

Therapy Today

For counselling
and psychotherapy
professionals

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Mindbody healthcare

Parkour in St Petersburg: rehabilitating young offenders

Mindfulness: further connections with psychotherapy

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The British Association for Counselling and Psychotherapy aims to:

- Promote the understanding and awareness of counselling and psychotherapy throughout society
- Increase the availability of trained and supervised counsellors
- Maintain and raise standards of training and practice
- Provide support for counsellors and those using counselling skills, and opportunities for their continual professional development
- Respond to requests for information and advice on matters relating to counselling
- Represent counselling at national and international levels.

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- Counselling Children and Young People (CCYP)
- BACP Healthcare – formerly Faculty of Healthcare Counsellors and Psychotherapists (FHCP).

For further information about joining any division
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Contents



Sarah Browne
Editor

Up to one third of people consulting a GP will have medically unexplained symptoms (MUS) – from breathing attacks to chronic back pain – as part of their problem. The financial burden of MUS is phenomenal – around 16 per cent of the total cost of healthcare services in the developed world – and much of this is being wasted on unnecessary and inappropriate tests and treatments. Psychiatrist Tim Webb gives his perspective on why our healthcare services have failed to deal effectively with MUS for so long and why that may be about to change.

Given that the NHS is being asked to shave 15 per cent off its operating costs by this time next year, our healthcare services may be forced to give serious consideration to rethinking how to tackle MUS. Any transformation in approach would involve major changes in how clinical staff are trained and deployed to create a system that positively identifies and treats the psychological causes of these problems. For therapists working in healthcare, Webb suggests, this would offer ‘unlimited

possibilities’. But while doctors would need to be trained in how to recognise when a patient’s ‘physical’ illness has its basis in anxiety or depression, so therapists would need a working knowledge of the signs and symptoms of underlying physical disease.

When patients are given a diagnosis of tension myoneural syndrome (TMS), they are not told that their pain is all in the mind; they are told that it is real but is caused by a physical response to a psychological process rather than by structural damage. Alan Gordon argues that when our coping mechanisms are overwhelmed and the emotions too painful to experience, the body attempts to protect the psyche by experiencing the pain physically. In treating TMS, one of the primary goals is to help clients reframe the meaning of their pain and to use it as a guide to introspection. When Dr John Sarno introduced the concept of TMS in the late 1970s, the mind and body were widely viewed as separate entities. Now at last mainstream medicine is embracing the mindbody connection.

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Funding will help Welsh veterans

A pilot project to support armed services personnel experiencing mental health problems is to be extended. The service to access expert help, which was trialled in the Cardiff and Vale and Cwm Taf health board areas, will now be rolled out across Wales from April.

The investment of £485,000 a year will provide servicemen and women with access to clinicians with expertise in veterans' mental health, who will assess their

needs and provide suitable treatment. The £135,000 two-year pilot based at the University Hospital of Wales, Cardiff, was funded by the Welsh Assembly Government and Ministry of Defence. The new all-Wales service, which will be funded fully by the Welsh Assembly Government, will also inform veterans and carers of other services and support that they are entitled to.

Health Minister Edwina Hart said: 'I am determined

to improve the care for people who have experienced health problems as a result of their military service. We owe them a debt of gratitude and have a duty of care to them. I understand that people who have been supported by this pilot project... have found it extremely beneficial. That is why I am acting quickly to fund the expansion of this service to maximise the benefits for individuals and their families across Wales.'

Welsh Assembly Government

Motherhood cuts suicide risk

A study published in the *Canadian Medical Association Journal* has found that having children can cut the chances of a woman committing suicide. In one of the largest studies of its kind, researchers looked at data involving 1,292,462 women over 20 years. Their findings show that motherhood does indeed have a protective effect, which increases in proportion to the number of children a woman has. The research team set out to study the theory that parenthood protects against suicide, first suggested by sociologist Emile Durkheim in 1897.

The Telegraph

Websites told to remove material promoting self-harm

Doctors have called on websites to remove material which romanticises or promotes self-harm by young people, as figures emerged suggesting a significant rise in the numbers admitted to hospital. Around one in 10 11–25 year olds, mainly but not only girls, will deliberately harm themselves at some point. According to the Centre for Suicide Research at Oxford University, admissions of under-25s who have damaged themselves deliberately with a sharp object have risen by 50 per cent in five years, from 1,758 in 2004/5 to 2,727 in 2008/9. One in five young people questioned by the centre said that they had first heard about self-harm from reading about it or watching a video online.

The Royal College of Psychiatrists is calling for new curbs by website operators



Call for websites which promote self-harm to be curbed

and moderators on self-harming content. Dr Margaret Murphy, chair of the college's faculty of child and adolescent psychiatry, said: 'Unicef's report at the end of 2007 suggested young people in the UK were faring worse in terms of mental wellbeing

than in other parts of Europe. The reasons behind it are very complex but many young people who self-harm describe it as being a way of dealing with intolerable feelings and releasing or coping with them.'

The Guardian

Mental health costs Wales £7.2 billion pa

Promoting better mental health would save money and boost life expectancy by seven-and-a-half years, says the All Wales Mental Health Promotion Network. It estimates costs at over £1bn for the Welsh NHS, over £2.5bn in lost economic activity and nearly £3.5bn in the loss of quality of life for sufferers.

The network is calling for more money to be spent on intervention during childhood, parenting programmes and support for people with mental health problems to stay in work.

All Wales Mental Health Promotion Network

Mother's love keeps sons on straight and narrow

Experts who analysed data provided by around 6,000 youngsters aged 12 and under, found that boys who never forge close relationships with their mothers are more likely to be aggressive and suffer mental health problems. By contrast, boys grow up to be calmer, more self-confident and more empathetic if they have been able to seek comfort from their mothers as children. Relationships between mothers and sons break down from a young age if children are repeatedly dismissed when trying to turn to their parents for help, the study published in the journal *Child Development* found.

Pasco Fearon, Associate Professor of Psychology at the University of Reading, who led the study, said: 'Secure children have had repeated experiences of a caregiver who is responsive



Mother-son relationship featured in study

when support and proximity are needed and expect the caregiver(s) to be available and comforting when called upon. In contrast, children with insecure attachment relationships may have had experiences in which bids for proximity have been discouraged, rejected or inconsistently responded to.

They rely more heavily on secondary coping processes to deal with stress and challenge. More specifically, children who seem unable to maintain a coherent strategy for coping with separation are at greatest risk for later behaviour problems and aggression.'

The Telegraph

First National Clinical Director

Professor Louis Appleby will be the first National Clinical Director for Health and Criminal Justice. The move reflects an increased focus on improving the mental health of offenders and develops responsibilities from Professor Appleby's current work as National Clinical Director for Mental Health Services.

Professor Appleby will champion the Government's action plan 'Improving Health, Supporting Justice', which set out measures for health and criminal justice services to work together more effectively. It aims to address health and social care problems as early as possible in a person's contact with the criminal justice system and to develop more effective interventions for offenders.

Department of Health

Six out of 10 people have suffered mental health problems

Six out of 10 people (62 per cent) in Britain have had at least one time in their life where they found it difficult to cope mentally, according to a recent survey. Mental health charity Together said the figures showed that there should be an end to a 'them and us' attitude to the topic.

The research, commissioned to launch the charity's annual Mental Wellbeing Week, found that 70 per cent of people had suffered stress, 59 per cent anxiety and 55 per cent depression.

Liz Felton, the charity's

chief executive, said: 'This research shows that mental health and wellbeing is an issue relevant to most people, not just those with diagnosed issues. We hope the results go some way to try and reduce the "them and us" mentality about the topic that can lead to stigma, and perhaps prevents some people from seeking help, or talking about what they're going through when they need to.'

Commenting on the findings, Care Services Minister Phil Hope said: 'As this survey makes clear,

many of us will be affected by mental health problems at some point and that is why we are bringing forward a radical new approach which includes the national roll-out of our successful talking therapies programme, NICE guidelines, new action on suicide prevention and a plan to tackle the stigma shrouding mental illness. The recently launched NHS Stressline also offers practical and emotional support for people suffering from anxiety, depression and stress.'

Together

Community Links in top 100 best companies

Leeds-based Community Links, a mental health service provider, has scooped a prestigious place in *The Sunday Times* 100 Best Small Companies to Work For list. The organisation, which employs more than 160 people, received the accolade following employee feedback to monitor staff satisfaction, motivation and wellbeing, as well as an evaluation from *The Sunday Times*.
Round Foundry Media Centre

GPs demand end to therapy delays

An 'overwhelming' response to a survey sent out to GPs by the Royal College of General Practitioners (RCGP) has painted a picture of patchy availability of adult psychological therapy services across the country and an even poorer availability for children. The situation of children was worse than for adults, with 78 per cent of doctors saying that they could 'rarely' get help for a distressed child within the recommended two months' waiting time. Professor Steve Field, president of the RCGP, wrote to members asking whether adult patients suffering from depression or anxiety disorders and requiring specialist psychological therapy were able to get treatment within two months. Some 1,150 doctors replied, with 65 per cent answering 'rarely'. Only 15 per cent of them answered 'usually', with 20 per cent responding 'sometimes'.

When asked about children

suffering from emotional or behavioural problems who needed such therapies, 78 per cent of the GPs replied that 'rarely' could they get the child help within two months, and just 5.8 per cent said they could 'usually' access treatment within the NICE guideline of two months.

The survey was carried out as part of a campaign launched this month by the RCGP, the Royal College of Psychiatrists and the mental health charity Mind, calling for all political parties to make a manifesto promise to back a new deal for children and adults with mental health problems. The chief executive of Mind, Paul Farmer, said: 'When someone is assessed as being in need of counselling or CBT, it is crucial that they can start treatment as soon as possible. Waiting months and months for urgent treatment would not be acceptable for patients with other health problems, and it should not be acceptable for patients with depression.'



Survey response reveals patients often have to wait for therapy

But while extra money has been given to health trusts around the country, it is now no longer ring-fenced and the campaigners want a political commitment to the Improving Access to Psychological Therapies (IAPT) programme from whoever wins May's general election. 'There has been some great work from the Government and they deserve credit for being the first British

Government to take mental health seriously,' said Richard Layard of the London School of Economics. 'IAPT has made very good progress, but it is still at a fragile stage if the political will is not behind it. We need to get mental health raised up as a national priority and see significant pressure brought to bear on primary care trusts to invest.' *The Guardian*

Do we know when our clients get worse?

About five to 10 per cent of the time, people in therapy get worse instead of better (see www.bps.org.uk/harm).

A new study¹ considers what counsellors and psychotherapists do when their clients deteriorate. Derek Hatfield et al studied data gathered at a student counselling centre where clients provided symptom feedback prior to each weekly session. Although placed on record, this data wasn't fed back to the therapists in a systematic way and there was no alert in

place to signal symptom deterioration. Rather, the therapists had to rely on their own judgment.

Hatfield's team identified 70 clients who at one particular session were in significantly worse shape compared with their state before entering therapy. The researchers then scrutinised clinical notes made by the therapists after each session. In only 15 of these 70 cases had the therapists made a clinical note suggesting they had noticed a deterioration. On those occasions, the most

common noted choices for courses of action were drug referral and continue as usual. Hatfield et al then surveyed hundreds of American Psychological Association-registered psychological therapists about what they would do, hypothetically speaking, if they had a client who'd deteriorated. Popular answers included 'discuss the deterioration with the client'. This research comes with a caveat – dependence on therapists' clinical notes is a far from perfect indicator

of whether they noticed client deterioration. The researchers said: 'It is hoped that therapists will be open to the idea that additional information concerning client progress will enhance their clinical judgment, particularly concerning potential client deterioration.' *British Psychological Society*

REFERENCE:

1. Hatfield D, McCullough L, Frantz S, Krieger K. Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology & Psychotherapy*; 2009. <http://dx.doi.org/10.1002/cpp.656>

Whither pride?

Kevin Chandler

You find me in playful mood. Might be the fact that the 'Dun Listening' sign is in the window and I'm looking forward to a long weekend off. I've been reflecting on words. One of the things I enjoy most about therapy and counselling is the endless opportunity (no, more than that, the requirement) to ponder the meanings of language. And the word that is the object of my current fascination... PRIDE.

I find pride the most puzzling, and troubling, of emotions. Ever conscious that it often precedes a fall, I might confess (on a good day) to feeling a measure of pride in certain aspects of my working life. Pride in self, I can understand. It is pride in the achievements of others that I struggle with.

I began considering this in earnest after the Beijing Olympics when watching on the TV news the glorious bevy of British medal winners stepping off the plane to the adulation of a proud nation. What's wrong with me, I wondered, as my chest failed to swell with pride? I was happy for 'our' winners, delighted that their years of training and commitment had culminated in medal success. But proud of them? Nope, it just wouldn't come. Is it because I'm half-Irish, I wonder, that inhibited me from taking pride in their achievement? Perhaps. But I suspect there's more to it.

When we swell with pride at 'our' athletes' success, aren't we really feeling good about ourselves, taking personal comfort that maybe this little island isn't so bad after all? And isn't it much the same with parental pride? 'That's my boy/girl!' we beam, as our offspring secures the clutch of A-star grades that ensures their place at Oxbridge, or scores the winning goal for

the school hockey team?

But whose success are we really celebrating, theirs or ours? And with that success, the blessed confirmation that we weren't such awful parents after all? If delight is generous, then pride seems selfish. My heart leaps with joy and relief when one of my offspring passes their driving test at the umpteenth attempt; my eyes fill with tears when another shows me her baby daughter for the first time. I say, 'Well done you, that's great' and mean it. But the words, 'I'm proud of you,' never seem to occur. And if they did, they'd probably stick in my throat.

And what of 'national pride'? Our birthplace or parentage wasn't due to our own endeavours, so is there really anything to be proud of in accidents of conception and geography? I've lived in Britain all my life. I recognise myself in some of its idiosyncrasies; I marvel at its varied landscape; comfort myself with some of its traditions; hate its traffic jams and its class-ridden institutions; I appreciate its architecture and enjoy its range of accents. I may like Britain, or loathe it, but pride doesn't enter into it. Threatened with invasion during the 2nd World War, thanks largely to Churchill and the heroic efforts of 'the few', we 'many' enjoy a relatively free and independent nation. But do I feel pride in the Battle of Britain? No, I feel deep gratitude to those who fought

I've counselled many clients over the years who remain not only convinced, but also deeply pained, that their parents do not feel pride in them'

and gave their lives. Maybe my problem (or saving grace?) is that I don't easily do collective; or do I mean possessive?

If pride is one side of a coin, then the flipside is surely shame. If I grant myself the right to be proud of you, then I must also have the right to be ashamed of you. Pride and shame seem essentially concerned with self; one inflates us beyond our measure; the other makes us cringe and shrink from exposure.

Well, that more or less states my case. Trouble is, I've stumbled across a flaw in my argument, and it's been gnawing away at me. I've counselled many clients over the years who remain not only convinced, but also deeply pained, that their parents do not feel pride in them. Not content with care, or love, it is parental pride that these clients long to elicit above all else; that expression of pride which they would then construe as evidence that they are indeed good enough. But the more I reflect upon those clients and their yearning to be a source of pride to their parents, the more I sense that their desire is not simply to be judged approvingly, but something deeper still... The longing to be joyfully recognised and claimed as the other's own. It feels good hearing a teacher, parent or supervisor say, 'You've done really well!' But perhaps what some of us long for even more than approval and appreciation is to be happily claimed as the other's own, and the words that seem to convey this sense of belonging and connection, like no others, (despite my misgivings) seem to be, 'I'm proud of you!' ■

Kevin Chandler is a therapist and supervisor in private practice, and author of Listening In: A Novel of Therapy and Real Life.

In the client's chair

In the flow

Emma Munro

We've settled into a routine now. My therapist and I sit opposite each other in armchairs in a dimly lit room. A coffee table separates us, with nothing on it but a copy of the flow diagram he presented to me in session five. This represents a distillation of my patterns in intimate relationships, with sections highlighted in different coloured fluorescent marker pens.

He asks, 'So how are you?' This question is greeted with a wry sigh or near hysterical laughter. The first five to 10 minutes are spent with him listening as I relate the events that have occurred in the time since we last met. You don't need to watch *EastEnders Live* if you are living my life. He watches me intently, usually silently. Perhaps with the odd interjection, such as 'How did that make you feel?' or 'That must have been very difficult for you'. I find it almost impossible to make eye contact with him. I can see the attraction of the invisible priest in the confessional box. I urge myself to trust him. I have to fight the fear of being judged as ridiculous or a bad person.

We then have a dialogue about what I have been saying. My therapist will ask me a lot of questions. He will make connections or propose theories and point out possible patterns of thinking or behaviour. Obviously, it can be quite a challenging intellectual discussion and I feel at a real disadvantage. When I am concentrating hard on what I feel and making absolutely certain that I am articulating it in a way that is accurate, it takes a lot out of me and I go into myself. I then find it hard to come out of that place to listen to what he has to say or

'I find it almost impossible to make eye contact with him. I can see the attraction of the invisible priest in the confessional box'

to engage meaningfully.

He can sometimes speak for a few minutes, proposing something quite complicated, often referring back to the flow diagram, and asking a number of questions at once. I just don't seem to be able to take in what he says, or keep in my head all the questions in a way that I would normally do in a conversation. It would seem that I cannot listen or retain information when I am deeply emotionally engaged. Perhaps I can only have an intellectual conversation about myself when I'm not in the emotional zone.

A friend who has just been diagnosed with a tumour in her eye, told me that the consultant gave her a CD recording of their meeting, so that she could listen to it later and it has given her the opportunity to take it all in when she felt calmer. I think I might propose recording our sessions. I just can't remember half of what my therapist says, even an hour later.

I pull up my therapist if I don't think what he says is right. He challenges me that maybe I want to be right all the time and this is a characteristic of all my relationships. I challenge him again. No, a lot of what you say is right, but sometimes I think you are way off the mark. How can my therapist possibly know me in a matter of hours, when I have been interacting on this planet for nearly half a century? I am

open to the suggestions that he makes. I will think about them as he says them and in the days that follow. I struggle, and I hope succeed, not to take what he says as criticisms. Perhaps I am just feeling emotionally open and raw.

I feel a bit resentful and irritated by the piece of paper that sits between us. This flow diagram is a useful tool. It puts down a marker. It is a discussion topic. It is recognition that my therapist gets it. However, my life and relationships seem so much more complicated than the essence they have been reduced to on a piece of A4. I don't believe that every relationship I have can be understood by it or interpreted through it. I ignore the piece of paper. My therapist refers to it, sometimes apologetically.

To my relief, towards the end of the session he says that he will modify the diagram, taking on board some of the issues that I have raised today. I will be interested to see if these changes represent a moving on for me, or whether they are about a greater understanding by the therapist of where I am. I do believe it is a document that should evolve.

Our sessions seem to be over in a flash. I would like them to go on for longer. When I leave the therapy room I can't say that I ever feel positive. I am more likely to be further confused. I am certainly contemplative. I hold on to the hope that at some point my therapist will help me find a way through to having more successful intimate relationships and a real sense of contentment. I am optimistic that he can do this – provided the flow diagram keeps on flowing. ■

Some details have been changed to protect identities.

The wrong hoops?

Martin Halifax

As postgraduate students, we currently find ourselves at the sharp end of the course, represented for many of our number by the looming spectre of another extended written project. As has been the case throughout the two years of the course, many of us continue to fit in our one day at college and our placement commitment around earning a living and/or raising a family. Money and especially time are tight, and in this context, so close to successful completion, a whispering disquiet has begun to question the place of such academic exercise on what feels like a vocational course.

In terms of the course in general, the counselling placements we are all engaged in have maintained a level (we keep on putting in the hours; keep tallying them up to the aggregate 150 we all need to matriculate). If the live counselling has not got *easier*, it is fair to say that most of us would attest to feeling more *at ease* in this role as time has gone on. We have become more familiar with its demands, have developed a more secure sense of the working alliance that exists for us with both clients and the organisations/institutions we work for. We have come to feel, if you like, more like 'proper' counsellors.

But whilst the live practice has fallen into a steady pattern, the demands of the written components of the course have become more arduous – the word count for the two assignments this year has doubled and in the context of pressured time, the final project has hovered like a final straw for some.

It is unhelpful to generalise – the folk on the

course come from a range of circumstances – but it is fair to say that, compared to the undergraduate population in the same institution, there is not the blanket background of school or college habit or achievement. The phrase 'academic exercise' has started to occupy the air in a fairly pejorative sense to describe our final task – we are directed to design a research project into an area of counselling – but that research need never be carried out. The task requires us, in addition to the complexity of reviewing existing research in our chosen topic area, to secure a grasp of research methodology and practice – fields we may be interested in but which, for most of us, feel a long way from the counselling skills we are trying to hone and sharpen and a long way down the line.

Of course, the task gives us the opportunity to explore an area of personal interest, to read around issues that may inform our personal practice, but the issue is with having to write it down in essay form. In what sense does this exercise measure the skill set of an effective 'qualified' counsellor?

Emphatically, the modes of communication employed by the practising counsellor are verbal and physical. There is a requirement to keep clear client notes, but these are not in the academic

style. Which raises the question of how counsellors should or might be trained in the future. Is counselling primarily an academic pursuit and does it sit well in academic institutions or, as has been the case in the training of new teachers on the Graduate Training Programme, will more emphasis be put on performance in the workplace?

