Therapy Today

For counselling and psychotherapy professionals

April 2014
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Are we thinking enough?

Isha McKenzie-Mavinga: connecting with racism

When the workplace bully is a counsellor

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ii. to advance the education of the public in the part that counselling and/or psychotherapy can play generally and in particular to meet the needs of those members of society where development and participation in society is impaired by mental, physical or social handicap or disability.

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Contents

Sarah Browne
Editor

What part does our emotional attachment (or the 'affect heuristic') play in our choice of and loyalty to our therapy modality? What part does finance play – the fact that we are likely to have invested thousands of pounds in training in a particular approach? I recognise this emotional investment in a particular approach from my own experience of therapy and training and also the general reluctance on the part of other trainees to question or deconstruct a particular school of thought, particularly when they have shelled out a lot of money for the course.

In our cover article this month Colin Feltham – who describes himself as a 'critical friend' of counselling and psychotherapy – asks why there is such a lack of critical thinking in our field. Why are therapy's critics more likely to be sociologists, philosophers, scientists and ex-clients than therapists themselves? Why is it so difficult to discuss big questions – like the difference between counselling and psychotherapy, whether we need personal therapy in training or whether a particular therapy works – in a logical rather than an emotive way? Does the fact that most therapists are focused on interpersonal and clinical work rule out devoting time to more intellectual critiquing of therapy?

Colin argues that trainers, for example, are much more likely to have been emotionally influenced by their therapy experiences than to have spent years studying texts on theory and research before deciding that a particular approach is for them. He asks how much trainees are encouraged to question and critique therapy, suggesting that far more weight is given to what you feel and not what you think. Even doctoral candidates, he argues, tend to remain wedded to their beliefs and display superficial levels of critical thinking.

Perhaps it is unrealistic to expect hard-pressed practitioners – who may be struggling even to get paid employment – to be concerned about such questions. Let us know your views.

Features

Cover illustration by Mark Smith

Regulars

BACP

TherapyToday.net

This month: Mark Smith writes about the challenges of illustrating *Therapy Today*; plus the latest news and TherapyToday.net noticeboard.

Are you happy at work?

Counsellors rank 71st out of 274 occupations for job satisfaction, a new report on social wellbeing and public policy says.

The report, *Wellbeing and Policy*, was produced by a commission chaired by former Cabinet Secretary Gus O'Donnell and including Professor Lord Richard Layard. It was published by the Legatum Institute, which argues that population wellbeing is a better reflection of national prosperity than Gross Domestic Product.

The report uses Cabinet Office data to map the relative job satisfaction scores of the most common occupations. Top of the list are clergy, with a score of 8.29/10, followed by chief executives and senior officers (7.95) and farm and horticultural business owners/managers (7.94).

Counsellors scored 7.51, below alternative and complementary therapy professionals (7.71, 16th), medical practitioners (7.83, 7th) and physiotherapists (7.78, 12th). But they are happier in their work than psychologists (7.37, 119th) and welfare officers (7.44, 92nd).

The occupations with the lowest scores were publicans (6.38), construction labourers (6.39) and debt and rent collectors (6.56).

The data suggest that job satisfaction has little to do with pay: vicars earn on average £20,568 a year, publicans £25,222, and seven out of the top 10 occupations earn less than £35,000 a year.

The report says young people should be able to check the average life satisfaction of different professions when choosing their future careers, just as they can check the pay scales and qualifications required.

http://www.li.com/publications/wellbeing-and-policy

New website aims to make the perfect match

A new mental health and wellbeing website is aiming to make finding a therapist much less of a postcode lottery.

Welldoing.org is the brainchild of Louise Chunn, former editor of *Psychologies* magazine and the *Guardian* women's page.

The site uses a different approach to matching clients with a therapist. Rather than searching by postcode and type of therapy, the client is asked to complete a questionnaire with information about themselves, their mood state, what they can afford and what they expect to get out of therapy. The website then uses the information to match the client with local therapists whose ways of working are best suited to their needs and preferences.

The site also publishes a wide range of articles by well-known writers, psychologists and psychotherapists on emotional health and wellbeing issues in general, with topics such as 'Knitting as therapy', 'Tiger parenting' and even 'Talking to your daughter about sex'.

IPGGUTENMERGUKLTD/THINKSTOCK

Over 1000 therapists have so far signed up to the site.

'With most sites, it's very easy to be overwhelmed by the huge choice and the terminology and qualifications that mean nothing to the average person,' says Louise Chunn. 'I want to demystify therapy and reach an audience who are interested not just in therapy but also in human behaviour and the mysteries of life. That makes it an incredible resource for therapists because they are directly reaching an engaged audience.'

See http://welldoing.org

'Choice' extended to mental health

The Government has rolled out its 'choice' initiative to include mental health services and counselling.

But the freedom to choose your preferred therapist will be limited and is not legally binding on the NHS.

The NHS England *2014/15 Choice Framework* says that from April 2014 people with mental health problems have the same legal right as those with physical health conditions to choose the 'consultant-led team' they want to treat them, in an organisation that is deemed to offer 'the right care and treatment for your condition'.

The right to choose will not apply to patients needing urgent or emergency treatment, or if they are detained under the Mental Health Act or in prison or on temporary release.

From April NHS patients in England may also be able to choose where their GP refers them for counselling or psychological therapy. But this is not a legal right. In its guidance NHS England says availability will depend on 'what clinical commissioning groups, GP practices and patients think are priorities for your community'.

From October 2014 NHS England is also rolling out the legal right to a personal health budget to all adults and children receiving NHS continuing healthcare for long-term conditions. The budgets can be used to pay for counselling, personal care and other therapies and equipment to support people in their home.

Mixed race children's needs

Mixed race children and young people are at greater risk of mental health problems because of greater difficulties in their lives, says a report from the National Children's Bureau.

Mixed Experiences reports the first-hand accounts of people of mixed race background growing up in the UK and elsewhere.

The report says not all mixed race children will have problems but that they do experience greater risks to their mental health because of their particular difficulties in finding an identity with which they feel comfortable.

According to official data, young people of mixed race are significantly over represented in the youth justice, child protection and the looked after systems. Research also suggests they are also potentially at greater risk of mental health problems as a result of poor self-esteem, hostile and rejecting relationships and discrimination from both black and white peers.

The report says that schools and public services in general need to be aware of this and develop ways of working with them that are sensitive to their needs.

But the accounts also show that mixed race children's resilience can be built by strong and supportive families. 'While adolescent experiences were often particularly difficult, with the mixed race young person frequently being the "out-grouper", by young adulthood many of these issues had been overcome, with more or less all the research participants feeling happy with their mixedness and proud to be who they are,' Co-author Dinah Morley says.

www.ncb.org.uk/what-we-do/publications

LSD eases end-of-life fears

A controversial form of therapy using LSD can help terminally ill people manage their fears about death, a new study has found. Patients with life-threatening illnesses and high levels of anxiety received two drug-assisted and six non-drug-assisted therapy sessions over two months. At the end of treatment, patients who received a 200mcg dose of LSD had improved by 20 per cent on measures of anxiety. Those receiving just 20mcg had got worse.

Journal of Nervous and Mental Disease

MUS service cost-effective

A specialist psychotherapy service that helps GPs support patients with medically unexplained symptoms (MUS) and complex needs improves outcomes and is cost-effective, a new report says.

The Primary Care Psychotherapy Consultation Service (PCPCS) is run by the Tavistock & Portman NHS Foundation Trust in Hackney. It offers training and support to GPs and a range of psychological therapies to patients. The Centre for Mental Health says the service improved the mental health of 75 per cent of patients and helped over half to recover significantly. It has also reduced demand on GP and hospital services.

www.centreformentalhealth.org.uk

YoungMinds launches 'medsite'

DIEGOCERVO/THINKSTOCK

YoungMinds has launched a website on mental health medication for young people aged 13-25.

In a survey conducted for the launch, 49 per cent of young people said they felt worried, 32 per cent felt scared and 26 per cent felt frightened when they were prescribed mental health medication. Half said they wanted more information about side effects.

HeadMeds is funded by Comic Relief and the Nominet Trust. Like the 'Talk to Frank' drug website, it gives information about potential side effects and answers to questions young people may not want to ask their GP.

The website is endorsed by the Royal College of General Practitioners and the College of Mental Health Pharmacy.

www.headmeds.org.uk

Psychotherapy 'adds value'

A review of published studies shows that psychotherapy 'adds value' to usual GP care for people with severe depression. The meta-analysis of 92 psychotherapy studies included CBT, IPT, psychodynamic therapy and non-directive counselling. Post-treatment, 62 per cent of the patients receiving psychotherapy no longer met the criteria for major depression, compared with 43 per cent of patients in the control conditions and 48 per cent of those in the care-as-usual conditions. The added value of psychotherapy over care-as-usual was calculated at 14 per cent.

Journal of Affective Disorders

Therapy Today.net

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Side by side with pain

Ruth Bridges

Counselling in cancer care often prompts a level of reflection that has a distinct gravity to it. Through almost 10 years, I have been privileged to accompany many clients as they have found – often battled – their way through some very dark and difficult places.

Some have been carers – Madeeha, for example, fighting hard to manage the emotional and physical demands of caring alongside a part-time job, yearning to redefine her sense of spirituality. Others, like Tom, have been negotiating their own illness. His battle was to reconcile his desire for security with an emerging sense of wanting to 'run away' while aching to connect with his teenage children in a way that felt more meaningful. I accompanied Alim until he died, negotiating and renegotiating the therapeutic process as his physical fragility slowly assumed a presence and permanence impossible to deny.

Many of my clients have entered freely, fully and courageously into a fierce questioning as the diagnosis of cancer has violently shattered the assumed predictability of life. These for me are deeply intimate and powerfully raw encounters that draw on the heart. I firmly believe that, if I am to accompany my clients with integrity and honesty and have the courage to truly listen, I have to face my own dark nights too – nights of considerable and disturbing awakening. Inevitably I meet my own shadows here, and I greatly value working with a personal therapist and a supervisor who are not afraid to meet me with the realness and the rawness of their humanity too.

> 'My work with clients who are witnessing their own dying surely demands that I acknowledge my mortality too'

I frequently have to challenge myself not to stand back or retreat and not to unconsciously use my reflective silence or meditative practices to try to hide from my own existential vulnerability. Accompanying clients who are facing the uniquely intimate grief of witnessing the pain and the process of their own dying surely demands that I acknowledge my mortality too. I am acutely aware that I witness a level of pain and fragility that is common to us all and one that I often do not wish (do not dare, perhaps) to truly acknowledge. When I think I am weeping for my clients, are my tears actually for me?

In practice, these are profound and acutely alive experiences that stand out sharply against the more muted background of the ordinary and everyday. Priorities may radically shift; old beliefs may shatter; others may evolve. Here the unvoiced often finds its way into expression; words may flow, uncensored, within the freedom to 'say it as it is'.

For me there are different rules here. Against the backdrop of significant and serious illness, the time and place of counselling can be unpredictable. Sessions may take place on hospital wards or in makeshift bedrooms, in chapel spaces or prayer rooms. Rigorous treatment regimes, with related fatigue and nausea, may make weekly counselling sessions impossible and the 'counselling hour' may feel far too long, or far too short. Emma found an hour too physically demanding, so we would work for 30–45 minutes, guided by her capacity. Harry, towards the end of his life, often asked for sessions of between one and two hours as he expressed and explored his anger, fear and pain with a level of courage and openness that I found quite breathtaking.

I offer a flexibility that, while upholding safe and ethical practice, reaches to the limits of these boundaries. I work with my clients to establish a pattern of meeting and a level of encounter that is manageable for them and that acknowledges their physicality and their emotional and spiritual processes.

I believe that counselling in this realm demands from me deep levels of strength, authenticity and compassion. I feel inspired, humbled, challenged and highly privileged to be invited to meet my clients in such intensely personal places. To capture the essence of these encounters in words on a page is clearly impossible. Fundamentally, this work demands expression of an entirely different form. ■

Names and details are entirely fictitious examples based on Ruth's work.

Ruth Bridges offers counselling in two Macmillan Cancer Centres and in private practice. She is a visiting lecturer for the MA in Clinical Counselling at the University of Chester and facilitates counselling courses in community education. Email ruthmbridges@hotmail.com

A different set of eyes

John Sampson

I'd been in prison for about five months. It was my first and only time. I'd suffered a breakdown a few years back and my mental health didn't get back to normal and I lost the plot. I was working every hour that God sends and trying to be at home with my partner and son and I was using cocaine as well. But I thought I was alright. I thought I wasn't that kind of person who has mental problems. I'm not from the UK and my family and community don't accept mental illness, so the stigma was hard for me. I was embarrassed to tell anyone I was in trouble.

I got sent down for affray and criminal damage. Prison didn't help at all. They stopped my antidepressant medication for the first two weeks and then they wouldn't give me the right kind and it was six weeks before they sorted it out.

When I came out I went straight back to work. I'd been a chef all my life and the team I worked with knew the trouble I was going through, so that was quite supportive. I lasted about two weeks. I realised I wasn't as well as I thought. I was back drinking again and using cocaine. So I took myself out of the situation before I got myself in such a bad way again. I pat myself on the back for that – that I was able to notice I was getting in the same state again. That was me opening my mind a bit more.

But then I started isolating myself. I was suffering badly with anxiety. I wouldn't leave the house all day. I was adamant that I was broken and I couldn't be fixed. After a few weeks my probation officer recommended the HOPE project to me. I thought it would look better for me on my probation record if I gave it a go. I never thought I would get out of it what I have.

It took me a few weeks to engage. It was the boxing that kept me here at first. I've always liked boxing since I was a young child. It's something I am dead serious about. So when I heard about the coaching sessions I pricked up my ears. It's one and a half hours a week – just fitness and pad and bag work. I began to open up after that.

They suggested I had counselling. I saw the project manager. She said, 'Just give it a try, you're not going to lose anything' and that first session I thought, 'It's not that bad.' I had tried counselling before a few years ago but it didn't help. I'd go there for an hour a week, let it out a bit and then go back out and take it all with me. At the HOPE project I was a bit more open-minded and I was more able to let it out and talk about things I had put on the back burner. I could look at my life with a different set of eyes. We met once a week for six weeks. I think it helped that I didn't just have the weekly sessions. The counsellor would follow up a few days after the session to see if I was alright, if there was anything bad about the session, anything that would make it easier for me to go to the next session. It made me feel a bit more special, that she was actually concerned about how I was feeling. I thought 'I'm a worthwhile person really' and that helped me open up more.

