism specifies engagement, intent and capability to cause harm. Using this framework, Amira’s brother would present a low score for such risk, given his recent change in appearance.

Another key reference are the Terrorism Acts of 2000 and 2006. These have a very broad, even sweeping, definition of terrorism. This includes the use, or threat, of action involving serious violence, or damage, in order to influence the Government. As any counselling student knows, any person with knowledge of a person, or of a client, who is involved in terrorism must a) report it to the authorities (eg via the hotline 0800 789321), and b) not inform the client that they are making this report.
However, Amira’s anxiety about her brother seems to be a long way away from constituting clear evidence of a definite risk of terrorism at this stage. His dramatic change in behaviour might simply signify a commitment to a more traditional religion, rather than the effect of radicalisation. In any case, Amira is the client here, not her brother, and Duncan needs to tune in more to her needs. Some background reading and catch-up CPD on confidentiality and the law might help to reduce his anxiety about reporting duties for counsellors in the university sector. This could then enable him to work much more effectively with Amira, as the main focus of his concern.

REFERENCES:

Caught in a parallel process

Beverley Lester
BACP, UKCP accredited psychotherapist, supervisor, ETG facilitator, and visiting lecturer at the University of Hertfordshire

Duncan needs to follow his own advice and trust in the safe and confidential space of his supervision, where he can share anything that’s troubling him. As he’s only in his second year of training, it’s probable that Duncan is new to placements and supervision. We don’t know how many times he’s met with his supervisor – perhaps they’ve not yet had time to establish a working supervisory alliance. It would be helpful for the supervisor to be thinking about this with Duncan, so he can begin to make good use of supervision as a space for learning, listening and being heard; a creative and supportive space where it’s possible to bring whatever he needs without feeling anxious about being persecuted for his feelings. If he can be encouraged to exchange his need to make a good impression in supervision for a congruent and authentic relationship with his supervisor, he’ll feel more supported and safer in his client work.

It’s essential that Duncan and his supervisor discuss the counselling of the client in such a way that enabled her to talk about her real concerns. I would also encourage him to explore his client’s concerns further, without rushing to premature conclusions about what she’s describing to him. Why is Amira interpreting the wearing of Islamic clothing as potentially about radicalisation? What is her relationship with her brother like? Has this changed in any way recently? What would she like to see happen now? What does she hope to get for herself by coming for counselling?

All of these questions – and more – are important to explore before any decisions are taken about escalating this case to an institutional Prevent co-ordinator. Prevent legislation can be interpreted in a heavy-handed, ‘report-any-suspicion’ way, or, as at the institution where I work, with a ‘soft-touch’ approach, which emphasises responding to student vulnerability as a priority, and working as part of a team, when difficult decisions about reporting concerns are made.

Explore the client’s concerns

David Mair
Head of Counselling and Wellbeing, University of Birmingham

First, it’s important to normalise Duncan’s response. It can be unnerving to be faced with a situation that may require a breach of confidentiality. Very few of us immediately know exactly what to do; difficult cases often need to be thought about and talked through with a head of service and supervisor. Not knowing all the relevant legislation is not necessarily a problem; trying to cover up a lack of knowledge is.

Hopefully, Duncan is working in a setting where he has quick access to a supervisor and to the head of service. As a trainee, he shouldn’t be expected to make such decisions alone, and this should have been communicated to him when he started his placement. His host institution should have clear Prevent policies and guidelines (for staff and students), but he doesn’t need to try to interpret these himself.

As a head of service, I would expect Duncan to come to me to talk through his concerns and get my perspective on this situation. If a desire to ‘look competent’ gets in the way of approaching his head of service, that would be a serious concern; it would potentially leave Duncan, and the university, vulnerable if it emerges at a later stage that he tried to cover something up.

From a head of service point of view, I would want to reassure Duncan that he has done the right thing in talking to me, and commend his ability to address the immediate reticence of the client in such a way that enabled her to talk about her real concerns.
Duncan needs to explore with Amira her understanding of what ‘being radicalised’ means, as reflected in her brother’s behaviour. Does she believe that he’s vulnerable or at risk of supporting terrorism or forms of extremism? Is Amira herself at risk of being radicalised? Duncan should use supervision to evaluate the risk and, if there’s a disclosure or risk to Amira, seek guidance on how to proceed.

‘Duncan should use supervision to evaluate the risk and, if there’s a disclosure or risk to Amira, seek guidance on how to proceed’

Explore what ‘being radicalised’ means

Myira Khan
Counsellor in private practice and founder of the Muslim Counsellor and Psychotherapist Network

There seems to be concern around the confidentiality boundary that is leaving Duncan unsure and conflicted about how to proceed. It’s understandable that, having just begun the placement, he doesn’t fully understand the legal implications in his clinical work, which may account partly for why he feels frightened to tell his supervisor, alongside wanting to make a good impression. However, for his clinical development, he needs guidance from his supervisor to develop his understanding of working within the remits of a counselling contract and the BACP Ethical Framework, including the boundaries around confidentiality, the university and legal obligations, and the impact of these on his therapeutic relationships.

Duncan needs to be clear about the legal remit for breaking confidentiality and the legal duty for reporting disclosures. He is required by the Counter-Terrorism and Security (CTS) Act 2015 to have due regard to preventing people from being drawn into terrorism and to report any risk of terrorist activity. This risk comes under safeguarding legislation, and requires all universities to take all reasonable measures to ensure that risks of radicalisation are minimised.

The definition of ‘radicalisation’ given by Prevent is ‘the process by which a person comes to support terrorism and forms of extremism leading to terrorism’.

Duncan needs to explore with Amira her understanding of what ‘being radicalised’ means, as reflected in her brother’s behaviour. Does she believe that he’s vulnerable or at risk of supporting terrorism or forms of extremism? Is Amira herself at risk of being radicalised? Duncan should use supervision to evaluate the risk and, if there’s a disclosure or risk to Amira, seek guidance on how to proceed.

July’s dilemma

Charlie, a 13-year-old of Ghanaian origin, was born female but, for as long as she can remember, has felt she should have been a boy. She was raised a Catholic, and her parents view homosexuality and gender variance as a sin. Charlie has tried hard to conform to their expectations of how a girl should act and behave because she’s terrified of their response should they find out she’s transgender.

Some days Charlie thinks her only option may be to transition, but this brings up powerful feelings of shame and embarrassment, and the thought of transitioning scares her because of how her family will react. The stress of this, combined with feeling confused and upset by the onset of puberty, has led Charlie to make an attempt on her life and, as a result, she has been referred to a counsellor via CAMHS.

She tells the counsellor she just wants to be a ‘normal girl’ and asks them for help to make ‘these feelings go away’. If you were Charlie’s counsellor, how would you respond and what would you do?

Please email your responses (500 words maximum) to John Daniel at dilemmas@bacp.co.uk by 29 June 2016.

The editor reserves the right to cut and edit contributions. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but they will not be answered personally.

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Suzanne experienced a severe and debilitating reaction to a drug given routinely when she was in hospital for treatment. The reaction to this medication included hallucinations and extreme fear and distress. This went unrecognised and Suzanne was sedated in an attempt to manage her distress. However, this only exacerbated her feelings of helplessness and fear. An already difficult situation—a reaction to a routinely administered drug—was made considerably worse by the sedation, which continued over a long period of time, and the experience resulted in a diagnosis of PTSD two years later. Suzanne’s life was devastated by fear, hypervigilance, flashbacks and unmanageable, intrusive thoughts. She often felt ‘out of it’, as if she had lost time, and she described feeling a significant loss of control over her life. She became suspicious of healthcare professionals and was reluctant to access any further treatment, including visiting her GP.

Stories of poor and inadequate care within the healthcare system continually feature in the media headlines. An estimated 500,000 patients are harmed and 3,000 die each year as a direct result of safety failings in the NHS. However, this is likely to represent just the tip of a much larger iceberg: not all errors in healthcare settings result from poor care; nor does all harm occur because of unsafe practice or error. It is also rarely acknowledged that non-fatal incidents or even just a difficult interaction with the healthcare system can lead to significant patient harm.

This article is about the psychological effects of the experience of harm in a healthcare setting, whether through intentional abuse, unintentional neglect, misdiagnoses, surgical errors, the mismanagement of care or the subsequent failure by healthcare organisations to acknowledge the harm and its resulting long-term effects. It is the subject of my doctoral thesis and much of what is written is based on my personal experience of working with people who have experienced this harm and have been damaged by the experience and the way it was handled by the healthcare authorities.

For the purposes of this article, ‘harm’ is used to describe any physical or psychological injury that has a significant impact on the individual’s mental and/or physical health and on their everyday functioning. The psychological injury includes post-traumatic stress disorder (PTSD), as defined in DSM-5, but also more subjective responses that manifest in symptoms of anxiety or depression or in physical symptoms.

Psychological trauma

The psychological impact of a traumatic childbirth, the aftermath of intensive care and of surviving a serious life-threatening illness, major surgery or physical trauma are all acknowledged and well researched. Much less attention has been given to patients who experience what appears to healthcare professionals not to be a life-threatening event but who go on to develop symptoms of trauma or extreme distress. Their experience is rarely acknowledged or recorded.