Clearly there is an imperative for all of us to demonstrate a working knowledge of the theories that underpin the discipline and to be able to explain what we are doing in the counselling room and why we are doing it. We need to place our practice inside a theoretical framework. But perhaps asking for extended and dryly theoretical essays from a student population for whom academic writing takes them a county away from their comfort zone, represents a situation in which the right people are being asked to jump through the wrong hoop.

The counselling field is full of practitioners who also pen theory and reflection (I know – I have done the reading). It is a prerequisite of the theorists we do read that they have been counsellors first. But there is no such prerequisite on the opposite carriageway. Just because you counsel does not mean you have to write a book.

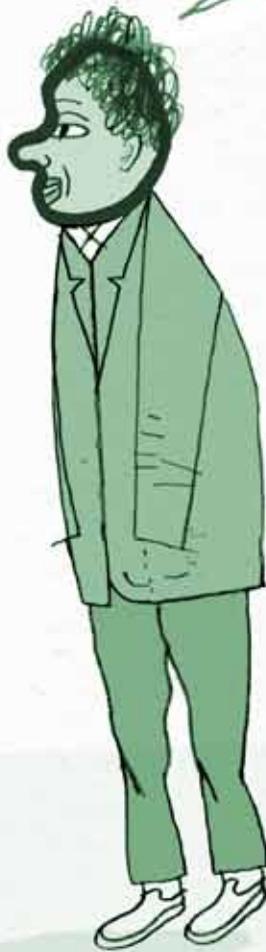
It would be interesting to find out how students who fare well in the written components of postgraduate counselling courses progress in the world as qualified counsellors compared to those who do relatively badly. Someone should design a research project... ■

Some details have been changed to protect identities.

'A whispering disquiet has begun to question the place of such academic exercise on what feels like a vocational course'

I HAVE
A BAD PAIN
THERE

You think
you do?



Medically unexplained symptoms

Addressing medically unexplained symptoms has huge potential to reduce the burden of illness and the cost of health services. Yet our systems of healthcare delivery militate against it, writes

Tim Webb. Illustration by Paul Davis

Half a lifetime ago, as I trudged through medical school, I learned that mental disorder, in forms as variable as repressed frustration to a downward lurch in serotonin production by nerve endings in the thalamus, sometimes takes on the form of physical symptoms that have no definable basis in physical illness.

Had I realised at the time that my tutors were talking about up to one third of all medical problems that present to the average GP, and over 50 per cent of those that present to some hospital outpatient clinics, I might have paid more attention. But how was I to know? The topic took up only one talk in a course that featured nearly 2,000. I would be surprised if it gets a greater airing in the current syllabus, though it may be about to acquire one.

Explaining MUS

The term 'medically unexplained symptoms' (MUS) is set to become fashionable. It may yet achieve a permanent place in the healthcare lexicon, as it has all the qualities of a fine modern phrase. It is self-explanatory, it encompasses the entire field it is coined to describe, and it contains no pomposity.

'Medically unexplained' refers to symptoms or signs of physical distress or malfunction that cannot be accounted for by any physical disorder a patient is known to have. It includes both symptoms in the absence of apparent illness, and the emergence of severe symptoms in those who have only mild illness. Symptoms are often multiple or in clusters, though some patients have a single dominant one.

The intention of the term is to exclude those symptoms caused by physical illness that has yet to be discovered, though inevitably there will be an unknowable but small proportion in this category. The two other main categories have psychological causes (as shown in the box on page 13). However, MUS are often not clear-cut, and these categories tend to overlap in real life (see the box on page 12).

Studies in primary care in the UK have concluded that between 15 and 30 per cent of patients who consult have MUS as a part of their problem.¹ This figure does not include those who present with a mental health problem that does not involve physical symptoms.

The range of MUS covers all manner

of complaints affecting all parts of the body and all their conceivable functions. The most common seen in primary care are musculoskeletal (30 per cent), abdominal (18 per cent) and ear, nose and throat complaints (8 per cent), with more general complaints such as fatigue, dizziness and malaise also prominent.^{2,3} The severity can range from muscle sprains made more taxing by school or college exams, to decades of unexplained paralysis or blindness. In the broader run of things,

physical care facilities are drawn into assessing and treating manifestations of mental disorder in many ways. For example, considerable efforts are often made to spot or exclude possible physical causes of symptoms and deterioration where none is to be found, or to limit the impact of the physical effects of a psychological problem. Besides the cost burden of all this clinical activity, the eventual outcome is most often failure to recognise or to deal with the real cause of the problem.

The cost of MUS

The overall cost to healthcare systems of dealing with MUS is mind-boggling. The simplest and most frequently quoted figure for systems in the developed world is 16 per cent of total costs.⁴ In terms of the NHS, this equates to roughly £8.5 billion per year, costs accruing to every part of the healthcare system. This excludes the run-on costs into social care, disability pensions, carer costs and the broader community.

In an NHS that is being asked to slice 15 per cent off its operating costs from spring 2011 without impacting the quality or availability of care, it may be that serious consideration of how best to tackle MUS has reached its moment.

There are few ethically sound ways of cutting the cost of healthcare. Getting people better more effectively is one. Reducing negative test results and pointless interventions is another. Both can be achieved by a better approach to dealing with MUS. The case for improving our management of the psychosomatic component of medicine has always been clinically and financially sound. It is now topical too.

The challenges of tackling MUS

It has been accepted since ancient times that there are mechanisms by which the mind, brain and/or body transform psychological distress into physical symptoms. Instead of (or as well as) feeling anxiety, low mood or irritability, some individuals experience pain, paralysis, unexplained skin rashes and other symptoms. However, the mechanics of how this occurs are generally poorly understood, and indeed are likely to differ from one type of presentation to another. Moreover, even as knowledge is growing, the greater challenge, running in parallel, is that medical convention militates against formulations that allow for understanding a problem simultaneously in physical and psychological terms.

Take the example of chronic pain. For decades we have known that if clinical depression and painful injuries or illnesses co-exist there is a chance that the one will exacerbate the other. The depressed brain will often register pain that is mild to moderate and occurs occasionally as being severe and lasting for much of the time.

We know that there are typical changes to the pattern of pain in

The complexity of MUS

In real life, MUS do not usually fit into neatly defined categories of imitated illness, amplified symptoms or straightforward physical problems, as illustrated in the following brief examples.

Case example 1: breathing problems

Mary has had asthma since childhood. It has generally been kept under fairly good control with various inhalers. However, she often has a bad time after a chest infection, as she did two months ago. A few months previously she crashed her car and has since become nervous when driving. Since then she has been having more asthma attacks, especially when she has to drive. She has also started smoking again.

Case example 2: ‘funny turns’

Paul has had epilepsy since he was a teenager. Initially his attacks were diagnosed as emotional outbursts. At the time he found that alcohol and cannabis made life more bearable, and he has always used a bit too much of each. He is married and in work, but he struggles with both. Over the past year he has been having more attacks, some of which are pseudo-seizures. His wife cannot cope any more and has threatened to leave and take the children, which has increased his anxiety levels. He has been drinking more to deal with the stress.

Case example 3: living with diabetes

Kylie’s doctor cannot get her diabetes under control but then he’s useless. She’s been in hospital three times in the last year, had to miss exams and everything. They want her to stick needles in herself like a junkie. They don’t know what these drugs do to you in the long run anyway. And picky diets are just so not cool unless you’re fat, which Kylie isn’t. Someone else can have diabetes – Kylie’s got better things to do. If they can’t work that out then that’s their fault.

‘We need to define pathways of care that deal with the problems patients present, rather than slotting patients into pathways designed to accommodate outmoded service configurations’

many such cases. Pain is worse in the morning; spreads into neighbouring areas of the body; worsens in direct or indirect proportion to mood; and can be felt in unconnected parts of the body simultaneously.

Specialist pain journals have been full in recent years of descriptions of a variety of chronic pain syndromes, such as the complex regional pain syndromes (CRPS). CRPS have been sub-divided into a type that involves only the area around the site of the injury, and a second type that seems to involve how the brain and central nervous system (mis)process the pain signals coming from that part of the body. Debates have been conducted around what is (or is not) a reasonable level of pain, since pain is a subjective experience that cannot be measured objectively. However, there is no tradition of bringing together our knowledge of how depression affects individual experience of pain with our knowledge of how chronic pain affects the processing of pain signals. Physical and mental health specialists work in different fields, which is why multidisciplinary teams in pain clinics rarely include psychiatrists.

Perhaps the greatest challenge of MUS – in my younger days I would have said scandal – is that the evidence suggests that there is a great deal we can do about some or all of these conditions. If we were to apply the psychological therapies and drug treatments, which we know stand

a high chance of working, at points in patient pathways where they are known to impact best, patients would get better quicker, clinicians would be satisfied with a job well done, and the costs to the health service would come down. So why does it not happen?

The answer lies mainly in the ways we have designed and implemented healthcare services in the UK, though to be fair it would be difficult to cite a healthcare system that handles things in a fundamentally better way. Traditional service structures tend to mirror our understanding of what constitutes illness, coupled with a certain amount of pandering to medical influence and fashionable causes.

Few healthcare configurations reflect the clinical realities of illness. Our healthcare institutions, recreated in the structures of its professions, encourage the view that illnesses are so complex that considerable specialism is required. We divide specialities by parts of the body, the age of its inhabitant and/or the interventions intended. Each speciality homes in not only on one bit of us, but also often on specific approaches regarding what to do when that bit goes wrong. Each speciality spawns its own training schemes and articulates the need for greater and greater specialism among the professions expected to work within it. Further, doctors trained and practising in this era of techno-medicine become

The three categories of MUS

Somatisation (imitated illness)

Somatisation occurs when psychological distress manifests itself as a physical problem. The distress can be anything from an unresolved emotional conflict to an incipient psychotic illness, via all manner of psychosocial problems and neurobiological disorders.

Amplified symptoms

Just as common and probably more so, is when an individual who is known to suffer from a particular illness or disorder develops symptoms that cannot be fully explained by the nature and extent of their physical condition.

Undiagnosed illness

The fear is often that a patient with MUS might have a hitherto undiagnosed physical illness. This justification has been used for centuries to avoid positively diagnosing and tackling underlying mental distress.

‘The case for improving our management of the psychosomatic component of medicine has always been clinically and financially sound. It is now topical too’

concerned when dealing with conditions that cannot be diagnosed using objective tests. They fear the culture of blame, shame and claim, and its practitioners, always lurking in the shadows.

A way forward

Some or all of the above factors may explain the muted response on the part of the NHS and other healthcare systems to deal with the otherwise obvious and major problem of MUS. Thus the challenge for an NHS intent on saving money by getting people better more effectively is how to restructure our approach to the delivery of healthcare, to enable more joined-up working.

We need to define pathways of care that deal with the problems patients present, rather than relying on slotting patients into pathways designed to accommodate outmoded service configurations. Few if any existing patient pathways contain a point at which the 20-50 per cent of patients whose presenting problem has a major psychosomatic component have that part of their problem assessed and dealt with. Usually the only approach available is to refer patients to another inappropriate pathway.

Successfully achieving the transformation to services that deal effectively with MUS will need major changes to how we train and deploy clinical staff. Creating a system that positively identifies and treats the psychological causes of MUS will challenge those who commission services as much as those who provide them. Teamwork at an unprecedented level will be key. Clinicians in acute hospitals and primary care will need to be aware of the signs that most or all of a patient’s ‘physical’ illness has its basis in mental health problems. They will also need to be able to differentiate between those who require a biological approach from those who need a psychological one.

For therapists working in healthcare settings, such developments will offer almost unlimited possibilities, along with equally massive challenges. Those assessing what psychological approaches are required will need a working knowledge of the symptoms and signs of underlying physical disease in much the same way that many mental healthcare professionals have to get to grips with the biological/psychological interface in mental health work.

This sort of change needs to happen in fairly short order, yet it has not happened in the first 60 years of the NHS, and the power of inertia cannot be underestimated. Whether it will happen and how soon is open to debate – though it may be sooner rather than later because of the cost implications of not acting: money is a powerful master. For the time being, we need to watch this (wide-open and centuries-old) space. ■

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Questionnaire

Colin Feltham

Facing redundancy at the age of 60, *Colin Feltham's* idea of perfect happiness is to gain enlightenment and win the lottery on the same day

Why did you decide to become a therapist/counsellor?

I had primal therapy in 1978–79 in Los Angeles and thought I might be good as a therapist/counsellor myself.

What gives your life purpose?

An organismic survival instinct that's even stronger than chronic doubts and miseries. My adult children. Thinking and writing.

What is your earliest memory?

Various scenes in West Hampstead where I was born: my little sister; Christmas Eve. I don't have a very good memory.

What are you passionate about?

I don't think people who know me would describe me as passionate. I get less passionate as I get older. But I have a quietly passionate belief that I understand the human condition!

Do you always tell the truth?

Unfortunately not – how could you survive a day in any employing institution without lying? In principle I support 'radical honesty' but in reality I'm sometimes a hypocrite.

What has been the lowest point in your life?

Being dumped by my first love, around 20, leading to depression. Right now, facing redundancy at 60 is quite a low point!

How do you relax?

Far too much TV; cinema; sitting in coffee shops; reading; laughing; music.

What keeps you awake at night?

Insomnia – not a joke, I'm afraid; I've suffered for years. But don't ask why – I agree with Gayle Greene's view in *Insomniac* that some of us seem wired to sleep badly and there are no real cures.



What makes you angry?

Bureaucracy and bureaucrats, technology, parking tickets, noisy neighbours, cant, the 'mad world' we've created.

Who has been the greatest influence on you professionally?

Probably Windy Dryden, in person. But 'ideologically' Krishnamurti, Janov, Fromm, and many others.

How do you keep yourself grounded?

I'm not sure I am 'grounded' (I live in my head) but I seem to have some sort of resilience, possibly inherited from my stoical working-class father.

Do you fear dying?

I used to confidently say 'no'. Now I don't know if I do (I don't believe in any hereafter) but I do fear old age, poverty, illness, dementia, loneliness and pain.

What would you have written on your tombstone?

I won't have a tombstone or any memorial. But I heard that someone's last words were, 'What was all that about?' and these would perhaps sum it up for me.

What do you feel guilty about?

Too many unkind deeds and thoughts to mention but I don't agonise over them. I wish I had led a more courageous, adventurous life.

What makes you laugh?

Many TV comedians, particularly creative, irreverent, surrealistic or caustic wits like Paul Merton and Frankie Boyle.

Where will your next holiday be to and why?

New York – while I can afford it and before I die (obviously). I'm a big city person in spite of being theoretically anti-urbanisation.

If you could change anything about society what would it be?

Almost everything: off with MPs' and bankers' heads for a start; high taxes for the rich; radical overhaul of education; humanise the workplace; a regime of austerity to fight climate change and the absurdities of consumerism.

What is your idea of perfect happiness?

Becoming enlightened and winning the lottery simultaneously, and having no remaining lust or greed. Or Angelina Jolie turning up on my doorstep.

Do you believe in God?

Absolutely not. Nor in spirituality. My first degree was in theology and I have had a few moments of transcendence but I think 'the spiritual' is suffused with self-deception.

What's your most treasured possession?

My book collection, sadly.

What do you consider your greatest achievement?

Still being alive. Being a decent father. I suppose becoming a professor and being published, from an 'uneducated' family background. Writing *What's Wrong With Us? The Anthropopathology Thesis*. ■

Colin Feltham is Professor of Critical Counselling Studies at Sheffield Hallam University until August 2010. After that he will continue to write, offer workshops, counsel and supervise. His latest book, Critical Thinking in Counselling and Psychotherapy, is to be published by Sage this summer.

Miracles of mindbody medicine

A small but growing number of healthcare professionals believe that chronic pain is often a psychophysical phenomenon that responds well to psychological treatment. *Alan Gordon* and colleagues tell the story of tension myoneural syndrome (TMS)

Everyone has experienced physical pain at one point or another, but for some that pain is severe and persistent. Albert Schweitzer once said that ‘pain is a more terrible lord of mankind than even death itself’¹ – and many people who experience pain chronically would likely agree.

For years the medical community has struggled to understand the cause of many forms of chronic pain, which is prevalent worldwide. In the USA alone, over 70 million adults suffer from chronic pain,² resulting in a cost to the public of over \$100 billion annually.³

Common treatments for chronic pain include acupuncture, transcutaneous electrical nerve stimulation, ultrasound, nerve blocks, physical therapy, trigger point injections, medication and surgery.⁴ Evidence has shown that these interventions have limited effectiveness with regard to long-term pain relief.⁵ One of the world’s foremost pain experts, Dr Patrick Wall, recently wrote that it was time for a paradigm shift in the way we understand pain.¹ It is the aim of this article to provide a new perspective on the purpose of and treatment for chronic pain conditions.

The mindbody connection

In the late 1960s and early 70s, Dr John Sarno was the director of outpatient services at the Rusk Institute of Rehabilitation Medicine, New York University Langone Medical Center. Treating clients primarily with neck, shoulder and back pain, he practised conventional pain management techniques and grew frustrated with the results, which were unpredictable and inconsistent. More troubling still was the

fact that clients often did not have pain where one would expect, given the findings of their physical examinations.⁴ Sarno began to take a deeper look at his clients’ medical histories. He was surprised to find that 88 per cent of them had a history of one or more tension-related conditions, such as ulcers, headaches or irritable bowel syndrome. He began to wonder, ‘Is it possible that the bulk of musculoskeletal pain is not the result of structural damage, but is in fact tension-related?’⁶

Tension myoneural syndrome

After surveying the research on musculoskeletal pain and meeting with thousands of clients, Sarno concluded that the majority of neck, shoulder and back pain syndromes were not the result of nerve, muscle or ligament damage, but rather the consequence of psychological processes. He referred to the condition as tension myositis syndrome (TMS,⁶ recently renamed tension myoneural syndrome). In addition to musculoskeletal pain, Sarno found that fibromyalgia, repetitive strain injury (RSI), headaches, tendonitis, gastrointestinal disorders, pelvic pain, and various other pain syndromes were also physical manifestations of the same underlying psychological process.^{4,7}

In 1979 Sarno began bringing clients with medically unexplained symptoms together for seminars on the nature of their pain. They covered the onset of TMS pain, its underlying purpose, how it is perpetuated, and the steps necessary to overcome the symptoms. Often, this psychoeducation alone was enough to bring relief to long-term pain sufferers.

In some cases, he referred clients to psychologists specialising in TMS for further treatment.^{4,6}

Physiology of TMS

When pain sufferers are initially given a diagnosis of TMS, a common response is, 'Are you saying that it's all in my head?' The answer is an unequivocal, 'No.' Although the origin of the pain is not structural in nature, the pain is most definitely real.^{4,6,7}

John Sarno theorised that the autonomic nervous system is responsible for the great majority of chronic pain conditions. This system controls the circulation of the blood in the body; for example, an increase of blood flow to the cheeks when a person is embarrassed, or a physiological reaction to a psychological trigger. The autonomic nervous system can also reduce blood flow to certain muscles, nerves, ligaments and tendons in the body. When this occurs, there is less oxygen available to the tissues, and the result will be symptoms, such as pain, numbness, tingling and sometimes weakness.⁴ Various studies have supported this hypothesis.^{20,21,22}

When diagnosed with TMS, clients are told that their pain, although quite real, is not caused by structural damage, but is a physical response to a psychological process. In other words, the mind is responsible for generating the pain. This of course begs the question: Why?

The purpose of TMS pain

Our bodies often try to help us in ways that are difficult to understand. Anxiety attacks, for example, are often unwelcome, but the body's underlying

goal in producing one is to increase the chances of survival against a perceived threat.²³ The result may be unpleasant, but the intent is noble.

It is the same with pain. In 1918, psychiatrist Henry Maudsley wrote that 'The sorrow which has no vent in tears may make other organs weep'.²⁴ When our habitual ways of coping psychologically are overwhelmed, we are capable of somatising psychological pain.²⁵ In such cases, the mind senses that the emotions are too painful to experience, so it attempts to protect the psyche. Experiencing the pain physically, as terrible as it may feel, is more tolerable than feeling the depth of the psychological pain.

This is primarily an unconscious process. Neuroscientist Paul Whelan wrote that 'Most of what we do every minute of every day is unconscious'.²⁶ Because of this, many people are not aware that they have repressed emotions. In fact, when many TMS clients are initially interviewed, they report that psychologically they are 'feeling fine'. It is only on further inquiry that emotional pain is discovered.

Due to a variety of life experiences, certain emotions have the capacity to become 'off limits'. For example, a child who grows up with an alcoholic mother may learn that anger is too scary. An adolescent who was not allowed to fully grieve her father's death may learn that sadness is not acceptable. TMS clients avoid a variety of feelings, including anger, sadness, helplessness, dependency, envy, rage, guilt, even happiness.

Sarno and the psychologists he worked with found that when TMS clients were

focused on their physical pain, they were less apt to focus on deeper psychological pain.⁷ Many if not most people have experienced the process of distracting themselves from difficult emotions. To relieve anxiety or depression, people overeat, smoke, drink alcohol, use drugs and bite their fingernails. All these activities serve to shift a person's focus from their emotional pain to a different sensation. The generation of physical pain is simply the mind's way of shifting this focus for us.