> 'I was more able to talk about things I had put on the back burner. I could look at my life with a different set of eyes'

I'd been thinking about CBT for a few years but there was always a long waiting list. Through the HOPE project I got a referral to another project offering eight weeks of CBT. I found that useful and I'm using it on a day to day basis. I was getting myself worked up over certain situations and I learned how to stop that. Instead of thinking the worst and getting worked up straight away, now I can stand further away and look at it from a different point of view and see what's actually happening.

It was my son's birthday recently. I can't see him because of the restraining order. Last year I got in a real mess but this year I could look at the situation and accept it. I just kept myself occupied with stuff.

I've been at the project about 18 months. It has changed my whole outlook on life and it's what I want to do now – to make the stigma of mental health easier for other people and change people's attitudes. They asked me if I'd stay on as a volunteer, working as a mentor for new clients, and now I'm in charge of all the other volunteers.

I've been attending the Recovery College at Prestwich Hospital in Manchester. I am hoping I can get enough qualifications to get a job in mental health. All the people teaching the courses have been through the mental health system themselves. I thought I'd never get a job like that but people who have had these problems themselves are best placed to teach other people about recovering from them. ■

John Sampson is a pseudonym.

The HOPE project (Hope Outside Prison Environments) in Manchester is run by Greater Manchester West Mental Health NHS Foundation Trust for people at risk of custody who have a mental health condition. www.gmw.nhs.uk/search/venue/hope-project-140

How to choose a supervisor

Rosie Dansey

There may be too much choice in society today but when it comes to choosing or changing a supervisor there may be no choice at all if an employer allocates the supervisor, or limited choice when an organisation or training course requires a supervisor to be chosen from an approved list.

However, in practice, it's usually possible to add a supervisor to the list if they meet the criteria of the college or organisation.

Even with free choice, there may be a limited range from which to choose in some parts of the country. Every therapist will have their own shopping list and you can start by searching websites but it is often more helpful to network with colleagues to get local information. Criteria may include gender, cultural background, modality, whether the supervisor is qualified/accredited/registered, years' experience and geography – how far do you want to travel? Phone or online supervision may be an option to consider here.

You may want to be challenged by working with someone from a different orientation or a different gender. Disabled access may be a factor. The choice is widest if you're seeking a white, middle-class supervisor. If you want someone from a different ethnic background or class, you will find it much harder. Academic qualifications may matter less to you than personal qualities but some therapists will choose the most qualified supervisor or look for depth or breadth of experience, or a strong theoretical or ethical background or someone known to be challenging. If you are working in a specialist field, do you need specialist supervision? Would a supervision group, facilitated or peer, offer the required level of support and challenge?

> 'Paradoxically, as I become more experienced I find I need more, not less, supervision'

Research[1] has shown the importance of the supervisory relationship. Do we pay as much attention to choosing a supervisor as we encourage clients to give when choosing their therapist? Many training courses provide little information about supervision and maybe the best way of learning about it is by experience. However, for some trainee therapists it will be a journey into the unknown; they may have little knowledge by which to evaluate the supervision experience. Also, the supervisee's previous experience of supervision in a work context may have been line management, which may influence their first encounter with a supervisor. I believe it is helpful for supervisors to suggest an introductory meeting with potential supervisees before contracting with them. I have found that some students are so keen to have a supervisor in place that they contract with the first supervisor available whose fees they can afford. This is understandable if one of the main criteria is the cost but a good supervision relationship can enhance the therapist's work with clients and their learning.

The relationship begins with the initial contact by telephone or email, when both the supervisor and supervisee can evaluate each other. With a more experienced therapist the supervision relationship is likely to be more collegiate. It is a two-way process: a potential supervisee may set alarm bells ringing for the supervisor. Some supervisors will not supervise people they have counselled. This is my practice, to keep firm boundaries, even though it has sometimes meant I have lost to another supervisor therapists with whom I would have loved to work.

I also believe in clear contracting. I prefer a written contract that states clearly whether the supervision is to be free-flowing or structured and sets out the responsibilities of supervisor and supervisee and the frequency of review sessions. I believe it is important to include whether the supervisor can be contacted by phone or email between sessions. The availability of phone contact has been important to me. I have only used it once in my career, for an ethical dilemma, but knowing I can phone my supervisor between sessions has felt like a lifeline. My supervisees too have not abused this contact and, again, it has usually been to discuss an ethical dilemma.

Perhaps paradoxically, as I become more experienced I find I need more, not less, supervision as I take on new challenges and I appreciate the BACP requirement for monthly supervision. In the US supervision rarely continues beyond a couple of years post-training[2] and I wonder how managing without this safety net affects practice. If you have views or experience of this, I'd like to hear from you. Please email rosiedansey@hotmail.com. ■

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Hard-wired for empathy?

Barry McInnes

It's interesting how new developments in human understanding can sometimes lead us to different or even new interpretations of old questions or phenomena. I've been reflecting on one of the cornerstones of therapy – namely, empathy. My musings have been prompted by the book *Neuro: the new brain sciences and the management of the mind*.[1] Its authors bravely attempt to map the neurological 'colonization' of the social and human sciences and provide a critical evaluation of a process that has seen the 'neurofication' of everything from psychiatry to economics. It's a dense, at times challenging but ultimately rewarding read.

Carl Rogers said of empathy: '... a high degree of empathy in a relationship is possibly the most potent and certainly one of the most potent factors in bringing about change and learning.'[2] He also believed that empathy is a way of being that can be learned from others, given the right conditions.

Empathy is so much part of the fabric of therapy that I realise that I've never actually questioned it. What is it? What purpose does it serve? Is there an optimum level of empathy? I have always seen a large part of my own journey in the world of therapy as being a way of making sense of the early experience of being mother's confidante – that my empathy was grown and finely tuned in a relationship from which there was no escape at the time. But I'm now beginning to wonder if I wasn't already hard-wired for empathy.

During my first counsellor training experiences I recall that we were encouraged to practise mirroring in role play, using our partner's communications through posture, gesture and voice to gain a sense of what it might be like to live inside their world. It now appears that there is a neurological basis for this practice.

The existence of a 'mirror-system' in the brain was discovered in the early 1990s, from the observation of macaque monkeys. It was noticed, using functional magnetic resonance imaging (fMRI), that neurons – so called 'mirror neurons' – in the same part of the brain were activated whether the monkeys were performing an action or simply watching the same action being performed by another. These same patterns have since been noted in humans.[3]

It appears that this mirroring not only applies to observing another perform an action but also to observing another experience an emotion. Chris Frith puts it thus: 'The idea that there is a mirror system in the brain arises from the observation that the same brain areas are activated when we observe another person experiencing an emotion as when we experience the same emotion ourselves.'[4] In other words, we can comprehend what other people are feeling not just through observation and inference – theorising – but through feeling what they feel – we literally 'feel their pain'.

It is suggested that mirror neurons serve a critical role in the phenomenon of 'social cognition'. This has been described as '... the processing of any information which culminates in the accurate perception of the dispositions and intentions of other individuals.'[5]

> 'In other words, we can comprehend what other people are feeling not just through observation but through feeling what they feel'

It isn't difficult to see the evolutionary advantages of such a capacity, and VS Ramachandran has even argued that the development of the mirror neuron system 'set the stage for the emergence, in early hominids, of a number of uniquely human abilities such as proto-language... empathy, "theory of other minds", and the ability to "adopt another's point of view"'.[6]

In contrast to the way that reduced mirror neuron activity appears to be associated with autism spectrum disorder,[4] might a highly active mirror system leave an individual so highly attuned to the distress of others that it becomes unbearable? Can too much empathy actually become a handicap? It would seem desirable that therapists not only have high empathic capacities but also the ability to regulate them when we need to, so as not to be overwhelmed. I have my own ways of doing that and I'm sure you have yours.

Maybe Carl Rogers was right in arguing that empathy can be learned. But I've now moved beyond thinking that the seeds for the development of my empathy were sown in the early maternal relationship. I have a feeling that they were already dormant in my genes, just waiting to germinate in preparation for some early mirroring. ■

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Should we have the right to die?

A Bill to legalise assisted suicide will shortly come before Parliament. Most people say they would like the choice to be helped to die. *Catherine Jackson* asks counsellors and palliative care specialists for their views

Later this year, MPs will debate a Bill to legalise assisted suicide. The Bill, drawn up by former Labour Lord Chancellor Lord Falconer, will allow doctors to prescribe a lethal dose of medication to terminally ill patients who have just six months to live. It will be voted on in the House of Lords before the summer and, if supported, will pass to the House of Commons. Conservative and Liberal Democrat MPs and peers have been given a free vote (their parties will not tell them which way to vote); the Prime Minister David Cameron and Deputy Prime Minister Nick Clegg have both said they will not back the Bill. Care Minister Norman Lamb has said he will. His view, he told Sky News in early March, is that relatives who want to help their loved one take their own life need legal protection against prosecution: 'Can we really be comfortable with a situation where people, acting out of compassion for a loved one who is dying, are left uncertain as to whether they will face prosecution?'

The Assisted Dying Bill is heavily hedged with safeguards. The person must be aged over 18, be registered by their doctor as having a terminal condition for which there is no cure, have only six months to live and have signed a declaration of their wish to end their life, witnessed by someone who is not a family member or involved in their care and countersigned by two doctors. It requires a 14-day 'cooling off' period before their doctor can prescribe the drugs. The drugs must be obtained by a doctor or nurse, who can prepare the medication and assist the person to take it, but cannot actively administer it and must sit with them until they have taken it and have died. If the person changes their mind, the health professional must take the drugs away and return them to the dispensing pharmacy.

Previous attempts to introduce a law permitting assisted suicide in England and Wales have failed, and commentators see little chance that this attempt will be any more successful. The death earlier this month of MSP Margo MacDonald is likely to bring to a close attempts to legalise assisted suicide in Scotland. MacDonald died of Parkinson's disease, and her long campaign to persuade her parliamentary colleagues to back her Assisted Suicide (Scotland) Bill was driven by her own determination that '... I should have the right to curtail my own, and my family's, suffering', as she told a BBC Scotland documentary in 2008.

But the majority of the public, in English and Wales at least, support assisted dying. In a YouGov/Dignity in Dying poll conducted in April 2013, 76 per cent of the 1,700 people questioned backed legalisation (just 12 per cent said no) and 72 per cent said they themselves would want to be able to choose to end their life (10 per cent said they would not). There was little difference between men and women and across the age groups: the least support was among the 18–24 age group and the most among those aged 40–59.

However, the British Medical Association, which represents doctors in the UK, is against all forms of assisted dying, as is the Church of England. The Royal College of Nursing has adopted a neutral stance, advising its members that they must act within the law and make clear to patients that they cannot assist them to die or help them obtain the means to end their own life. The Royal College of Psychiatrists has no policy on the issue.

Nor does BACP. But in its response to the consultation on the Assisted Dying Bill, it did propose that people considering assisted suicide should have access to independent person-centred counselling. 'We feel it would be an important additional safeguard for individuals to talk to a counsellor, who isn't a family member and isn't assessing them psychiatrically and has no vested interest in the outcome,' Nancy Rowland, Director of Research, Policy and Professional Practice, says. 'Counselling can provide a space where people can unpick their reasons and motivations. It's a different process from a psychiatric assessment. And there should be counselling for the family too. They may support the person's decision but afterwards have very difficult feelings.'

Current law and guidance

Currently assisted suicide is prohibited in the UK under the Suicide Act (1961) and is punishable by up to 14 years' imprisonment. However so-called mercy killings are rarely prosecuted. In 2009, following a Law Lords ruling in favour of Debbie Purdy, who had multiple sclerosis and wanted her husband to be able to take her abroad where she could be helped to die, the Director of Public Prosecutions (DPP) published guidance clarifying the circumstances when the Crown Prosecution Service might pursue a case. They include financial motive, mental competence, whether someone has a mental illness, and any suggestion that the person was persuaded or pressured into taking their own life.

Writing in *Therapy Today* in December 2009, solicitor and psychotherapist

Barbara Mitchels and counsellor Andrew Reeves explored the ethical and legal position of a counsellor whose client expresses an intention to take their own life because of degenerative illness. In their example, the counsellor respected the client's wish for confidentiality and informed no one. They highlighted the lack of guidance available to counsellors at that time on their liability to prosecution in such circumstances. The Assisted Dying Bill addresses this by making clear the circumstances in which it would be a crime to assist someone to die; it does not specifically create an offence of knowing that someone intends to take their own life and doing nothing to prevent it. So, as Reeves and Mitchels wrote in 2009: 'Ethical practice and the duty of care to clients still demand that client confidentiality is maintained wherever possible and appropriate and therapists must still pay careful attention to the current law, employment requirements, mental health policy expectations and the capacity of the client to make an informed choice about their living and dying.'

Assisted suicide is legal, under tightly prescribed circumstances, in Switzerland, Germany, the Netherlands, Luxembourg, Mexico and the US states of Oregon, Vermont, Montana and Washington. Voluntary euthanasia (where a doctor administers the lethal drugs on the patient's explicit request) is legal only in Belgium, the Netherlands and Luxembourg. Belgium also recently passed legislation allowing terminally ill children, under strictly defined circumstances, to choose euthanasia.

A small number of people from the UK have made arrangements to end their own life through Dignitas, the Swiss-based organisation whose motto is 'To live with dignity; to die with dignity'. According to Dignitas, just 244 people from the UK have used their help to die in Switzerland in the 16 years since it was founded, in May 1998. Indeed, the numbers have been falling year on year since 2009, apart from a spike in 2012.

This is a very pertinent point: to receive their help, the person must be a member of Dignitas, yet only 14 per cent of all those who join and, having completed all the necessary assessments by Swiss doctors and Dignitas itself, are given the 'green light' to obtain the lethal drugs on prescription, actually take their own life at Dignitas.

Fear of death

Writing in May 2013, in response to the YouGov poll, columnist and priest Giles Fraser explained why he opposes assisted death. 'People say they want to die quickly, painlessly in their sleep and without becoming a burden. Apparently this is what a good death now looks like… I do want to be a burden on my loved ones, just as I want them to be a burden on me – it's called looking after each together… Of course I will clean you up. Of course I will hold your hand in the long hours of the night… This is what it means to love you.' He went on: 'My problem with euthanasia is not that it is an immoral way to die, but that it has its roots in a fearful way to live.'

This is a message repeated by many of the counsellors and psychotherapists consulted for this article. 'People aren't necessarily afraid of death. It's the process of dying that frightens us,' says Judy Parkinson, counsellor and psychoanalytic psychotherapist who worked at the Royal Marsden Hospital with people with terminal cancer for many years. 'Some people who are dying want to feel in control of the process. They might feel they have lost all control, or a lot of it, of their physical body, of their relationships, that they are not in charge of their daily life any more because they are so ill. Therefore anything that gives them a sense that there is something they can do to be in control might be important to them.'