The NHS is expected to monitor adverse incidents, but these measures focus specifically on clinical conditions, such as hospital-acquired infections or pressure sores. The perception from healthcare professionals may be that, if a patient has been discharged from the hospital setting, they are well enough to go home and can have experienced only minimal harm. Hospital staff will be unaware of harm that persists into the medium or long term and, unless a patient has ongoing contact with the healthcare provider or highlights the harm through legal proceedings, formal complaint or other mechanisms, may not even be aware it has occurred or that it has had long-term consequences. It is easy then for the harm to be minimised, not recognised and not acknowledged.

Harmful hospital experiences do not always result in a formal diagnosis of PTSD, or even psychological distress. However, for those who do find the experience traumatic, it can change and shape how they view themselves, their future and the world in general, and can result in long-term psychological distress. This, in turn, can impact on their ability to manage daily life, and may lead to a fear of further interaction with the healthcare system.

There is a common misconception that psychological trauma occurs only as a result of a major event—for example, an error or severe neglect. I wonder if this is perhaps in part due to a misunderstanding of the DSM-5 criteria, which seem to suggest that the precipitating event or events must always be life threatening. If you take these criteria at face value, many client experiences of harm in the healthcare setting would not be recognised as traumatic in a clinical sense. However, counsellors of all modalities have described to me encounters with clients who experience traumatic reactions triggered by a range of events, and not just those that are life threatening. Of course the DSM-5 criteria describe a specific ‘disorder’ and the debate continues around whether a trauma reaction is ‘disordered’ or a natural reaction to a traumatic event or series of events. According to Elhers and Clarke, it is the client’s perception of threat that is important, rather than

When the healthcare system causes harm

Linda Kenward is researching the counselling needs of people who have experienced harm within the healthcare system.
that of the healthcare professional or other individual making the assessment. As McCaffery has also observed in relation to pain: ‘Pain is whatever the experiencing person says it is.’ The same could be said of trauma.

The lack of parity of esteem between physical and mental health is particularly pertinent when considering the experiences of those harmed in healthcare. It is so much easier to see, measure and assess physical harm and to directly attribute a consequence, or series of consequences, to that harm. Past and current beliefs, experiences and coping strategies prior to the traumatic situation may all be contributory factors to a client’s experience of psychological harm. Elhers and Clarke’s cognitive model of PTSD is useful when considering the possible contributing factors, even if the counsellor does not practise CBT.

Alongside past experiences, the cognitive processing that occurs during the trauma is seen by Elhers and Clarke as significant. This is particularly important when considering harm in healthcare settings, where cognitive processing might be affected by medication, unfamiliar surroundings and fear, resulting in a client interpreting a situation as being threatening. The threat might be to physical or psychological integrity, or indeed to both.

Counsellors’ role

Many clients will have struggled with their difficult feelings, psychological distress and physical symptoms over many years. The validity of these feelings may never have been acknowledged, even by the clients themselves, and may only surface when other issues trigger a crisis, such as a bereavement, a job loss, or a difficult relationship, and bring them to counselling. The impact of harm from healthcare can be one of many losses experienced by clients, and counsellors and therapists may find that a myriad other issues emerge during sessions.

From my own experience with my counselling clients and talking to others who have experienced harm in healthcare, it is clear to me that they have specific needs from the healthcare system. They want an acknowledgement of the harm caused, a meaningful and genuine apology, understanding, and an explanation of what happened. Many individuals want, altruistically, to ensure that what happened to them does not happen to others. Counsellors can offer an opportunity for clients to talk in a non-judgmental space about what happened, where they won’t feel pressured to have to evidence their experience, as is likely when talking to the healthcare provider. Counsellors can also provide a much-needed empathic ear and a genuine desire to understand the client’s perspective. Those who have had this experience tell me that being understood and heard is crucial for them to be able to explore and address the symptoms, emotions and feelings. Clients have a need to tell their story and for someone to listen, without judgment. In many cases clients will be living with the long-term effects of the harm when they come to counselling. These may include physical impairments, physical changes, cognitive impairments, loss of abilities, anxiety, distress and depression. Clients may also be dealing with pain, loss and low self-esteem. These effects may require further physical or psychological treatment. Some will be having to cope with changes in their financial situation, due to these issues.

But those who are harmed or injured in the healthcare system rarely want further contact with it, unless there is no alternative. This (understandable) mistrust of the healthcare system is a common feature in clients I have worked with. Clients may present with other issues of loss or bereavement, or may have arrived at such a point of desperation that they feel they have no alternative but to come for counselling. Recognition of their harm is important, as is the acknowledgement of their perspective and their unique experience of trauma. For many clients this acknowledgment by someone whom they regard as a healthcare professional may be highly significant in their moving forwards. It is vital that counsellors model the empathic and therapeutic relationship that the client should have experienced in the healthcare setting.

Betrayal of trust

When they enter the healthcare system, clients should at least be able to trust that the professionals within the system have their best interests at heart and that, to the best of anyone’s ability, they will be protected from harm. To be harmed by a system that they believed was there to restore and safeguard their health can be devastating and may lead a person to question other long-held beliefs about the world, as well as their own ability to assess threat and danger.

Most counsellors will recognise that trauma reactions are multi-factorial. The traumatic event is experienced from
the unique perspective of the individual, who brings all their past understandings, current issues and fears and worries and predications about the future. The client is likely to bring a complex array of other emotions related to their experience. Guilt is a significant presenting issue. They may feel guilty about being angry with caring professionals; they may feel bad about highlighting the inadequacies of NHS patient care and for criticising a much-loved national public institution. Clients may also feel guilty about not speaking up before. Victims of healthcare harm typically berate themselves for being subservient, particularly if they believe that behaviour not to be congruent. They often fail to recognise the pressure on them to adopt particular roles, attitudes and values when they enter a healthcare setting. This can be particularly distressing for relatives of those who have been harmed, who feel that they may not have done all that they feel they ‘should’ to safeguard their loved one.

In my experience, feelings of guilt can be particularly problematic when the client who has experienced harm is also a healthcare professional themselves. Feeling betrayed by one’s own organisation, whose values and ethos you personally espouse, is both deeply troubling and distressing for healthcare professionals. Having spoken at conferences about the focus of my research work, I am always surprised by how many health professionals approach me and want to talk about their own experience of being harmed, and by how angry and betrayed they feel as a result. Brewin highlights the impact of interpersonal trauma as being significant and this is especially relevant to those harmed in the healthcare setting.8 People who enter the NHS or access other healthcare providers expect to be kept safe, to be listened to, and to be supported through their patient journey. When they experience the sudden withdrawal of that support following an incident, or it was never there in the first place, they may find themselves questioning their deeply-held, longstanding trust in and beliefs about the healthcare system.

Saying sorry

Healthcare that results in lasting distress or psychological harm is especially difficult to acknowledge for the healthcare system itself.9 The NHS Litigation Authority guidance on Saying Sorry10 demonstrates something of the attitude in healthcare settings to experiences of harm. The guidance was published to help clinical staff disclose errors to patients. Since November 2015 NHS staff have been subject to a ‘Duty of Candour’,11 which requires that certain errors are disclosed, even if harm has not occurred. Saying Sorry uses the language of ‘suffering’, ‘distress’ and ‘upset’ to describe the patient experience, but uses the word ‘traumatised’ only in relation to staff who may have unintentionally harmed patients. While it is important that the traumatic impact on staff is recognised and, indeed, researched, there seems to be a demonstrable lack of parity of recognition in the guidance on the patient’s experience. This resonates with Vincent’s research,9 which suggests that patients experience an initial first harm and then a second harm if the experience, trauma and long-term effects are not acknowledged and reparation offered by healthcare professionals.

Nancy Berlinger’s12 work on medical error and ethics considers the kind of apology that patients may receive, if indeed they do receive one. Apologies that are given as part of a formal restitution process, rather than as a genuine expression of sorrow and recognition of harm, are not relational. Formal apologies may be given unwillingly, in the hope that an apology will stave off litigation or will allow the clinician to move on or achieve what Bonhoeffer called ‘cheap grace’ in the form of forgiveness and the assuaging of guilt. Clients may have complex feelings about the experience of receiving an apology, or perhaps they have not accepted it or feel that they should now be able to move on, as an apology has been received. Others may not have received one at all. Some clients may have experienced the healthcare system as obstructing their search for answers to what happened to them or to others, and the experience of having to fight for information, meaning and justice can exacerbate the trauma.

For many clients a simple acknowledgement or meaningful apology can make a big difference,12 but in the current litigious climate healthcare providers may be loath to acknowledge damage has occurred, regardless of the statutory Duty of Candour. The Duty of Candour is in its infancy still, and may prove to help restitution. However, concern has recently been expressed that creating a ‘safe space’ for healthcare professionals to admit their mistakes may allow them also to avoid legal and professional responsibility and accountability.13 It remains to be seen how the ‘safe space’ and Duty of Candour will enable improvements in the disclosure of harm in the future.

Linda Kenward is an MBACP registered counsellor and current doctoral student researching ‘help after harm’. She is a registered nurse and Principal Lecturer in Adult Nursing at the University of Cumbria. She also volunteers for Cruse Bereavement Care Scotland and works in private practice. Email Burnbankcounselling@yahoo.co.uk

References

**Professionalism isn’t everything**

I read the interview ‘Counselling changes lives’ (Therapy Today, May 2016), but only after noticing Hadyn Williams’ highlighted quote: ‘BACP members want to know that their professional body champions their professionalism.’