Treatment of TMS

Before a diagnosis of TMS is given, it is essential that a physician rules out a purely physical cause for a client's pain symptoms. Once TMS has been clinically diagnosed, the client's acceptance of the diagnosis is an integral part of recovery. This is because as long as a client continues looking at the pain physically, it will continue to serve its psychological purpose.⁷ One of the roles of the TMS practitioner is to help the client look at their pain as the somatic expression of underlying psychological processes. This is done by educating the client in the effects of emotions on the body, as well as pointing out correlations between the physical pain and emotional issues (E Sherman, personal communication, 09/05/09).

One of the primary goals of TMS treatment is to help clients reframe the meaning of their pain.⁴ Instead of focusing on it with frustration, fear and powerlessness, the client learns to use the pain as a guide to introspection.⁷ My pain just increased; what is going on psychologically right now? The

The puzzle of pain

For over a century, physicians and psychologists have been interested in the connection between the mind and physical pain symptoms. Sigmund Freud, Jean-Martin Charcot and Franz Alexander wrote extensively on the subject.⁷ But only recently has research started to explore the depth of the connection.

Whiplash

Whiplash is the term used to describe head or neck pain resulting most often from a rear-end traffic collision. Research has shown that about 10 per cent of whiplash injuries result in permanent disability.⁸ The director of the Association of British Insurers recently reported that whiplash had become an epidemic in the UK,⁹ while in Norway two per cent of the population have chronic disability as a result of the injury.¹⁰ The medical community has been confounded by this phenomenon, as there is no structural reason why this condition should persist and become chronic.¹¹

In an attempt to understand this enigmatic syndrome better, a team of researchers turned to Lithuania. In Lithuania, the general public has little awareness about the potentially disabling consequence of whiplash injury. The researchers were interested in whether this lack of awareness would impact on the syndrome's prevalence. They interviewed 202 collision victims, as well as 202 control subjects. Their findings stunned the medical community. Not a single

collision victim had persistent head or neck pain as a result of their accident.¹² The syndrome simply did not exist, prompting one medical journal to publish an article entitled, 'The best approach to the problem of whiplash? One ticket to Lithuania, please.'¹³

The surprising results of the Lithuanian study led a group of researchers to hypothesise that the cause of chronic whiplash was unrelated to physical injury. To test this theory, they set up an experiment where 51 volunteers were involved in a placebo collision. The study involved a simulated car crash, with corresponding sights and sounds to make it appear to the subjects that an accident had taken place, though there was virtually no physical impact on the body. Three days after this placebo collision, 20 per cent of the study subjects reported symptoms of whiplash, and four weeks after the experiment, 10 per cent were still symptomatic. The mere thought that one was in an accident was sufficient to bring about pain in these subjects. Furthermore, the researchers found that psychological factors were highly predictive in determining who would develop pain.¹⁴

Back pain

In the USA, low back pain is second only to the common cold as the reason cited by patients for seeking medical care.¹⁵ But despite the fact that manual labour has decreased, and medical technology vastly

improved, back pain is far more prevalent than it was 40 years ago.¹⁶ Indeed, between 1964 and 1994, the rate of disability claims related to low back pain increased by 14 times the rate of population growth.¹⁵

Although magnetic resonance imaging (MRI) is often used to diagnose the source of back pain, it is an ineffective assessment tool. Authors of a *New England Journal of Medicine* article found that 64 per cent of people with no back pain have disc bulges or protrusions, and concluded that such spinal abnormalities are often incidental and unrelated to pain.¹⁶ Further studies have indicated that there is no relationship between lower back pain and disc degeneration.¹⁷ In fact, 85 per cent of back pain has been found to have no apparent physical cause.¹⁸ Like whiplash, the enigma of chronic back pain has continued to puzzle the medical community.

A group of researchers at the University of Washington shed some light on this phenomenon. In one of the largest studies ever conducted on back pain, the investigators found that psychological factors were more predictive of the onset of back pain than any of the physical variables analysed. Of particular interest, they found that subjects who stated that they 'hardly ever' enjoyed their work tasks were 2.5 times more likely to report back pain than subjects who 'almost always' enjoyed their work tasks.¹⁹

symptoms often serve as a signpost to unaddressed emotional issues. The pain exists for a reason. It is a manifestation of emotions that, due to experiences generated throughout one's life, have become difficult to tolerate. An essential part of treatment is to help clients learn to identify these emotions, and eventually accept and express these painful parts of themselves (E Sherman, personal communication, 09/05/09).

As a result of Sarno's treatment programme, many of his chronic pain clients began showing significant improvement. Indeed, he had a much higher success rate treating pain psychologically than he had had years earlier using a variety of physical interventions. However, after publishing his findings in the late 1970s and early 1980s, and despite the success of the TMS model, he encountered significant resistance from the medical community, because the concepts it emphasised contradicted mainstream medical thinking.⁷ There was little belief at the time that the mind was capable of such profound effects on the body. And TMS treatment remained relatively unknown.

Evidence for TMS

Sarno conducted three formal retrospective studies at the Rusk Institute in 1982, 1987 and 1999 to assess the effectiveness of TMS treatment. In all, 371 randomly selected chronic pain clients were interviewed six months to three years after treatment to determine their level of pain and functional ability. Seventy-two per cent reported being free or nearly free of pain with unrestricted activity, while 16 per cent reported some

improvement, and 12 per cent little to no improvement.^{4,6,7} One of these studies was unique in that it included only clients with documented herniated discs. Over a third had been previously advised by physicians to undergo surgery. However, when interviewed between one and three years after TMS treatment, 88 per cent reported being free or nearly free of pain.⁴

Howard Schubiner of Providence Hospital, Michigan, with researchers at the University of Michigan, recently conducted the first randomised controlled study of TMS treatment. It involved 45 clients with fibromyalgia, 24 of whom were treated with a TMS approach and 21 assigned to a wait-list control group. After six months, the intervention group had significantly lower pain severity and higher self-reported physical function. Further randomised controlled trials comparing the effectiveness of TMS treatment to other pain treatment models are underway (H Schubiner, personal communication, 28/07/09). In addition, several functional MRI (fMRI) studies (which measure brain activity) to assess the pain pathways in the brain before and after TMS treatment are under discussion. These and other studies aim to provide further scientific evidence for the efficacy of TMS treatment.

The future of TMS

For years, dozens of physicians and psychologists have been treating pain clients from a TMS perspective throughout the USA and Europe. In March 2009 they came together in

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Perspectives on TMS

TMS recovery: a UK perspective

My work as a physiotherapist of over 20 years was until recently based on physical diagnoses and a physical approach to treatment. Nevertheless, for many years I was puzzled by inconsistencies in the ways that patients presented and their treatment outcomes. For example, why did so many patients with diagnosed structural abnormalities, such as spinal stenosis, severe disc degeneration and prolapse, become pain free, and remain so, after gentle hands-on treatment, some even cancelling spinal surgery? Why did so many ‘injuries’ have no apparent cause, and pain persist despite no definitive diagnosis?

My search for answers to these questions involved extensive reading and research on the mindbody relationship, and my discovery of tension myoneural syndrome (TMS). My professional development into working with patients with TMS included visiting John Sarno in New York in 2007, and ongoing peer review with other TMS specialists in the USA (where the majority of practitioners work with patients individually, with just a handful running more structured programmes, like Sarno’s). Most TMS recovery programmes involve individual face-to-face appointments and/or group sessions, and one is run completely online.

The decision to develop my own TMS recovery programme was based on a desire to provide a structured course that could be available to anyone, as long as they attended initially for diagnosis. The programme follows an initial six-week phase, supported by a course workbook,

and regular follow-up via telephone or face-to-face meetings, a web-based seminar (webinar) and email support throughout. Ongoing support is available to those who need it, and has been taken up throughout the UK and Europe.

A retrospective study into the results of patients with TMS attending the Huddersfield Pain Relief Centre showed that 20 of the 24 who followed either the full TMS recovery programme or their own self-directed learning after a diagnosis, reported a greater than 80 per cent subjective improvement in pain and functioning. Similar results were recorded a year later in the 20 patients who could be contacted, reinforcing for me the importance of this work, especially for those who have tried everything else but are still living with chronic pain.

My own steps to raise the profile of TMS in the UK have included delivering seminars to medical doctors and other healthcare professionals. Undoubtedly, mainstream medical thinking around chronic pain continues to hold back the development of TMS awareness, despite an interest among some GPs. My ongoing plan is to develop a training programme for medical professionals who are interested in TMS, and eventually to set up a research project to study the results in people undertaking TMS recovery.

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TMS: a practitioner perspective

As a chiropractor for over 20 years, I have treated many people with recurring back and neck pain, sciatica, migraine headaches and other physical pain. X-ray and MRI results have indicated problems in their spines, including subluxation, disc degeneration, spurs, and other abnormalities, which were usually pointed to as the physical causes of the pain. Over recent years I found I wanted to learn more about the mindbody connection, so I completed a graduate programme in counselling. This was when I researched tension myositis syndrome (TMS, recently renamed tension myoneural syndrome) and the corresponding theory that these findings are 'normal abnormalities' that do not necessarily cause pain.

I soon began to recognise that patients who complained of pain 'only when standing' or 'only when exercising' could have TMS. I began to see patients in my practice who had had a sudden onset of back or neck spasm so severe that it kept them from work or normal daily activities, and on inquiry found that a strong emotional stressor had usually preceded the spasm. The evidence that

TMS was present in the majority of the chiropractic patients I was seeing became so obvious to me after just a few months that I decided to train with a TMS doctor to learn more. After attending his workshops I started educating my chiropractic patients about TMS, and also developed a two-part workshop for those who could accept the diagnosis of TMS and wanted to end their pain.

I also see symptoms of TMS in my counselling clients. Chronic pain limits a person's ability to function fully, and as a result, clients may suffer depression, anxiety and other psychological maladies. If a client is open to the idea that TMS may be the cause of their pain, and undergoes a physical examination to rule out physical causes, he or she can learn how the unconscious mind is the origin of the physical pain.

The work John Sarno pioneered has helped many people who are no longer restricted by physical pain, and have gained a much deeper understanding of themselves. I look forward to the day that this information becomes common knowledge, and is utilised by healthcare professionals of all types as another tool to alleviate human suffering and decrease the enormous cost of medical care that burdens society.

Audrey Berdeski has been a chiropractor for over 20 years and is also a psychodynamically-trained psychotherapist who specialises in mindbody healing.

Michigan for the first professional TMS conference. A formal TMS Association is in development, an accreditation programme is in the works, and research funding is being generated.

When John Sarno first introduced the concept of TMS, the mind and the body were looked at primarily as independent entities. Physical symptoms were treated physically, and psychological symptoms treated psychologically. Now, more than ever before, the scientific community is embracing the connection between the mind and the body: eminent neurobiologists are writing books on the benefits of meditation, prestigious universities are developing psychoneuroimmunology centres. Patrick Wall's call for a paradigm shift in the way we view physical pain is taking place.

TMS treatment is gaining momentum, and author and physician, Dr Marc Sopher, speaks for many when he writes: 'Ultimately, I am confident that TMS theory will become part of mainstream medicine for the simple reason that it is correct, and more successful at alleviating pain than any other modality.'²⁷ ■

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'The evidence that TMS was present in the majority of the chiropractic patients I was seeing became so obvious to me'

The art of moving

Parkour involves overcoming obstacles by adapting one's movements to the environment. *Gabrielle Pearson-Heavisides* visited a programme in St Petersburg that uses the discipline to restore young offenders to mainstream life

During August 2009 I was part of a group which visited Russia with an organisation called the St Gregory's Foundation,¹ which provides aid to Russia and the former Soviet Union. Despite the very visible wealth of some Russians, many people still struggle to find their place in society, many have no access to appropriate medical help or social care and many see no alternative to poverty and alcoholism. There is much work to be done to build up charities and aspects of the caring professions that were not allowed to develop under the communist regime. St Gregory's supports many community projects, mostly in St Petersburg and in the region of Karelia, by providing resources that enable them to improve their work through training, resourcing, networking and administrative support.

A new centre for offender rehabilitation

Among other things, the St Gregory's Foundation has set up the St Basil's Centre for Young Offenders. St Basil's is the only available residential centre for young offenders on probation, in the absence of any state-funded programmes. It offers an intensive course in social skills and aims to get young men into training or employment, giving alternatives to a criminal lifestyle. The St Gregory's Foundation fills certain gaps in funding by financing a club for course 'graduates', which supports them in their new, responsible lifestyle.

Manager Yuliana Nikita has built up the reputation of the centre. The courts now recognise its role in supporting and re-educating, and will offer offenders, who might otherwise be sent to prison, the opportunity to be placed at St Basil's. Those who the courts recommend are then assessed by a psychologist to ensure they are committed to the programme. Six boys are offered a place, and if they accept, are bound by strict house rules. They live at the centre for a full three months and neither alcohol nor drugs are permitted. A special area for smoking is allocated but the boys are not allowed to swear and the only music played is classical. Since this regime was instituted the atmosphere has become much calmer. The boys follow a strict daily routine with fixed times for getting up and going to bed.

Social skills

All shopping, cooking and cleaning is done by the boys; high standards are expected and they sit down together for the evening meal, which is eaten by candlelight. Yuliana insists this helps to

give eating together an importance and a sense of occasion the boys have never experienced before. She also believes in the value of good nutrition and the effect that food can have on mood and behaviour.

The education programme

Apart from the social skills aspect, an education programme includes daily visits to one of the city's museums and weekly theatre visits. Yuliana's experience backs up her strategy, so she dismisses the boys' complaints of 'museum torture', telling them they will find these things are good for them. She believes that alienation is a huge part of the boys' difficulties. They are often 'social orphans' with no parental care, inevitably excluded from school, outcasts from society. Museum visits give them an understanding both about Russian history and the history of St Petersburg, which reconnects them to their culture and gives them identity and a sense of belonging. The staff work individually with the boys where possible, encouraging them in their interests and helping them to develop their own skills and talents.

Enter parkour

Young people who are fully engaged in sport are far less likely to be involved in crime, drug abuse and drinking. For the young people of St Basil's, problems are created by limited resources and cash, and, of course, the urban environment of the city with its 'no ball games' culture and few designated play spaces. However, over the last few years, the sport of 'free running' or parkour has become very popular in Russia. Young Russians have found out about it through advertisements – which make it seem 'cool' – and YouTube, which has thousands of parkour 'stars'.

Parkour originated in Paris in the 1980s and is a highly physical training discipline that involves manoeuvring through the urban environment in a highly fluid and efficient way by running, jumping, climbing, balancing, dropping and finding one's way through the shapes, structures and architecture of a modern city, rather than being restricted by them, and so exploring a new sense of freedom. However, it is the philosophy behind parkour that makes it particularly interesting to those working with difficult or excluded young people. Parkour was established to be non-competitive, to value community, creativity and personal inner strength. It is not only about the physical challenge of finding your way through any terrain using just your body, but also about learning to navigate all obstacles in life with a positive attitude and self-discipline.



The focus is on perfection of movement and balance, requiring a calm, clear mind. The control and discipline required develops a new positive approach to responding to life challenges. These are just the values that St Basil's seeks to promote. Yuliana Nikita realised the boys were imitating what they were seeing on the internet and found a volunteer trainer in Evgenii Krynin, who is head of the St Petersburg Parkour Association and proved highly popular with the boys. When Evgenii asked the St Gregory's Foundation to establish links with the UK parkour community, they were only too glad to help.

Parkour in Westminster too

In 2008 Evgenii organised the first parkour festival in St Petersburg. Dan Edwards and Daniel Ilabaca, two leading parkour practitioners from the UK, were invited and undoubtedly helped to attract attention. They explained that a pioneering parkour project, run by Westminster Council, showed that parkour can help troubled children turn their lives around. The council employed an organisation called Parkour Generations,² which is at the forefront of training trainers and developing parkour as a sport in the UK, to provide free classes for school children during the school holidays. This not only helped to

improve those children's school performance but also dramatically cut the local youth crime rate. The local authorities in St Petersburg were pleased with the festival and have pledged support for future festivals. There is hope of support from the city for developing parkour to be used particularly with disaffected young people.

Outcomes

The benefits for the boys of St Basil's have been immense. Apart from increased physical fitness, muscular strength, co-ordination and balance, they have also developed an awareness and pride in their own achievements, increased respect for themselves and others, and an inner certainty that they can face up to personal barriers and find solutions. The self-discipline and control required to practise parkour has led to a change in how they would normally respond to tricky situations, and to a more reflective style, with a reduction in defensiveness and aggression. Interestingly, it has also given them a new perspective on their city – rather than feeling marginalised, they now see their urban landscape as an environment that they can navigate around with a new sense of freedom.

Parkour is not without its opponents. Evgenii says, 'Many people in the prison service dislike the teaching of parkour.

They cannot see the difference between parkour and escape from prison. So we have to educate the prison staff, too, so they understand the theory behind parkour.'

Much more needs to be done in Russia, not just for young offenders but also for many marginalised groups. Staff members at St Basil's are dedicated, yet isolated. They work hard, not just to make St Basil's a success, but trying to change the hearts and minds of the authorities and the criminal justice system. It seems unbelievable that this is the only alternative to a harsh custodial regime for young offenders, and wonderful that they were starting to be recognised and their voices heard. It felt humbling that, even with so little funding, they were doing so much, providing activities that appeal to young people and getting positive results. ■

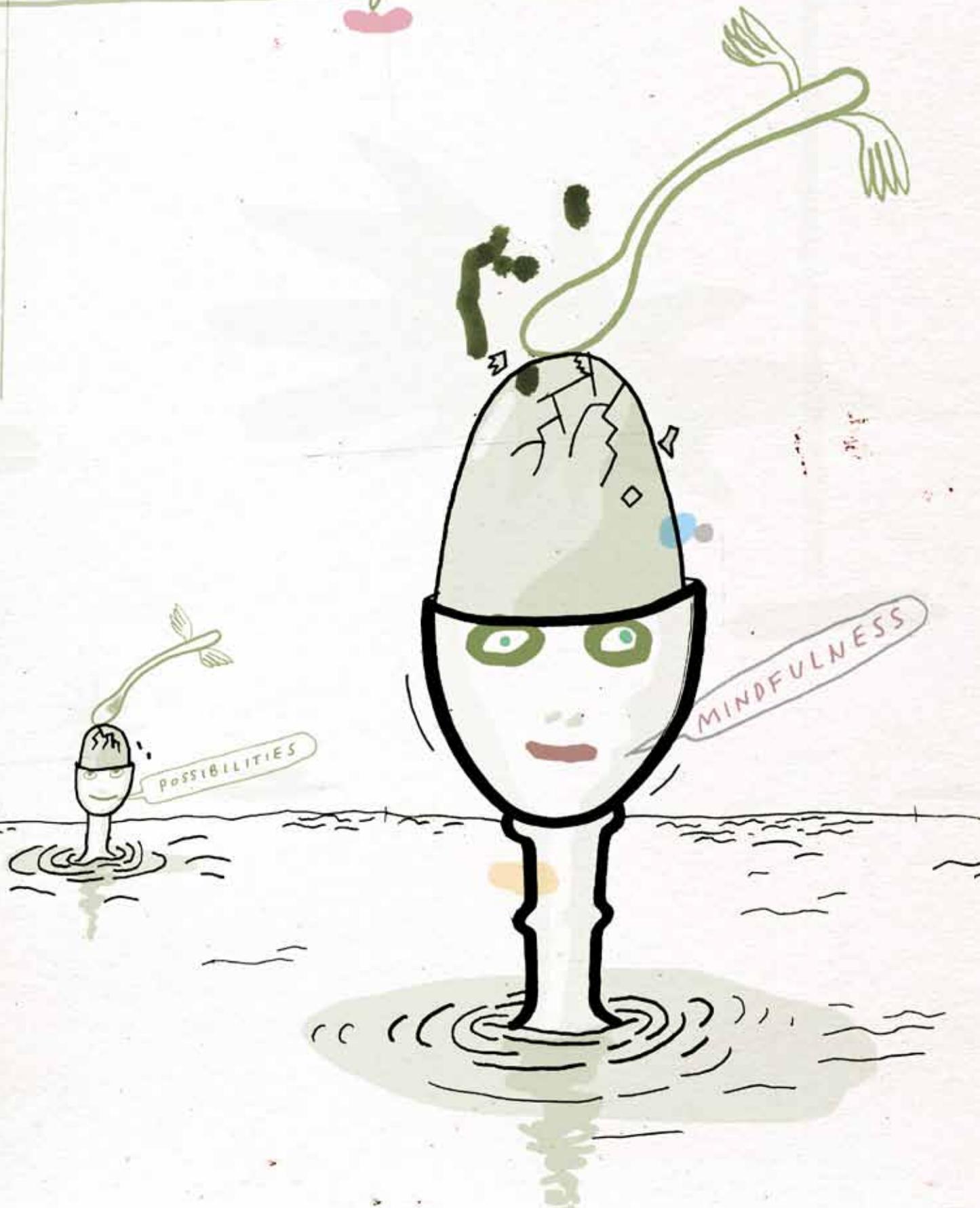
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the SPOONS of INSPIRATION



The Big Idea was a conference in London in March which aimed 'to encourage, illuminate and energise', and, as the conference chair Professor Brett Kahr put it, 'to crack open our thinking'.