As a committed Christian she believes that only God can determine the right time to die. 'However, this is my own belief and I am respectful of people who either do not have a belief or who want to be able to discuss their own decisions about how and when they will die. We are considering an ethical and moral question here: one that is complex and also one that usually involves not only one person but all those who are in relation to that person – relatives, loved ones, those who look after the dying person in hospital and at home.'

Louis Heyse-Moore, a retired doctor, somatic experiencing practitioner and integrative psychosynthesis counsellor, spent much of his medical career in palliative care. As a doctor, he could never have assisted someone to die, he says: 'Medicine is so very much about doing no harm. To take someone's life just doesn't feel right to me.

'I would try to find ways of working with their distress. My question to a dying patient who talks to me about assisted death would be, "We can explore this and also we can explore what would be helpful to you right now – for example, relieving your pain and supporting you when you feel distressed. It's not just the talking,' he emphasises. 'Psychological and physical distress go hand in hand and

'In a way, suicide is "the last human right". The people who call us have lost some or all of what they consider to be quality of life. Who are we to judge what is the right quality of life for them?'

the one sets the other off in a spiral. To break the spiral you need to attend to the physical, psychological, social and the spiritual – their sense of who they are, whatever their beliefs – as Dame Cicely Saunders said. A person can lose their sense of meaning and fall into despair.'

Psychodrama psychotherapist Kate Kirk has worked extensively in palliative care with children and adults. Even when someone has made very clear plans to take their own life when their condition progresses to a certain point, suicide is very rare; very often the saying of it is enough to provide some relief, or they are struggling with an issue – pain, family problems – where they can be helped.

'It's about Erikson's eighth stage,' she says; 'integrity versus despair.' Erikson theorised that human life encompasses eight psychosocial stages, the last of which occurs in late life when we look back at what we have achieved. If there is any unfinished business, guilt or sense of failure, we are plunged into despair, depression and hopelessness. If we feel we have lived a successful life by our own standards, we attain what he called 'wisdom' – a state of closure and completeness, which enables us to accept death without fear. 'I often ask people to think what their obituary would say. Is there anything they haven't done yet and they can still do? Are there relationships that are still broken? It's about the integrity of knowing you have done everything you could have done versus the despair of not having done all these things,' Kate says. 'We should be working for a good ending. A person's life is their responsibility and ultimately we need to be respectful of their choice. But we need to address the feelings that might be influencing that choice.'

Talking about death

Dignitas argues that there is a taboo around suicide that is inconsistent with a culture and society that is based on self-determination. Sylvan Luley has been working with Dignitas as a volunteer for over 10 years and spends much of his time responding to telephone calls and emails from desperate people seeking help to end their suffering, whether physical or mental. 'People in our Western society want to be successful, lucky, healthy, in control of their life, fulfilling their wishes, reaching their goals, being respected, taken seriously, loved etc –Maslow's pyramid at its best,' he says. '"Being oneself" and "doing what one wants to do" are even considered a sign of strength and character, until it comes to the last part in life. Then, if the individual wants to have all this at the end of their life, there come all these doctors, politicians, pro-lifers, priests and so on saying "No you are not allowed to do this". Suddenly, the right to self-determination is withdrawn, as if someone who wishes to end his suffering is not competent. It's paternalistic. It's a contradiction. You are expected to be self-responsible and make rational decisions all your life and then, at the end, you are suddenly treated like a little child.'

The right to end your life is enshrined in European law, Luley points out. The European Court of Human Rights, in its decision no. 31322/07 of 20 January 2011, states: '... that the right of an individual to decide how and when to end his life, provided that said individual was in a position to make up his own mind in that respect and to take the appropriate action, was one aspect of the right to respect for private life under Article 8 of the Convention.'

'We seem to have forgotten that death is part of life,' Luley argues. 'In a way, suicide is the ultimate self-determination, "the last human right". The people who call us have lost some or all of what they consider to be quality of life. Who are we to judge what is the right quality of life for them? Do I want a doctor, psychiatrist, ethicist, priest, politician or whoever telling me whether I have to live and whether my life is still worth living? We at Dignitas take people as individuals. We try to discuss with them their problems that brought them to contact us in the first place and interestingly in these conversations people often find solutions themselves. Sometimes we can help them in finding doctors and therapists who are more open minded so they feel they and their wish to end their life are taken seriously.'

Judy Parkinson welcomes the debate in Parliament because she believes it will help people feel more able to talk about the issue. 'It can become part of our discourse about death as a society. It frees us to think and talk, and the effect of that may be that a patient is more able to talk to their friends and relatives and to feel freer and a lot of relief from that.'

Family distress

A family psychotherapist who has worked for over 30 years with families facing life-limiting conditions, clinical psychologist Jenny Altschuler, like Judy Parkinson, argues that the individual's decision to end their life affects many other people too, and very fundamentally. There can be significant psychological repercussions for family members and friends: 'What is missing in the Bill is is any consideration of the family.' She describes one woman with an advancing degenerative condition who decided to end her own life with the help of a friend because she didn't want to be dependent on her children. She didn't tell them. 'Some of the children said they respected her decision, that she wouldn't have wanted to live with increasing disability. But the young woman I saw had been much more involved in her mother's care and she was devastated: first that her mother hadn't trusted her enough to tell her; second, she felt she could have done something to avoid her taking her life if she had known, and third, she wished she could have known because there were things she wanted to say, to ask, to do. She was left with unfinished business. She felt rejected. It made her experience of mourning much more complicated.'

The subject of assisted death becomes even more complex where the person has a mental health problem, rather than

> ‘If someone is well supported they should be able to die naturally and, hopefully, without anxiety and fear... It’s part of life to go through the process of leaving it. We need to honour that’

a terminal physical illness. The Assisted Dying Bill covers only physical, terminal illnesses but in Switzerland assisted suicide is legal for any competent adult, regardless of their health; the key issue is the motive of the person assisting them. So people with severe and enduring mental illness can, in theory, access an assisted suicide and anyone assisting them will not be prosecuted, provided they are not going to profit from their death. In practice, however, very few psychiatrists are willing to provide the necessary in-depth report and only a Swiss psychiatrist can write the prescription for the lethal drug.

Rachel Freeth is a psychiatrist and person-centred psychotherapist in the UK. She says she can understand why so few people actually follow through with Dignitas. ‘I have known people who create a stockpile of drugs. It gives them a sense of control. They feel there is a way out; they do have the means. When people tell me that it doesn’t alarm me... I recognise that having some sense of control and power is very important. It’s the lack of power and control that perpetuates people feeling hopeless and disturbed and for me that is at the heart of the mental disturbance anyway.’

For her, to assist the suicide of someone with a mental health problem would be to abandon hope, to accept that there is nothing that can be done about the person’s own hopelessness. ‘Faced with utter despair I could understand the wish to want to help someone end their suffering, but it’s such a final ending. I would still see my job as a psychiatrist as about understanding a person’s despair and what has led to it and to try to support the development of hope. That is what we need to be challenging – that absence of hope. There is a culture of hopelessness among professionals working in very resource-strapped services and it’s very easy to get into that mindset because we feel hopeless about the services we are offering, the culture in society and levels of exclusion and stigma. I not infrequently feel quite hopeless but you need to be careful not to put that onto patients, not to let it influence how I am with patients who are feeling hopeless.

‘We as a profession need to do a lot more thinking about the nature of hope, what enables people to have hope and what leads people to feel so hopeless, and that is about understanding our culture and context. It’s not just about disease. It’s feeling wanted, a valued citizen; it’s about social inclusion... The wider aspects of people’s lives need attention.’

Dignitas says that no more than six people a year, on average, choose assisted death with Dignitas in order to end their suffering due to mental illness. Indeed, says Luley, Dignitas prevents far more suicides than it assists, which explains why it sees itself as a suicide and suicide attempt prevention service. ‘People with suicidal ideas tell us again and again, they have negative experience of being “treated” with medication, being sectioned, not being taken seriously, their GPs not having time to listen and so forth. It may sound absurd, but in order to successfully prevent suicide, and prevent the much higher number of suicide attempts, one has to upfront accept suicide as a fact, as one of a number of options humans can take as to end their own suffering. ‘

Honouring death

‘Our bottom line is suicide is OK but it should be an accompanied suicide, as Dignitas does it, which includes an evaluation of the reasons for suicide, discussion, time and involvement of the loved ones of the person who wants to go,’ Luley says. ‘We offer a space in which suffering people can discuss those issues. The counselling we do is very non-scientific, non-psychotherapeutic, non-psychiatric. Are palliative care experts afraid they will earn less money if a patient says, “Thank you doctor but no thank you. I would rather take a different route?” Is it the same for psychotherapists? Or is it an ego problem: “My patient does not need me any more and I cannot control his fate any more”? If you look deeper into the issue, there are signs of an unhealthy mix of money, paternalism, egos, conservative religious ideas, taboo.’

Soul midwife Felicity Warner’s work is all about accompanying people to the very end of life. She developed the profession some 20 years ago and there are now around 400 soul midwives in the UK and increasing numbers in the US and Australia. She works in hospices and as an independent practitioner with individual clients. Mostly, she says, they tend to be people who do not have a close family or social network. ‘The most important part of our work is listening, witnessing and hearing. It’s almost a priestly role.’ She shares Louis Heyse-Moore’s concern that more attention should be paid to the spiritual dimension. ‘Dying isn’t just a physical process. It’s psycho-spiritual. I don’t think we even have the vocabulary to talk about that. Even priests seem quite reluctant to talk about these issues.’

She has discussed assisted suicide with her soul midwife peers, and most, she says, would not feel able to sit with someone who was actively taking their own life. ‘We obviously work very strictly within the law, but we have discussed hypothetically what we would do if we were asked by someone to accompany them to Switzerland, to Dignitas. Some soul midwives said absolutely not and others that, if it were the person’s choice, it might be the right thing to do. But for me it goes against the ethos of soul midwifery and I would say 98 per cent of soul midwives would agree.’ To take one’s own life, however calmly and deliberately, is to artificially cut short a natural process, she argues. ‘We believe that if someone is well supported they should be able to surrender naturally to the process and die very naturally and, hopefully, with ease and without anxiety and fear. Obviously it can’t always be like that but that is what we hope to achieve. It’s part of life to go through the process of leaving it. We need to honour that.’ ■

Whatever happened to critical thinking?

Colin Feltham questions what he sees as a dearth of critical thinking in the counselling profession

Illustration by Mark Smith

For many years I have promoted the idea of thinking critically about the psychological therapies (and more broadly about human distress and the human condition), most recently in my books *Critical Thinking in Counselling and Psychotherapy*[1] and *Counselling and Counselling Psychology: A Critical Examination*.[2] Since the origins of BACP in 1970, we have seen many enthusiasms in the form of new schools of therapy, a great deal of professionalising in the form of ethics documents, training and supervision norms, accreditation procedures and statutory regulation, and a push for research activity. But the field still suffers, in my view, from insufficient critical thinking.

In this short article I want to explore three issues: first, the place of thinking and theorising in counselling; second, the neglect of and suspicions about such thinking, and third, areas in which critical thinking might suggest some priorities for our profession and beyond.

Thinking and theorising

We could begin by asking questions about thinking *per se* but that would take us into philosophical areas that many readers might believe to be irrelevant and that I lack the expertise to explicate rigorously. Pragmatically, let me begin instead by asking how tutors come to subscribe to and recommend certain theories of psychological therapy and how trainees are taught to evaluate the texts prescribed in course reading lists. It seems doubtful that many tutors of whatever academic or professional background devote years to sifting earnestly through therapy-related texts on theory and research before concluding, 'Yes, this one ticks all the boxes and can be recommended.' It is much more likely that the process that Daniel Kahneman refers to as the 'affect heuristic' is responsible.[3] In other words, those leading the promotion and training of therapy like, or are strongly emotionally influenced by, certain texts and related therapy experiences and, in falling under their sway, become relatively uncritical about them. This phenomenon has been referred to as belief-dependent realism but I think the term 'personality dependent realism' is more accurate.[4] Choice of and adherence to a therapeutic approach seems to be part of the powerful emotional faith that most counsellors invest in the therapeutic enterprise.

Now, it's also true that intra-professional promoters, tutors and researchers may commit themselves to *developing* their chosen approach on the basis of what may look like critical thinking, by adding certain concepts and references to research. But how often do we hear anyone pronouncing, 'I have

rigorously evaluated these claims and, since I find them wanting or defective, I have decided to abandon this approach'? Very rarely indeed, unless we include all those originally wedded to psychoanalytic practice principles who defected or created their own approaches (eg Jung, Perls, Ellis, Beck, Janov *et al*), having become disaffected with psychoanalysis. But why should early emotional investments in various therapies so rarely change significantly? Well, perhaps we have here not only an *emotional* path dependency but also a financial one, of sunk costs: unless you are paid to be objective regardless of where your thinking takes you, most cannot afford to abandon livelihood-related theoretical beliefs.

Most training is now academically validated in systems where it has always been an expectation that students will learn to think, discuss and write analytically and critically. Indeed, given the rise of doctoral demands in counselling, counselling psychology and psychotherapy training, we ostensibly expect high levels of rigorous critical thinking. We probably should ask what differences exist between undergraduate level (eg foundation degree) and doctoral level (eg PhD, doctorate in counselling, doctorate in counselling psychology, professional doctorate) training standards and how these impact on practice competency – but we don't. I am frequently surprised to read doctoral theses that, apart from obligatory discussions of the merits of qualitative methodologies and some Foucauldian or similar jargon, demonstrate somewhat superficial levels of critical thinking. Doctoral candidates mostly remain wedded to their beliefs, make micro-analyses of selected practice issues, and uncover little that is genuinely new.[5]

Once qualified and in practice, what kind of thinking do we expect from practitioners? Requirements for supervision, accreditation and continuing professional development entail a certain amount of clinical and ethical reflection, theory-into-practice case studies and engagement in self-chosen workshops, conferences and additional training. But there are no real markers of the level or originality of thinking expected: only the amount of activity and sometimes a justification of rationale. This may be due to BACP's well-intentioned, historical refusal to align training standards with higher academic levels but, even if this were to be mandated, as it is for the British Psychological Society, it would be no guarantee of rigorous, authentic, independent critical thinking*.