Well, not this one, he doesn’t.

In their interview Andrew Reeves and Hadyn Williams use the words ‘profession’ and ‘professional’ so many times that I began to feel assaulted. If I am wary around these words, it is because it seems to me that there are two distinct meanings, and we need to be careful about what we intend. Amateurs can be professional – it doesn’t matter whether they are musicians, mathematicians or counsellors. The word implies a certain seriousness, as opposed to being merely dilettante. I note, however, that the word ‘profession’ is used all too often as a means to establish status.

I can understand that there are counsellors who see themselves as ‘Professionals’, with a capital ‘P’. I also think that there is a danger in doing so, not only for practitioners but also for their clients. Status can be equated with power, and power can become corrupting. What I have always appreciated about most of the counsellors I know is that they do not seek high status, and it seems to me that their work benefits precisely from that fact. They do not assume any air of professional authority. They work with clients; and clients can therefore, I think, feel greater confidence around their own autonomy.

I see myself, not as a professional but as a counsellor, who happens to get paid for what I do. I have never worked full time, and have only ever worked with small numbers of clients, who pay me relatively small fees. That does not mean that they get a second-class service; simply that my own willingness to accept a lower status than other ‘professionals’ does, I think, reflect in my relationships with my clients. I do not use status as a means to intimidate them, or to prevent them from voting with their feet if they are not happy with the service they receive. I have no quarrel with those who work full time and who seek a higher status. Please, however, do not forget those of us who do not work in that way.

William Johnston
Person-centred counsellor in private practice

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**A limited vision of spirituality**

I was a bit taken aback by the article on spirituality by Alistair Ross (Therapy Today, May 2016). His ideas about the matter seemed very limited, and the little piece of research he did seemed quite inadequate. There are a number of existing maps of the spiritual realm, whether the simple ones like that of Ken Wilber (2000) or the more complex ones like that of Mike Daniels (2005). To ignore all this seems strange.

Personally, I prefer the simple ones, because they fit so well with my own experience. Wilber, for example, says that it is a question of levels of consciousness. The earlier levels of consciousness have been well described by Piaget, Maslow, Kohlberg and so forth. They also deal with what Wilber calls the Centaur level, and what others have called the authentic self, the real self, the actualised self, the post-conventional self etc – the level that most counsellors and therapists are familiar with from their own training and experience.

Wilber then goes on to say – and this too fits with my own experience – that beyond this comes the Subtle level of consciousness, where prayer makes a real appearance. It is also the level of dreams, creativity of the surrendered type, spiritual connections with nature and such things as archetypes (the stag and the doe, for example), mysticism, nature spirits, symbol systems and more. This is also the realm that is instantly opened up by psychedelic drugs of one kind and another. It is an exciting realm, filled with phenomena such as colours, lights, heavenly choirs and time standing still.

Beyond this, Wilber tells us (and this is my own experience again) there is the realm of the Causal, where we suddenly realise that everything is One. The One may be the All, the None, the Ultimate, the Absolute or God, the One without a second, the pure substance of Being – there are many names for this, but the essence is always that all is One. This is a one-off perception – we either get it or we do not – and it is best reached by meditation. In fact, I would say that meditation is the only way to get this as a stable stage and not just as a fleeting impression.

But the realisation that everything is One is still an assumption, and the process of psychospiritual development is a process of giving up false assumptions. When we give up this final assumption – that everything is One – we are then plunged into the Non-dual, where there are no assumptions, no signposts, no handrails and no words or concepts. I have urged elsewhere that it is only at this level that one can ‘get’ a Zen koan, but that is another argument.

As I say, this is just one map, and there are plenty of others. But to ignore all the existing maps, and then struggle to produce a quite inadequate map like that on page 24 of May’s Therapy Today is just not good enough for our more sophisticated age.

Dr John Rowan

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**Healing one heals all**

Thank you to Alistair Ross for his article on spirituality (May Therapy Today) – a taboo area explored at last! After 40 years as a psychotherapist and as a priest in the Church of England and now the Catholic Church, it’s the article I have always wanted to write. Having just read The Hidden Freud by Joseph H Berke, it seems that the truth is slowly emerging.

A key Freudian clinical principle is always to ‘look for the avoided areas’,
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and for Freud it turns out that his background in Hasidic spirituality and religious practice was the hidden area in his life and marriage. It was, of course, also the background out of which his psychoanalytic theory emerged, to be presented in a modern, scientific light. Similar arguments can also be put forward about the theories of Jung and Rogers, who both drew on Protestant Christian traditions, although they were less vehement about trying to separate their work from their families’ religious traditions.

I am now at the end of my career. I have enjoyed my trainings in theology and in psychodynamic psychotherapy. I have worked happily in parishes, a college of Higher and Further Education, general medical practice and community counselling services. I have supported all the struggles to develop standards and improve quality and training in counselling. I have enjoyed, too, being involved in the management and development of services and in the arrival of a broad tapestry of theories and clinical approaches, some scientific and some not.

As I sail along, getting ready to go under the final bridge, I am still left with a view about how inevitably messy the world of psychology is and will continue to be. I have always seen counselling and psychotherapy as part of a wider human endeavour to heal a broken humanity. For me, the endeavour involves all the knowledge and experience of religion and science being brought to bear on the human condition. However, how we talk about what it is to be a human being remains a puzzle. Freud wanted to heal the psyche. Sadly the incorrect translation of his work from German into English by Lytton Strachey rendered ‘psyche’ as ‘mind’. Although ‘mind’ is just as vague as ‘soul’, it sounds more scientific and becomes part of the split. It has helped the perception that ‘mental health’ is somehow separate from the wellbeing of the person.

It means psychology, psychotherapy and counselling will continue to be untidy areas of activity. Practitioners will continue to be untrained and trained, amateur and professional, voluntary and paid. It will continue to be practised in every institution and individual setting you can imagine. Practitioners, too, will continue to come from every background imaginable.

How good it would be if future thought could come up with a richer, deeper and more comprehensive understanding of what the ‘psyche’ might be.

Let’s hope, however, that the future will continue to be creative and that the impulse to be involved in the restoration and repair of the human condition will remain strong. A beautiful Hasidic thought tells us, ‘The healing of one person heals the world.’

Fr Peter Marden
Senior accredited registered MBACP

Bring back the practice counsellor

I read with interest and excitement the news report in the May Therapy Today, ‘NHS to fund IAPT therapists to support GPs’ (News, p5) – the vision of an additional 3,000 counsellors and therapists in community centres and GP clinics seemed to me a breakthrough in thinking that would provide the opportunity for BACP to engage with commissioning bodies to facilitate the return of the practice counsellor, albeit in a modern format.

The practice counsellor, that valued and essential role, has all but vanished from primary care in England with the introduction and growth of the IAPT programme. I worked as a practice counsellor in the late 90s, as I built the hours I needed to qualify. It was a practice that had not had a counsellor until I negotiated a placement and, even though I was a greenhorn trainee, the practice manager and GPs saw value in the role and continued to employ a counsellor, albeit on voluntary placement, after I left.

Sadly, the last nine years have seen the diminishment of the role in favour of the politically safe, heavily administrated and monitored mental healthcare pathway provided by the IAPT programme. In short, there is little wriggle room for GPs to engage the diversity of their patient’s worldviews with the diversity of mental health approaches thriving in our society.

I would like to offer a vision, informed by my eight years’ experience of IAPT as a practitioner and service manager. I believe that counselling professionals can, with a little training, be introduced to the concept of guided self-help and behavioural activation techniques. Such training would supplement their knowledge, integrate with the IAPT systems and, offered appropriately, using a person-centred approach, enhance client choice.

I believe that many service users would benefit from having a greater choice than the two diagnoses on offer – anxiety or depression – which ironically limits a service user’s access to psychological therapies. On 2 December 2010, Paul Burstow, then the minister responsible for mental health, delivered a speech at the New Savoy Psychological Therapies Conference in London in which he said two things. He said: ‘At the moment, IAPT is a little too much like Henry Ford’s business philosophy… you can have any therapy as long as it’s CBT.’ That has changed now with the introduction of other modalities such as counselling for depression, and IAPT should be applauded for engaging with BACP to enable that approach. In the same speech, he said: ‘If we really want to open people up to talking therapies, then talking therapies themselves need to open up to people.’ And that has not changed, because there are still only two choices – anxiety or depression – and if you don’t own one of those diagnoses, then you don’t get treated by IAPT.

However, I believe that the addition of a third option, a catch-all diagnosis of ‘life issues’ to the diagnoses of depression and anxiety disorders, would realise Paul Burstow’s vision, and the positivistic English IAPT programme
would engage with a new interpretivist paradigm – a ground-breaking pluralistic approach, to facilitate its clients’ diverse worldviews, edging closer to the political vision of improving access to psychological therapies.

Even before the extra funding becomes available to realise the vision of an extra 3,000 IAPT counsellors and therapists working alongside GPs by 2020, I would call on commissioning bodies to be brave and bold, to take the ‘old’ wisdom of the practice counsellor and blend it into the ‘new’ IAPT programme. Such a pluralistic approach, seated close to GPs, would benefit all and provide an opportunity for IAPT, BACP and their partners to demonstrate the value of combining positivistic and interpretivist approaches to mental healthcare.