It was based on the innovative format of bringing together a large group of experts to give short presentations in rapid succession to stimulate unexpected connections, sharp insights and powerful inspiration.* It was organised by Confer, an independent organisation that has been running cutting edge continuing educational events for psychotherapists, counsellors, psychologists and other mental health workers for over a decade.

The Big Idea presented a programme of 19 speakers in nine hours. Each presentation was limited to 20 minutes in order to focus delegates' minds on the heart of the matter, and to get clarity of vision and explanation. For me the effect of this experiment was akin to the difference between short-term and long-

term therapy: your mindset had to be tuned to a brisker pace. Kahr suggested that delegates viewed the event as an express train. It was an apt analogy: we crossed continents of ideas, revisiting familiar places and hurtling towards the unknown future. At times the room was buzzing with excitement, at other times it was silent with a sense of awe.

The idea that we needed a 'big idea' was itself controversial. Joe Schwartz, psychotherapist and author of *Einstein for Beginners*, asked if the need for a big idea was a symptom of something lacking. He argued that we already have one: that relationships are central and that we live in a culture that doesn't support that reality. Many speakers stepped up to the bar to present their ideas and theories, both passionately and succinctly, but there was no boasting, no elbowing others out of the way. What emerged were practical initiatives: new thinking about areas of social change;

Facing the future

Nineteen leading thinkers came together at the Big Idea conference in London in March to present their bold proposals, visionary ideas and inspiring concepts for the future. *By Roz Carroll.*

Illustration by Paul Davis



‘Delegates were challenged by the speakers to consider the accelerating change facing us as individuals, families, communities and globally’

a proposal for a new attachment classification as well as a desire to ‘bin DSM’; an innovative practice called ‘Visual Medicine’; new research from neuroscience; and new perspectives on psychotherapy. It was a high-quality conversation between serious thinkers on the platform and the audience, who played with ideas, moving them back and forth, gradually expanding and refining core themes and principles and integrating new perspectives.

How do we face the future?

One of the overarching themes of the conference was: how are we facing the future? Though the tone did not become apocalyptic, delegates were challenged by the speakers to consider the accelerating change facing us as individuals, families, communities and globally. Gestalt therapists Jon Blend and Claire Asherson-Bartram kicked off by focussing on the dramatic changes in family life, and in particular the emergence of step-families as the fastest growing family type. Blend talked about his work with children dealing with loss and shock, and how they adapted or suffered within new family configurations. Asherson-Bartram spoke of the need to recognise the difference between the experience of the biological parent and the step-parent. Both emphasised that change can be traumatic when too much happens too quickly and when there is a pressure to live up to an ideal. Rather than blending or homogenising, families need to allow for differentiation. With steadier pacing

of change, and time given for families to evolve, step-families can show great resilience, variety and openness.

From many different perspectives, the conference tackled the theme of seeing, recognising and assimilating what is going on, what will happen and how we can sustain empathy, engagement and agency. I felt these questions, sometimes explicitly, sometimes implicitly, rebounding and resonating around the room. In an urgent plea, Paul Maiteny, therapist, anthropologist and ecologist, outlined his view of the psychological defences preventing people from taking seriously the ‘suicidal trajectory’ of short-term consumer gratification. This includes ‘cognitive inversion’ of the dependence we have on the earth’s ecosystems, by acting as if we can only ‘afford’ to look after the environment once ‘adequate’ economic wealth has been generated. He quoted Lazlo’s warning: ‘[Fearful of the future] we manage individual crises while heading towards collective catastrophe.’¹

Group analyst Gabrielle Rifkind spoke on the effects of war and endemic conflict on the countries of the Middle East. She pointed out that war used to be fought largely out of view but now, in this global age of 24-hour news, everything is visible and gets into people’s minds. Even in remote, war torn, deprived areas there are TVs, computers and mobile phones spreading images and, as Rifkind argued, ‘frightening images make us lose our empathy’.

One of the criteria for PTSD is that there has been exposure to traumatic

events ‘beyond the range of usual human experience’ and I was struck by the fact that we are all often challenged now with seeing, hearing and experiencing events happening to others, such as the earthquakes in Haiti and Chile, including the destruction of the ecosystem and the massive changes in social systems that are beyond what is normal, beyond what has been known before.

Apparently normal

In this respect, Ellert Nijenhuis’ presentation on trauma and dissociation – a *tour de force* – seemed to speak to the overwhelm that may be felt by the individual in relation to world events. His paper took an overview of trauma theory, and though referring to individual trauma, his model seemed to me more widely relevant and applicable to groups as well.

Dr Nijenhuis, a clinical psychologist from Holland, began with the challenge we face to integrate all dimensions of time, of relationship, of action, of understanding. This is both a challenge to the theorists from the huge range of disciplines involved in the study of human life, and an existential challenge – to make sense of the moment in the context of needing to survive. His proposal, which draws on a large body of interdisciplinary research, concerns the split that occurs between the ‘apparently normal personality’ (ANP), which he links to the need to survive as a species, and the ‘emotional personality’ (EP), which protects the individual in situations of threat-to-self.**

‘What stops big ideas emerging are little ideas, fear and denial. These are like carpetweed on the pond’ *Isabel Clarke*

The ANP maintains family and group structures, despite even extreme abuse. The EP draws on a range of emergency responses, such as freezing or total submission, as well as more relational, proactive behaviours. In counselling and psychotherapy we need to relate to and understand all parts of the self (there may be many), so that they can begin to know each other’s motivations and functions. Readers will recognise in this theory elements of many other psychological theories. What is hard to convey in a summary is how deftly Nijenhuis whittled down a vision/principle that both drew on the rich tradition of psychotherapy theory and moved the ideas forward.

Furthermore I felt he encapsulated the essence of a kind of ubiquitous response that haunts us as a species right now. The ‘apparently normal’ coping with everyday life, avoidance of the big picture both within (our internal worlds, our dreams, our unconscious knowledge) and without (responding to family change, social change and global environmental change). Of course this links to a big idea (the unconscious, splitting) that has been developed over a century of psychoanalytic thinking, but what has changed is the introduction of the concepts of intentionality, agency and self-organisation.

In this contemporary view, actions under stress are not irrational, or primitive or infantile, rather they are the most effective strategies for defence available. Adah Sach from the Bowlby Centre illustrated this by arguing that

the behaviour of clients which is often attributed to the category known as ‘disorganised attachment’ actually has an intrinsic coherence, despite its seeming destructiveness.

Developing self-agency

One of the dominant themes of the conference was agency or self-agency. Psychiatrist and psychoanalyst Dr Brian Martindale presented a model for psychotherapy as part of the Government’s Early Intervention in Psychosis strategy. This can enable a therapist to visit someone who is experiencing psychosis in their home and start an immediate dialogue with them. The aim is to establish support, find meaning in their history and its link with the onset of psychosis, and to communicate with the family. Studies from Sweden demonstrate that swift action, ongoing dialogue and adequate support can lead to dramatically better outcomes than we see in Britain. This includes much reduced use of neuroleptic drugs and hospitalisation, as well as improved and sustained patterns of recovery.

A few speakers hinted at a recipe of techniques for restoring agency but the most fascinating papers I found were those that deepened my understanding of what lies behind the capacity for agency, at the level of brain and body, and in terms of human interaction. Jean Knox, a Jungian analyst, dug right into the roots of the nature of agency itself. She mapped out the infant-child-adult’s optimal development of self-

agency, from the ability to recognise one’s effect on others to the capacity to truly consider and remain open to what is in one’s own and others’ minds. In particular, she showed how ‘turn-taking’ in interactions and conversation is now thought to underlie many other more advanced patterns of behaviour. Turn-taking is fundamental to the co-construction of meaning with others; it is the give and take that allows a conversation to evolve. This proposal is supported by the developments in neuroscience outlined by senior researcher Ruth Lanius, who spoke by video link from Canada. Social emotions and interactions activate the widest networks in the brain. Trauma destroys the sense of an adaptive agentive self, and this is reflected in the neural networks of those with PTSD, where areas relating to self-reference and social interaction are markedly diminished.

Self-agency is a very different idea from ego, or positive thinking; as Jean Knox put it, ‘Agency is always relational – it can be internal or with the world, or with God, with anything.’ Jon Blend gave a moving illustration of supporting the self-agency of an electively mute, phobic schoolboy through work with creative arts. He took us through Kris’s journey from communicating his states of fear through a drumbeat, to drawing the panic state as it crept up on him, to pounding it out with clay, and eventually being able to write and sing his own rap song. Nick Totton and Joe Schwartz in different ways called to therapists to find their own self-agency in dealing with the

'We must hold, foster and elaborate a larger vision for ourselves and our clients through steadily inviting imagination, experiment and trust in creativity'

public and the Government's proposals for regulation.

Sea change, seafaring and surfing

I am always interested in the threads of imagery that characterise the language of any event or process. Fittingly for a conference addressing the sea changes in the counselling and psychotherapy field and in the world as a whole, the predominant imagery/metaphors were of water and fluidity.

Suzette Clough, an artist and psychotherapist, struck an important note with her opening quote from André Gide: 'One does not discover new lands without consenting to lose sight of the shore for a very long time.'² She articulated the need for us to 'embrace the unknown with acceptance and fearlessness'. The theme of yielding to flow, and as body psychotherapist Nick Totton put it, 'tolerating the anxiety of not being in control', was echoed by several contributors. In a breathtaking metaphor, Totton talked about embodiment as 'a process, not a state' with the 'witnessing aspect of mind rhythmically leaping like a dolphin above the sea of the body'.

Laurie Slade, in a presentation entitled 'Dreaming the future – emergent thinking in the face of the unknown', drew on the work of Bion and the artist Sugimoto. Bion held that 'the only point of any importance in a session is the unknown... out of the darkness and formlessness, something evolves'.³ Sugimoto speaks of the power of the sea as a source of inspiration: 'Mystery

of mysteries, water and air are right there before us in the sea. Every time I view the sea, I feel a calming sense of security, as if visiting my ancestral home; I embark on a voyage of seeing.'⁴

The call to trust in the fluidity of experience came from a number of quarters. Isabel Clarke contrasted the either/or with the both/and imperative. In the latter, she suggested, 'We are relationship, we become part of the whole and the other becomes part of us.' Human beings are 'like surfers, sure to tip up. What stops big ideas emerging are little ideas, fear and denial. These are like carpetweed on the pond.'

Creativity is not a luxury

Flow and self-agency came together in another overarching theme of the conference: that we can and must hold, foster and elaborate a larger vision for ourselves and our clients through steadily inviting imagination, experiment and trust in creativity. Paul Mainteny declared, 'What's missing is our collective dream,' and Laurie Slade argued that 'joining up the imagery is as important as joining up the big ideas.'

As if answering their call, Suzette Clough gave an inspiring talk about a spiritual creative practice, originated by her, called 'Visual Medicine'. She described it as a 'radically simple painting process that allows images in a sense to be born, not painted'. She showed a short video clip of how the paint makes images through an unusual no-brush process. We saw how

what arises from this are extraordinary images of stunning beauty which echo forms in nature with their infinite complexity and integrity.

Clough teaches the practice of Visual Medicine in groups and it includes a writing process called Inner Dialogue to facilitate deep personal enquiry and problem solving. She works with women who have experienced the criminal justice and mental health systems. I was very moved by her heartfelt commitment to helping people get in touch with the 'moment by moment attunement to the act of creation'. She talked about 'creating a space for things to arrive' and 'befriending vastness', the value of the participatory rather than the consumeristic. Her statement that 'creativity is not a luxury – it can bring us other answers' seemed to crystallise the aspiration of others in the room and others repeated the phrase.

Among the most memorable presentations were those which, like Clough's, Totton's and Slade's, emphasised holding the space for the ongoing creation of ideas of self, world, and self-in-the-world. They gave us encouragement to use our creative minds for self-and-other repair and to engage with problems on the grander scale.

Throughout the conference there were questions about norms, normality and orthodoxy, from a number of speakers – notably Adah Sachs in relation to working with DID (dissociative identity disorder) clients and Nick Totton speaking on 'Wild Therapy'. Brett Kahr reminded us that it was

‘Nick Totton and Joe Schwartz called to therapists to find their own self-agency in dealing with the public and the Government’s proposals for regulation’

Ferenzci who first argued that technique must be elastic. Claire Asherton-Bartram observed at the end of the conference that one of the themes to emerge was finding ‘unorthodox solutions’.

Harmonics and strange attractors

In one of the final papers of the conference, Dr Jeremy Holmes spoke about working with clients in two dimensions, following the melody (the story) and listening to the resonances or harmonic dimensions (the atmosphere evoked in being with the client). This inspired one of the concluding comments from a member of the audience who told us that in harmonic singing the purpose is to attune to other voices and wait for the emergence of the third to appear. Even with musical knowledge, the singer cannot predict where it will appear and what it will sound like.

As well as being a metaphor for the therapeutic process, this made me think of an observation by the neuroscientist Llinas about the human imagination. He compares the processing in association cortices of the brain to ‘sympathetic chords’, internal resonances that are self-activating.⁵ While the importance of creativity is not a new idea, it is a process that we can always benefit from appreciating more fully. Ruth Lanius told us that the next frontier of research in neuroscience is on the resting state of the brain. She defined this as the default network when the brain is not focussed on the external but the internal world. It seems to me that this is not resting exactly (a bias of the

scientist who privileges outward activity) but self-repairing and restoring.

Perhaps in this conference we were reminding ourselves that the most valuable tool we have as counsellors and therapists is our trust in the processes that emerge through attending to the subtle, unexpected, unrehearsed resonances. These are like strange attractors, as chaos theory would call them, which emerge when a system is far from equilibrium and can lead to dramatic shifts and reorganisations of structure. I talked about this with Chris Robertson, a director of Re.Vision, in one of the tea breaks. He said that he thought that ‘attractors are more like “purpose”’: that emergent sense of what is pulling us forward in life as opposed to being driven. A purpose is not a goal but is more mysterious. In the hierarchy of spiritual thinking, purpose is closest to mystery, values the most ordinary/human and meaning is what links these two.’

A community with a purpose

At the end of the conference Jane Ryan, Director of Confer, suggested that perhaps a ‘big idea’ is ‘a theory, but also a possibility’. Ryan is a psychotherapist whose background includes 15 years in community development. Over the 11 years of running Confer she has brought together the most experienced practitioners and researchers from many fields to build bridges between schools of thought.

Brett Kahr tied together this history with the overarching themes of the event

when he declared that Confer offered the hope that ‘the whole Noah’s ark of mental health can come together’.

Interestingly, during and after the conference, I felt neither pessimism nor optimism as a result of this encounter with the ideas about and for the future. Rather I felt alive, calm and stimulated; I felt energised by the imperative to keep seeing, trusting and engaging with what lies before us and within us, as therapists and clients. ■

Confer plans to web cast some of the talks and they will be available free for those who are interested. For further information, email info@confer.uk.com or visit www.confer.co.uk

Roz Carroll likes to go to psychotherapy conferences to meet people and hear about their ideas. Visit www.thinkbody.co.uk

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Footnotes

* Based on the TED (Technology Entertainment Design) model of multidisciplinary conference featuring 18-minute inspiring maverick and expert speakers.

** The terms derive from the British psychiatrist CS Meyers who in 1915 coined the term ‘shell shock’.

In light of the launch by GPs of a campaign advocating self-care for minor ailments, *Emma Redfern* argues the case for therapeutic self-care

DIY therapy

Recent news items concerning the launch of the GP-led Self Care Campaign, together with an article in *The Times*¹ citing an example of the rise of DIY therapy, have led me to commit to paper ideas that have been in my head for a while now. As a counsellor, how much is it incumbent upon me to empower my clients to become their own therapist? Isn't this what happens in therapy anyway for some, maybe many, clients?

Self-therapy for all?

The GPs and other interested parties involved in the launch of the medically-based Self Care Campaign recommend that the layperson 'manage minor ailments'² and self-treat for 'the common disturbances to normal good health'.³ In the same way, I am advocating psychotherapeutic self-care for the 'worried well'² rather than for those in need of more specialised external expertise. Similarly, I firmly believe in the healing power of the therapeutic relationship. Indeed, a reparative/developmentally-needed relationship⁴ (often in long-term work) can be the most appropriate vehicle for helping clients. I am not suggesting that clients opt for self-care instead of psychotherapy/counselling; rather that clients are encouraged to embrace the best of both worlds: therapy from or with another/others *and* self-therapy. I would like to highlight three areas in which self-therapy may emerge as part of the accepted outcomes generally espoused by counsellors and psychotherapists, or as a direct result of the therapeutic relationship and any take-home tools offered by the therapist.

Empowering the client

A potentially revolutionary idea offered by counsellors is that an individual can be responsible in and for his or her own life;⁵ that he or she has agency. However you offer this to your clients, it is implicit

(even explicit at times) in the work, whether through enabling a young person to choose their own painting materials and subject in art therapy or encouraging a depressed businessman, recently made redundant, to complete his CBT homework. Alongside this concept of self-responsibility go those of self-direction, self-regulation and self-soothing.

Perhaps as a counsellor you consider yourself a relative non-interventionist. Even so, by sitting holding the space as a client lets her tears flow for the first time, and allowing her to find the time and means to let the tears stop naturally under her own agency, you are facilitating self-regulation. This experience is then incorporated and taken by that client into the world, where she may use it later to help herself. In a group therapy setting a participant might be encouraged to experiment in the group with new ways of being and behaving (in an analytic group perhaps) or they might enlarge their role repertoire (in a dramatherapy group, for example). Successfully facilitated, such exercises in the therapeutic setting will impact positively on the client's sense of self beyond the boundary of that setting.

Internalising the therapist

As therapists we model to our clients certain ways of being. We offer congruence, unconditional positive regard and empathy. None of these are exclusive to the profession. Clients can and do learn these ways of being, these skills, from us and use them when relating to others and to themselves. Similarly, therapists are enquirers. Part of the job is to co-explore with the client, with respectful and appropriate curiosity, their map(s) of the world. In this way we provide permission which says that it's OK to be interested in what goes on inside (the intrapersonal) and how that may affect what occurs on the outside between people (the interpersonal). As therapists we foster self-exploration, self-awareness and

learning about oneself.

Indeed, for some presenting issues, a therapist might introduce to their client(s) the idea of becoming an observer/visiting anthropologist seeking data (non-judgmentally) about their own individual lives, thoughts, patterns, feelings and actions as a first step in bringing about change. Thus, the keeping of a food diary might be introduced to someone who overeats. The client can be taught how to use such a tool in their daily life.

Teaching and learning

In a profession in which personal therapy is not mandatory, I am heartened by the more universal acceptance of some form of continuing professional development. As professionals we are expected to continue learning. As professionals we implicitly expect our clients to learn too – about themselves, their issues, how 'to do' therapy etc. As educated and educating professionals we may also be explicit about our expectation that our clients learn. Many of us recommend (or prescribe?) reading materials, even poems and films, to our clients for therapeutic purposes and learning.⁶ On the other hand, I'm fairly sure many, if not most, clients like 'being learnt about' or 'teaching' their therapist about themselves and their views and so on.

Similarly, at some point or other, many of us will teach a piece of theory, a therapeutic model or a therapeutic tool to our clients for their use. As Dr Dixon, a GP in Cullompton, Devon and proponent of the medical Self Care Campaign, is quoted as saying of his own profession, 'Our teaching role is one we need to invest in as well.'³ Ideally, a collaborative sharing of knowledge can foster client empowerment, rather than a more one-sided dispensing of wisdom from the learned expert to the helpless, dependent sufferer.

Some schools of counselling are more proactive in this regard than others. An ex-supervisor from the person-centred tradition once seemed horrified when I

suggested that I might engage in some psycho-educational work around assertiveness with a client; that wasn't counselling, I was told. At the other end of the spectrum, imago relationship therapy will, via a weekend entitled Getting the Love You Want, actively teach couples therapeutic techniques to use to facilitate communication and self-exploration. One such technique involves mirroring, validating and empathising; skills taught on most counselling courses.

Therapy as a way of life

Just as some people rely more heavily on their GP than others, some clients become overly attracted, even addicted, to the therapeutic journey,⁷ perhaps to the detriment of feeling 'good enough' or 'fixed enough' to 'go it alone'. Perhaps if we as therapists could encourage an attitude of self-help in such clients, the idea of being their own therapist might help them see that having professional therapy isn't an either-or position but a matter of degree.

In the current economic climate it may be difficult for some to value something that might go on for months and cost upwards of £30 per hour, once a week. Certainly, I know trained and practising counsellors who are unwilling to make such a financial commitment at the moment. However, explaining that the single hour per week will impact, if they let it, on the rest of the week, indeed the rest of their lives, and that they will learn tools and ways of being that will benefit them enormously between sessions, might make the financial outlay more appealing. For others, the outlay in other forms of investment (time, commitment, energy) may seem too great, especially if the client is hoping to find an expert who will fix them quickly in a few cost-effective sessions giving guaranteed outcomes.