Neglect of critical thinking

It is natural to wonder if the faith-oriented, often emotion-loaded ethos of counselling is at odds with critical thinking. It has been argued that trainees need first to be immersed in therapeutic dogma before being encouraged to apply stringent and even radical analytical thinking to it.[6] Intellectualisation portrayed as a psychoanalytic defence mechanism may colour our views about the value and importance of thinking over emotional investment. Suspicions may be engendered by the Critical Parent of Transactional Analysis. The emphasis given in training to relational factors, to personal awareness and emotional openness, may discourage too much play being given to critical thinking. The well-known phrases 'He's so much in his head' or 'I asked you what you *feel*, not what you *think*' may militate against thinking. Even presumably more thinking-oriented CBT courses are likely to severely limit the free rein that could be given to fulsome critical thinking that sceptically challenges the very foundations of all therapeutic theory and outcome claims. And let's note too that passion and critical thinking are not necessarily mutually exclusive.

Those opposed to statutory regulation who were vocal in their arguments often discovered that the pro-regulation lobby simply refused to engage in the core arguments, as if an attitude of 'Of *course* we must have regulation' were self-evidently true. Try to engender a debate about whether or not supervision, or personal therapy in training, is necessary and you meet the same, or worse, kind of indignation, and an unwillingness to discuss the issue logically. This kind of non-engagement has been called 'ignoring [one's opponents] to death'.[7] Jeffrey Masson, who dared to rock the psychoanalytic establishment, was not ignored so much as vilified by many therapists, or his accusations that most therapists are abusive were derided or ignored. As a 'critical friend' of counselling and psychotherapy since 1992,[8] I am quite used to book reviews that offer bland pseudo-appreciation or identify minor faults rather than engaging seriously with the core issues raised. The irresistible picture that emerges is that critical thinking isn't wanted here, any more than Richard Dawkins is welcome in church. The response, 'We know therapy works and our traditions are sacred' may be backed up with predictably confirmatory research but that's usually the end of the discussion.

For some reason, empirical research has been elevated as the premier mode of analysis of theoretical and practice issues. Hundreds of postgraduate dissertations

'The emphasis given in training to relational factors, to personal awareness and emotional openness, may discourage too much play being given to critical thinking'

and theses now routinely investigate nuances of counselling phenomena and researchers confidently proclaim that the effectiveness debate stemming from the 1950s is over; the battle is won; 'We know therapy works.' But critics are far from satisfied that the research can ever get at the complex variable experiences of thousands of actual clients. Meanwhile much research tries to establish the most effective therapeutic ingredients, as if new, important practice variables are waiting to be discovered that will significantly improve therapeutic delivery. But who really believes that typical therapy practice will improve a great deal, indefinitely, or indeed that it has improved hugely across the last few decades? Can we even entertain an idea like 'the cure for depression' to compare with medical research into a cure for cancer?

Priorities for critical thinking

My hunch is that an article such as this will be regarded as a minor nuisance at best or waved aside with a dismissively humouring 'There he goes again' response. I meet relatively few in our field who believe we face serious problems of credibility, particularly since counselling and CBT have been established in the NHS. Therapy's critics remain a mixture of sociologists, journalists, philosophers, scientists, ex-clients and others who have variable motives and a not always accurate grasp of the field. Internal debates about and schisms around regulation, research, inter-approach wrangling and pluralism continue. But the pressures from critics don't go away; recent additions include that of the counselling psychologist Paul Moloney.[9] What are some of the main objections to therapeutic theories and practice, either perennial or topical, and what might be learned from these?

1. The field of the psychological therapies is somewhat detached from the question of, and research into, the deeply intertwined causes of widespread human distress. Therapy is something like a 100-year-old set of touted theories and practices at odds with each other yet all claiming to identify the key (intrapsychic and interpersonal) causes of distress and to bring significant and lasting relief via disciplined listening and talking. Would it be too much to ask for an attempt to produce an interdisciplinary and coherent picture of the probable causes of mental distress, to include genetic, neurological, socioeconomic, individual-developmental and other inputs?
2. Is it credible and inevitable that we have hundreds of different and competing therapeutic theories? On top of that we have eclecticism, integrationism, pluralism and unification – that is, different but indeterminate bids to link, blend or rationalise diverse therapies. We could produce a theory of the underlying causes of such multiplicity; we could investigate the problems caused by this fragmentation; we could also philosophically analyse the possible merits of this proliferation. But we don't. Instead new approaches are constantly invented, unchecked. Why? And what prevents greater co-operation rather than such sprawling creation?
3. It suits us to see research conducted into outcomes, usually by insiders of the psychological professions, that always happens to confirm the effectiveness of therapy, seemingly regardless of the approach being investigated. Yet much anecdote, the reservations of some psychologists and sociologists, client publications and ex-client websites (eg www.therapyabuse.org; www.trytherapyfree.workpress.com; www.debunkingprimaltherapy.org) suggest that significant levels of dissatisfaction persist. Is it ethical to rest on the laurels of still questionable research?
4. If we accept, or put aside, some of the above 'messiness' of the field, we are still confronted with a reality of unknown numbers of clients with a variety of personal problems being seen by thousands of practitioners in different settings, each of whom has trained in various, often incompatible theories and associated skills, and who bear different professional titles. Many therapeutic outcomes may be modest or indeterminate rather than wholly successful. We do not ask who make the best therapists (practitioners are self-selecting) but we know the majority of counsellors are women. Are there no significant questions for us here?
5. Related closely to the above is the problem of training courses turning out far greater numbers of practitioners annually than there are employment openings, and probably many more than can find enough clients to provide a living in private practice. Many therapists continue to practise into late life, which also reduces work available for younger qualified practitioners. This problem has economic and ethical dimensions (the over-selling of training); it has been raised over the years but has received almost no critical attention or action. I have even heard it said that this is not a topic for serious critical thinking, compared with supposedly more intellectually worthy questions. Who will take this question on?
6. Our field has neglected inputs and criticisms from evolutionary, genetic and political analysts of the human condition. This is probably due to a combination of sincere opposition to those proffered aetiologies and also

'One conclusion we might come to is that the complexity and messiness of the therapy world simply reflects the human condition... we're all just doing our limited best'

to the urgent, practical orientation of most therapists, whose business is primarily interpersonal and clinical rather than intellectual in nature. Critical psychologists are usually well informed politically and invariably oppose physical treatments but they are often critical of low levels of political engagement among counsellors. Many therapists have humanistic affiliations and spiritual inclinations and oppose medical interventions with people suffering from psychological distress. Is there some sort of unarticulated pro-science vs pro-spiritual vs pro-political dynamic at work here? Contrary to person-centred claims to a 'quiet revolution', might not most therapy constitute a rather conservative, indeed collusive, anti-revolutionary quietism?[10]

7. Somewhat in contrast to the above point, we see an emergence of climate change engendered models of ecotherapy. This development seems to show that at least some therapists are seriously engaged with the threat of climate change and the need for a radical psychological change to meet its challenges. But here we have disagreement, many also arguing that the business of therapy must only reflect what the individual client brings, that we are practitioners involved in deep therapeutic relationship work, we are not social activists. Can there be any consensus on these matters?

We could certainly add more critiques. One conclusion we might come to is that the complexity and messiness of the therapy world simply reflects the human condition. No one can know everything or cover all angles; no one is an enlightened saint or fully-functioning person; we're all just doing our limited best. Marie Adams' book *The Myth of the Untroubled Therapist*,[11] based on her own doctoral research, shows that therapists are probably no more free of depression, anxiety, relationship problems, illness and physical pain than anyone else, although they presumably retain sufficient skill and discipline to attend meaningfully to others' distress. But would we equally accept that the entire 'profession' of therapy can be described in terms of this myth of the profession that understands and addresses all psychological distress successfully?

James Joyce referred to us as 'unhappitants of the earth'[12] and Samuel Beckett declared, 'You're on earth; there's no cure for that.'[13] A growing band of depressive realists argue that life is fairly grim, a struggle that ends in death, and that this view should not be pathologised as merely a projective cognitive distortion of depressed individuals. This is the tragic view about common unhappiness that Freud shared, while humanistic therapists tend to hold a romantic view of inevitable progress and CBT folk hold fast to an ever-upward problem-solving optimism. Could we even see a humanistic-CBT truce soon, as former antagonists agree on a pro-positive psychology agenda? It's quite possible that counselling and psychotherapy (the enduring dichotomy of these names reveals a central problem) will never achieve a consensus of views, language and practice. Not only do we suffer periodically or incessantly as human beings; we also generate endless social and professional absurdities and impasses, and seem unable to resolve these. Indeed, we seem to have little appetite even to discuss them. Discuss? ■

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**Editor's note: BACP supported the development of the Quality Assurance Agency's (QAA) subject benchmarks for counselling and psychotherapy (QAA, 2013) and its professional Education and Development Forum (PEDF) is currently devising training guidance. The QAA benchmarks apply to Level 6 and 7 HE courses but can inform curriculum development across all practitioner training. An interplay between criticality, skills capacity and reflexivity, thereby facilitating trainees to advance a profession in which criticality underpins theory, research, training and practice.*

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'The irresistible picture that emerges is that critical thinking isn't wanted here, any more than Richard Dawkins is welcome in church'

Talking point
Challenging racism in our ranks

Kris Black and Suzanne Keys invite BACP to join in the conversation about racism in the profession

The conversation between Eugene Ellis and Niki Cooper in the December 2013 *Therapy Today* was a welcome start to a more widespread conversation on diversity and equality. As Eugene and Niki argue, honesty and openness about the uncomfortable subject of racism in training are indeed needed, as is learning new 'invitational' ways of thinking and being in training and in the therapy room so that the experience of people who identify as black or minority ethnic (BME) is recognised, acknowledged, taken seriously and included. Changes are needed in training curricula, facilitation and counselling theory. We agree and re-iterate their argument that we need to find a language and theory to voice the previously unspeakable in terms of the collective experience of racism.

It is shocking that many current trainings do not address these issues adequately and that black trainees often report feeling silenced and invisible, leading to many giving up on the counselling profession. Inadequate training in these issues not only alienates BME students but also, worryingly, means that many counsellors are ill-equipped to deal with the dynamics of difference in the counselling room. The risk of re-traumatising BME clients is real, through counsellor ignorance of their own identity construction, and the impact of racism contributes to this. If we cannot recognise racism within our own profession and training programmes, how can we hope to hear or understand the experience of clients?

In May 2013 the Psychotherapists and Counsellors for Social Responsibility (PCSR) organised a conference titled 'Taboo!' to open up an honest exploration of race, gender and sexual minority issues within the profession. We looked at the implications of discrimination and prejudice and how we are all affected by racism and homophobia.

Following the conference, a sub-group wrote an open letter to more than 170 training and accrediting counselling and psychotherapy organisations, including BACP. The open letter calls on the psy-professions to take action to address prejudice and discrimination, particularly within training, and ensure meaningful change – ie not the tick box, one-off diversity module on a training programme approach but action that *truly* addresses the discrimination experienced in the profession and in society as a whole.

We received just three responses. We are still waiting for a response from BACP. A petition was started at http://chn.ge/1c219Qx and currently has over 650 signatures. The comments there provide further evidence, if any is needed, of just how widespread the experience of discrimination is within the psy-professions and why change is needed.

In the *Therapy Today* article Eugene Ellis writes: 'There is a conversation to be had and it hasn't, for the most part, even started.' We would like to add some questions for consideration. Where is BACP in this conversation? Where is the gold standard of training/guidelines that enable these issues to be addressed? Where is the support for new language and theory to challenge the mono-cultural assumptions and discrimination embedded in our profession? Where are the standards requiring cultural competencies in training and accreditation processes? How does BACP monitor equality of opportunity and outcome on training courses? How does BACP account for the lack of representation of BME students and trainers within its membership? How is BACP communicating these concerns to members [***Editor's note**: partly through encouraging debate in Therapy Today*] or addressing its own unconscious bias or legal obligations under the Equalities Act 2010?

The Black and Asian Therapists' Network (www.baatn.org.uk) has initiated a regular trainers forum. At its inaugural meeting in January 2014 at the City Lit Institute in London, it was clear that, for many of us, this was the first time we'd felt welcomed, encouraged, supported and resourced to explore racism, prejudice and discrimination in training.

BAATN is a wonderful network and resource but expecting survivors of a flawed system to identify needed change potentially adds insult to injury. We look forward to these vital conversations happening in a meaningful way with and within BACP. Such conversations require humility, empathy and courage – core moral qualities embedded within the BACP *Ethical Framework*. ■

Kris Black MBACP, UKCP is a member of the PCSR steering group, and an integrative arts psychotherapist and supervisor in training. Suzanne Keys MBACP is a member of the PCSR steering group and a counselling diploma trainer at the City Lit Institute, London.

When the bully is a fellow therapist

Therapists often work with the victims of bullying, but what if the bullied and the bully are both therapists? *Werner Kierski and Jessica Johns-Green* explore a rarely discussed issue *Illustration by Mark Smith*

Therapists work at the coalface of mental and emotional health. Workplace bullying is among the many issues that our clients bring to us.

There is no universal definition of bullying[1] but there are clear psychological and physical risks associated with it. According to a report from the Royal College of Psychiatrists,[2] they include 'frequent illnesses such as viral infections, headaches/migraines, tiredness, exhaustion, constant fatigue, sleeplessness, nightmares, waking early, irritable bowel syndrome, poor concentration, forgetfulness, panic attacks, sweating, trembling, shaking, tearfulness, lethargy, anger and low self-esteem'.

Potentially, workplace bullying can affect anyone, regardless of occupation or profession. In recent years the media has reported numerous incidents across all professions, occupations and grades, from the shop-floor worker to the City financier. The Dignity at Work website cites research showing that 80 per cent of managers, across all industries, admit that bullying takes place in their organisation.[3] It has to be assumed, therefore, that victims will also include counsellors, therapists and psychologists working in therapy and healthcare services. In this article we explore this possibility and describe some of the experiences of workplace bullying reported to us by therapists.

The therapist as bully

Professionals working in health and social care are expected to adhere to ethical principles. Expectations are no longer implicit; they are written in charters, codes and criteria for clinical practice, the ethical basis of which is based on clinical experience, public expectations and guiding principles that prioritise the wellbeing of clients.

Criteria for good practice among practitioners – standards for how we treat one another in the profession – are less explicit and much of what we expect of one another as professionals performing self-reflective, caring roles remains implicit. What can be said, in our view, is that our expectations that fellow practitioners will behave in reasonable, sensitive or respectful ways towards each other are not necessarily prioritised by our professional and regulatory bodies.

What if it is the therapist rather than the client who suffers bullying? What if the workplace of the therapist is exposing him or her to bullying that eventually affects their client work?