Whether such a vision could develop into a reality is dependent on a multiplicity of factors and relationships.

Beyond the silence

Reading the anonymous article ‘Working with Extreme Abuse’ in the April issue of Therapy Today, I found so many points resonating with my own experience as a client in therapy working through childhood sexual abuse trauma and dissociation. The article’s powerful honesty will be of great encouragement to many therapists struggling in their work with clients who have experienced extreme abuse.

For me, the article underlines the essential importance of a secure attachment in the therapeutic relationship. It demonstrates that specialist knowledge and skills are secondary to the therapist’s ability to build a genuine, accepting and understanding therapeutic relationship with the client. My own therapist brought to her work with me that same strength of relationship and level of commitment described in the article.

‘I would call on commissioning bodies to be brave and bold, to take the “old” wisdom of the practice counsellor and blend it into the “new” IAPT programme. Such a pluralistic approach, seated close to GPs, would benefit all’

That is what enabled me to process my childhood sexual abuse experiences.

The article also highlights a lack of support available from the statutory services and indicates some significant challenges for therapists when holding risk of harm in the work. Raising awareness of wider implications around extreme abuse is vital to gain an accurate understanding of the impact of it for both the therapist and the client.

In April this year BBC1 broadcast the documentary film Abused: the untold story, exploring the long-term impact of sexual abuse. The documentary included my story of taking my abuser to court and the ordeal of the legal process and the current inquisitorial court system. The risk of not being believed in court is very great, as Frances Andrade’s sad death illustrates, and as I too experienced when my abuser was found guilty on only the corroborated charges. Even though the other charges were upheld, I felt profoundly disbelieved; a reflection of the silence and disbelief that has traditionally smothered the accounts of those giving evidence in child abuse trials. It is a testing and difficult process. However, my therapist accompanied me through it every step of the way, seeing the importance for me that my abuser should be placed on the sex offenders’ register; the only comfort is knowing my court ordeal will safeguard other children from sexual harm.

I will be speaking at a conference in Leeds on 8 July, ‘Time for Change: Beyond the Silence’, which will bring together the legal, social and therapeutic perspectives and focus on how to improve services for individuals, families and communities affected by childhood sexual abuse.

I am heartened that the profile of abuse is at the moment being raised in such a constructive way and I’m thankful to the author of this article who was prepared to write so candidly about their therapeutic work. If you’d like more information about the conference, email sueedominey@hotmail.com

Katy Woodger
Children and young people’s therapist, writer and long-distance swimmer

When we’re out of our depth

Thank you for publishing the articles on working with extreme abuse (April Therapy Today), which I read with great interest. I felt moved to write briefly about my experiences.

I am a BACP-registered therapist. I suffered extreme abuse at the hands of a family member and a paedophile ring from the age of three for over 10 years, after which it mysteriously and abruptly stopped. It has taken me nearly 30 years of hard, personal work to reach this point in my life where I feel truly able to accept myself.

It all started to come to a head when the family member died, and I had a very abnormal grief. An acquaintance suggested I see a counsellor she had seen and highly recommended. Very fortunately, this counsellor was and is the most amazing therapist, and worked with me through the whole process, patiently, and with great care, flexibility and firm boundaries. It took me over a year to tell her anything of the abuse, and over two years before I showed any emotions apart from dissociation and reliving abuse, as I was unable to verbalise it. I saw her for well over 10 years, with a gradual weaning off from therapy and her support.

During the later years I went to see other counsellors and therapists and found so many of them unintentionally abusing me with their ignorance and fear, which were of just the dissociation, as I didn’t give much detail about my abuse; just that I had been abused and suffered from long-term depression. Fortunately I was able to rescue myself in these
instances. It is not that I expect everyone to have experience of every subject matter presented in counselling; it is knowing how to handle the situation and what to do when one feels out of one’s depth, not abandoning the client or making them feel it is their fault or the dissociation is just attention seeking.

I so appreciated my therapist sticking with me; I don’t know what she went through but she never indicated she would not support me through this journey. If she had said she had no experience of the subject but would help me find someone that did have experience, I think I could have worked with that and the honesty, but to just make excuses and leave destroys one’s confidence, and one feels abandoned and annihilated all over again.

Name and email address supplied

Volunteering costs the therapist

I would like to respond to Mary Godden’s letter, ‘Make counselling truly accessible’, in the May issue.

First, most counsellors have done voluntary work of at least 100 hours by completing a placement during their training. Many continue in that placement (usually with a charitable organisation) until they are able to find paid work.

As a therapist in private practice, who is lucky enough not to need to earn my living as a counsellor, I offer reduced fees for those with financial constraints. My normal fee is £25 per session, but this can go as low as £5 per session for clients on low income. I am happy to do this but may I point out that, with the inevitable fluctuation in the number of clients I may have, I could be in a position where the client fees I earn might not cover my living as a counsellor, I offer reduced fees for those with financial constraints.

It is a paradox of truly Chestertonian proportions to suggest that making it impossible for counsellors to earn enough to live on would ‘make counselling truly accessible’.

If Mary Godden is suggesting that BACP might like to subsidise counsellors to take on private clients who cannot pay the full fee, then yes, indeed, that would be excellent, but I doubt she meant that, and I can’t see BACP putting its money where its mouth is and saying, ‘Counselling works, and it is so important that we will help to provide it.’

So I am saying to BACP, ring-fence some funds – apply for a grant if necessary – to subsidise a number of therapists to provide counselling free, UK wide, without being out of pocket themselves. Publicise it; advertise it;

I would be very interested in seeing if BACP could do something to support counsellors so that they would only be giving their time and expertise, rather than having to ‘pay’, effectively, to do charity work.

Margaret Gutcher
MBACP (Accred) counsellor

Subsidies for volunteering

I was amazed to read Mary Godden’s letter ‘Make counselling truly accessible’ (Therapy Today, May 2016) in which she calls for BACP to ‘look at the possibility of supporting, even encouraging, counsellors to take on some unpaid work’.

This mystifies me, in a context in which most counsellors do nothing but unpaid work, with – if they are lucky – a few private clients whose fees do not even cover CPD, room hire, insurance and advertising.

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I am saying to BACP, ring-fence some funds to subsidise a number of therapists to provide counselling free, UK-wide, without being out of pocket themselves

What’s good about wellbeing

BACP Chair, Andrew Reeves, claims that the ‘wellbeing agenda’ presents the greatest threat to counselling (May Therapy Today, p46). This appears to be a rather naïve and simplistic view that suggests an ignorance of the workplace context. Further Education has indeed seen some counselling services subsumed into ‘wellbeing departments’, but this is not a universal trend in the wider workplace environment.

Since Employee Well-being Support was published in 2008,8 we have seen ‘wellbeing’ increasingly embraced by organisations as both a cultural ethos and a strategic framework for employee support. Quite the opposite to being a threat, wellbeing has become a boardroom agenda item, which has not only heralded a top-level commitment towards the health and duty of care towards staff but has also often resulted in ring-fenced investment for established counselling provision and introduced a plethora of new employee support initiatives (including counselling) in organisations that did not previously offer them to employees.

To say the wellbeing agenda is threatening is like saying clients are threatening – some might be, but the majority are not and we need them.

Rick Hughes
Employee support consultant.
www.counsellingaberdeenshire.co.uk

REFERENCE:
Reviews

Therapists as agents of the state?

The future of psychological therapy: from managed care to transformational practice
John Lees (ed)
Routledge, 2016, 177pp, £31.99
isbn 978-1138886384
Reviewed by Catherine Jackson

This is a book that will illuminate, appall and entertain in equal measure with its intelligent unpicking of what its editor, John Lees, calls the ‘fantasy’ that is IAPT and the tautological car crash that is ‘managed care’ in the UK national health service.

IAPT has achieved much: it has made talking therapies more freely available on the NHS; it offers a proven helpful alternative to antidepressants and a treatment for emotional distress that does not require a psychiatric diagnosis.

But, write the contributors to this book, it does so at a very high cost – to the values and principles of psychological therapy, of the frontline workers and service managers it employs, and of the third sector organisations it partners.

The ‘juggernaut’ of managed care, writes John Lees, is carrying the therapy professions headlong towards a future where they are simply agents of the state, delivering state-regulated, manualised therapies to a government agenda that is all about shaping the model citizen to feed the machine of economic productivity. IAPT is part of a much wider programme in which citizens are ‘moulded and chipped away at so as to become attractive to the market’ (p97), as Jay Watts puts it so well in her excellent chapter on ‘IAPT and the Ideal Image’.

There is so much of brilliance here, even if you don’t always agree with it: Rosemary Risq’s superb offering on New Public Management that draws on Kristeva’s theories of abjection to show how the current obsession with monitoring, surveillance, diagnostic categorisation and evaluation within IAPT is all about ‘exil[ing] the emotional, messy – and maternal – aspects of caregiving’ (p79); Nick Totton’s questioning of the emphasis on risk-management in therapy... ‘We don’t need boundaries, we need ‘boundlessness’, ‘generous abundance... and our clients need it even more’, he argues (p144); Stuart Morgan-Ayers’ warning that, by uncritically buying into regulatory processes, ‘we become part of it... controlling rather than enabling clients’ (p35); John Lees on the cul-de-sac where the evidence-based agenda has parked research, bringing professional development and creativity to a juddering, oxygen-starved halt; Del Loewenthal on the dry rot of neoliberalism, spreading its lethal spores throughout the healthcare system. And there is much more to provoke thought, debate and, above all, questions.