Is the financial contribution to the economy of the 'worried well' who pay for their therapy known? I estimate that most

self-employed counsellors fail to make an adequate living from such a group but supplement their income in many ways – supervising other counsellors and teaching trainee counsellors, for example – and the voluntary sector is full of counsellors giving their time for free to gain hours for qualifications or accreditation. Personally, I don't see the idea of self-therapy alongside some paid therapy for this group as too revolutionary. For example, the continued increase in popularity, in America in particular, of emotional freedom technique (EFT) or tapping suggests that a form of therapy that combines paid therapy (from an empowered and charismatic individual who may work one-to-one, in groups, in teleconferences, via audio downloads etc) with self-therapy (EFT practitioners teach their clients how to tap on themselves), could offer a successful paradigm for some practitioners. If I may use myself as an example: I have been combining both approaches for some time. I have been paying for therapy for over 10 years (individual and group, from a wide variety of schools of therapy). At the same time, I have read numerous self-help books and paid to attend a lot of psycho-educational, experiential CPD which combines therapy with training, the techniques and tools of which I use in a self-therapy way. I do not wish to suggest that my self-help approach is in any way related to poor therapeutic provision. To any of those with whom I have worked who may be reading this article, I would emphasise that you have been, and still are, of tremendous value to me – just as working on myself for myself by myself is valuable also.

Social and political impact

With the reader's permission I will indulge in some wondering. I wonder if the Self Care Campaign in the medical field has arisen as a counter to the overly, in my view, paternalistic nature of the NHS? Perhaps the public has taken to taking all

their common disturbances to their GP because the NHS has itself fostered overreliance on the medical profession, with an overreliance on prescriptions and tests, as opposed to fostering the individual's innate ability to know what's right for their own body?

As one of my favourite authors writes, 'It is change that is always the true quarry, however much a therapist may court insight, responsibility-assumption and self-actualisation.'⁸ And isn't deep personal change, which includes increased self-awareness, a little countercultural? It seems to me that much of what society and the Government requires of an individual is to be a self-anaesthetised spending machine reliant on as many 'drugs of choice' as possible (TV, alcohol, chocolate, nicotine, the media, retail therapy, holidays).

For me, therapy of the paid kind and the self-help kind leads to individuals expecting more from themselves and from life (and the Government perhaps?), expanding rather than contracting, wanting rather than denying, living rather than existing. ■

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Feelings as feelings,
thoughts as thoughts,
therapy as therapy



The growing interest in mindfulness has opened the doors of meditation to the helping professions, but mindfulness-based CBT represents merely the beginning of many possible connections still to be made between Eastern contemplative practices and Western psychotherapy, argues *Manu Bazzano*.

Illustration by Paul Davis

There have been many attempts in recent years to incorporate meditation and psychotherapy. The best known methodology in the UK has remained confined to what is commonly known as ‘third-wave CBT’, ie the combination of a specific kind of meditative practice (mindfulness) combined with a specific therapeutic orientation (cognitive-behavioural). I have studied (and subsequently taught and facilitated) mindfulness-based CBT programmes. I have found this methodology fascinating and fairly effective. I feel, however, that it represents merely the beginning of many possible connections still to be made between Eastern contemplative practices and Western psychotherapy. The variety of approaches to meditation is as rich and varied as the number of current psychotherapeutic orientations. More specifically, the link between meditation and humanistic psychotherapy is largely unexplored.

My experience of meditation

Meditation informs the way I am in the world and consequently the way I am with clients. I am a person-centred/existential therapist with a background in Zen Buddhism. I have practised meditation for 30 years. A long time ago I thought meditation meant stopping the mind, interrupting the flow of thoughts and experiencing the stream

of life directly (an impossible task), as well as seeking altered states of consciousness outside the everyday.

With hindsight I can see how naïve and even counterproductive that notion was, even though it made complete sense at the time. Instead of trying to stop the mind, meditation has come to mean being with and attending to arising thoughts and feelings more fully, without attachment. I continue to practise meditation daily, and this process is still ongoing and very much alive.

For years I continued to meditate and to work as a therapist without reflecting on how meditation might have influenced the way I was with clients. What I did notice was that if I discontinued meditation practice for a day or two, the quality of attention and empathy I gave to clients was affected: the quality of my awareness became more opaque, and the ability to be in the present moment with the client did not feel as natural.

Meditation is nothing special

As my meditation practice developed, it shed its aura of specialness. It became an embodied practice – awareness of the body posture as well as of thoughts, feeling and emotions. It also became awareness of the wider field, of what Rogers calls ‘organismic experiencing’.¹ I started to discern that these two fields

Mindfulness in context

Viewpoint

of enquiry – therapy and meditation – complement each other, and it was exciting to see that the meeting point between the two is experiential. The significant shift consisted in moving away from a search for transcendence to a more accurate awareness and appreciation of phenomena.

On reflection, there are four significant elements to my current experience of meditation:

- Meditation is no longer associated with goals or expectations but is the appreciation of what is
- Meditation is not a search for ‘answers’ but allows space for deeper questioning and enquiry
- Meditation allows an unravelling of content (thoughts, feelings, emotions) via an unravelling of the observer himself: a fluidity of experiencing which opens the observer/experiencer to a clearer insight into the self as process rather than a solid, self-existing entity
- Meditation allows a deeper acceptance and trust in the wider process of life itself.

The comparative study of meditation and therapy ranges widely, from the integration of psychodynamic psychotherapy and Buddhism^{2,3,4} to the integration of a meditation practice within the Theravada school of Buddhist meditation known as mindfulness with cognitive behavioural therapy (CBT).⁵ There is also an established tradition

of more general studies and research presenting a ‘panoramic’ view of the two disciplines.^{6,7,8,9,10,11,12} In the more specific field of meditation and contemporary person-centred psychotherapy, there is the influential work of David Brazier.¹³

A small-scale research study

I have conducted a small-scale heuristic research study, which started with my own experience of meditation and the ways in which it informs my work with clients. It has been a collaborative enquiry as well: I have recorded four separate interviews with four therapists who meditate on a regular basis. I have then listened to the tapes repeatedly over the course of several weeks, each time taking notes and reflecting on nuances emerging at each new listening.

For several months I remained with the general question, which is the key of my exploration: how does the regular practice of meditation inform the work of a therapist? I have kept the question alive in the background of my being on a daily basis, as a diffuse ambience that kept on as I went through my work, study and daily meditation sessions. I also had several informal meetings with colleagues who are experts in the field, and I participated in two week-long meditation retreats and two weekend workshops which, directly or indirectly, dealt with the same question. I gained

inspiration from meeting and discussing the topic with six people who are experts in the field, some of whom have written extensively on the integration of meditation and therapy. I also received invaluable help and monitoring from my supervisor, who has experience in the field of research methodology.

Preparing the interviews

Before conducting my interviews, I noted the following four sub-questions to help me focus during the interviews:

- What is the experience of meditation for you?
- How does it influence your work as a therapist?
- How does your experience and understanding of the person-centred approach inform your meditation?
- How is meditation helpful or unhelpful to your work as a person-centred therapist?

The fourth question implies an inbuilt challenge to my own assumptions that meditation is always beneficial to the practice of therapy. Conversing, learning from and sharing ideas and experiences with practitioners from different orientations have helped me avoid remaining inflexible within my own hypotheses.

I have found the process inspiring and recognised its similarity with my experience of Zen *koan* study, where one reflects intensely with one’s being and

‘Meditation can be used as a form of escape, as a passive response to life’s challenges, particularly if it is practised to corroborate rigidly held Buddhist beliefs’

embodied presence on the existential dilemma posed by a particular question. As with heuristic research, *koan* study can provide unexpected openings in perception and understanding, providing one can suspend one's own judgement and remain open to the experience. In a similar vein, Moustakas¹⁴ defines indwelling as the 'turning inward to seek a deeper, more extended comprehension of the nature or meaning of a quality or theme of human experience.'

Analysis

Some focal points highlighted the way meditation informs person-centred practice, each of these first experienced in meditation and then reflected in the therapeutic relationship:

- Unconditional, non judgemental openness
- Embodied presence
- Staying with – being present to both pleasurable and difficult experiences
- Curiosity – the ability to stay with a question
- Compassion – the self-nurturing provided by meditation overflows into natural empathy and unconditional positive regard.

As to my question whether meditation might not be helpful for therapy, this sparked an interesting exploration. A couple of things came up: one was that meditation can be used as a form of escape, as a passive response to life's

challenges, particularly if it is practised to corroborate rigidly held Buddhist beliefs. One such belief is the inevitability of suffering within the impermanent, unsatisfactory nature of life: a belief which is the very foundation on which Buddhist teachings rest. We found that in our own practice this can, in less inspiring moments, lead to acquiescence.

In spite of the highly subjective nature of the experience and the participants' responses, a consensus emerged that saw meditation as a conscious response and a willingness to stay with discomfort and be open to the possibility of change. It was generally suggested that the ability, fostered by meditation, to stay with the client's discomfort is invaluable to a therapist who values the ethical principle of non-directiveness. All participants concurred that the regular practice of meditation makes it less compelling for the therapist to 'jump in' when working with a client and try to rescue and direct. This is how one participant expressed it: 'If a client expresses difficult feelings, I can stay there without easing the pain... Staying with it will not destroy me or the client and it can allow for a sense of freedom and inner strength, the same things that I do to myself when I sit.'

A crucial element that emerged from the interviews is that of relating. Practising meditation changes the way

a therapist relates to the client. Meditation is 'present' and 'brought into the relationship'. The therapist becomes 'the instrument of the work'. One interviewee suggested that person-centred practice allowed him to value meditation more 'because of the effect it has on me, on my way of being, because the approach is about where you are and you as a person'.

Meditation might be something private that I do on my own (although I prefer sitting with friends) but it makes me aware of the interdependent nature of my experience as a human being. It helps me become more aware of my own shortcomings. It is a practice from the heart – cultivating an open heart as well as a mind able to express congruence but also genuine empathy for the client, an appreciation of our humanness.

Mindfulness of the human condition

Both meditation and therapy represent imaginative and inspired responses to the conundrum of the human condition. Buddhist meditation, as I understand it, is not rooted in belief, but in the very dilemma of being human, ie facing the certainty of death and the uncertainty of its occurrence. In the 576th verse of the *Sutamippata* (a collection of around 1,000 verses), the Buddha compares the human condition to that of a ripe fruit constantly on the point of falling.¹² Another striking image that the

'Buddhist meditation is not rooted in belief, but in the very dilemma of being human, ie facing the certainty of death and the uncertainty of its occurrence'

Buddha presents in the same collection is that of cows grazing happily in the field, blissfully unaware that each of them is in turn being taken away to the slaughterhouse.

Mindfulness must be seen in context – ie mindfulness of the human condition, awareness of the uncertainty of life, of its impermanent and unsatisfactory nature. Mindfulness is recollection. The original Buddhist term for mindfulness is *smṛti* in Sanskrit and *sati* in Pali, both meaning recollection, remembering. What we do remember is, in this context, impermanence: we recollect our mortality, the transient nature of life.

Of equal importance is the fact that the Buddha invites us to recognise feelings as feelings, mind as mind, phenomena as phenomena. That means not giving in to the temptation of interpretation and not using meditation practice (as indeed seems the case with mindfulness-based CBT) as reprogramming.

Mindfulness in context

It is wonderful that mindfulness-based CBT has opened the doors of meditation to the helping professions, even to its most sceptical segments. It would be a little unfortunate, however, if all we were to understand of meditation were to be confined to one-sided concentration and miss its

wider applications, namely a deep inquiry into the existential dilemma of the human condition. Meditation practice remains countercultural: it emphasises questions rather than prescriptive answers; it stresses the importance of staying with uncertainty and taking fully on board the pain of our collective condition, the unsatisfactory nature of life, what the Buddha called *dukkha*.

As a co-facilitator of the eight-week mindfulness programme at the Priory Hospital North London and Hove, I have had the opportunity to experience firsthand this approach and saw its efficacy in alleviating the discomfort of those suffering from bipolar disorder. I also noticed, however, that the core of the experience, the felt sense of the meditative experience, was missing and the focus seemed to lie instead on ‘normative’ elements, ie the help meditation can provide in reframing thoughts and behaviours deemed to be ‘unhelpful’.

Appreciation of the everyday

Meditation helps a therapist become aware of the field, of the wider organismic reality,¹⁵ which is central in humanistic and existential therapy. Awareness of the field also means awareness of what is normally deemed as ‘obvious’. We avert our gaze from everyday life in search of something

better, more satisfying, more rewarding, more spiritual, more psychologically sound (and so on), and in this way miss the ordinary miracle – a ‘miracle’ that can only be grasped, at any given moment, through the body and the senses, through the ordinary yet wondrous experience of being in the world.

As therapists we might need a training that helps us be in touch with everyday phenomenological reality, in order to better remember and recollect, and attend to it more fully. It was suggested that perhaps such meditation training would help the practitioner cultivate what Rogers calls a way of being, rather than becoming proficient in a technique. The regular practice of meditation would assist a process of focusing and centering that can make a therapist a better instrument, more finely tuned to empathic awareness and congruence, one who can better assist a person in distress or a person exploring issues in his or her life. ■

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The art of coaching

Learning from assessment

Linda Aspey

One of the hot topics around the corporate coaching world is how some organisations, particularly larger ones, are increasingly using assessment centres to select coaches to work with them.

If you haven't yet encountered the term, they assess several coaches against key criteria or competencies (ie knowledge, skills and experience, usually evidenced by behaviour). They utilise a variety of exercises so that coaches can demonstrate their competencies in different ways, hopefully enabling fair, transparent and accurate selection decisions. Occasionally they are run purely as development centres, where coaches go through the assessment process and then decide for themselves if they want to apply to join the coaching pool.

Word of mouth alone is no longer good enough and it's easy to see why. Nowadays it's much more complex for purchasers to decide who to hire, faced with higher numbers of coaches, numerous types and levels of coach training, coaching methodologies, different professional standards and various accreditation processes.

Times have moved on and so must we if we want to coach in these corporate domains. But we may have to change the way we think. Bearing in mind we're trained to bring out the best in others, we're not always comfortable when it's us in the spotlight. We're trained to ask questions, not to answer them; to listen and draw out others' thoughts and ideas, not to give too many of our own; to affirm the client in the moment, not ourselves. So for some practitioners, the idea of an assessment centre where they need to shine, in a sometimes competitive environment,

fills them with dread.

Yet whilst there are horror stories of assessment centres that allow little or no preparation time, with scary interviewers firing questions at breakneck speed, and highly pressurised exercises – in one case I heard of 'speed coaching', where you have to coach an assessor for five minutes then move on to the next one! –, many organisations are investing considerable efforts in making sure that their selection processes are validating and enriching experiences for the coaches too. In effect, they are modelling the type of coaching they want for their own organisation.

I've been designing assessment centres for many years and am heartened by the growing number of positive stories out there. For example, a colleague recently applied to join the coaching pool in a large public sector organisation. They invited him to a day-long assessment at an assessment centre, to take place four weeks later, fully explaining all the activities he'd be asked to undertake. A week beforehand they called to ask if he had any questions. He duly arrived on the day, well prepared with two anonymous case studies to discuss – one where he felt that he'd done his very best work, and the second where he'd learned a significant, even difficult lesson. He then participated in a group discussion about different approaches to supervision.

'If coaches can see assessment centres as a positive challenge to learn, stretch and grow, so much the better'

After lunch he was shown around the organisation, following which he met with a 'client' for a one-hour coaching session (a real manager, with a real-life issue) which was discretely videoed.

He then met with two assessors for a mutually discursive interview, and finally, at the end of the day, was offered their feedback. They didn't feel he was yet ready to join their coaching pool, and gave him several examples of where his strengths had shone through and where they had not. For example, he didn't create a safe enough space in the coaching session and moved the client on too quickly towards action. They offered him the video of his coaching session to take home and he was invited to give them feedback on their own process there and then, or if he preferred he could reflect and write in. Despite the rejection, the skill and care with which the day was conducted and the way the feedback was handled left him feeling validated, respected, stretched and developed.

If coaches can see assessment centres as a positive challenge to learn, stretch and grow, so much the better. If you're invited to one, I'd encourage you to seize the opportunity as you might really get something more from it than a 'yes' or 'no'. And whilst not all organisations will manage their processes as well as that experienced by my colleague, I think it's increasingly rare to find assessment centres that treat you like you're on *The Apprentice*. Honestly! ■

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End of life care

Working as bereavement co-ordinator for St Christopher's Hospice in South London, Christine Murray is responsible for the day-to-day management of the service

*Interview by John Daniel
Photographs by Phil Sayer*

I'm usually up at 7am. I live in Greenwich and it's a seven-mile drive to Sydenham where I work. The drive is the most stressful bit of my day because I have to negotiate potholes, roadworks and temporary traffic lights. It's at that point that I switch from Radio 4 to something a bit more lively.

I work four days a week as the bereavement service co-ordinator at St Christopher's Hospice. I'm a UKCP registered psychotherapist and senior accredited counsellor, and work as part of the multi-disciplinary team. Dame Cicely Saunders founded St Christopher's as the first modern hospice in 1967. It is a frontrunner in the provision of palliative care, and combines care, education and research to provide compassionate support to people approaching the end of their lives and bereaved relatives and friends. The hospice covers a population of 1.5 million in five South London boroughs. Every year it cares for 2,000 people who are dying. It has 48 inpatient beds and a further 850 patients are cared for in their own homes on any one day. St Christopher's is a charity and all its services are free.

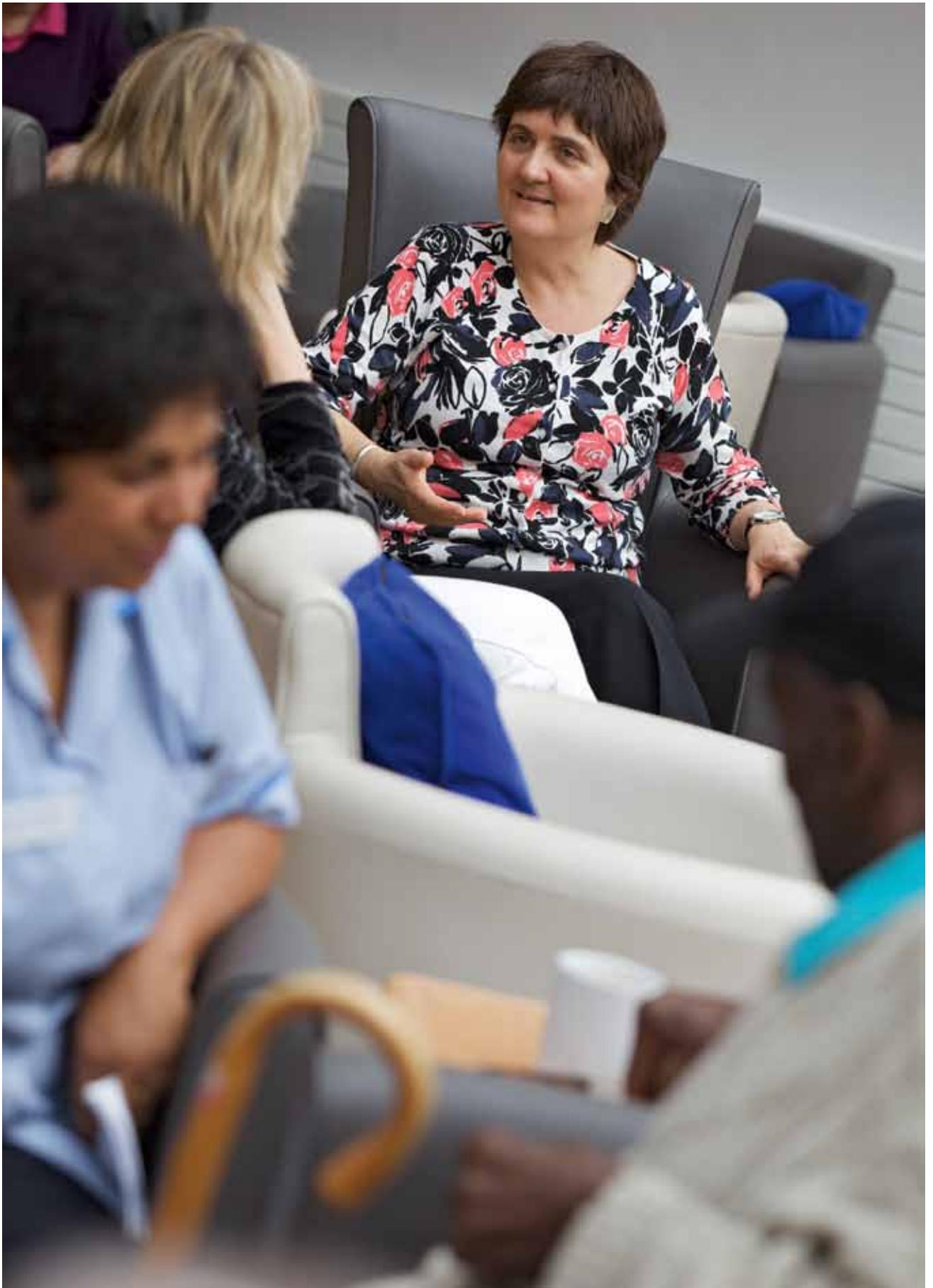
I'm responsible for the day-to-day co-ordination of the bereavement service, which includes having my own caseload of clients; recruiting, training and supervising volunteers; providing advice, training and consultation for the multi-disciplinary team and visitors; being involved in research and audit; teaching in our education centre; and attending internal and external meetings.

I don't have a typical day. Switching on the computer and checking phone messages might be the first thing I do, but I might also have a meeting to attend or a client to see. Visitors often wait in

St Christopher's relaxed café-style Anniversary Centre. Because of the legacy of Dame Cicely Saunders, St Christopher's has an international reputation as a centre of excellence and we get a lot of visitors. I am part of the multi-professional team which offers training for those involved in end of life care.