Both of us have either witnessed or experienced bullying while working as therapists. Almost by accident, over a lunchtime meeting, we discussed how we had discovered the existence of workplace bullying in therapy workplaces. One of us had experienced it as a senior counsellor in a counselling service; the other witnessed it as a trainee on placement in a forensic mental health team. We wondered whether our experiences were isolated events or whether other practitioners had experienced it too.

When we asked other therapists about their experiences of workplace bullying we received a number of personal accounts. There was a shared desire among those who responded to raise awareness about the issue. This exploration of workplace bullying in the therapy profession will draw on a number of these experiences of bullying reported to us (all names have been changed to ensure anonymity).

As we further explored the topic, we discovered that there is no research into bullying in our field. Nevertheless, one source sheds light on bullying in a related mental health profession – that of psychiatric trainees in the West Midlands. Hoosen and Callaghan[4] report that an astonishing 47 per cent of these trainees had felt bullied. Freeth's recently published account of bullying in the NHS[5] adds an additional personal note to this topic as she describes her own experience of aggressive management. Discussions in *Therapy Today*[6] and letters to the editor in *The Psychologist*[7,8] have asked if unpaid placements deter people from a wider range of socio-economic backgrounds from entering the profession and whether this practice is abusive in taking advantage of a highly competitive field to justify unpaid work. It is a pattern that can help to establish an overly self-sacrificing approach in the profession.

Considering the thousands who work as therapists, counsellors and psychologists, and our professional understanding of workplace bullying, it is curious that this issue should be ignored. How come we don't hear about it more? Could the absence of discussion be linked with the professional identity that belongs to our specific line of work? Young, Klosko and Weishaar[9] and Young[10] believe that 'self-sacrifice', 'unrelenting standards' and 'emotional deprivation' are common among therapists. Emotional deprivation is the belief that your emotional needs will not be met by others: that you won't be nurtured, understood or protected. Self-sacrifice as well as subjugation relates to an excessive focus on the needs of others to avoid feeling guilty or to maintain connection. Unrelenting standards give rise to the belief that you must meet excessively high standards, often to avoid criticism.

Young and colleagues propose that schemas can function as a mechanism to mediate negative emotions caused

‘Rachel, who experienced bullying from a supervisor while on placement, said: “It’s almost taboo and we are not encouraged to speak about it”’

by other schemas. In other words, therapists are potentially people who have an excessive focus on others, hold unrealistic standards and believe that, generally, they will be hurt in relationships. No one expects therapists to be immune from unhelpful beliefs or behaviour patterns,[11] but surely, with our understanding of the factors affecting relationships and our knowledge that therapists might have issues that could negatively affect interpersonal interactions, we should be more self-aware as a profession?

Why do we do it?

Sue, a trainer who experienced bullying after she challenged sexual intimidation, referred to a behaviour pattern to which therapists subscribe: ‘This field is about taking responsibility for your own feelings, therefore no complaints.’ Others had theories about why we don’t look at bullying within our profession more closely. Rachel, who experienced bullying from a supervisor while on placement, said: ‘It’s almost taboo and we are not encouraged to speak about it.’

Emma: ‘I wonder whether bullying within the helping professions is like mental distress and illness within helping professions: “Oh that doesn’t happen to us, we’re trained not to let it.” It’s like a defence; we (as a profession and as individuals within it) can’t admit to possessing the potential for certain qualities/behaviours. We like to think those things aren’t a part of us, when actually they’re in everyone. This makes bullying harder to recognise, as it seems so alien and so opposite to what we see ourselves as representing. It makes it harder to approach, as there might be an implicit assumption that we can avoid it happening altogether, or we have the resources to deal with it on our own if it does happen. Maybe our own curiosity/analytical thinking styles as psychologists make us believe we are overthinking things and turning them into something they’re not. Or we overthink the possible consequences of doing something about it, and so choose not to.’

Ellen described a pervasive pattern of bullying in her role as manager of a counselling department. She felt angry and demoralised when her manager began to exclude her from meetings without telling her and when he challenged her in front of others on matters of team performance without discussing it with her beforehand. All this caused her to doubt herself as a manager. Natasha was bullied when a trainee and was so stressed by it that she was prescribed beta-blockers. Rachel was also bullied by a supervisor and wondered if the supervisor’s own insecurities could play a part in the bullying behaviour.

Sue: ‘They are very clever and understand how emotional things work, and they know how to manipulate you and still smile.’

The emotional and mental effect of bullying on therapists is particularly problematic because a therapist’s emotional and mental health can determine their ability to engage therapeutically with clients. It is not just our own wellbeing that is at stake but that of our clients as well. The impact of bullying can seriously undermine a therapist’s capacity to work with clients and deal with their distress. Yet there is little evidence that the strain that therapists are under is being addressed, even in supervision.

Young and colleagues[9] write about patients and therapists whose schemas collide in a dysfunctional manner, making it difficult, if not impossible, to work together. Perhaps when two therapists meet their own schemas can be triggered and showing weakness is frightening, giving rise to difficult relationships at work, and even bullying.

A recent Austrian study of the risks of psychotherapy[12] found that negative side effects in therapy may be higher than you might think. The main drivers behind these negative side effects are interpersonal difficulties between therapist and client. Considering the potential effects of bullying on the mental wellbeing of the therapist, bullying can thus enter the therapeutic space and cause damage. For example, the therapist may be preoccupied or stressed by antagonistic and undermining behaviour at the hands of managers or colleagues.

Bullying in organisations

An important issue is what goes on when bullying occurs in an organisation. Klein and Martin[1] point out that bullies tend to manipulate organisations into thinking that they, the bullies, are the victims. This would allow them to claim that their actions are a defence rather than a damaging way of dealing with people. This is why we think that the complexity of bullying patterns is on a par with the coercive patterns found in other abusive relationships.

Mary: ‘My first experience of bullying in counselling was during my training… I made a formal complaint to the manager of the course… Counsellors are far too concerned with being nice, being liked and being professional, whatever that means. Very often this makes them treacherous… [they] have learned to manipulate people.’

Still, bullying is poorly defined and it can be particularly difficult to ascertain

‘Counsellors are far too concerned with being nice, being liked and being professional. Very often this makes them treacherous... [they] have learned to manipulate people’

who is at fault – who is bullying whom. It is conceivable that, because of their professional identity, therapists may find the experience of being bullied too difficult to handle. Additionally, therapists could be too focused on the needs of the other, including those of the bully. We received several accounts of being bullied by a supervisor or line manager where the problem was pinned on the victim, with claims that it was their behaviour that made the workplace difficult. This creates a difficult dynamic where a lack of clarity about who is the victim could easily trigger schemas leading the therapist to overly focus on the bully’s feelings or try to meet their high standards.

Two other studies into workplace bullying, one from the US,[13] the other European,[14] highlight a surprising trend when looking at the gender constellation in bullying. The European study, in which over 21,000 Europeans in different countries participated, showed that the risk of bullying by your manager is greater if your boss is female. Co-author Maija Lyly-Yrjänäinen, a research officer at Eurofound, suggested that this may be because female managers have often spent a long time on a lower rung of the career ladder and, when put in charge of people, may struggle to handle conflict.[14] Women also could be seen broadly to use more subtle, passive means of dealing with conflict and may struggle with assertive behaviours. In the workplace, in a male-dominated profession, this could create an atmosphere of mistrust at best or, at worst, bullying.

The US study found that the US workplace is becoming more toxic for women as the rate of bullying by females on females has risen from 71 per cent to 80 per cent. These findings are worrying for the therapy profession because it is predominantly female.

Some of our respondents also saw being female as a factor in bullying.

Beth: ‘I wonder how much of it had to do with [female manager’s] personality, or even my own? I know competition and ambition can make people behave in strange ways, and in psychology there is a lot of competition for promotion/training places. I don’t think, as a profession, this is acknowledged in terms of the impact it can have on dynamics and working relationships.’

All the therapists we spoke to believed that training institutions, accrediting bodies and mental health care employers need to pay more attention to this issue. Many reported feeling unsupported by their professional body. Rachel, as a clinical psychology trainee, felt trapped when bullied on a placement. She felt that if she complained to her supervisor she would risk getting a poor review, but if she complained to the university her career would be in jeopardy.

We believe there should be more discussion about the issue of bullying within the profession, more support for victims, that regulatory bodies should set clear standards around bullying behaviours, and there needs to be more research. Klein suggests using more stringent assessment methods, such as those used by domestic violence agencies. These methods rely on an attitude of ‘sceptical empathy’ and the use of screening tools that are less open to manipulation.

We would suggest that our privileged understanding of relationships as a profession demands a closer look at this phenomenon. ■

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Setting up in private practice

Setting up in private practice can be a challenge for most counsellors as few receive any guidance in their training, write *Fiona Starr and Karen Ciclitira*
Illustration by Mark Smith

'Am I meant to be a businesswoman too?' This cry from the heart is from one of the participants who attended our BACP-endorsed CPD course that we ran at the British Psychological Society offices in East London in September 2013. The course focused on all aspects of setting up and working in independent practice.

Participants were mainly counsellors, counselling psychologists and clinical psychologists, and brought varied issues. One was looking for a good accountant; another was thinking about the pros and cons of building work to create a group practice space in her home; another was struggling with boundary issues and whether she could take referrals from an older relative who had known her since she was in nappies!

We have been working together as psychology lecturers at Middlesex University since 1999. Karen is a psychoanalytic psychotherapist working with adults; before she did her clinical training she worked in public relations, marketing and business for many years. I am a clinical psychologist working with young people and their families. We were both appointed 15 years ago to half-time posts at Middlesex University and have developed an excellent working relationship over this time. We have enjoyed debating and learning about the differences in our theoretical approaches and our teaching styles. We have been somewhat surprised to discover more commonalities than differences in our approaches to therapeutic work, and over this time our individual private practices have developed significantly. I left the NHS in 2000 after the birth of my first son, finding it too difficult to balance a half-time NHS post with a half-time university post and family life, and developed my own independent practice while working in academia and gaining a postgraduate teaching qualification (PGCert). Karen has gained a BSc and a PhD in psychology and a PGCert in Higher Education since leaving the business world. She subsequently trained in psychoanalytic psychotherapy and developed her own independent practice while also working in academia.

Over many years and too many cups of coffee we discussed the dilemmas of working in independent practice and talked to numerous colleagues in psychotherapy, counselling, psychiatry and psychology who felt equally ignorant

and, at times, fearful of working privately. Which is why we decided to a) conduct some research into the whole area of working in the independent sector and b) set up a series of training courses on 'Working towards independence – why and how to establish a private therapy practice'.

Working in the independent sector

The NHS pays the training costs for clinical psychologists and psychiatrists. It is hardly surprising therefore that no time is given in their training curricula to learning about how to set up in independent practice. Yet the subject is absent too from the majority of counselling, psychotherapy and psychoanalytic trainings, which are mostly self-funded by the student. This lack of knowledge can lead to risky practice for clients and it can also leave clinicians in a vulnerable position.

Some may seek help from books, such as Rob Bor and Anne Stokes' *Setting Up in Independent Practice: a handbook for counsellors, therapists and psychologists*.[1] While this kind of text is a good starting point, there is nothing better for boosting confidence and reducing isolation than meeting other people who are in the same boat and struggling with the same issues. Karen and I each came to this realisation after several years and separately booked ourselves onto different courses about working in the independent sector. We gained a lot of support and information on the subject and the experience enhanced our own thinking and practice. Yet, aside from the small cohort taking the course, we still had no overview of independent practice. What kind of therapists are out there? How many work independently? How do they practise? Where do they practise? What fees do they charge? So we looked into the existing research on these subjects – and found very little.

Peer reviewed UK-based research on working as a counsellor or psychologist in independent practice is scant. No doubt this is due to funding constraints, moral and ethical dilemmas, and the absence of infrastructure generally in the independent sector for conducting such research. Some suggest that, for psychologists at least, the stigma of working in independent practice has prevented research and public discussions about independent practice. The prevailing opinion, again in the psychology profession, seems to be that independent work is less worthwhile, that it bleeds the public sector of talent and funding and that independent practitioners are likely to be out of touch, incompetent, of poorer quality and on the fringe.[2]

There now seems to be a realisation that this work is going on out there with little or no understanding of who is doing what, where and how. Both BACP[3] and the British Association for Behavioural and Cognitive Psychotherapy (BABCP)[4] have recently conducted surveys about the work of their independent practitioner members. Until this year, the BPS had not conducted such a study. There exists no peer-reviewed research chronicling the practices of UK registered psychologists and therapists in independent practice.

We conducted our own research with members of the BPS independent practitioners (ip-prac) forum.[5] We surveyed 108 out of a possible 450 independent practitioners and found that levels of satisfaction across 15 domains, including salary, colleagues, supervision and training of others and being valued, were generally claimed to be higher in the independent sector than in the public sector. Reasons given for greater satisfaction were occupational autonomy, the physical working environment, the sense of being valued, the variety of work and the opportunity for professional development.

To get an overview, we asked how other independent practitioners run their practices. We found that a majority of respondents (84 per cent, n=92) see individual clients and groups of clients across a wide age range. About a third conduct organisational consultancy, medico-legal work (62 per cent, n=67), and training (45 per cent, n=48.6). The largest number (54 per cent, n=58) work in rented consulting rooms, and in other locations, such as solicitors' offices, schools and social services, as required.

It is essential to have regular supervision on all aspects of client work,[6] especially in the independent sector where there are no institutional systems in place to support, monitor and develop practice. Most practitioners who responded to our survey received peer supervision (n=47, 43.9 per cent), for which they did not pay; 35.5 per cent (n=38) paid for monthly supervision and 3.7 per cent (n=four) paid for supervision once a week. But an equal number (n=4) reported that they had no supervision at all. Other supervision consisted of consulting others when necessary, mentoring and rotating supervision between four colleagues.

Most were conscientious about updating their skills. Just over 78 per cent (n=85) attended CPD courses run by the BPS and other professional bodies. Respondents also listed attending conferences, writing books, giving and writing research papers, and participation in the ip-prac network itself as CPD.

We have recently secured funding for phase two of the study. We will be conducting qualitative interviews with independent practitioners to explore in more depth particular aspects of the work and meanings and experiences that affect us all. We have also made some practical recommendations to the BPS – which may equally apply to BACP – about what might assist its members when setting up as independent practitioners. They include increasing opportunities for local networking, conferences and trainings, setting up an independent practice helpline, establishing awards specifically for people in independent practice and promoting different ways of working, such as renting or providing shared practice space and creating training and working hubs – which would also address the problem of isolation raised by respondents to our survey.