Some chapters are poorly edited; some dress old arguments in new clothing, but what lifts and carries this book is Lees’s underlying purpose: to demonstrate that all is not lost; that therapy, in his words, ‘is still fresh and alive and has the capacity for innovation and individual and social transformation’ (p7), if only therapists would wake up to the political reality that IAPT obfuscates. Catherine Jackson is Commissioning Editor with PCCS Books

Practical guide to groupwork

Great groups: creating and leading effective groups
David R Hutchinson
Sage, 2016, 296pp, £55
isbn 978-1452268347
Reviewed by Frances Lampert

As someone just embarking on the facilitation of therapy groups, I found this an incredibly useful and practical text to get me started. The author’s plain English and encouraging, direct and conversational style are engaging from the outset.

The book is aimed at students who are working towards developing and leading groups. It has an emphasis on work with semi-structured therapy groups, but would be helpful for anyone running any kind of group. Each topic is laid out clearly, using summary boxes, exercises to aid practice and reflection, cartoon illustrations and signposts to other sources. The fact that the author is writing for an American audience is only apparent in the occasional reference, and doesn’t distract from or adulterate the book’s relevance to a broader readership.

Included is a brief introduction to some history and theory associated with groups, a consideration of leadership skills and qualities, a look at specific types of groups, such as those aimed at particular topics or stages of development, and an exploration of relevant ethical issues.

The main focus, though, is on group dynamics and the broad stages of development of a group. The author takes us through the planning, beginnings, middles and endings of groups, offering specific advice and suggestions on handling the challenges that each stage may throw up for a group leader. He illustrates this by providing many personal examples from his own, extensive experience, as well as inviting us to follow the process of an imaginary group taking place in a high school. This works well to illustrate the leader’s role within each stage of development, and how issues such as resistance and obstruction among members can be handled with skills like ‘drawing out’, ‘cutting off’ and ‘selective attention’.

The final chapter reminds the reader about the importance of caring for different parts of the self as a group therapist, and about other ways that we can promote the wellbeing of our clients through social action and advocacy.

This is very much a practical text, so probably not for someone looking for a detailed book on group theory. However, it succeeds in offering an in-depth understanding of a wide range of issues that are important to consider when forming and facilitating successful groups, while managing to remain accessible and readable.

Frances Lampert is a counsellor and supervisor
To honour all by burying one

Zsofia Kaplar finds many resonances in *Son of Saul*, the excoriating story of one man's mission to bury his son, slaughtered by the Nazis in a concentration camp

There are many ways to depict the unspeakable horrors of the Holocaust. *Son of Saul*, the 2016 Oscar winner for Best Foreign Language Film, is a dark counterpart to *Life is Beautiful*, which took the same prize in 1999. Both centre on a man's desperate action to save (something of) his son while captive in a Nazi concentration camp. The mission of one is to pretend that it's all a game, so his child survives in body and spirit; the other makes a heroic and desperate attempt to give his son, murdered in the Nazi gas chambers, a proper burial.

Hungarian director László Nemes' first feature film is far from easy viewing. The conveyor belt of systematic murders provides a relentless background to Saul's (Géza Röhrig) single-minded mission – to salvage some humanity for one child among the millions of people who have been systematically stripped of it.

This portrayal of mass murder without obvious emotion reminded me of how some clients recall trauma. As therapists, we often feel the buried emotion. Transgenerational and vicarious trauma are well known in the context of the Holocaust.

Saul 'earns' his own grim survival by working in the *Sonderkommando*, a team of captives charged with herding up and disposing of fellow Jews in return for slightly more food and a little more time alive. Although, as Saul puts it, these 'Keepers of Secrets', complicit in the lie that the gas chambers are showers, are also already dead. Saul and his colleagues unearth a still breathing child from a mound of lifeless bodies hauled from the gas chambers. The child's life, like that of six million others, is soon extinguished by a German doctor checking the dead.

Saul becomes convinced that the boy is his own son and starts the dangerous undertaking of giving him a proper funeral. While others plan an attempt to break out from the concentration camp before they are executed, Saul focuses on his equally impossible quest to find a Rabbi to say *Kaddish* for his son's soul. Like Antigone, Saul's mission may be difficult to understand. At what point does our determination to do the right thing in extraordinary circumstances triumph over our survival instinct? In therapy, we often strive to carry hope when it seems to be lost. Sometimes, even that seems impossible and we have to live with no happy endings. I have tried hard to find a glimmer of light and to understand Saul's destructive choices. Perhaps to give a proper burial to one is to honour all? A funeral helps validate lives lost by sharing the experience. It can also relieve pain by expressing emotion through ritual. It is about honouring and celebrating the subject, a step towards living with a loss that may seem impossible to accept. That is a function of therapy, too.

Zsofia Kaplar is a counsellor and supervisor in private practice

Son of Saul (2015; 107mins) is directed by László Nemes, and stars Géza Röhrig, Levente Molnár, Urs Rechn, Sándor Zsótér

Ruptures in the counselling room

When hurt remains: relational perspectives on therapeutic failures
Asaf Rolef Ben-Shahar, Rachel Shalit (eds)
Karnac, 2016, 208pp, £24.99
isbn 978-1782202073
Reviewed by Nicola Strudley

There still appears to be a professional shame within counselling and psychotherapy, not so much around making mistakes but about speaking or writing about them. We rarely publicly own or discuss ruptures that occur in the counselling room.

The editors of this book have brought together a collection of integrative writings on a range of hurts, injuries and ruptures from the counselling room in order to normalise therapeutic failure and to contribute to the learning process. The book is written for a wide audience, and presented in separate sections for trainee counsellors, clinicians, clients and the lay reader, with a mixture of case reflections, case studies, academic papers, biographies and interview-style conversations. The downside of this is that readers from one category might be left wanting more. The editors’ attempt to provide a little insight to a wide audience may have been too ambitious.

I enjoyed the challenge presented in the section exploring the binary success–failure polarity. Although our ethical code provides clear pointers to what is right or wrong, life is not that clear cut. What happens as a result of the interaction in the therapy room is a dynamic process. Life involves risks, particularly when it comes to interpersonal relationships. While we cannot guarantee results for our clients, we can assure them of a level of quality in the service we deliver. Is that enough?

Another poignant relational perspective that provoked thought was the suggestion that the clients about whom we care most can be the clients we fail the most. By caring we are more exposed to hurt and to hurting.
We therapists can end up playing the hero when we sense people need to be rescued, or take on the role of the expert when we sense the client expects a solution from us. Elsewhere the book explores the limitations of relying on techniques and how they can present an obstacle to successful therapy.

Therapy is fraught with inaccurate turns and uncomfortable endings. This book prompts us to distinguish between common or unfortunate failures and failures with a capital F. N Nicola Strudley is a psychotherapist in private practice.

**Taking tea with Winnicott**

**Tea with Winnicott**

Brett Kahr, with illustrations by Alison Bechdel

Karnac, 2016, 288pp, £22.60

ISBN 978-1782203421

Reviewed by Jane Cooper

I enjoyed this book enormously. It is the first in a new series from Karnac of ‘posthumous interviews’ with famous psychoanalysts; Freud, Klein and Bowlby are to follow. It is in conversation format and, to start with, I questioned the target audience of this book – was it supposed to be a scholarly account or something more lightweight? It succeeds in being both. By the end of its 10 chapters, or ‘cups’, as we are invited to call them, I felt that I had met Winnicott (and his secretary, Mrs Coles, who brings in the tea) in person and, a month later, I can remember quite a lot of what I read. What feels delightfully accessible, quirky and playful is actually very scholarly, well organised and memorable.

Brett Kahr is, of course, an expert on Winnicott; his biography won the Gradiva Award in 1997. But, rather than just regurgitating facts, Kahr has used this unusual genre to tease out some fascinating aspects of Winnicott’s life and work. Perhaps most useful for those studying psychodynamic theory for the first time, in Cup 8 Kahr invites Winnicott to give what he never did in his lifetime – a potted summary of his theory of human development.

“I love the beautiful illustrations by Alison Bechdel; we recognise her portrait of Winnicott from his appearance in her graphic memoir *Are You My Mother?* The other aspect I particularly value is the 40-page biographical register at the end of the book, which gives a wealth of fascinating historical information about all the people mentioned in the interview portion of the book.

This is a treat to read and an ideal present for colleagues. I am sure Winnicott would have loved its insight and playfulness; he might, as Kahr suggests, have been surprised that his ideas continue to have a profound influence on counsellors.

Jane Cooper is a counsellor and supervisor.