Trained volunteers deliver most of the bereavement support we offer. Some have the equivalent of a counselling skills training and some are trained counsellors. We have up to 20 volunteers – the service couldn't run without them. People wonder if you have to have had a loss to do this work. I'm sure people do come from a sense of wanting to contribute from their own past losses but these have to have been resolved to some extent before people can do this work.

The service we offer is not time limited and we can work quite flexibly. Initially after a death, it's common for people to feel overwhelmed, and some people might need a couple of sessions just to know that how they're feeling is usual. Others might need longer-term support. It's important not to rush in too soon with bereavement counselling. Research suggests that, if you move in too early, people might not use the support they have around them. Immediately following a death, most people need practical support – how to go about registering a death, how to find an undertaker, etc. Most people don't need bereavement counselling but there will be a small number who do, particularly if the circumstances surrounding the death are difficult. It may be the death was sudden or traumatic, or that stressful things were happening at the time – like relationship, housing or financial difficulties, or a past history of anxiety or depression.





‘You do have to be quite relentless about how you look after yourself. Sometimes those small things, like choosing when to look at your emails, can make a big difference’

We cover a big area and a very diverse mix of people access our services. People need to be allowed to grieve in ways that are culturally appropriate for them. We’re still learning in terms of how we think about bereavement. In some ways you could say that we have quite a Western individualist approach to death and that for some communities grief is more of a collective experience.

There’s a lot of talk in the bereavement field about resilience – what makes one person more resilient than another. Resilience is about being able to be upset at times and, at others, able to get on with things. You could get two people with a set of similar circumstances and one person manages and the other needs help.

Lunch is usually a salad at my desk. Then I go out for a walk in Crystal Palace Park. I’ve got a Fitbug pedometer that connects to my PC. It measures the number of steps I do and inputs them into a computer programme. It sets you targets for the week and motivates you to exercise.

In the afternoon I might meet with the bereavement service administrator to discuss how long clients have been waiting. One of my goals is to allocate cases within two weeks – certainly I like to think we can offer somebody support within a month. We did an evaluation of the one-to-one service last year. Ninety-three per cent of people said they would recommend it. People said that bereavement support or counselling had helped them to feel calmer and more confident, better able to think about their own needs, and to be more accepting of their loss.

Then I might have group supervision with our volunteers. Following that,

I might put the final touches to a training presentation or answer emails. As part of my own self-care I try not to look at emails all the time. Irene Renzenbrink talks about the need in hospice work for ‘relentless self-care’. You do have to be quite relentless about how you look after yourself. Sometimes those small things, like choosing when to look at your emails, can make a big difference.

Once a month I help to run a bereavement evening. Three to four months after a death we invite the next of kin to come in and have a chance to reflect with other bereaved people. People are welcome to bring other family members or friends with them. We give a general talk about some of the common reactions to grief, and break into smaller groups for further reflection.

Most days, however, I leave work at 5pm and drive through Greenwich Park on my way home. In the evening I might go to a yoga or gym class. I like to do physical things to unwind. On Sunday I ran a mile for Sport Relief. I also enjoy the arts. Last week I went to the cinema to see *A Single Man*. The portrayal of shock and disenfranchised grief – the central character isn’t allowed to go to his lover’s funeral – is excellent, as is the way it shows life going on in slow motion with the bereaved person not feeling part of it.

I go to bed around 11pm. Sometimes I watch a bit of TV. I like a good documentary but as a bit of light relief I might watch something like *The X Factor* – I’m a bit of a Simon Cowell fan! Not much keeps me awake at night, although I might suddenly remember something I’ve forgotten to do and make a mental note to do it the following day. ■

BPD: rounding the picture

I am writing in response to Gillian Proctor's article in last month's issue, which I read with some frustration. There are various points I would like to make. The first concerns the idea that giving a diagnosis of Borderline Personality Disorder (BPD) 'explains away' strategies that people use to survive abusive lives. Whilst there is no doubt that this diagnosis has become stigmatising and often carries a pessimistic feel, the giving of a DSM-based diagnosis does not in fact explain anything, it is merely a description or shorthand label for a variety of feelings and behaviours – as listed on page 18 of Dr Proctor's article. I would agree that the term itself is misleading and can sound very negative.

Dr Proctor takes issue with the idea that 'emotions are located within the individual woman rather than understood as a reaction to the social context of women in distress'. This seems a strange statement; surely any counsellor would see emotions as *both* located within people *and* as a reaction to their various life experiences.

However, most counsellors and mental health workers tend to see individual people who present to us with unhappiness and extremely distressing emotions and it is these people, and their emotions we must focus on – we cannot go back into their past and undo the wrongs done to them, nor right the inequalities and oppression in society that caused them (although we should not remain quiet about this knowledge).

Implicit in the article, I felt, was the social constructionist unhappiness with any suggestion that people have differences that are partly

'The giving of a DSM-based diagnosis is merely a shorthand label for a variety of feelings and behaviours'

attributable to biological variation. In seeking (rightly) to challenge the dominance of the bio-medical position in 'mental health', it seems that any suggestion that biology contributes to an individual's emotional disposition is seen as blaming that person for their distress.

Dr Proctor gives a woefully inadequate account of the therapies now available for people with a diagnosis of BPD. This is strange as most of what she says about seeing the difficulties with extreme emotions and emotional regulation as survival strategies, or simply as the result of oppression and abuse, is at the heart of these therapies. Not describing them in any detail, or with a one sentence criticism (as she does with Dialectical Behaviour Therapy, DBT) and then presenting her own position in this way strikes me as misleading and unfair to those who have worked so hard to develop effective therapy systems for what until recently has been seen as an 'untreatable' condition.

More strangely, she does not mention Schema Therapy (fortunately covered favourably in the *Therapy Today* book reviews a few months ago), and its highly effective treatment outcomes in Holland. The central concepts of this therapy are again validation, understanding the damage done to people by their abusive pasts, a focus on

a highly supportive and containing therapeutic relationship, and on experiential and behavioural work to change self-damaging patterns of behaviour.

She makes no mention of Deborah Lee and Paul Gilbert's work on Compassion-Based Approaches, where again the same themes are found – developing compassion for oneself, understanding that you are not to blame for your emotional overwhelm, and the teaching of self-soothing techniques, something people with this diagnosis find so hard.

Finally, Dr Proctor recommends that counsellors/counselling can make a positive contribution to working with people diagnosed with BPD. I would be cautious about such a conclusion, for two reasons. Firstly, what little evidence there is tells us that positive therapeutic work in this area should be long term (18 months to three years plus) and ideally at least twice a week. Most therapy programmes also offer additional telephone crisis support. I imagine that very few counsellors are in a position where they can offer this intensity and duration of therapy.

Secondly, the emerging evidence base indicates that effective therapy tends to come from particular integrative models (DBT, Schema Therapy, Mentalisation-Based Therapy), rather than any of the 'traditional big three' models in which most counsellors are trained (psychodynamic, CBT, humanistic). As such, providing only counselling to people diagnosed with BPD may risk adding to a client's feelings of failure and the all too pervasive pessimistic sense that BPD cannot be resolved.

Sam Coates-Stephens
Clinical psychologist and counsellor, BABCP accredited

Contact us

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Claims lack substance

When *Therapy Today* dedicated a significant amount of space to Human Givens (HG), I thought, well, there are so many similar things around, it does not do any harm. But when I read the following sentence in Ivan Tyrrell's response to a not particularly strong critique in the last issue of *Therapy Today*, my attitude changed: 'Currently, apart from HG, there are no schools of psychotherapy that use the very latest biological, psychological and sociological knowledge and integrate it in a variety of practical ways.' I will refer to HG's website as source in this letter since a large proportion of Tyrrell's response is actually cut and pasted from the website.

The *Mental Health Review Journal* in December 2008 reviewed the body of knowledge on HG. The vast majority of the publications were HG's own. The review article called for better research design and methods because what was available was very weak (descriptive case studies and anecdotes). So there had not been a change in the reliability of HG research from May 2007, when the rewind technique was looked at.¹ It probably has not changed – I was unable to find proper data on the Luton project. What is clear, however, is that it was a self-reporting project, thus a control group would have been necessary to consider it valid to any degree. I repeat: currently there is no peer-reviewed publication on this method.

HG claims that it is very keen on a research base, but

what it proposes, what it calls practice-based evidence, is just an attempt to avoid scrutiny. Here is a simple proposal for the beginning of a proper test for the utility of HG:

1. X number of participants, who may or may not have diagnosed depression (as HG is an unproven therapy, the level of depression cannot be severe) measured with the BDI (Beck Depression Inventory)

2. The therapists may not know the result of BDI

3. The participants are allocated to four groups: those who receive HG, those who receive an approved therapy, those who receive high level empathy with tea, those on a 'waiting list'

4. The participants may not know which group they are in and the therapists may not inform them what therapy they receive

5. Evaluation on BDI (after the therapy, after three and six months). The evaluator may not know which group the participant was in.

The concept itself is not more validated than its efficiency. On its website, HG attempts to get around the lack of evidence by listing unrelated scientific papers as references, by unconstructed logic, by use of anecdotes and by references to authorities irrelevant to the subject (eg Ignác Semmelweis).

HG summarises its breakthrough method in points and it helps to demonstrate these attempts:

1. *The expectation fulfilment theory of why we dream.* This is based on Griffin's assumptions for which there are no peer-reviewed publications.

2. *How to lift depression safely and quickly.* This starts² with an unproven and discredited

claim that depression is the cause of suicide (statistically). The article then continues with many referenced points, followed by a paragraph without a reference: 'The human givens approach to counselling works with what we are all born with – our genetic endowment – namely the physical and emotional needs programmed into us by evolution, which seek their fulfilment through our interaction with the environment, and the innate resources provided to help us meet those needs.' The earlier references disguise the fact that there is no evidence for this claim and that it does not follow from the previous references. These are outdated views, anyway – could HG explain how social needs (with its variety) are born with us and how evolution produced this? The article does not give a logical construct for this (how can evolution of the human neural system result in the desire to build up a share portfolio, or to secure funds for old age in countries without adequate pension systems?) because there is none.

The logical shortcuts are numerous in the article, for example: 'When emotional needs are not met or when our resources are used incorrectly, we suffer considerable mental distress – most commonly anxiety and/or depression.' Or equally plausibly it triggers action. They also claim: 'The dreaming brain which preserves the integrity of our genetic inheritance every night.' While there are many dream theories, one would expect some logical explanation or some evidence for such an outlandish claim. 'There is evidence to show

that the function of dreaming, which occurs predominantly during REM sleep, is the metaphorical acting out (not the resolving) of unexpressed, emotionally arousing preoccupations, so that the arousal can be discharged and the brain freed up to deal with the concerns of the following day.' Unfortunately, the reference for these claims is Griffin's book... The claim combines popularised and somewhat misunderstood neural phenomena and Freudian assumptions in an ad-hoc manner. From this the article concludes: 'The process of discharging, and thus completing, patterns of arousal in this way preserves the integrity of our core personality.' What is core personality? The rest of the page is similarly depressing – logical mistakes, confused terms (eg brain and mind). The evidence for the efficiency and efficacy of HG? The leaders' own publications!

3. *APET model.* The theoretical basis of the model³ is a 19th century view of the relationship between the physical aspects of neural system and consciousness. The references actually do not support the conclusions HG draws from them. The model is a mixture of neurology, Watsonian behaviourism, and misinterpreted cognitive approaches and confusion of the brain and mind.

4. *Molar Memories.* This⁴ is a rehashed version of Jung's most esoteric assumptions mixed with some of the dubious points in evolutionary psychology and superficially interpreted conditioning. The references for HG's assumptions are only self-references.

5. *Dreaming forget.* In this

section⁵ the authors pile up quite a few references about the neural processes of sleep and dreaming, but ignore the fact that these do not support their conceptual framework; they are not even related to the proposed framework. The article confuses the nature of dreams, the neural processes of dreams, the relationship between the conscious and dreams and the assumed function of dreams.

6. *Great expectations*. After some grandiose claims, the article⁶ is essentially a rehash of the previous points using the same technique: references unrelated to the proposition and anecdotes.

7. *Post-traumatic stress disorder*. The article claims that HG has many cases to show the effectiveness of the rewind technique. Why have these not been submitted to peer-review? It clearly confuses the operation of the neural system and its function in the mind. In any case, there is no published evidence that it works and the proposed mechanism contradicts our knowledge about the neural system and the conscious.

8. The last of the claims: *the road to recovery* is a collection of unrelated, unsubstantiated anecdotes.

So, where is the use of ‘the very latest biological, psychological and sociological knowledge’?

Laszlo Czaban

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Limitations of ‘rewind technique’

I would like to add some observations to Ian Stevenson’s letter regarding Human Givens’ claims about the treatment of clients with post-traumatic stress disorder (PTSD). I work in a primary care mental health team and for several years I used the Human Givens ‘rewind technique’, with varying degrees of success, to treat clients with PTSD. Specifically, it seemed to be effective for clients who had suffered single event traumas and I was very successful with a couple of clients who had experienced traumas whilst under anaesthetic. However, I also became aware of the limitations of the ‘rewind technique’ and subsequently trained in EMDR, which provided me with a much broader understanding of the complexities of PTSD and introduced me to the realm of dissociation. EMDR places an emphasis on client safety and an early part of the protocol requires a thorough exploration of the client’s trauma history and an assessment for possible dissociation. This is based on the assumption that there are potentially underlying traumas which could be feeding a more contemporary one. In this respect, treating a current trauma without first checking the client’s past history could be likened to pulling the head off a weed without digging out the roots! Additionally, many clients with PTSD when confronted with reminders of trauma are likely to dissociate, especially those who have suffered

traumas in childhood, and it is important that the practitioner is aware of this before attempting to undertake any treatment.

In my opinion attempting to treat a trauma – which may initially appear to be quite innocuous – without assessing for previous trauma and dissociation, is potentially deleterious to the client’s mental health. Whilst I cannot comment on other training offered by Human Givens/MindFields, I am uncertain how they can make realistic claims to resolve traumas so rapidly; evidence and my own experiences would suggest otherwise.

Ian Plágaro-Neill
MBACP (Accred)

Ditch the evangelical style

I have never read beyond the first page of the MindFields promotional leaflets. Any therapeutic approach that seems to offer itself as ‘the way, the Truth and the Light’ I tend to bin. In my eyes, MindFields leaflets appear to offer quick fixes that pander more to funders than any serious attempt to help people in psychological distress. Michael Soth’s criticism (*Therapy Today*, February 2010) that the Human Givens (HG) approach ignores the ‘giants on whose shoulders we all have the benefit of standing’ certainly rang true for me. Therefore, it was most interesting to read Ivan Tyrrell’s robust defence of the HG approach in response to Michael Soth. In his letter, (*Therapy Today*, March 2010)

Tyrrell acknowledges other ‘giants’, outlines the way the HG approach has developed and presents a case for the effectiveness of working from the HG model. If the promotional literature reflected more of this, it might be more appealing.

I hope that Ivan Tyrrell as Principal of MindFields College reflects on the feedback from Michael Soth and Ian Stevenson (March 2010). I can’t speak with their authority about the HG approach, but it’s clear to me that MindFields’ promotional publicity lacks humility. The MindFields College message might reach me and others if they ditched the evangelical style and produced less irritating, grandiose promotional material.

Anita Tedder
MBACP (Snr Accred)
counsellor and supervisor

Human Givens a serious body

In the March letter titled ‘Extraordinary claims’, Ian Stevenson raised further issues concerning the Human Givens approach: ‘HG doesn’t even believe in the necessity for practitioners to have their own therapy.’

In his excellent comprehensive review of essential research findings into psychotherapy, Mick Cooper points out (p83) that: ‘One problem with this argument (that psychotherapists should have their own therapy) is that the research has yet to demonstrate a direct relationship between client outcomes and therapists’ engagement with their own personal therapy.’¹

In Human Givens training considerable emphasis is placed on the need for therapists to ensure their own psychological wellbeing, not through engagement in further therapy themselves, but in living meaningful and rounded lives that involve activities away from therapy. If a therapist is suffering from psychological distress they are recommended to seek help for their problems and would be recommended to be extremely careful in the sort of work engaged in, in these circumstances.

Is there any independent research to validate HG claims?
It is probably better to ask the question, Is there any independent research to validate *any* claims about psychological treatments? Scrutiny of the research literature used to inform NICE guidelines, for example, reveals that the greatest body of research used to shore up the various recommendations has come from the proponents of the various models themselves. CBT tends to be researched by CBT practitioners and trainers, DBT by DBT practitioners and trainers etc. This is not surprising, of course. However, it is also very sad that so many excellent practitioners of many different persuasions have in effect been disenfranchised because of lack of evidence of a particular kind.

Human Givens therapists have been making a serious attempt to evaluate their own effectiveness since 2005. This has led to the creation of a Practice Research Network in early 2007 (www.hgiprn.org). The HGIPRN publishes and regularly updates findings from practice on its website.

Independent analysis of data has been carried out on the Luton Pilot project and a paper has been prepared for publication. Independent analysis is in the process of being done on the three years of national data collection now emerging since the HGIPRN commenced in April 2007. These researchers analysing the data are independent and have no allegiance to HG. But, as we all know, the process of the road to publication is a slow one. This is why we regularly update the website with the findings that are emerging.

Are some clients/patients being treated for trauma by people who have had a day's course? The answer to this question is a most definite 'No'. Many of the attendees at MindFields training events are experienced practitioners with many years of clinical practice in a variety of disciplines in the field of mental health. Such people may have the confidence and experience to use the technique taught on this day because they will have the appropriate skills and supervision arrangements in place to ensure their clients are well protected. Those attendees without such experience are encouraged to obtain this experience, either through training in the entire HG training programme or in some other training.

Why is HG not being promoted by the universities or the Department of Health?
Human Givens Training is now accredited as an MA programme at Nottingham Trent University. The HG approach is a young and emerging one and maturation takes time. Much serious trauma treatment work has been and is being carried out

on a regular basis. The British Psychological Society spring conference will feature three poster presentations on the HG approach, two of them focused on trauma treatment.

We hope that, in time, the Department of Health will take much more notice of the HG approach and we actively encourage *all* schools of all varieties of therapeutic orientations to work towards building a robust evidence base, including quantitative and qualitative study designs, from real-world effectiveness studies, so that we can *all* begin to learn much more about what seems to work for whom. The thought of (traumatised people) being 'treated' by people who think one technique and a day's training makes them competent almost beggars belief. Indeed it would do, if this were true.

The technique used in the trauma-focused treatment as taught by MindFields College represents one aspect of the very comprehensive approach to treatment. HG treatment involves detailed assessment of unmet needs and the ultimate goal of all HG treatment is to assist clients to get lives that work effectively again. Sadly, we have all come across sufferers of trauma whose lives have been devastated and, even more sadly, some people have often had months or even years of psychological treatments, with little or no benefit. Surely it makes sense that we all unite as a field to attempt to find a common language we can agree on about what it is to be a functioning human being? Then to work to bring together our theories under better organising ideas that allow us to help clients live more effectively. This is an

important issue when we are trying to convince people we are a serious professional body.

The Human Givens Institute (HGI) fully endorses and encourages all practitioners to work with outcome informed practice. In fact, HGI has paid the licence on behalf of its members for access to the excellent internet-based CORE Net system so that as many members as possible can participate in the gathering of robust sessional data on every client at every session as recommended by one of the architects of the IAPT programme, Professor David Clark. Various clinical psychologists, psychiatrists, counsellors and psychotherapists who choose to work with the HG approach fully support the call for a change in emphasis in the NICE hierarchy from excessive reliance on the RCT and for a move towards consideration of the sort of high quality robust quantitative data collection recommended as best practice by the HGI. Along with this we recommend exploration of all other types of evidence, from single case studies to high quality qualitative studies and triangulation studies and, indeed, RCT studies. We believe all serious professional bodies should join with us in this movement to widen the envelope of evidence that influences NICE guidelines. CORE IMS has been encouraging the building of such an evidence base from the ground up for well over a decade.

Hundreds of practitioners have been trained in the HG approach to trauma and can

witness at first hand the enormous benefits for their clients. Meanwhile, the research process goes slowly on as the empirical base is built.

Bill Andrews

Co-ordinator HGIPRN

www.hgiprn.org

www.mindfields.org.uk/?wor=ouit&code=EB

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Working with brain damaged clients

I was interested in this excellent article in the March edition which highlighted many of the complexities of working with brain damaged clients. I have worked as a counsellor with individuals and families affected by stroke (an attack to the brain) for the past 14 years and during that time have fought hard to convince other health and social care professionals of the importance of offering counselling as part of the rehabilitation journey. The Stroke Strategy has recognised the need for psychosocial (emotional, practical and social) support post-stroke for affected families in conjunction with physiotherapy, occupational and speech and language therapy.