Independent practitioners are now being forced to undertake more complex work and need guidance on a range of matters. There may be potential for the umbrella organisations like BACP, BPS, BABCP, the British Psychoanalytic Council and the UK Council for Psychotherapy to work together on this.

Working towards independence

With this research and drawing on our own experiences, a plan began to emerge. We both hold postgraduate teaching qualifications, we had always received good feedback from students, and we know a lot about working in the independent sector – surely we should develop trainings on working in independent practice for our colleagues? As Karen was a member of BACP and impressed with its services, we decided to develop a course that targeted BACP members as well as psychologists. We designed the course and went through the rigorous and helpful BACP route to have it endorsed. After painful amounts of networking and advertising, the first of four courses was a great success. There were 15 participants, which was the perfect size to obtain a level of trust and intimacy without being so small that we ran dry.

The course was a chance to introduce newbies and more experienced

'There is nothing better for boosting confidence and reducing isolation than meeting other people who are in the same boat and struggling with the same issues'

practitioners who were on the point of leaving the public sector to the ideas and practicalities of independent practice. They came from the Midlands, Norfolk, Suffolk, Kent and London.

Throughout the day participants shared their personal concerns about private practice. We defined and described the essential ingredients. Participants learnt about the business aspects of independent work, like tax, fees and marketing, which are usually left to individuals to work out through trial and error. Everyone was relieved to discuss these details openly. We were able to network with like-minded colleagues. Private work can be isolating; without access to networking and modelling, it can be hard to continue to develop skills. Towards the end of the session we each identified goals for moving on. Participants felt it was too easy to plateau when working outside of systemic and managerial hierarchies, however experienced you might be.

Feedback showed that course participants were extremely pleased with the practical information, that they had used the space to think through the main tensions and dilemmas, and that they ultimately felt more confident about working privately in what, for most people leaving the public sector, is a new and unprotected world.

There was some discomfort with and discussion about therapy, counselling and dealing with human distress as a 'profitable business'. This tension affects all independent therapists, and has an influence on decisions about how much to charge and professional confidence. After some consideration, participants seemed able to sit with this tension and supported each other to do so. We concluded that helping people in distress and charging for this service *can* co-exist for the benefit of the individual and for society. Karen and I will be exploring this aspect of independent work in more depth in our follow-up study.

The future

Rob Bor and Anne Stokes suggest that businesses fail as a result of failure to change and adapt to the market, inadequate marketing and cash flow, bad debts, wasting resources and other, personal reasons.[1] Some of these issues were touched on in the course, and there was particular interest in the future of therapy in an online world. We also discussed Skype and email therapy.

The course ended with some thinking around targets and plans for the future. Again the collaboration between participants was extremely helpful in working this out. In the feedback forms attendees told us how much they valued the collegiate approach that Karen and I facilitated. We learnt something from our colleagues, as is nearly always the case in teaching and in therapy. We were also pleased to have contributed and to have been able to share some of our practical and research knowledge and use our teaching expertise. We are now planning the next course in 2014. ■

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Fiona and Karen are repeating the course, 'Working towards independence – why and how to establish a private therapy practice' in September 2014.

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Inside story: working in a women's prison

Having worked as a counsellor in a women's prison, *John Fletcher* explains why he supports BACP's campaign to find better alternatives to custody for female offenders

Four years ago, I began a two-year placement in a women's prison as an honorary counsellor with a small, prison-based charity. It was by far the most profound experience in my 16 years of practice as a person-centred therapist. I was touched and moved in ways that no other counselling experience has ever come near, before or since. I am still trying to understand why.

Other professionals have reported being similarly affected. Liebling[1] described the effects on her team as they carried out their two-year research project in prisons. Her staff were tempted 'to drink and smoke more than usual, listen to extra loud music, drive too fast and resort to other stress-related behaviours'. Like me, they also turned to books and reflection to try to understand what really happened and why it felt so 'emotionally turbulent'.

I emerged from the experience firmly convinced that, for the vast majority of women offenders, prison is a completely inappropriate sanction that does not work, is unnecessarily punitive given the nature of their offending, and needlessly inflicts suffering and distress on children through the enforced separation from their mothers.

On my first day I was given a standard one-page referral form, completed by a prison officer, for a young woman who had been admitted to prison for the first time a few days earlier. It gave the reason for seeking counselling as 'bereavement'; no other information. I think it was seen as a straightforward request for bereavement counselling.

When I located my new client she looked upset and distressed. I introduced myself and then asked about her bereavement. Who had she lost? It was her baby son. 'Can you tell me about it?' I asked. Pause. 'It's what I'm in here for,' she replied. Taken aback, I managed to offer some empathic responses, got a little of her story and arranged to see her the following week on my next day in. I had never before thought about how to work with someone who was grieving for a loved one for whose death they were responsible. I never saw her again. She was transferred to another prison a couple of days after our meeting. Transfers and releases from custody frequently occur randomly and without warning. Counselling in a prison involves working constantly with this tension. Every session might be the last and you need to be ready for anything.

I had been warned that another of my clients, who had engaged really well in what was her first experience of therapy, might be returned to a different prison after her court hearing. Despite the warning, I could hardly believe how affected I was when she did not return. How could our therapy be ended like that? What was the point of offering therapy here? I remember hoping that my client was dealing better than I with the sense of powerlessness and lack of consideration. As I accumulated such experiences of sudden transfer or, worse, suicide, I would sometimes pause at the wing door and say to myself before entering, 'She's dead. She's been transferred.' Over the top, perhaps, but sometimes I needed this bit of self-protective preparation.

Counter-therapeutic

In my training I had learned that it could be unsafe to begin counselling without a structure that could hold the therapeutic process safely. Some have argued that it is not safe to attempt psychotherapy in a prison at all.[2] Therapists who do frequently have to navigate situations that are contradictory to their training.[3]

I experienced much else that was contradictory to my training. At a practical level, for example, there were no designated therapy rooms. Sometimes there would be no room available on a wing and I would have to go looking somewhere else, anywhere else. Once I held a session in a tiny storeroom among buckets and mops and stacks of plastic chairs. Security issues might prevent me from getting to a session and I needed to warn clients, 'If ever I don't arrive it means that something has happened and not that I have forgotten you.' Privacy was not possible. Just being seen with me advertised that someone was in counselling. Nor could I guarantee privacy in therapy. Most sessions took place in the 'Association Room', which was always sited opposite the wing office, so its occupants were clearly visible. Prisoners queuing outside the office would stare. Passing friends would wave. People – including officers – would come in to get something or ask how long we would be. I would suggest to my clients that they sit with their back to the corridor windows, to avoid these distractions, and that if someone came in to get something we would both simply remain silent until they left. This helped us feel we were at least able to protect our space virtually and keep the therapeutic process under our control.

Explicitly naming these issues to clients as deficiencies and discussing how we could deal with them together conveyed empathy and respect and helped to support a therapeutic frame. I tried to apply the same approach more generally in my behaviour. Small things such as knocking on the cell door before looking through or lowering the hatch (officers, including male ones, would usually just lower it without knocking) were ways of demonstrating respect and acknowledging the women's loss of privacy. For a person-centred therapist this was a practical expression of Roger's six conditions and, I hope, gave an indication of what therapy with me might be like.

For the great majority of the women with whom I worked, their offending arose from personal histories of neglect

and abuse in childhood that had made them vulnerable to further abuse and exploitation in adulthood. They mostly did not seek a criminal lifestyle for the money or what they could get out of it. Their offending tended to be about survival – their best responses to the awful and traumatic nature of their lives.

The experiences and narratives they brought to therapy were generally extreme and typically included domestic violence, abuse, rape, rage, murder, drug use, prostitution, desolate childhoods and grieving for children lost to adoption. As an experienced social worker and counsellor, I was used to working with clients with such backgrounds in other settings, but they would be a small number, in a more varied caseload. In prison almost all of my clients brought these experiences. When I thought I'd heard the worst story ever, it would not be long before I was listening to something even more appalling. I even came to expect this. I remember on one occasion feeling so distressed by a disclosure of childhood sexual abuse that immediately after the session I had to find a quiet space to scribble down the feelings of anger and distress it evoked. This has happened to her and she is *in prison*!?

Pervasive distress

The charity where I was placed was explicitly funded to provide 'offence-focused' therapy and clients had to agree at the outset that the therapy must include talking about their offence. Although I understood the reason for it, I became increasingly uncomfortable about introducing therapy in this conditional way. To imply that the aspect of their lives in which I was most interested was their offence just seemed to replicate how they had been viewed by the courts: as offenders meriting punishment first, rather than troubled women desperately in need of support.

Being confronted with such intense distress and suffering not only in therapy sessions but around me daily in the prison seemed to open up something in me. So much of the privacy and protocol of everyday life gets stripped away from prison inmates; suffering and sadness cannot be hidden and is visible everywhere. But prisons, by their nature, are distressing places and you have to be able to tolerate an environment where distress is pervasive if you are to be able to function as a therapist. I tried to be open to hearing and acknowledging my clients, to let them know that I could bear their most distressing feelings. I was aware that any unconscious self-protective retreat or diversion on my part might impede their processing, acknowledgment and understanding of themselves. I would often wonder if this was more challenging for me, because I am a person-centred practitioner who tries to work at relational depth, than it would be for therapists who use manualised or less relational approaches.

But I know that mental health practitioners of all modalities found the prison environment emotionally challenging. Good peer support and supervision were essential and they sustained me. Our small group of honorary and employed therapists was able to integrate mutually supportive self-care into our everyday professional life and I really appreciated my colleagues' warmth, comradeship, wit and wisdom. Lunchtime sandwiches and the daily debrief meeting before going home were valuable opportunities to talk about our day.

I had monthly private individual and group supervision and fortnightly in-house group supervision, which was especially valuable as our supervisor was very experienced in prison work. I was also in weekly personal therapy. My supervisions were helpful in different ways. In the prison-based group, for example, I was reminded of the danger of thinking of our clients only as heroic survivors of abuse and neglect; that some of these women had committed acts of extreme violence, including murder and were capable of manipulation and coercion and some posed a threat to other inmates and prison staff. I also got better at understanding what an offence might mean or represent in the life of each client. I usually found this to be an enlightening exploration.

I tended to take my feelings to my private individual and group supervision, and especially to the individual sessions where I too could be fully acknowledged. I had tearful moments when I was relating the sadness I encountered, and angry moments when talking about the outrageous injustice and oppression in the lives of some of my clients.

Sometimes just the look on my supervisor's face in response to what I was conveying was the most affirming acknowledgement of all, mirroring how I felt: it's not just me, it really is that awful.

Hatch conversations

I also felt it was important that my clients experienced me as separate from the system that had locked them up. For this reason I stopped looking them up on the prison database, where I could read their offence and offending history. I wanted to approach them as I would any other client and to acknowledge their autonomy in deciding what to bring to therapy and what information about them I should have. My agency readily accommodated this view, provided that the offence was discussed at some point. Ironically, every one of my subsequent clients brought up their offending anyway. Why wouldn't they? That was what was dominating their lives and why they were in prison. But it felt very important to me that they could do it at a time of their own choosing. They had mostly led disempowered lives and were

‘I found it difficult always to hold in mind that they were offenders when… so many had been the victims of offences far more serious than any they themselves had committed’

further disempowered in prison; I wanted their time with me to offer them an experience of choice and, at the very least, the authorship of their sessions.

It seemed to me that what these women needed in therapy was to be really listened to and understood *without judgment*. They had been judged one way or another throughout their lives and were mostly harsh judges of themselves, perhaps feeling guilty that they had failed their children or ashamed of the women they had become. I hoped that being received and acknowledged in this way, however briefly, would enable them to develop new insights and different understandings of themselves and their lives (including their offences) that could be the seeds of change and growth.

Some of their life stories were so truly shocking that talking about their offending hardly seemed relevant. I found it difficult always to hold in mind that they were offenders when they had been so offended against. So many of them had been the victims of unreported, unpunished and unacknowledged offences that were far more serious than any they themselves had committed. I counselled women whose teeth had been punched out; women with bones that had been broken in repeated violent assaults that sometimes caused miscarriage; women who had resorted to drug use to survive, and prostitution or theft to fund it. They had seldom, if ever, received any redress or justice for themselves. So many of their stories had never been told to anyone or were unknown to the justice system, which had responded only to their offending and put them in prison.

Initial contact was usually made through the hatch of a cell door. Every prisoner was locked in for two hours at lunchtime, after attending their morning classes or programmes, and this was the only time when I could reliably make contact. This hatch conversation was often a crucial encounter. Sad and troubled faces would appear at this small window. Sometimes it would be a cell with a single occupant but more often it would be a ‘dorm’ cell with perhaps four or five occupants. It could be hard to hear against the background noise of the wing. If I needed to raise my voice so my client could hear me, everyone could hear me. No privacy at all. A few such conversations might be needed over several weeks before a woman felt sufficiently trusting to be able to agree to start therapy. The hatch encounter was one of the most important skills we counsellors had to develop. It is difficult to think of a less facilitative setting in which to engage a vulnerable client.

Drugs and self-harm

For some, therapy was barely tolerable. The distress and fear of being in touch with their most disturbing feelings meant they might leave a session after 10 minutes. Empathy is at the heart of my counselling but some of my clients had limited capacity to receive it and, potentially, they could be overwhelmed by the feelings it evoked in them. I would try to gauge what they could tolerate. Although I was prepared to engage with clients on whatever terms they found possible, some would stop coming altogether, sometimes openly telling me that they just couldn’t bear their feelings and were not ready for therapy. Often they found it easier to engage in training, education or other group activities.

A common response was there was no point in coming to therapy until they had got off drugs. Drug use is a huge issue in female offending and it affected so many women in the prison. The methadone nurse would push her trolley into a wing and bawl ‘METHADONE, LADIES!’, followed by an instant crashing and banging of cell doors as women streamed out into the corridor to get their relief. Meditation was another highly valued form of relief and better access to it was needed. Getting off drugs was, for so many women, a prerequisite to making any other change in their lives. One client, with a typically abusive history, had first used heroin in adolescence. All her children had been removed and adopted and it was with profound shame that she told me that she had used heroin on the day she gave birth to her youngest child. She knew she had failed her children. Her motivation for rehab was her hope that one day her children might want to find her and she did not want them to find a ‘junkie’. She hoped desperately that she would get another chance to be their mother.

Another client had been introduced to heroin as a teenager by someone she knew well and trusted and who later raped her. She had also been sexually abused earlier in her life. After an episode when she fought back, she was given an IPP sentence (Imprisonment for Public Protection), which meant that she was considered a danger to the public and would only be released when a parole board considered her to be safe. She had already served her tariff but she was still awaiting a parole hearing. She would write about her drug use for me to read in her sessions, where she also regularly fought a losing battle with her tears. She was transferred to another prison after just seven sessions.