**Intergenerational inheritances**

**The social unconscious in persons, groups and societies, Volume 2: mainly foundation matrices**

Earl Hopper, Haim Weinberg (eds)

Karnac, 2016, 192pp, £22.99

ISBN 978-1782201854

Reviewed by Christopher Davies

The first volume in this series, subtitled ‘Mainly Theory’, broadly defined the concept of the ‘social unconscious’ as applied by SH Foulkes, the founder of group analysis. Central to this concept is the idea of the ‘matrix’, which Foulkes described as ‘a transpersonal network’ and ‘the hypothetical web of communication and relationship in a given group’. He saw this as being both ‘local’ (in, for example, a psychotherapy group which develops dynamically its own culture) and national/global – those things we have in common deriving from shared social and cultural backgrounds that are transmitted over generations. It is this that Foulkes defined as the ‘foundation matrix’.

The editors of this volume suggest, however, that theoretical models can seem abstract and too general and this book is thus an attempt to explore the foundation matrix concept through the lens of writers who look at their own peoples in the context of their societies.

The first three chapters of the book examine a number of myths, a significant element in the cultural dimension of foundation matrices, and the bulk of the book analyses the foundation matrices of people from different societies. Gerhard Wilke (Germany) examines the impact of encapsulated social trauma on the second and third generation of children from Nazi parents and Holocaust perpetrators. Olga Marlin too documents and illustrates social traumas that have shaped Czechoslovakia’s social unconscious – those of Nazi occupation and Soviet totalitarianism.

The chapter from Kaoru Nishimura (Japan) examines some of the contemporary manifestations of the social unconscious in Japan: in particular, the Japanese (originally Buddhist) term *mujo*, which implies impermanence and which Nishimura sees as rooted in Japan’s foundation matrix. He suggests that this has functioned as a defence against hopelessness and guilt, not just post-war but in response to several devastating tsunamis.

The chapter on Ireland (Alan Corbett and Tamsin Cottis) examines, with an interesting clinical vignette from a group for men with intellectual disabilities and a parallel group for their carers, how society punishes those with intellectual disabilities for ‘sins of the body and of the mind’, through systematic impoverishment, consigning people to church-run settings in which sexual needs are feared and ignored, and paranoid monitoring of their sexual desires. Finally, Carla Penna focuses on contemporary manifestations of the social unconscious – those of Nazi parents and Holocaust perpetrators. Olga Marlin too documents and illustrates social traumas that have shaped Czechoslovakia’s social unconscious – those of Nazi occupation and Soviet totalitarianism.

With its contributions from writers in very different cultures, this volume offers some new insights into how we might understand the social unconscious in context. There is, however, an underlying equation.
of ‘peoples’ (nations) with foundation matrices. Social unconscious processes, and their manifestation in foundation matrices, can also be seen in terms of wider social relations, which have power, sexuality and gender relations embedded in them – the subject, perhaps, of a whole new book?

An easier read than the cumbersome title might suggest, this is nevertheless, I fear, more a book for students of psychoanalysis, group analysis and the social sciences, although it has much to interest counsellors. Chris Rose is a psychotherapist and group analyst

Words from a therapist’s soul

Image, sense, infinities and everyday life
Michael Eigen
Karnac, 2016, 192pp, £24.99
isbn 978-1782203728
Reviewed by Els van Ooijen

In this book, Eigen reflects on his long life as a psychoanalyst and recounts many meetings (with clients, colleagues and authors) that are important to him. Eigen refers to himself as a ‘psychoanalytic mystic’ (p121), which may seem an oxymoron yet encapsulates the essence of his practice. If therapy is helpful, its effect should continue after it has ended; likewise for the therapist, as Eisen suggests here: ‘patients go on speaking in a therapist’s soul after therapy ends’ (p29).

Several chapters contain extracts from sessions in which Eigen’s exquisite attunement to his clients is apparent. The first chapter focuses on spiritual and psychological birth processes and transformation, followed by a reflection on images inspired by Eigen’s work with ‘Alan’, who was helped by ‘our being together, even if we didn’t know how or how much’ (p17). Chapter three explores the function of devil images in madness and art, and in chapter four the author ponders on the links between body states and spiritual experiences. Chapter five has a philosophical yin/yang quality, showing how opposites can turn into each other. Chapter six is a reflection on shame, with examples of Eigen’s work with ‘Peter’.

In chapter seven, Eigen recounts his experience as client with Andre Green. In chapter eight he picks up on themes from a forthcoming book on Grotstein and ‘weaves tapestries’ with elements of Winnicott, Klein, Bion, Elkin and patients (pxiv). Chapter nine contains lengthy sections of verbatim dialogue from therapy sessions with ‘Tom’ to illustrate that Eigen’s aim is not to ‘cure’ but to meet people where they are by entering their world and joining them in their stream of consciousness. The book ends with a brief autobiography and two of Eisen’s previously published reviews of works by Milner.

This wonderful book shows how rich psychoanalytic practice can be and will appeal to those with a spiritual and philosophical inclination.

Dr Els van Ooijen is a supervisor, psychotherapist, counsellor and author

REFERENCE:

The personal and professional

Interacting selves: systemic solutions for personal and professional development in counselling and psychotherapy
Arlene Vetere, Peter Stratton (eds)
Routledge, 2016, 142pp, £24.99
isbn 978-0415730853
Reviewed by Chris Rose

I can see why it was difficult to come up with a snappy title for this book, and why the need for such a compendious subtitle. Trying to capture its flavour in a short review is not easy as, despite its slimness, it contains a lot of muscle.

The authors have taken on the admirable task of writing about personal and professional development (PPD) not just for students or the new practitioner, but for trainers, supervisors and the experienced. They challenge us to ‘raise our game’: that is, to move on from a ‘sound but pedestrian’ level to something more creative and enriching for our clients, students, supervisees and for ourselves.

The contributors are from Norway, Greece, Ireland, the Netherlands and the UK, bringing a wide range of experience as practitioners and trainers. Each chapter needs digesting in its own right before moving on – very appropriate for a book that puts calm reflection and reflexivity at its heart. They share a systemic way of thinking that unifies the personal and professional, where learning is a dialogical, co-constructed process and where the self is fluid and multiple. ‘Is a verb masquerading as a noun’ (p25) is a quote that is worth repeating.

Much of the book is about supervision: Jim Sheehan linking internal and external narratives of client, supervisee and supervisor; Arlene Vetere and Rudi Dallos demonstrating the use of attachment theory in the practice of supervision; Anne Hedvig Helmer Verdeler attending to vaguely sensed movements in the supervision group and finding ways and space to reflect upon them.

Other chapters explore, for example, how we learn as adults; storytelling; relational resonance, and how to take care of ourselves. Readers are invited to engage through numerous exercises. I found myself so bombarded right at the start of the book that I defensively declined to do any of them – I felt as if someone I had barely met was relentlessly asking questions. At a later stage I was happy to reconsider, discovering some interesting and creative avenues that the exercises could open up. Here’s one you might like to consider (p14): ‘In groups of three or four, have the most fun (wacky, uncritical, playful, ribald, energetic, irreverent, novel) discussion you can manage.’

Chris Rose is a group psychotherapist, writer and Therapy Today Reviews Editor
From the Chair

Members may not be aware of BACP’s policy work behind the scenes, says Andrew Reeves

The recent launch of BACP’s new strategy, with more details to come over coming months, indicates a new direction for the Association that is much more attuned to our members’ work with clients. An internal restructure now enables BACP to work more effectively in supporting members and championing the value of the counselling professions.

We have, as an Association, undertaken many excellent projects over the years, but latterly these have not been within a coherent strategic aim. That is now changing and the strategy means that we will be much more accountable for our work to clients, members and other stakeholders.

While we have worked hard on communications, we have not always been able to reach all members about important policy work that we have been doing. Take the Improving Access to Psychological Therapies (IAPT) service, for example. A government-led initiative, it has received significant investment for NICE-approved therapies, such as CBT, dialectical behaviour therapy, interpersonal therapy, behavioural couples therapy and, of course, counselling for depression (CfD).

While increasing access to psychological therapies (and indeed, the acknowledgment of psychological interventions as having any value at all) must be welcomed, IAPT does not receive a clean bill of health across the board. For so long it seemed that a preferred ‘treatment approach’ was taking precedence over client choice. That is, while all approaches can be of value, they are not necessarily right for each person, simply because of a label such as ‘depression’ or ‘anxiety’. Likewise, many counselling services have seen a squeeze on their funding at the expense of what have typically been viewed as more ‘effective treatments’ – eg CBT. Referrals are high, the complexity of problems significant (with people with complex problems often referred into the third sector), terms and conditions of employment are inconsistent, and there is the constant threat of the closure of counselling services.

BACP has, for many years, been lobbying hard to challenge some of these practices and to promote CfD as an equally valid and important option for many people. We launched, at Westminster, our Parity of Esteem policy document that calls for parity between mental health and physical illness within the NHS in terms of access to treatment, funding and resources. This policy now seems more embedded in the political parable. Members tell us, however, that the rhetoric doesn’t match the reality of funding cuts in crucial mental health services. Nonetheless, the development of CfD has allowed for a comparison of treatments within IAPT, and what we find is that CfD is marginally more effective than CBT in supporting people with mild to moderate depression, according to IAPT national data, and achieves this outcome over a slightly shorter period of time. The argument here is not a CfD vs CBT one, but rather for treatment choice, so that each individual has the right to access the help that is right for them, rather than simply receiving one off the shelf.