Like most brain injuries, onset is sudden, often without any warning and for the survivor and family this can be traumatic. Losses ranging from mobility, speech, perception, change of role, self image, personal

and social relationships, to name but a few, can have a profound impact on those affected. For these reasons and many others, counselling is a vital part of the stroke care pathway. As the article points out, counselling is challenging, particularly with clients with severe communication problems (aphasia), but often essential. Feelings still need to be explored, even if the words cannot be found, and creative ways using gesture, artwork and poetry need to be in the counsellor's toolkit. Working with the partner who becomes the 'caregiver' is also important to help them understand and manage the physical and cognitive changes they face. As the article describes, a collaborative approach with other therapists is essential to achieve the best outcomes for the client, but this does raise issues of confidentiality and often stretches and challenges counsellors' ethical standards.

Many people who suffer brain injury or brain attack can, at some stage during rehabilitation, feel suicidal, and counselling offering containment through this difficult period is important. It is hard for a survivor to tell their loved one that they wish they hadn't survived, but it often needs to be voiced, and a counsellor can receive and handle that information appropriately. But this is difficult and demanding work for the counsellor, work that cannot be hurried or time-limited. Progress can be slow but, from my experience, rewards are great and many families learn to live with their disabilities and can move on with their life. I would like to add to this article the benefit

of using groupwork to enhance the counselling process. I have found that stroke survivors and carers have valued the opportunity to join a group following individual counselling. The opportunity to meet others who share the commonality of stroke is both supportive and empowering and is an important part of recovery.

Sally Lockwood

Bristol Area Stroke Foundation

Obituaries

Celia Hindmarch

Readers of *Therapy Today* will have noted the very moving article by Celia Hindmarch in October 2009, 'On being open and letting go'. In June of last year Celia was told that she had between six and nine months to live. So in the open fashion in which she lived her life, Celia wrote the article. Then she and Joyce, her partner, opened their home for a summer garden party for friends and family. She entered St Luke's Hospice after Christmas and died there six weeks later on 25 February 2010, aged 66.

Celia took a theology degree and became a teacher, expanding this via counselling training to become the manager of The Alder Centre in Liverpool in its early years which resulted in the book *On the Death of a Child*. She then developed a private practice in counselling and supervision, created a critical incident service for Cheshire schools, became Director of the Certificate in Counselling Skills, was one of four core tutors on the Thursday Advanced Diploma in Counselling and then with Bob Colderley, co-directed the Advanced Diploma in

Supervision. Her interests were wide: from cello playing to long-distance walking and travelling. Her circle of friends was so wide that a whole youth hostel was taken over in the Lake District to celebrate her 60th birthday. She is survived by partner, Joyce, son Rob and daughter Chris. She will be sadly missed by her many friends and colleagues in the North West.

Mary Berry

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Nicola Benson

Nicola Benson died on 12 February 2010 after a long illness. Nicola's background was in further and higher education where she taught and worked as a counsellor. During this time she set up a local network for college counsellors which is still in existence. She played a large part in establishing the Llanelli Counselling Service and an innovative service for parents of children who had been referred to NHS Psychological Services.

In 2002 Nicola joined the University of Glamorgan to develop the post of staff counsellor, which she did with much commitment and integrity; she joined the Staff Counselling SIG for AUCC and worked to promote staff counselling in the organisation. She chaired the SIG Committee for several years until 2008. She will be remembered as a bright academic, a dedicated professional and a warm human being with a real twinkle in her eye. She is sorely missed by all of us who had the pleasure to know her.

Marie Feltham

Chair AUCC Staff SIG Committee

CNH exposition

Constructivist psychotherapy: a narrative hermeneutic approach

Gabriele Chiari and Maria Laura Nuzzo

Routledge 2009, £20.99

ISBN 978-0415413138

Reviewed by Colin Feltham



The authors' constructivist, narrative hermeneutic (CNH) approach is a development of, and 'heavily based' on, George Kelly's personal construct therapy, originating in the 1950s. This book is in Keith Tudor's 'Advancing Theory in Therapy' series and is a well organised, up-to-date exposition of one of several constructivist approaches which all have at their core the principle of taking alternative ways of perceiving and interpreting one's world: we all interpret our world and therapy is a forum for intentional examination and re-evaluation of our constructs.

The intellectual history and context of CNH is given, along with explicit discriminations between some different constructivist psychotherapies. Drawing from Neimeyer, the authors discuss therapy as personal science, as selfhood development, narrative reconstruction, and conversational elaboration. CNH is said to overlap with the person-centred approach in its principle of acceptance and understanding, but any similarity surely stops there. Kelly was well known for championing the idea of the person as scientist, for the concepts of tight and loose construing, and for exercises in self-characterisation and his own ABC (activation, belief, consequence) model. These authors develop notions of meaning as needing a contrast, change as reconstruction, decision as always pivotal, pragmatism and narrative as central. Some interesting material is presented on preverbal constructs. Oddly little is included on the rest of the psychotherapeutic field, although some references to CBT and psychoanalysis

are found; some attention is given to transference and countertransference.

CNH draws very heavily from a host of philosophers but also from one or two major educational psychologists like Piaget. When we read of 'subjunctivising reality', 'orthogonal interaction' and of an 'epistemological constructivist matrix', we must pause to wonder whether CNH is unnecessarily and unhelpfully complex, at least in the manner of its presentation here. The authors try to claim that CNH is not overly cerebral but it is hard to find much in the book that resonates with an honouring of emotion as part of being human or of the therapeutic process.

As the authors themselves say, some suspect approaches like theirs of containing a 'lingering over-theorisation'. Although they dispute this, I agree that many will find off-putting an approach, and a text, that is so saturated in multisyllabic philosophical jargon, as well as diagrams and grids related to clinical practice. It is aimed at a postgraduate readership and probably a specialist one, possibly mainly psychologists. Although philosophically related to CBT, CNH is a more sophisticated system of thought and practice. This book does, however, raise the question of whether the theoretically clogged field of counselling and psychotherapy really needs yet more specialised and conceptually dense schools of practice. The glossary, however welcome, does not overcome the problem of a text being almost impenetrable, except perhaps by the most dedicated specialists.

Colin Feltham is Professor of Critical Counselling Studies at Sheffield Hallam University

Sibling relationships

Siblings in development: a psychoanalytic view

Vivienne Lewin and Belinda Sharp (eds)

Karnac 2009, £20.99

ISBN 978-1855756847

Reviewed by Eileen Aird



Siblings in Development is a collection of papers, transcripts and accounts of work presented at four conferences of the same title run by the London Centre for Psychotherapy in 2007. The genesis of the book is clear in its rather uneven quality; the movement between fully-worked-through papers and spoken presentations is disconcerting.

In their introduction the editors argue that sibling relationships have been disregarded, both in the consulting room and in psychoanalytic literature, in favour of the emphasis on vertical family relationships and the assumed centrality of the Oedipal position. Building on Juliet Mitchell's work, they explore the horizontal both in case content and in the transference, arguing that siblings are an internal object for each other as well as for their parents, not just an external phenomenon. In the transcript of his discussion with Juliet Mitchell, Ron Britton argues that siblings exist as internal objects for singletons also, who may

fear that they have murdered unborn others. Margaret Rustin similarly emphasises the importance of absent siblings to singletons. Four of the nine papers in the collection focus on twins.

One of the book's strengths lies in its emphasis on clinical observation and interaction. The opening paper by Toby Etterly is a beautifully written, clear, direct and often moving account of his two-year observation of dizygotic girl twins. He describes the parents' anxieties about differentiation and the potential conflict and envy between the twins, their parents and the parents and twins. One of the twins was in the Special Care Baby Unit after birth, and he notes that the parents overcompensate for this apparent disadvantage by identifying her as the brighter twin. In his conclusion the author gives a succinct review of theories on the attachments of twins to each other and to the mother.

Margaret Rustin's rich, multi-layered chapter 'Taking account of siblings – a view from child psychotherapy' gently points out that although the interest in siblings in adult work is to be welcomed, it may surprise child psychotherapists for whom sibling relationships have always been central. She offers a fascinating sociological account of why we may be emphasising siblings currently in a cultural context of extended adolescence, longer life spans and greater maternal employment. A detailed discussion of a psychoanalytical understanding of siblings follows, wonderfully illustrated by case material and literary analyses. *Eileen Aird is a psychoanalytical psychotherapist and supervisor*

Fear of flying

Overcome your fear of flying

Robert Bor, Carina Eriksen and Margaret Oakes
Sheldon Press 2009, £7.99
ISBN 978-1847090829

Reviewed by Joyce Allen



This self-help book, whilst useful to any nervous flyer, is really aimed at the absolutely terrified individual who cannot even board an aircraft. It is carefully constructed by three acknowledged experts in the fields of psychology and aviation. Their argument is that those who are really afraid of flying, and who do not seek help, are limiting their choices in many aspects of modern life.

The book explains how aircraft work, but most of all, it provides step-by-step guidance on how to overcome a fear of flying. The methods proposed are based on well-known cognitive behavioural techniques. The authors concentrate on practicalities: what an individual can do in the here and now to change patterns of thought and behaviour, rather than exploring why fear develops. They discuss fear at length, concentrating on the sufferer's unhelpful emotions, and each chapter incorporates exercises to practise psychological techniques for overcoming them. The book is well organised and designed to be read sequentially rather than as a volume to dip into. Chapter four, which explains anxiety, will be particularly

informative and useful to the sufferer, and the last chapter provides a useful summary of techniques taught. This is an excellent self-help book but it is a considerable undertaking for someone working alone and may be more useful if worked through with an expert helper. It could provide guidance for CBT and other counsellors, and also cabin crew.

Joyce Allen is a psychodynamic counsellor and supervisor

Supervision: a psychodynamic perspective

Supervision in counselling and psychotherapy: an introduction

Liz Omand
Palgrave Macmillan 2009,
£19.99
ISBN 978-0230006324
Reviewed by Julia Greer



This introductory text considers supervision from a psychodynamic perspective and is rooted in the tradition and theoretical concepts of Freud, Klein and Winnicott. The author also draws on Bion's theory of group dynamics to develop the reader's awareness of the complexity and possibilities of group supervision.

The book presents quite sophisticated theory and ideas in a straightforward way that are also practice-based. Supervision which takes place in different settings is considered from

the perspective of the supervisor, supervisee and the organisation. The authors cover practical dilemmas like suicide, self-harm and working with more disturbed clients, as well as difficulties arising in the supervisory relationship. Issues of difference relating to ethnicity, gender, sexuality, age and disability are considered in the context of projection and projective identification, and related to the process of idealisation and denigration. These processes are applied to work with clients and the supervisory relationship, shining new light on familiar ideas about difference.

This text is an excellent follow-on for therapists who have learnt the basics of supervision as trainees and are now experiencing the deeper meaning of supervision in terms of projective identification, countertransference and parallel process. While these concepts will be familiar to the psychodynamically trained therapist, they will also be experienced by therapists trained in other modalities. The down-to-earth case studies from the author's supervision practice illustrate what can get acted out in the therapy and in the supervision, and clarify ideas about supervision as a space for thinking rather than a rush into action. The text is also helpful for therapists considering their readiness for supervision training and describes the developmental stages of both therapists and supervisors. For experienced supervisors it is an excellent and refreshing read with rich references to the literature on supervision and to psychodynamic theory. *Julia Greer is a psychoanalytical psychotherapist and BACP accredited supervisor*

Learning from young people

Young people in post-conflict Northern Ireland: the past cannot be changed, but the future can be developed

Dirk Schubotz and Paula Devine (eds)
Russell House Publishing
2008, £14.95
ISBN 978-1905541348
Reviewed by Ruth Barnett



The title might suggest that this book is about the transmission of war trauma to post-conflict generations, but this is not its concern. The focus is on 'giving young people a voice'. It would seem obvious that consulting the consumers, and including them in planning for their wellbeing and future, would be more likely to succeed than deciding for them; yet this particular 'wheel' has to be re-invented again and again.

The book is largely based on the Young Life and Times (YLT) annual survey of Northern Ireland 16 year olds and Northern Ireland Life and Times (NILT) survey. Young people's views on mental health, bullying, diversity issues and poverty are sampled annually through a questionnaire, and the participants are encouraged to comment on the questionnaire and suggest improvements for the following year. YLT also runs an annual

essay competition for 16 year olds. By far the most interesting chapter is the winning essay for the year by Shaun Mulvenna, 'Is anybody listening?'

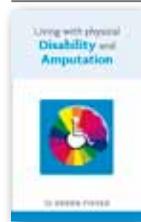
The message of the book is that we have a lot to learn from our youth, if we take the trouble to listen to them. The contribution they make, when they are consulted, can help society with endemic problems such as bullying. The research also shows that the roots of some problems lie in the attitudes young people develop through lack of adequate information.

Although interesting in itself, this book is more likely to appeal to teachers and others working with young people than to most therapists, other than for its research methodology. *Ruth Barnett gives talks in schools and colleges on anti-racism and trauma and is a psychotherapist*

CBT for people living with disability

Living with physical disability and amputation

Dr Keren Fisher
Sheldon Press 2009, £7.99
ISBN 978-1847090768
Reviewed by Vee Howard-Jones



Given the complexities of its subject matter (disability and living with amputation) I was surprised to receive

such a slim volume. I quickly realised that this is a book about applying cognitive behaviour therapy (CBT) and the techniques of its derivatives – acceptance commitment therapy and mindfulness – to the two subjects.

The text is a no-nonsense 'can do' approach to living more effectively with disability and amputation, and instructs and encourages the application of CBT techniques from the first chapter. The result is a pragmatic toolbox to help those affected by disability and amputation to cope more effectively with negative, irrational thought processes that might impede their recovery.

However, the author seems to assume a motivated reader, ready to move on from their trauma. It is only from chapter five onwards, where body image and self-esteem, PTSD, sexuality and phantom pain are discussed, that I began to see this work as clearly aimed at those with physical disability and amputation. In terms of engaging the reader, it might have been more helpful for these chapters to have been at the beginning, before endorsing the CBT approach.

In addition, there is an assumption that the reader has become comfortable with the labels of 'disability' and 'amputation'. Some discussion about what this might mean to people, their own value judgements about the words prior to their disability, and some acknowledgement of the fact that change and loss have a distinctive and peculiar parabola for them, might have been helpful for readers feeling isolated and confused by their reactions. The back

of the book states that this text is for those 'who are judged well enough to live with it', and I wondered who makes that judgment and how the reader would know?

This is a well written, practical, and brief guide to CBT and goal setting with some useful information on sexuality and phantom sensations following diagnosis/surgery. Overall, however, I think this is an ambitious title given the breadth and complexity of the subject.

Vee Howard-Jones is a lecturer at the University of Salford and a counsellor

Disability and child sexual abuse

Disability and child sexual abuse: lessons from survivors' narratives for effective protection, prevention and treatment

Martina Higgins and John Swain
Jessica Kingsley Publishers
2009, £22.99
ISBN 978-1843105633
Reviewed by Angela Cooper



In what the authors describe as 'a difficult book to read and certainly a difficult book to write', Higgins and Swain explore the stories of seven disabled people in order to give voice to their experience – voices lost through abuse and societal discourse.

They say that young people

who have disabilities and are sexually abused experience the 'double whammy effect' that reflects 'part of the history of man's inhumanity to man'.

The first chapter introduces the survivors who provide the narrative, and the importance of this narrative is explored in the next chapter. The focus then moves to social assumptions around impairment, and the way people express and survive the pain of their history. One of the most disturbing sections looks at organisational abuse, and the way abusive environments can develop. The question of who abuses and why also includes how perpetrators achieve their aim and why the disabled child is so at risk.

The complex issues behind establishing identity and the powerful role of the narrative are the subject of the next two chapters. Finally, implications for policy, practice and society are summarised from the findings.

This is an important and well written book which addresses subjects such as infanticide and false memory syndrome with a capable and compassionate attitude. The authors write of the need to distinguish between 'narrative truth' conveyed during the therapeutic

process as opposed to 'historical truth' which is associated with facts and the legal connotations. They also illustrate why the therapeutic relationship, with its focus on trust and safety, is crucial to the telling of the story; very relevant in the present climate of debate around the use of CBT.

The book draws on important research including that of van der Kolk and Etherington but never loses sight of the individuals whose stories form the heart of the work. The writers conclude with an acknowledgement of the experiences of the participants and how their narrative can provide a challenge to current policy and practice.

Two relatively minor points: I would have liked to see more on the place of neuroscience research, especially around the issue of attachment, as well as more on the role of the female abuser. Although recommended for those working in social and health services, this book is also highly relevant for counsellors working with young people with abuse issues without disability, as well as those coming into therapy as adults. *Angela Cooper is a BACP senior accredited counsellor and supervisor (group and individual)*

Essential 'how to' guide to research

Researching, reflecting and writing about work: guidance on training course assignments and research for psychotherapists and counsellors

Fiona Gardner and Steven J Coombs (eds)

Routledge 2009, £19.99

ISBN 978-041547230

Reviewed by James Costello



The timely arrival of this text accompanies the steadily growing pressure exerted by the IAPT directive for counsellors and psychotherapists to demonstrate and evaluate the therapeutic outcomes of what they do behind closed doors. The NICE endorsement of CBT reflects more the enthusiasm with which practitioners in this area have embraced a culture of inquiry, and less any unique claim this approach may have upon helping those in distress. With this in mind, we are asked to consider that 'the future of the

profession... hangs upon the successful education of the next generation of research-savvy practitioners'. This book provides an accessible 'how to do' social science research as a practising counsellor, psychotherapist, social worker or other caring professional.

With contributions from experienced practitioner-trainers/researchers, it successfully illustrates how therapeutic work is in itself a form of research, and research has an important role to play in personal development and organisational settings, as well as the voluntary and public sectors. The first four chapters address fundamental study skills and the ethical dilemmas of research.

All chapters conclude with useful reflective exercises. The rest of the book is concerned with material appropriate to postgraduate research. The challenging process of deciding which qualitative approach to use is clearly addressed in chapter five. What I like about this and subsequent sections are the examples used to illustrate how a given therapeutic situation lends itself to a particular methodology; the methodology fits the question, not the other way around. Chapter 10 reinforces the importance of publicising research findings.

James Costello is a counsellor, trainer, researcher and university lecturer

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Now available to order: *Counselling and psychotherapy for the prevention of suicide – a systematic review of the evidence*, by David Winter, Siobhan Bradshaw, Frances Bunn, David Wellsted.

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British Association for
Counselling & Psychotherapy

Seed corn project yields interesting findings about same-sex couples

Jan Grove reports on the findings of a small-scale study undertaken to explore the experiences of people who have engaged in same-sex couple counselling

Same-sex relationships have recently been the subject of particular interest, in the light of new legislation. The UK Civil Partnership Act (2004) confers legal status to same-sex unions with the same rights as a married couple in areas such as tax, social security, inheritance and workplace benefits. More recently, the Equality Act (Sexual orientation) Regulations, 2007, outlaws discrimination on the grounds of sexual orientation in the provision of goods, facilities, services, education; this means, for example, that same-sex couples cannot be refused double rooms in hotels, can attend antenatal classes as a couple, and cannot be denied access to a particular GP practice or educational facility because they are gay or lesbian.

The recent legislation affording rights to make a legal relationship commitment, including legal arrangements for children, raises the issue of assimilation. Richardson¹ argues that the claiming of equal rights 'reinforces both normative assumptions about sexuality and gender and the desirability of marital-style sexual coupledness' (p.392-3). As Auchmuty² says, heterosexuals do not have a monopoly on the best ways to engage in intimate relationships. However, offering a civil partnership, rather than the opportunity to marry, may place same-sex couples as second-class citizens³, one of the reasons why Kitzinger and Wilkinson³

decided to marry, despite their criticisms of marriage as a potentially oppressive institution. The context for same-sex couples and counselling is framed within a setting where difference is not always prized and acceptance may come with the strings of assimilation.

The conditionality of acceptance was illustrated in the *Daily Mail* article by Jan Moir (16 October 2009) following the death of Stephen Gately, in which she described the circumstances of his death as 'sleazy'. Stephen Gately and his civil partner had brought another man back to their flat, something Jan Moir described as 'a louche lifestyle' that 'strikes a blow to the happy-ever-after myth of civil partnerships'. In this she confirms the view of Clarke et al⁴ that same-sex relationships may only be acceptable if they conform to straight stereotypes. In 1996 Davies⁵ wrote that being invisible as a lesbian or gay man was still prevalent in society, commenting that, 'it could be said that "good gays" are those who are quiet about their lives' (p.45). It seems that society has moved on to an acceptance of same-

sex relationships, provided they do not deviate from the socially acceptable norms for heterosexual couples.

Given that same-sex relationships are more prominent and afforded greater rights, the question of how to provide high quality therapeutic help to troubled relationships is both topical and of great importance. In the same way that research has helped to shape ideas about working with individual lesbian, gay and bisexual clients,^{6,7} there is a need to determine the unique features of same-sex couple counselling and identify best practice. Supported by the BACP Seed Corn Grant, a small-scale survey was undertaken to explore the experiences of people who had engaged in same-sex couple counselling. Six women and three men were interviewed and a qualitative analysis undertaken (further details of the research process is available from the author). Affirmation and validation for the couples' relationships were important to respondents, as was a sense that the counsellor understood particular issues relevant to same-sex couples. These themes are discussed below.

Affirmation, validation and support for the couple

Respondents were generally alert to signs of acceptance and valuing of their relationships. One respondent, when out shopping for household

'There is a need to determine the unique features of same-sex couple counselling and identify best practice'

goods with a male flatmate, was very conscious of the ‘waves of approval,’ going on to say: ‘People thought we were a young heterosexual couple, setting up house together, and it really struck us because neither of us had ever had that affirmation, just going out and about doing our ordinary business.’