Self-harm was also everywhere. Arms scarred from wrist to elbow or shoulder, fresh cuts over older ones, always shocked me but, sadly, were not unusual, and it was a frequent theme in therapy. One very sad day there was a suicide. The dreadful news travelled swiftly around the prison and the effect on us all, including officers and other staff, was obvious, even though little was said. What was there to say? The next day I visited a client on the same wing. The atmosphere was hard to describe – they were perhaps the

‘Initial contact was usually made through the hatch of a cell door... It is difficult to think of a less facilitative setting in which to engage a vulnerable client’

feelings that the presence of sudden death can evoke in any of us. I sensed a feeling of real community on the wing that day, with everyone looking out for each other. I met an exhausted-looking chaplain who had been comforting and praying with women and blessing cells for hours. Some women were desperately asking to move to another wing. A small group of officers was responding to and containing this distress with calmness and kindness. I was impressed and hoped that they too were getting the support they needed.

Sometimes I would need to initiate monitoring and prevention measures for suicide or self-harm. Clients would usually plead with me not to do this as it could be intrusive. Cells might be searched for anything that could be used as a ligature or to cut. At night officers would shine torches through the door hatch into sleeping eyes until they saw movement.

Mothers behind bars

Most of my clients had been seriously abused in some way by men with whom they had a relationship of some kind – fathers, grandfathers, uncles, cousins, husbands, brothers or boyfriends. Working with me meant forming another relationship with a man. My training and experience told me to expect echoes, replays and transferences of these experiences in their relationship with me. I probably missed a lot and mostly I just remember feeling very paternal towards my clients. Perhaps this is what they needed to evoke in me. Possibly I offered a kind of relationship that they had never experienced with any man, including their fathers.

For the mothers among my clients, the most unbearable aspect of being in prison was often their separation from their children. All they could think of was getting back to them. More than once I had clients on remand who were going to plead guilty despite their lawyer’s advice. A guilty plea meant a quicker court date, a third off any sentence, plus the deduction of time spent in custody, which might mean immediate release, whereas there might be a long wait for a trial. That they would be getting a criminal record was not a consideration for them.

One of my clients was pregnant and after she had her baby we continued our sessions in the mother and baby unit. It was a completely secure area but, unlike the wings, it was self-contained, with no flow of people passing through. It was its own little world. I used to look forward to going there because, once inside, the atmosphere and energy were so different. I liked to think that the security regime, so dominant everywhere else, met its match in these babies and had to make concessions. Soft play equipment, carpets, sofas, toys – infant power! I would come away feeling refreshed.

A constant concern was how clients would cope on release. Progress made in therapy in prison can be fragile once outside and many would re-offend and return repeatedly. How could they maintain their ‘inside prison self’ out there? For so many their progress was blown away by returning to the same pre-prison life. How does one evaluate the efficacy of therapy in this situation when change and determination developed in prison becomes so much ‘Scotch mist’ on release?

Towards the end of my two years I began to feel the strain. Rather than burned out, I felt heavy and saturated. Whatever I was soaking up, I felt I could not absorb much more. I gained an insight into what might be happening to me when, in a supervision session, I talked about hoping that clients would not ‘come back’ to prison. My supervisor pointed out that I had said ‘come back’ and not ‘go back’. It was as though I was still in the prison.

After this, instead of eating sandwiches in the office, I started to go out at lunchtime and treat myself to lunch in a nice Italian deli. This made so much difference to how I felt at the end of the day that I sensed something more was going on than just the better food and change of surroundings. I realise now that I was ‘releasing’ myself by taking these proper breaks: not only from the prison building but also, perhaps, from an unhealthy over-identification with my clients, who were eating their sandwiches in their cells. This, possibly, had been contributing to my debilitating sense of saturation. In the midst of a distressed and incarcerated population, I had perhaps been unaware that I needed to give myself permission to exercise this freedom.

When I left I intended to return at some time but life and other things got in the way. Writing this has felt like a kind of return to that world and it is offered in appreciation of my colleagues, who were such a pleasure to work with, and to my clients, who shared so much with me. ■

BACP is currently working with the Centre for Mental Health and Women’s Breakout to improve access to counselling for women offenders and women at risk of offending.

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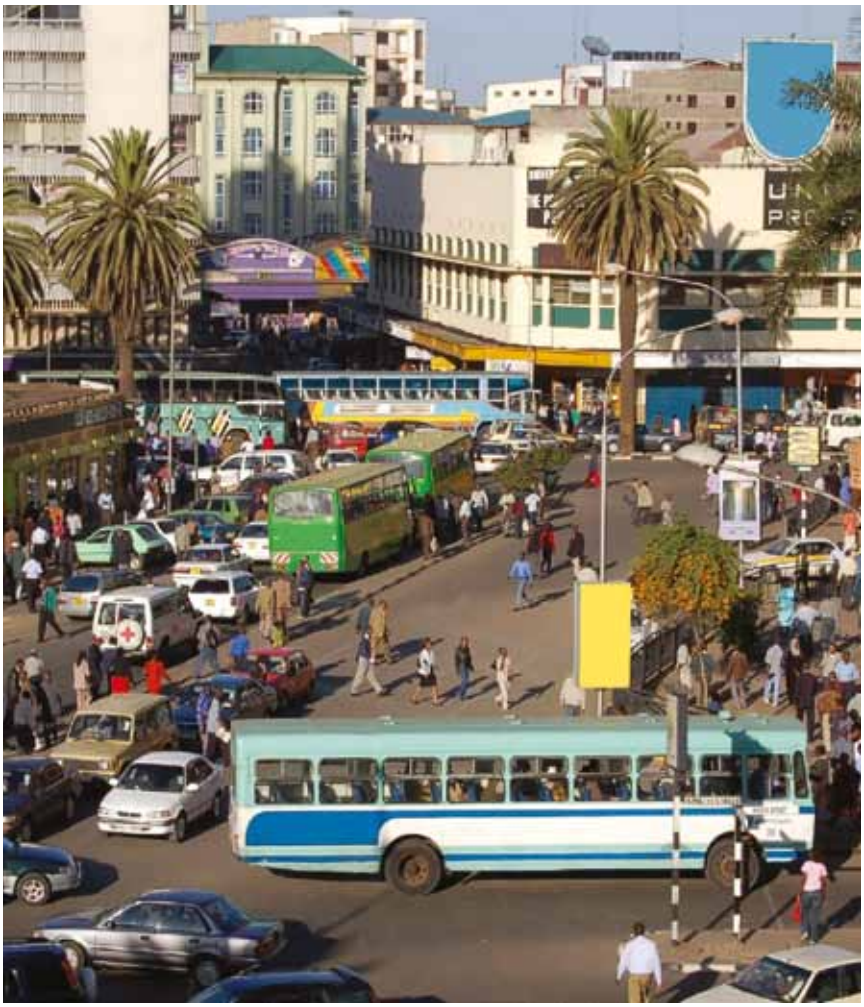
The differences between us



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Georgina Green argues that we need to voice the differences between us if we are to build trust and understanding when counselling clients from another culture

Kenya. Dust. Hundreds of people walking to work each day. Blazing sun. Tropical torrents of rain – when it comes. Roads deteriorating by the day, causing the *matatus* – the public transport minibuses – to veer off to the sides of the crumbling roads, creating four lanes of traffic instead of one. And yet a region that maintains a character of charm and strength in the face of poverty, and where the community has an ethos of togetherness, determination, and helping one another.

I am a white British woman. In October 2001 I left London for Uganda, where I spent eight years before moving to Kenya in January 2009. I have lived here with my family ever since, and throughout this time have been practising as a counsellor, gaining a Master's in Counselling in Nairobi at the Kenya Association of Professional Counsellors (KAPC), a leading counselling training institution in Kenya. The course is validated by Manchester University. Among the reasons I wanted to do my Master's in Kenya was to have the opportunity to study counselling in a multicultural context, to develop insight into how I would feel being among a predominantly African culture, and to try to gain a deeper understanding of African people.

My Master's thesis was titled 'A preliminary investigation targeting the experiences of non-indigenous white

counsellors living abroad in Kenya, and the implications on a cross-cultural counselling relationship'.[1] My suggestion from the findings of my research was for further research to be undertaken within Kenyan counselling training programmes to address the stark differences between black and white dyads and the impact this has on our counselling relationships. Multicultural group members' experiences need to be brought out into the open to address this difference, which continues to prevail but is now more hidden.

Naming the difference

My training experience was that, although there was one other white Westerner in our group, who was from a markedly different cultural background to my own, there were also students from other parts of East Africa who were culturally different, and these differences were not aired or mentioned by any of us. I felt awkward at the thought of bringing up my own colour or culture differences and, although I was named a *mzungu*, a term generally used for white Westerners and not necessarily derogatory, and which was in fact naming a physical difference about me, we still did not mention this difference, even during our counselling course. I was also aware that the Kenyan group members had strongly differing tribal identities, which in my view are similar to the British class system in being deeply rooted in tradition. But these tribal differences were not mentioned, due I believe to perceived stigmas of wealth and power that signified a person's position in the social pecking order.

In a recent article in *Therapy Today*,[2] Ellis and Cooper discuss the same issue around colour and cultural difference in a counselling training setting in England: no one dares to name colour and culture. Eugene Ellis says: 'There is diversity on the curriculum, it's dealt with objectively, as an issue out there, but not subjectively and personally. There is little examination of what's going on in the classroom.' They mention a kind of embarrassment at the thought of mentioning black people's culture and race in a group setting, calling it 'a silence and it's like you've just opened a huge hole in the floor. Somehow it becomes your fault'.

I am mentioning these blatant physical and cultural differences between humans and my emotional responses to the unspoken cultural diversity on the counselling course that I attended because I believe there is relevance when we think of the congruent relationship[3] that is needed when working multiculturally. When I am counselling, do I name the differences between me and my client, or do I keep quiet about who I am and who my client is, in case I cause embarrassment? In practice, I have learnt that naming culture and colour differences *when appropriate* has helped create a more trusting environment than if I had remained quiet. I have observed clients drop their shoulders and relax as they see me in a more authentic light because I have voiced the *unspoken*, such as: 'I am wondering whether you were expecting a female white Westerner?' I feel that not to name this racial difference in the client–counsellor relationship creates incongruence. My response to this incongruence is to take a risk, to face the fear of the unknown, to explore this 'forbidden area', and to trust that the client and I will be able to cope with our unknown, emerging feelings.

Multicultural complexity

I am an integrative counsellor using cognitive behavioural therapy (CBT),[4] schema therapy[5] and person-centred theory,[6] but more recently I have been practising predominantly in a person-centred/experientially focused way in my counselling relationships. Why do I believe this approach works better than the CBT/schema methods, which I also use? Simply put, because it addresses the *whole* person and not just the parts that are in trouble at a particular time. CBT is fashionable currently in the UK, and has gained a reputation for being effective and achieving fast results. However, in my view it is also a judgmental approach that seems almost to condemn the parts

of the self that are not working well by assuming that to focus predominantly on our clients' 'thinking' is helpful.

I find myself taking a directive stance when working with CBT in order to equip my clients with skills. I seek to make them aware of their thinking processes and what they are not doing right, rather than encouraging them to view the parts of their human existence in a positive, accepting way. How can the CBT approach address the human side that desperately needs nurturing, attention, love and, of course, empathy when working in complex multicultural relationships?

Multicultural complexity

I acknowledge that CBT does address these issues to some degree: we spend time hearing clients' anxiety with partial empathy and we set homework to address their needs, with the aim of releasing them from their unhelpful core beliefs. But what about when we are faced with multicultural complexity in our work as counsellors? How on earth, for example, can a Kenyan man, who is from a tribal culture and often has deep-rooted traditions, take on board negative automatic thoughts (NATS) or the ABC model, along with a schema therapy questionnaire? Whose frame of reference will he be in then? I believe he will be in my Western frame of reference as I direct the sessions using Western concepts that are alien to him. Person-centred counselling and also the IAPT, NICE-approved counselling for depression (CfD) model,[7] (which is also a predominantly person-centred concept), focuses more on the experience between counsellor and client and is, in my view, a more appropriate way of working when addressing a multicultural, complex counselling relationship in Africa.

How is it possible to be an effective white counsellor when working with black Africans? Writing (along with Colin Feltham) in *Therapy Today* of his experience of visiting Kenya for a counselling conference in Nairobi in September 2005, William West, said: 'I felt myself to be in a caste system of those with white skin who got power and privilege and those not white who did not... I was left wondering what black Kenyans really thought about white people.'[8]

How then do I cope with the multicultural relationship? And why have I come to the conclusion that a relationship/experiential-based therapy works best in Kenya? As counsellors working in a foreign country, we have so much to think about: colour issues, cultural issues, power dynamics, gender issues, age issues, tribal issues. Although counselling is rapidly being embraced by educated Kenyans and organisations in urban areas, African families in rural areas often still have a 'chief' to go to, who is almost like their counsellor. He is usually the oldest person in the extended family and is sought out for advice and comfort in the face of disaster or trauma. So coming for counselling for the first time must be more than a little daunting for a Kenyan client living 'up-country'.

Some examples

Let me give an example. How would Joseph, a 59-year-old Kenyan man, be able to relate to me, a younger white female therapist from England? Joseph came to therapy as he was struggling in his relationship with one of his wives because of her drinking. Joseph, who has two other wives, earns a living by raising broiler chickens and then slaughtering them. My first counselling consideration (which I would not have asked a white Western client) was to ask Joseph what tribe he was from and what tribe his wife was from. I wanted him to know that I understood the importance of tribal difference in his country. While this might appear to simply reflect my desire for an approbatory pat on the back from my client, it was in fact more an empathic response to the very different African culture and a demonstration of my willingness to want to understand. Second, it was important to understand that having three wives is not unusual as polygamous marriages are common and not necessarily frowned on. And third, I was also aware that it is often considered to be culturally disrespectful for an African woman to drink. Therefore I needed to make sure that my own frame of reference around marriage and alcohol did not get in the way of the counselling process. I needed to avoid having preconceived judgments, for example, about what a hard time my client must be having because he has several wives.

Cultural knowledge is important because it helps me be more aware of my client's frame of reference, as opposed to my own. There's a saying, 'The more you know, the more you know how much you don't know'. I have learned that an extensive knowledge of African culture is not necessary; rather than trying to acquire a huge amount of knowledge and expertise about a culture that is so rich and complex, I just need to know enough to offer an empathetic understanding of my African clients' world.