It remains a scandal however, that currently only 15 per cent of people with anxiety and depression are receiving psychological therapy through IAPT (there is a new target to raise this to 25 per cent): imagine if only one in four people with cancer received treatment, and the other three quarters... well. BACP continues to work tirelessly in its own right, as well as in our collaborative arrangement with UKCP and BPC, and also with the We Need to Talk coalition, for further changes in the constitution in IAPT, for changes in the way NICE collects evidence, for true parity of esteem between mental and physical health, for client choice, and for fair employment conditions for counsellors. Much has been achieved but we are not complacent and, for sure, there is much still to do.
Counselling and psychotherapy have an image problem. Although things have shifted hugely in the last 30 years in terms of public awareness and provision of counselling and psychotherapy, we’re still not very good at explaining to the public what it is we do, and what it is we don’t do. Only a few years ago a BACP survey revealed that members of the public experienced counselling and psychotherapy as being ‘shrouded in secrecy’ and ‘a bit like an underground movement’.

Many people haven’t a clue what happens in therapy, and myths and misunderstandings abound: that it’s just about ‘tea and sympathy’, for example, or that it’s delivered by medics in white coats, or, indeed, that you can have a quick solution to a problem without engaging in a process. A recent client of mine, in a student counselling service, thought I was a psychiatrist. (He wasn’t particularly interested when I explained the difference between a counsellor and a psychiatrist, but it was a reminder of the gap between how we think the public perceive us and how they actually perceive us.)

This matters because people may come to counselling expecting a quick solution. I’ve always been in favour of explaining to prospective clients what therapy entails rather than expecting them to somehow guess. Apart from anything else, I think they are more likely to come back if they understand what is expected of them. Stephanie Merritt’s negative and short-lived encounter with her first therapist sums this up:

‘I had imagined she would dispense sage, non-religious advice that I could go home and follow, a set of bullet points to make me calmer and more wholesome… I had failed to understand that I was the one who was supposed to be doing the work in these sessions… but this was never explained to me.’

Our culture is dominated by narratives of medical diagnosis and medical solutions, which increasingly threaten to drown out the quieter, more reserved voice of counselling and psychotherapy. It’s not just BACP that has struggled to explain to the public what we do. It’s the same across the profession, in the UK and in the US. ‘Clients still feel shame admitting that they go to therapy,’ writes Ryan Howes in Psychology Today. ‘Our research is not well known, our portrayal in the media is variable, and many assume that we’re a luxury for the middle and upper class.’

To have any chance of combating the predominant narrative of antidepressant medication and the medical model, therapy has to seem to people like a viable option. People ‘have to believe that therapy is a socially acceptable, effective, economically viable response to emotional and relational problems’ before they’re willing to give it a try. Otherwise, as Ryan Howes says, they’ll just take the pill or suffer in silence.

**BACP commitment**

BACP has done a good deal of public-facing work in the past: surveys asking the public what they think about therapy; a wealth of media work; public information sheets on how to choose a therapist or how to get the best out of therapy (www.bacpregister.org.uk/public/); leaflets explaining counselling that can be distributed in GP surgeries; a website for the public (www.itsgoodtotalk.org.uk), which includes our Find a Therapist directory; social media work; our ‘Ask Kathleen’ client advice service. But in the past this activity was somewhat fragmented and lacked a coherent strategic approach and commitment. In its new strategy BACP has placed public engagement firmly as a key objective. Public engagement is a crucial part of our social justice agenda. The new BACP strategy states that we will: ‘Educate the public about...’

‘Although things have shifted hugely in the last 30 years in terms of public awareness and provision of counselling and psychotherapy, we’re still not very good at explaining to the public what it is we do’
the practice and benefits of the counselling professions and learn from people how to develop responsive services and also ‘advocate the role and relevance of – counselling and psychotherapy… in our contemporary and diverse communities’.

The crucial thing about public engagement – and where it differs from marketing or media work – is that it’s a two-way process. It’s about helping people to understand what we’re doing and valuing their input. It’s about listening to feedback from clients, potential clients and people who would never dream of being clients.

We at BACP want to work more closely with communities that may find it difficult to access counselling, for whatever reason. They include the Black, Asian and Minority Ethnic (BAME) community, which is over-represented in the mental health system but under-represented in accessing counselling. We also want to increase our focus on older people, who we know from research benefit equally from counselling but are less likely to be offered it or to consider it. To achieve this we need to work with organisations already serving these communities and find creative ways to engage with hard-to-reach communities.

We need a sea change in the way counselling and psychotherapy approach research. Our research and our training are too preoccupied with therapists’ views and experiences of therapy. Do we really need any more studies of the therapist’s view on erotic countertransference? Wouldn’t it be more valuable and meaningful if those doing research at MA or PhD level were encouraged to look at clients’ experiences of therapy, rather than their own? Or are we afraid to ask clients what they think in case their answers don’t fit with our views?

Embedding public engagement

I recently went on some public engagement training that was aimed primarily at universities. One of the questions raised was, ‘What is the point of my research if I can’t communicate it to other people?’ If we don’t engage with society at large, we become stuck, irrelevant and out of touch. Universities do public engagement because they partly exist for the good of society and don’t want – and can’t afford – to become isolated, ivory towers. They cannot afford to appear unaccountable or to be a waste of taxpayers’ money, to be elitist or reinforcing inequality. Engaging with the public helps prevent this from happening. I know that confidentiality issues and gaining ethical approval for studies with clients can be much more complicated but we need to do something to improve this.

BACP’s charitable status demands that it acts for the good of society. As BACP Chief Executive Officer Hadyn Williams emphasised in last month’s Therapy Today interview on the new BACP strategy, BACP exists not to represent the clinical world of its members but ‘to represent the value of our profession, what it can bring, to society’.

Our committees consist mainly of BACP staff and members. I’ll be meeting with BACP Chair Andrew Reeves shortly to discuss how we will embed public representation throughout our governance structure in a meaningful way. Public engagement will be seeded throughout the organisation so that staff are encouraged to consider the public in everything they do. So, for example, our new website will be created with the public in mind: we will be thinking much more about how different public groups hear about counselling, how they can contact us and what resources we can provide them with. We will be thinking about who we can collaborate with as partners – voluntary sector organisations, and charities, schools, festivals, museums and galleries – to put on public engagement events in the community, locally, nationally and online.

We also want to encourage and support you, our members, to get involved in public engagement. Some organisations have awards for an outstanding piece of public engagement, whether that is a public lecture, a talk in a community centre, a blog or another kind of opportunity to engage with the public. Would this work for BACP and its members? Maybe you are already active in this area? If so, we’d like to hear about your experiences.

Sarah Browne is BACP Public Engagement Advisor. Email sarah.browne@bacp.co.uk

References

**Ethical Framework goes live next month**

BACP’s new Ethical Framework for the Counselling Professions will be formally adopted on 1 July 2016, replacing the existing 2013 BACP Ethical Framework.

Written by Professor Tim Bond, with contributions from many others, and following extensive consultation with members, the revised Ethical Framework takes us to a new and exciting level in ethical thinking in our profession.

You can view it now on the BACP website to familiarise yourselves with the changes and to begin to develop your practice in accordance with its principles. You can also feed back any thoughts or comments you have about the new Ethical Framework.

We’re currently developing an extensive range of supplementary guidance, which will be made available on the BACP website in the coming months.

To view the new BACP Ethical Framework for the Counselling Professions, please visit www.bacp.co.uk/ethics/EFfCP.php

**New additions to BACP Good Practice in Action guidance**

BACP has launched three additions to its Good Practice in Action (GPiA) series of guidance on legal issues for the counselling professions.

The GPiA guidance is intended to be read alongside the new Ethical Framework for the Counselling Professions and offers specific and specialist information on relevant legal issues.

Members working in mental health contexts will welcome GPiA 029, covering ‘Mental health law within the counselling professions in England and Wales’. Written by BACP’s expert legal consultant Dr Barbara Mitchels, it covers all aspects of mental health law relevant to counsellors and provides a detailed and comprehensive guide to patient rights, mental capacity and the therapist’s duty of care, among other issues.

The contents cover legal definitions relevant to mental health, compulsory detention for mental health assessment and treatment, community care and mental health treatment, therapists and private mental healthcare, an outline of the NHS mental health system and mental health pathway in England and Wales, mental capacity and consent for adults and for children and young people aged under 18, assessment and management of risk and the therapist’s duty of care, referrals and the therapist’s duty of care, NICE pathways and guidance, including the IAPT programme, and complaints and Mental Health Review Tribunals (MHRTs).

It also includes lists of relevant legislation, references and sources of further information, advice and practical help for members working in this challenging arena.

The other two new GPiA legal resources are for counsellors and counselling professionals working in Scotland. GPiA 025 covers ‘Counselling and psychotherapy in the context of adoption law in Scotland’, and is a companion guide to GPiA 003 and 005, which cover adoption law and practice in England and Northern Ireland and Wales, respectively. The contents include contracting, relevant law, making decisions about children, the legal capacity of children and young people, GIRFEC (Getting it right for every child), information sharing and child protection, and considerations on working with adoption issues.