There was a qualified level of support for the relationship from families that often made it difficult to ask for help with couple problems. Families tended to tolerate rather than validate the relationship, so that even where couples visited regularly and stayed with parents, there was a sense of those relatives’ discomfort. As one woman put it, ‘I don’t think either side of the family really know quite how to relate to us as a couple; I think that’s the bottom line.’ (Bernice)

An exception occurred with Fay’s mother, who positively acknowledged the couple relationship so that Fay felt safe enough to explore the difficulties: ‘One of the things that she did that I found really good actually was that she said how much she liked Teresa (her partner)... It made me feel very safe because I wasn’t ready to end the relationship yet.’

It was rare for respondents to feel that families gave full value to the relationship; for example, for Chloe in relation to heterosexual siblings: ‘Feeling like my sister has got a husband and their relationship is treated with more respect than ours.’ This impacted on the form of support for a troubled couple relationship where a respondent was not able to discuss difficulties in the same way as a sibling, as Bernice described: ‘I know my sister and her husband have

from time to time, for various reasons, had difficult times in their relationship and I know my sister’s been able to go to my mom and talk about that, and their relationship is legitimate in that way.’ Ingrid, too, felt that her relationship was merely tolerated, saying: ‘My sister just didn’t want to talk about it. I mean, she was very loving, but she really would rather that we didn’t talk about my relationship.’

It seems then that some respondents engaged in their couple relationships against a backdrop of subtle lack of acceptance and validation, even where there was no overt discrimination.

In seeking counselling, respondents searched for a sign that the counsellor or agency had given some consideration to non-heterosexual relationships; sadly for Alex, without success. ‘I tried to research it as in-depthly as possible, but in (the North of England) and the surrounding areas, there was not one counsellor that I could find who identified with LGBT issues or was aware of LGBT issues, so I just had to find someone.’

Just being able to access a mainstream couple counselling service conferred a sense of validation for one of the women, who felt that ‘the fact that they were saying... “we are now open to same-sex couples”, I think that actually was a big thing, it was a big sort of affirmation thing... but still, when those bits of affirmation come, they are precious.’ Agencies and counsellors can usefully signal that same-sex relationships have been considered and included as part of their ongoing work. The potential lack of in-depth support from families and validation for same-sex

‘Families tended to tolerate rather than validate the relationship, so that even where couples visited regularly, there was a sense of those relatives’ discomfort’

relationships needs to be understood by counsellors against a backdrop of a British context where there is a continued lack of acceptance for the expression of same-sex attraction. This is in addition to the very real fear of abuse and violence many lesbians and gay men still experience.⁸

Models, assumptions and stereotypes

It is likely that both counsellors and respondents will have been brought up with heterosexuality as the dominant sexuality with few alternatives to heterosexual models of relationships, and with a variety of assumptions about same-sex relationships.

The experience of many respondents was of counsellors imposing such models onto their same-sex relationships; for example, in assigning gender roles to the couple. Fay described the counsellor as being, ‘taken slightly off guard. I think she’d put Teresa (her partner) in a box as being, you know, this sort of down-to-earth, one-of-the-lads, straight-up kind of person.’

Transposing heterosexual concepts of relationships where, for example, household tasks are often aligned with perceived gender roles, misses the real experience of couples in

same-sex relationships. In these relationships there are opportunities to question the gender divisions of labour⁹ and decide who has the aptitude and skills to perform individual tasks.

Many of the female respondents were caught in a dilemma of recognising that their own behaviour conformed to stereotypes of women’s relationships. They wanted the counsellor to recognise and understand this from a lesbian cultural perspective, yet did not want to be pigeonholed or pathologised. Common amongst several of the women was the process of getting together in a way that they saw characterised same-sex female relationships. Ellie recognised this stereotype, saying, ‘It was quite strange, at the beginning and I think very quickly we did that old lesbian cliché thing, of getting quite involved very quickly.’

The respondents felt that a lack of understanding about the ways in which women sometimes embarked on new relationships caused issues in the counselling process, as Fay described: ‘So that a lot of women, I think, feel they have to apologise for the fact that women often move in together very quickly, that they often move to a great degree of commitment very quickly and we certainly found ourselves apologising for that, and I know of other friends who’ve been to couple counselling who’ve found themselves apologising for that because there’s an expectation from the counsellor that if you move to that very intense level of intimacy,

that there's some kind of problem.'

Another potential area for stereotyping women's relationships concerned keeping in touch after the relationship had ended. This seemed perfectly natural for the women, yet they recognised the possibility of this being seen as a stereotype. Alex expressed this as: 'I've had a stereotypical lesbian thing, we've always kept in touch, always been friends, it's always been a very mutual relationship break-up.'

Counsellors need to understand the context for same-sex relationships where ex-partners may be part of a larger friendship group,⁹ and not pathologise the maintenance of friendships with previous lovers.

Respondents were alert to times when they felt that the counsellor did demonstrate an understanding and sensitivity to different models of relationships, as one of the men described: 'I thought he was sensitive to the issues that do have to do with men who are in same-sex relationships; I mean in the sense that the personalities, you know, you have two male personalities with the stuff that can go with that, competitiveness and some of that stuff; male pathology, if you will.' (Darren)

Conclusion

New legislation provides legal safeguards for same-sex couples and opportunities to have the relationship validated through official recognition. The Stonewall survey of 2006¹⁰ reported a high level of tolerance towards lesbians and gay men amongst the respondents and a commitment to anti-

discrimination. However, discrimination continues, often in subtle forms where, for example, lesbians, gay men and bisexuals have found mental health professionals making assumptions about heterosexuality.¹¹ It is also worth noting that Stonewall's 2008⁸ report on hate crime found that one in five lesbians or gay men had experienced a homophobic hate crime or incident in the past three years and that in one in six cases this resulted in a physical assault.

It is within this context that same-sex couple counselling takes place, and it is important that counsellors and therapists understand this backdrop and the unique features of being in a same-sex relationship. This needs to include an awareness of the potential experiences of the couple, for example of non-acceptance that may or may not be manifested in outright homophobia. Heterosexual models of relationships cannot automatically be transposed onto same-sex relationships where there are different ways of getting together and managing gender issues. Finally, counselling agencies can enhance their services for same-sex couples by reviewing how they and the counsellors validate the same-sex relationship both before and during the therapeutic encounter.

Jan Grove

Senior Lecturer in Counselling,
Newman University College

Further research

participants wanted
Clients wanted who have had same-sex couple counselling to complete a short online survey (visit www.survey.bris.ac.uk/leicester/couplecounselling).

Acknowledgements

My thanks go to the men and women who participated in this research, the research assistant Simon Blasby, and my two research supervisors, Val Owen-Pugh and Liz Peel. I am also grateful to BACP for the Seed Corn Grant and to the support of my employers, the University of Birmingham and Newman University College.

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BACP research conference

The research conference 'Research Impacts' runs over two days, Friday 14 and Saturday 15 May, with a pre-conference workshop presented by Professor John McLeod on Thursday evening (13 May) about systematic case studies to which all delegates are welcome.

We look forward to a packed and interesting few days, with a varied and stimulating selection of papers, workshops, symposia, posters and excellent keynote presentations. There will be four symposia, comprising up to four papers each, and five workshops, including one by Professor David Rennie, York University, Toronto, who will present 'Issues in qualitative research'. The keynote speakers will be:

- Friday 14 May – Professor Dr Bernhard Strauss, Past President, Society for Psychotherapy Research, Institute of Psychosocial Medicine and Psychotherapy, University Hospital, Friedrich-Schiller-University Jena, Germany, presenting 'Research impacts on training in counselling'
- Saturday 15 May – Dr Chris Mace, Chair, Psychotherapy Faculty, Royal College of Psychiatrists, St Michael's Hospital, Warwick, and Department of Psychology, University of Warwick, UK, presenting 'Coming soon to a screen near you? Impacts of research on practice'.

For a full list of all the presentations, visit the research pages on our website (www.bacp.co.uk/research).

Policy and public affairs

BACP's responses to recent consultations and its statement response to Mind's call for regulation

Following a meeting held by BACP representatives with Conservative health spokesman Mary Scanlon MSP in the Scottish Parliament, a series of Parliamentary Questions about counselling and psychotherapy in Scotland were raised with the Minister. These included questions about access, service provision, waiting times and school counselling.

The Department of Health (DH) has published 'Realising the benefits: IAPT at full roll out' (for the full document, visit www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications/PolicyAndGuidance/DH_112982). The document sets out the DH's vision for completing the roll-out of evidence-based psychological therapy services across England in the period 2010/11 and beyond. It also prompts the NHS to undertake an analysis of the expected gap towards achieving this goal.

A good practice guide on the use of self-help materials within IAPT services has also been published (which can be accessed at www.iapt.nhs.uk/wp-content/uploads/iapt-self-help-good-practice-guide-final.pdf). The document has been produced in response to the need for expert guidance on the use of self-help materials, given the wide range of different materials and media all purporting to offer helpful advice and information to people about a range of problems and disorders.

Mind has published a survey about barriers people face when trying to make a complaint about counsellors and psychotherapists. Mind's snapshot poll found:

- 1 in 5 people were not satisfied with the service they received from their counsellor or psychotherapist
- 85 per cent want to see counsellors and psychotherapists regulated
- 77 per cent did not make a complaint because:
 - 37 per cent said they didn't know how to complain
 - 32 per cent were worried they would not be believed
 - 25 per cent feared the complaints process was not independent
 - 25 per cent stated there was no one to complain to
 - 73 per cent of those who complained were unsatisfied, with a third finding the process confusing and 65 per cent stating that the complaints procedure had not been independent.

Alongside its survey, Mind took the opportunity to call for urgent independent statutory regulation of counselling and psychotherapy. Paul Farmer, Chief Executive of Mind, said: 'Independent statutory regulation of counsellors and psychotherapists is a crucial step which needs to be taken to protect the public. Therapy is an important treatment and, while most therapists do an excellent job, the people that do have a bad experience have very few options on how to complain and no guarantee that malpractice will ever be held to account.'

'It is clear that self-regulation is not working. Whilst regulation won't end abuse, it will provide a mechanism to ensure a basic standard for therapists, provide a unified and unbiased channel for grievances and ensure that anyone struck off is legally barred from practising

under the title of counsellor or psychotherapist again. People seek counselling or psychotherapy when they are in distress and we would urge the next government to treat regulation as a priority, in order to protect patients who are already in a vulnerable place.'

BACP responded to Mind's call for regulation by issuing a statement urging members of the public seeking counselling to use BACP members until the issue of regulation is resolved by the Government (to view BACP's statement, visit our website www.bacp.co.uk).

BACP responded to four consultations during February, including the Scottish Government consultation on 'A national approach to anti-bullying for Scotland's children and young people'. BACP suggested that the range of strategies to promote positive relationships and behaviour and prevent and tackle bullying embedded in the culture of the school or organisation should include counselling.

BACP commented to the NICE scope consultation for the 'Stroke rehabilitation guideline'. BACP suggested that the key clinical issues to be covered should include psychological interventions, including counselling and psychotherapy.

BACP also responded to the Department for Health, Social Services and Public Safety consultation on 'Palliative and end of life care strategy' and the Welsh Assembly Government consultation on 'Draft service specification for services providing care to adults in Wales who have been sexually assaulted or abused'.

For further information, please contact us at policy@bacp.co.uk

BACP fees 2010–11

Continued membership of BACP will keep you up to date on key developments within the psychological therapies arena. Membership fees allow BACP to sustain its work on educating the public about counselling and psychotherapy.

The membership fees below have been approved

by the Finance and Policy Committee for the financial year 2010/11 and will apply from 1 April 2010. Members will receive details of their fees on their renewal notice. Visit www.bacp.co.uk to see the full list of categories and current fees or contact Customer Services on 01455 883300.

Individual membership of BACP

Category	Standard 2010-11	Reduced 2010-11
MBACP Accred	£158	£79
Member	£142	£71
MBACP	£142	£71
Student	£64	£32
Associate	£132	£66
Affiliate	£94	N/A

Individual membership of divisions and faculty

In conjunction with individual membership of BACP

Division or faculty	Standard 2010-11	Reduced 2010-11
BACP Workplace	£30	£15
AIP	£18	£9
APSCC	£20	£10
AUCC	£40	£20
CCYP	£20	£10
BACP Healthcare	£30	£15

Organisational membership of BACP

Category	2010-11
Local voluntary and charitable	£200
National voluntary and charitable	£260
Commercial	£492

Organisational membership of divisions and faculty

In conjunction with individual membership of BACP

Division or faculty	2010-11
BACP Workplace	£75
AIP	£40
APSCC	£25
AUCC	£120
CCYP	£35
BACP Healthcare	£50

Overseas postage

Non-UK postage annual surcharge	£17
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General Election 2010: taking counselling to the next Parliament

We are now just weeks away from a General Election and BACP wants you to use this opportunity to promote understanding about, and the importance of, psychological therapies amongst Parliamentary candidates in the hope that they take that knowledge of counselling with them to Parliament if they are elected.

What can you do?

Many of the candidates for your constituency will be knocking on doors, canvassing in town centres and supermarkets or phoning people over the course of the election campaign. As a voter and maybe a future constituent, candidates want to know what's important to you, and with over 32,000 BACP members, together we can potentially speak about counselling to every MP that will be returned to Parliament at the election.

If you meet any General Election candidates over the election period, we would like you to ask them the following simple question: *What would your party do to increase counselling services?*

Should you wish, you can then follow this up with your own local and personal knowledge and experiences about counselling provision and mental health services in your area.

To help you make the most of this opportunity to promote counselling at this election, BACP has prepared a briefing for you with facts and figures about mental health in the UK, additional questions that you can ask your candidates and other ways of contacting them during the election campaign. This is available for you to read from the Policy and Public Affairs section of our website (www.bacp.co.uk/policy).

BACP's new online CPD module

BACP is pleased to announce publication of its new online CPD module 'Psychopharmacology and counselling and psychotherapy'. This is aimed at counsellors and psychotherapists seeking

to advance their knowledge of psychiatric drugs and to increase their awareness of the influence of drugs on the psychotherapeutic process.

You can view the module online at www.bacp.co.uk/learning/online%20learning/

(priced at £10 for members and £15 for non-members). Any queries should be directed to Christina Docchar, Project Manager, Supervision and CPD (christina.docchar@bacp.co.uk).

Do you ever have ethical dilemmas with your practice?

Have you bought your copy of the anthology of Information Sheets yet? *The Talking Therapies: An Essential Anthology (2nd edition)* contains more than 40 of the current Information Sheets, bound in a slim volume, that can always be readily available to pick off the shelf. Invaluable for practitioners, supervisors and students alike, these sheets should be read in conjunction with the *Ethical Framework for Good Practice in Counselling and Psychotherapy* and should aid you with your ethical decision-making.

Information is provided on a variety of broad and specific matters, ranging from employment issues, such as how and what to consider when setting up a counselling service, and research issues including results of counselling effectiveness studies, to general questions often asked by practitioners, such as 'Am I fit to practise as a counsellor?'.

The Talking Therapies: An Essential Anthology (2nd edition) is available from the BACP online shop at a cost of £20 to members and £25 to non-members.

Newly accredited counsellors/ psychotherapists

We would like to congratulate the following members on achieving their BACP accredited status:

Erik Abrams
Julie Baker
Bridget Barling
Caroline Barnes
Sandra Barrow
Rose Blackadder
Kate Boldry
Loretta Bradshaw
Cari Bridgen
Nicola Buchan
Rachel Burns
Rachel Butler
Julie-Ellen Carmichael
Sally Chubb
Joseph Coney
Joanna Cornick
Susan Cullingford
Elizabeth D'Arcy
Shelley Daldy
Breege Dolan
Lydia Edmondson-Jones
Julia Fellows
Julie Fitzhenry
Catherine Fitzpatrick
John Fletcher
Elaine Freeman
Vanessa Gajewska
Vivien Gibbons
John Goodchild
Virginia Graham
Nicola Grainger
Steven Grant
Suna Guven
Joanne Heap
Carol Hindle
Lianne Hogg
Liz Hopkinson Wildi
Karen Ilott
Rela Iwano
Julie James
Sevilay Kazim
Pam Kernaghan
Vicki Kerwin
Linda Lowe
Vivienne Lowe
Susanna Martin
Yvonne Mc Kenna
Peter McDonnell
Claudio Mendes
Heather Milne

Zohreh Mirmohkam
Barbarette Mortimer
Julie Paddock
Toni Pehrsson-Knudsen
Tracy Pennells
Anna Phillips
Mia Phillips
Christina Ponniah
Joanna Prince
Isobel Quirk
Sue Ranson
Stephen Redman
Carol Rich
Christine Roberts
Angela Rochester-Daley
Lynda Rolington
Sylvia Sanders
Pete Smith
Julie Smith
Chris Stavri
Yara Steel
Jenny Stevens
Alison Still
Alison Terry
Carol Thomas
Jocelyn Walker
Helen Walley
Nicola Wasserman
Phyllis Wood
Nuala Woods
Shannon Woolf
Cheryl Woon
Patricia Wymer

Newly accredited counselling supervisor of individuals and groups

Nan Williamson

Newly accredited counselling supervisor of individuals
Wendy Morris

Newly accredited counselling supervisor of groups
Joanna Goodfellow

Newly accredited counselling services
Youth Information Service (YIS) Counselling Service

Members not renewing accreditation
Whether it is through retirement, illness or

perhaps moving on to a different career, we would like to thank the following for their contribution, to offer our good wishes for the future, and to confirm that they may no longer describe or advertise themselves as BACP accredited members:

Ruth Archer
Harjinder Kaur Bahra
Debra Bartrop
Margaret Boulton
Anne Clydesdale
James Cook
Shirley Franklin
Judith Gallagher
Shirley Gardiner
Philippa Glenn
Peggy Heron
Jane Herring
Deanne Howley
Salwa Ibrahim
Jean Lennon
Carol Martin-Sperry
Joan Mason
Nicola McFarland
Sara Rose Miller
Pauline Mitchell
Annie Morgan
Rosalind O'Melia
Tricia Payne
Teresa Pike
Kathy Reed
Sandy Rowlinson
Jan Shannon
Brigitte Stein
Howard Straughen-Simpson
Linda Tanner
Marie Teague
Gail Thompson
Yvonne Thorp
Polly Verrier
Robert Wheatley
Sandra Wick

Members whose accreditation has been reinstated
Vesna Mandic-Bozic
Veronica Wade

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

Applying for accreditation: supervision

In the third of our guidance articles on accreditation, assessor *Stephen Hitchcock* looks at reflective practice criterion 8.3: supervision

For criteria 8.2 and 8.3, applicants for accreditation are asked to provide case material to demonstrate their way of working. You can write about your work with one or two clients – the choice is yours – but the total 3,000 word limit still applies.

In this article we will be concentrating on criterion 8.3 – your use of supervision and its influence on your practice. The precise wording is as follows:

In your case material, demonstrate how supervision influences your practice by:

- 8.3.1 *Describing the awareness you have gained through reflection in and on supervision*
- 8.3.2 *Showing how you apply that awareness in your practice.*

So, as you can see, it is a two-part process that you are asked to describe: what you have learnt from supervision, and how you have applied that learning in a subsequent session or sessions with your client.

A key word in criterion 8.3 (as in 8.2) is ‘demonstrate’; in other words, show by example how you have made use of supervision, with reference to your work with an actual client. Applicants sometimes fail criterion 8.3 because they have described supervision in general, theoretical terms, whereas it is illustration from real-life practice that the assessors are looking for.

You don’t need to write about every supervision session in which that

client was discussed, or about everything you ever discovered in supervision regarding that client. However, you do need to refer to at least one occasion when you explored a particular issue or concern or question with your supervisor, with reference to this client.

You then need to show how that exploration affected subsequent work with the client – for example, how you have developed as a practitioner and integrated that learning into your practice, using the awareness gained from supervision for the benefit of your client.

Some applicants fall down on this second part, 8.3.2. They may have provided a clear description of their awareness gained in supervision (8.3.1), but they have not gone on to show how they have used that awareness in subsequent client sessions.

Within your case material, each and every sub-criterion under 8.2 and 8.3 needs to be addressed. We ask you to reference the sub-criteria wherever

you consider they are being met, for example by section headings, or writing the criterion number at the end of relevant sentences, or alongside in the margin. This is not only to draw the assessors’ attention to that piece of evidence, but also to satisfy yourself that every element has been addressed, and none overlooked.

In the supervisor’s report, your supervisor needs to comment on the use you made of supervision, both in general and with reference to the case material within your application. Therefore, it is advisable to discuss the case with your supervisor at an early stage in your application process, to ensure that he or she is familiar with the case you intend to write about. It would be a shame if you had spent time preparing your case material, only to find that your supervisor had no recollection of that piece of work!

To help with preparation for counsellor accreditation, BACP organises workshops around the UK. Workshops cover all application criteria. They are popular, so early booking is advised. We have several workshops in the upcoming months.

Please visit the BACP website (www.bacp.co.uk/accreditation/AccreditationWorkshops/index.php) for further details or contact our Customer Services Team on 01455 883300.

Stephen Hitchcock
Accreditation assessor

‘Applicants sometimes fail criterion 8.3 because they have described supervision in general theoretical terms’