GPiA 026 covers legal issues in relation to counselling children and young people in school contexts in Scotland. Its contents cover the counselling service, the legal context in Scotland, GIRFEC and child protection, and data protection and information. The aim of this guidance is to show where boundaries and responsibilities lie and provide counsellors with sufficient information and signposts to decide when it is necessary to seek further legal help and advice.

All the GPiA publications produced to date can be downloaded at www.bacp.co.uk/ethics/newGPG.php

**Ethical issues in the supervisory relationship**

Supervisors often face the challenge of how to balance collaboration with their supervisees with appropriate use of the authority inherent in their role.

BACP is running a Professional Development Day on Monday 18 July in Manchester on ‘Supervision: relationship, authority and ethics’, which will explore the qualities we seek to establish in our supervisory relationships, informed by our own experience, feedback from supervisees and the research literature.

Participants will explore the nature and purpose of ‘supervisory authority’ and some of its shadow aspects, such as authoritarian, tendencies and the risks in abdicating authority. Referring to the new Ethical Framework, they will also explore the connections between ethical practice, the supervisory relationship and the supervisor’s authority.

The PDD will be repeated on 27 September in Bristol and on 17 October in London. For more details and to book, visit www.bacp.co.uk/events
Since May’s Therapy Today, we have seen elections across the UK. In Scotland the SNP won a resounding victory, as predicted, although not quite regaining the majority they had in the previous government. Nicola Sturgeon has recently pushed through a cabinet reshuffle, including replacing former Minister of Mental Health, Sport and Wellbeing Jamie Hepburn MSP with Maureen Watt MSP, who will hold the newly created post of Minister for Mental Health. In their manifesto, the SNP promised for Mental Health. In their created post of Minister MSP, who will hold the newly of Mental Health, Sport and Wellbeing Jamie Hepburn replacing former Minister re-shuffled ministerial posts so that Vaughan Gething AM now takes the post of Cabinet Secretary for Health, Wellbeing and Sport and Rebecca Evans AM takes up the post of Minister for Social Services and Public Health, replacing Mark Drakeford AM, who previously held the post of Minister for Health and Social Services.

In Northern Ireland, the Democratic Unionist Party came out top with 29.2 per cent of the vote and Sinn Fein in second place with 24 per cent. The DUP promised to ‘increase spending on mental health each and every year of the next Assembly term’ and also to appoint ‘mental health champions’ across the public sector and establish a ‘world leading mental trauma service’. Sinn Fein promised to ‘improve the provision of age appropriate care for children and young adults with mental health issues’ and ‘commit £1 billion to additional health spending’.

In Wales, the Welsh Labour Party took first place under the leadership of Carwyn Jones AM. Among their manifesto promises for mental health, the Labour Party promised to ‘prioritise greater access to talking therapies at earlier stages’, ‘end the stigma of mental health’ and ‘work to improve wellbeing at work, in education and in our communities’. As in Scotland, the Welsh Government has re-shuffled ministerial posts so that Vaughan Gething AM now takes the post of Cabinet Secretary for Health, Wellbeing and Sport and Rebecca Evans AM takes up the post of Minister for Social Services and Public Health, replacing Mark Drakeford AM, who previously held the post of Minister for Health and Social Services.

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Research award winners announced

The following members were presented with awards relating to their research at the BACP Research Conference in May.

Stuart Gore was awarded the BACP Outstanding Researcher Award 2016. The aim of this Award is to reward the excellence in counselling research that has been completed in the last 36 months, with a view to inspire future generations of researchers in the field.

Stuart’s research is entitled ‘Multiple obstacles to psychological care from the viewpoint of addiction service users’. Stuart received a personalised crystal plaque at the Research Conference in recognition of his research and he will be invited to submit a manuscript for publication in CPR.

Shelley Gilbert won the CPR New Researcher Award 2016, sponsored by Wiley. The aim of this award is to share the results of research by a current student, or an alumni of 24 months, that contributes to the evolution of the counselling field. Shelley Gilbert will be filmed discussing her research with the editor of CPR, Dr Clare Symons, and the resulting video turned into a podcast.

Shelley's research is entitled ‘Good grief: a grounded theory study of grief and bereavement with young people prematurely bereaved’. Shelley was presented with £100 worth of Wiley books at the conference and will also be invited to submit a manuscript for publication in CPR.

Bettina Gross won the PCCS Books Student Prize 2016. The aim of this award is to recognise excellence in person-centred/humanistic research conducted by an undergraduate or postgraduate student.

Bettina’s research is entitled ‘Investigation of counsellor experiences of moments of disconnection with clients’. Bettina received a cheque for £500, sponsored by PCCS Books, and will also be invited to submit a manuscript for publication in CPR.

Marta Shepherd won the CP-CAB Counselling Research Award 2016.

The aim of this Award is to assist with the dissemination of research that has important implications for counselling training or counselling practice. Through highlighting significant research, documenting it on video and disseminating it for free online, the award aims to make the research accessible and engaging to all counselling trainees and practitioners. Marta’s research is entitled ‘It’s like I’m sitting in front of myself: an exploration of therapists’ experiences of countertransference when working with parallel client issues’. Marta will also be invited to submit a manuscript for publication in CPR.

June’s research enquiry of the month considered ‘What makes outdoor therapy effective?’ An electronic search was conducted using Google Scholar and also our internal abstract database using the search terms ‘outdoor therapy’ AND ‘factors’ AND ‘effective’. This produced a very large number of research articles on the effectiveness of outdoor therapy, specifically from client perspectives.

It is important to note that ‘outdoor therapy’ can refer to a wide range of outdoor activities, including adventure and wilderness therapy.1

Using interpretative phenomenological analysis (IPA), Kyriakopoulos explored the experience of six participants with self-reported depression and anxiety who received individual therapy combined with adventure therapy. Twelve themes emerged, which were categorised into four major domains: enhancing intrapersonal relationships; improving interpersonal relationships; providing an experiential outdoor venue for achieving therapeutic change, and offering a secure, personal place for achieving inner healing. The intervention was perceived to improve the ways in which participants related to themselves and others. The author concludes that outdoor experiences offer a suitable location for achieving personal change and appear to enhance the therapeutic process.

Revel et al.2 also investigated participants’ perspectives of helpful aspects of outdoor therapy; in particular, the actual processes that are inherent in the outdoor therapy experience. A total of 43 complete responses were received to an online survey. Being outdoors emerged as the most helpful factor in both the quantitative and qualitative analyses. It was ranked the most helpful of 19 aspects of outdoor therapy, and ‘being outdoors’ emerged as a main category in the thematic analysis. Although this was a preliminary survey, findings suggest that further investigation into the meaning attached to being outdoors and how this might affect/impact the therapeutic relationship is required.

These studies highlight some of the important aspects of outdoor therapy as perceived by clients, within a wealth of research literature published on this topic.

If you have any research queries or questions, or would like to know more about June’s enquiry of the month, email research@bacp.co.uk.

REFERENCES:
Sanction compliance
Patricia Day
Reference No: 529791
London N8

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the March 2016 edition of the journal has been lifted. The case is now closed.

This report is made under clause 5.2 of the Professional Conduct Procedure.

Sanction compliance
Karen Woodall
Reference No: 704956
London E14

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the September 2015 edition of the journal has been lifted. The case is now closed.

This report is made under clause 5.2 of the Professional Conduct Procedure.

Sanction compliance
Christine Usher
Reference No: 573333
Bishop’s Stortford CM23

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the May 2015 edition of the journal has been lifted. The case is now closed.

This report is made under clause 5.2 of the Professional Conduct Procedure.

Withdrawal of membership
Roddy Macdonald
Reference No: 598547
(Previously known at)
Edinburgh EH12 8UJ

A sanction was imposed on Mr Macdonald following a Professional Conduct Hearing.

Mr Macdonald failed to comply with the sanction and subsequently his membership of BACP was withdrawn. Any future application for membership of BACP will be considered under Article 12.3 of the Articles of the Association.

Sanction compliance
BACP Professional Conduct Hearing
Findings, decision and sanction
Dean Addams
Reference No: 545242
London SW5

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

The Panel made a number of findings and it was unanimous in its decision that these findings amounted to Professional Malpractice, in that the service for which Mr Addams was responsible, fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill. The Panel found that Mr Addams had provided an inadequate professional service. The Panel found evidence of mitigation and imposed a sanction.

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

Sanction compliance
BACP Professional Conduct Hearing
Findings, decision and sanction
Gerry McKinney
Reference No: 580567
Londonderry BT48

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

The Panel made a number of findings and it was unanimous in its decision that these findings amounted to Professional Malpractice on the grounds of incompetence and the provision of inadequate professional services, in that the service for which Mr McKinney was responsible fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill.

The Panel found no evidence of mitigation and imposed a sanction.

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

Each year BACP offers a Small Research Grant worth up to £5,000 to support BACP members to undertake an empirical study. The winning applicants this year (out of 20 applicants) are Joanna Omylinska-Thurston, who has received a grant towards researching ‘Client perceptions of hindering experiences in CBT within IAPT serving an inner city/deprived area’, and David Murphy, who has been awarded a grant to research ‘A comparison of good and poor outcome cases of person-centred and emotion-focused therapies to identify therapist variables that support socially anxious clients’ engagement in the early stages of trauma focused work’.

Winners of the 2015 BACP Small Research Grants

This report is made under notices/hearings.php

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