The other consideration I needed to keep in my mind as Joseph and I sat together was who I was and who my client was. How could I begin to understand what his world must be like, viewing it as I did from my own, different frame of reference, expectations and general Western way of doing things? I believe it is just as important to consider my awareness of my own culture as it is to consider Joseph's culture. This is the part that I feel Westerners often miss. We can be so interested in other people's culture that we forget that we have one

'Naming culture and colour differences *when appropriate* has helped create a more trusting environment... Clients drop their shoulders and relax because I have voiced the unspoken'

too. Dyer says: 'As long as race is something only applied to non-white peoples, as long as white people are not racially seen and named, they/we function as a human norm. Other people are raced, we are just people.'[9] Understanding what my culture is saying in my client relationships will create a transparency[10] about me and therefore a transparency will be available within my counselling relationships. Reaching out to Joseph and hearing his struggles in his cultural context demonstrated the warmth and empathic understanding that was needed in order to gain his trust.

When Lillian, a 30-year-old Kenyan woman from the Luhya tribe, came to our first counselling session, I could see that she was nervous as her legs were shaking. Lillian has lived in Kenya all her life and is the oldest of eight siblings, all from the same mother and father. Her role while growing up had been to look after her younger brothers and sisters. Lillian told me that she was seeing me for counselling because she had never been in a relationship with a man.

The counselling consideration in Lillian's sessions was for me to understand that Kenya is a collectivist culture. Compared with the individualist culture in the UK, Kenyan people are likely to define themselves as having a 'group way of thinking' and therefore pay less attention to their internal locus of evaluation and more to an external locus of evaluation.[11] How, therefore, can counselling, which originates from a Western individualist culture, be of use to the African collectivist way of thinking? I have struggled with this question throughout my time counselling in Kenya, and often feel cynical about the whole counselling concept, which is essentially Western-based and about encouraging self-growth. However, by offering a trusting relationship to Lillian, I saw her relax in our first session. She told me that she felt very nervous because she had only known counselling to be for people who were terminally ill.

The core conditions of empathy, congruence and unconditional positive regard, a fundamental part of person-centred counselling, seemed vital here so that Lillian could be accepted for who she was and could gain strength in who she was. I believed that, although she could not change her collectivist culture, she could change herself and the way she related to people within her tribe, without necessarily experiencing rejection. I also considered that, if I had taken a more directive theoretical stance and taught Lillian to use CBT skills that were not understood by her culture, it might have felt threatening to her tribal traditions and group members. Person-centred theory, I believe, provides a way of being that gave Lillian the self-confidence to reach a potential she may not otherwise have known about, and a self-trust to understand how to move towards the intimate relationship that she desired.

Final thoughts

Although cognitive and behavioural approaches may be appropriate for some clients in a multicultural setting, in my experience the overriding need is to create a trusting relationship, using the necessary ingredients to create a functioning relationship: acceptance, empathy and congruence.[12] Without these fundamental ingredients, or 'core conditions', I believe neither Joseph nor Lillian would have told me about their emotional struggles at such a deep level, as they would not have believed that I could possibly understand them. I think that naming the experience, the unspoken words or the emotion in our counselling relationships enables us to connect with our client within a multicultural relationship, and this connection can allow change or therapeutic movement to take place. We can't touch these emotions or experiences, but we can theoretically 'grab hold of them', shake them around, and move on. ■

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'Rather than trying to acquire a huge amount of knowledge and expertise about a culture... I just need to know enough to offer an empathetic understanding of my African clients' world'

Dilemmas
Client confidentiality online

This month's dilemma

Sam works as a counsellor in a local Further Education college. The counsellors have been encouraged to experiment with using technology and to blog about their work. Sam was originally sceptical but became a convert and has joined a professional networking group.

Users sometimes discuss client issues and Sam posted a message about a client whom he had found particularly challenging. He believed that the client's identity had been sufficiently protected as he did not use real names and he changed the client's gender.

However, a different client has, unknown to Sam, been a member of the same group, and believes that she has recognised herself in the description. She is threatening to bring a formal complaint against Sam and against the organisation.

What are your thoughts and what should Sam do?

Opinions expressed in these responses are those of the writers alone and not necessarily those of the column editor or of BACP.

William Johnston

Person-centred counsellor in private practice

To misquote an old saying: 'What happens online, stays online – forever!'

Teenagers aren't the only people who seem to underestimate the dangers of sharing things online with people they do not know. Counsellors who include client material in books would normally, I hope, obtain client consent. Even the Dilemmas pages in *Therapy Today* would seem, ironically, a risky place to share problems related to real clients.

There are two questions that I find myself asking. First, was feedback in supervision not enough for Sam? Second, if he really needs additional feedback, does he not have a network of fellow counsellors with whom he could discuss such problems privately?

I cannot see, in fact, that there is any dilemma here at all. I would suggest that the only choice Sam has is to reassure the client who believes that she has recognised herself that this is not the case, and hope for the best. There is no need to lie. Sam will not, however, be able to get round the fact that he has been discussing client material online. This is not something that his client will be able to ignore. She may feel that, even if he was not discussing her, she has good cause to complain and, if Sam is being honest, he will have to agree with her. Even though the material he published online had nothing to do with this client, he still owes her an apology.

If he is really lucky – and sufficiently skilful – then these circumstances might allow his relationship with his client to deepen. This

'Even the Dilemmas pages in *Therapy Today* would seem, ironically, a risky place to share problems related to real clients'

can only happen if Sam is honest about his failing, his apology is genuine, and he is able to offer his client the chance to discuss her responses without either losing himself in his own shame and guilt – and panic – or becoming so 'professional' that he loses sight of his own humanity. Sam's humanity and vulnerability may indeed give his client permission to share her own, and he still has to be able to maintain the boundaries of the sessions. The relationship may, of course, not survive at all.

An even more problematic scenario would, of course, have arisen from the actual client recognising him or herself. Even here I cannot see that there would be a dilemma. Lying cannot be an option. The only choice would be to offer an apology and, again, hope for the best.

In either case, whether a client complains about him or not is outside Sam's control. All he can do is be as honest as possible. And make sure that he never, ever again discusses clients under any circumstances where he does not have total control and trust over both the material and those with whom he discusses it.

And the people running the Further Education college, who were responsible for encouraging Sam to embark on this course in the first place, need to re-think their policies very carefully indeed.

Linda Aspey

BACP Fellow, Coaching for Leaders

I feel deeply uncomfortable about counsellors blogging about clients on unsecure sites, even if the clients are disguised. It could go anywhere and be read by anyone, even in so-called 'closed groups', unless there's a proper level of online security. There's nothing to stop people printing or cutting and pasting material, or sending links to others, so real caution should be exercised unless you know you are in a highly secure environment.

I'm sure the college didn't intend for this to happen so I'd be interested to know what they hoped for when they encouraged the counsellors to blog about their work. Had they fully thought through the implications? How secure is the site? Are the staff, including Sam, adequately trained in using online technology, and what are the college's general policies on using the internet, blogging and social media?

While Sam wasn't writing about this particular client, it's useful to consider the wider picture. Ethically, the first rule of discussing client work with third parties is to inform the client, as we do when we discuss them in supervision. Using online forums to discuss work with clients is like taking the work to the community for supervision. When we use client material in case studies in traditional print media, we seek their permission or use a composite to disguise any identifying features.

So what should Sam do now? I think the best thing would be to invite the aggrieved client to come in and discuss it. Sam can

genuinely reassure her that he was not writing about her but that he appreciates that it has caused her some distress. She may be feeling exposed and vulnerable about being discussed online, and this may have influenced her view of Sam's trustworthiness.

She may also have concerns about what Sam actually wrote – the brief says he found the client particularly challenging. Non-maleficence is a core principle in the BACP *Ethical Framework* – so does the client feel she has been done harm? I'd hope that an honest discussion would be enough to allay her concerns. If not she may still raise a formal complaint. What provision can be made to support her now?

It can't be easy for Sam either – was he encouraged or coerced into using technology? Can he take the opportunity to reflect and make his own independent choices about how he uses technology to develop and discuss his work? Why does he need to discuss a client online? Is he getting enough supervision, or the right supervision?

This dilemma offers an opportunity for everyone to step back from the immediacy of the internet and take a good look at their policies and practices. To support this, BACP has produced a number of guides about the use of technology in counselling. There is also a useful source of information for organisations and individuals about online safety and security at https://www.getsafeonline.org

Clare Ireland
Psychodynamic couple and one-to-one counsellor

However professionally Sam tried to disguise the client issues, the content he posted to the networking group has created another dilemma with another client.

There is no question that networking online can be a useful tool for sharing ideas, theories and hypotheses arising from our clients' stories, emotions and feelings in the therapeutic space.

It seems that Sam has encountered what may happen if a client's personal story, however well protected, is sent into the ether where, once the send button is pressed, there is no control over its effects on unknown bloggers' inner worlds. The person threatening to bring a formal complaint against Sam and the organisation would probably not get anywhere in law on a hypothetical and imagined personalisation. However the organisation should warn their workers against this kind of sharing in future.

Linden Stefaniak
Counselling psychologist

This dilemma interested me as there seem to be more questions than answers.

First, who encouraged the counsellors to experiment with technology and to blog about their work? Did this person understand client confidentiality and all its implications? Presumably the implications were not discussed closely before the work went online.

'Using online forums to discuss work with clients is like taking it to the community for supervision... in print media we seek their permission or use a composite'

Were the other members of the professional networking group that Sam joined all counsellors? We are told that its users sometimes discuss client issues, so presumably they are all counsellors, or Sam had reason to believe so. In that case, I wonder if the former client is herself a counsellor and, if so, would this make a difference?

Sam believed he had protected the client's identity sufficiently by not using their real name and by changing their gender. Counsellors have to be very careful, for reasons of confidentiality, about what information they put online.

Did Sam categorically state that details and gender had been changed, or did he assume this woud be taken as read? If the networking group are all counsellors, he might assume that they would understand this.

However, Sam's former client believes, for whatever reason, that he is discussing her case. She was Sam's client and the details seem to fit. Sam can deny it until he is blue in the face but how does he now prove it is a different client without breaking the real client's confidentiality? The ex-client is threatening to bring a formal complaint against Sam and against the organisation (presumably the organisation that runs the networking group).

If he hasn't already done so, Sam should contact his professional organisation for help and advice. His insurers may also have a helpline that offers support in such cases. Sam seems to have acted in all innocence but has been caught out by circumstances and by assuming things were safe when they were not as safe as they could be.

Next month's dilemma

Alex works as a group therapist for a large mental health organisation. The participants are all users of the service and have self-referred themselves into the group.

There is a group rule that members should not be violent or aggressive within the group. However, recently a group member has been verbally abusive to the point where the whole group has felt de-stabilised, and on one occasion Alex himself has left the group in tears. He and his co-worker would now like to exclude this person from the group but their manager, who has psychiatric training, has refused to allow this to happen, saying that the group leaders should be able to cope.

What are your thoughts and what should Alex and his co-worker do?
Email your responses (500 words maximum) to Heather Dale at hjdale@gmail.com by 28 April 2014. Readers can send in suggestions for dilemmas to be considered for publication but these will not be answered personally.

To be fully ourselves

Isha McKenzie-Mavinga talks to *Colin Feltham* about challenging racism in counselling and the need to create a space for students of all ethnicities to talk safely about their experiences of oppression

Isha, can you tell us a bit about your background and your journey to becoming a therapist, Reiki practitioner, trainer and supervisor?
I was born in Birmingham of European Jewish and African Caribbean Catholic parents. My father, a Trinidadian Catholic, died when I was four months old and I was raised in a children's home for Jews in London. I survived my first 16 years having only seen my mother a couple of times. Luckily one of my sisters mentored me at the age of 13, so I had some surrogate mothering. At secondary school I made friends with some of the girls who had arrived from the Caribbean and I became more aware of my African Caribbean heritage.

I had my first child aged 17, with no idea how to parent except by watching my big sister who by then was married with young children. Eventually I married and later had three more children. I divorced in 1980 and studied for a degree in social sciences, became a youth worker and then trained to be a therapist at Westminster Pastoral Foundation. I worked with women affected by domestic violence and in 1990 became Clinical Manager at the African Caribbean Mental Health Association. I became acutely aware of the role of racism in depression and mental ill health, which sparked my interest in traditional healing, transformation ritual and other ways black people address their mental health. My attention was also drawn to concerns about the misdiagnosis of black men and those who died in the mental health system. I provided therapeutic support in Broadmoor Hospital and met Orville Blackwood before his death due to restraint and over-medication. In the meantime I learned the practice of Reiki and began integrating healing energy with talk therapy. This became a useful support tool with individuals who felt shackled by psychotropic drugs and had difficulty sharing their emotions.

I taught at Goldsmiths University and obtained an MA in Applied Psychoanalytical Theory. I taught on other counselling courses and offered transcultural counselling workshops. I decided to study for a Doctorate when I was working as a senior lecturer at London Metropolitan University. I became more aware of how marginalised black issues were in counsellor training and I wanted to change this.

Your book *Black Issues in the Therapeutic Process* (Palgrave) was published in 2009. What were the reactions to it?
The book had good reviews and has been adopted by some therapy training organisations. It's considered very useful for practising therapists and students and a confirmation of the needs of some black individuals. With the support of BAATN (the Black and Asian Therapists' Network), I have since been presenting workshops in the UK to assist reflection and active use of the concepts presented in the book.

Can you tell us about recognition trauma among black people, and particularly its features in the therapeutic context?
Recognition trauma describes the powerful feelings and responses that black, Asian and white people go through when they become aware of racism or of being in the perpetrator group. The concept arose from my work with counselling trainees, exploring the impact of racism in black issues workshops. We needed a name for the powerful feelings evoked in the group dynamic. The black trainees were experiencing a range of emotions directly related to their past and present experiences of racism and to the presence of white trainees in the discussions. It evoked a range of responses, including rage, sadness and being unwilling to share or afraid to tell their stories in case they upset the white trainees. This was commonly met with silence from the white trainees, and an inability to articulate empathy. Their responses included denial and defensiveness, gratitude that some stories were being shared, and guilt and fear of being seen as racist. For the black students, coping with these responses was a traumatic experience that was linked to a recognition of how racism had affected their lives.

This dynamic emotional situation challenges the therapist to connect with feelings about experiences of racism and understand the importance of working through this process with clients.

You have discussed (in your chapter 'A can of worms') the 'outpouring of questions and emotions' involved here.
Yes, there has been an outpouring of questions, which is a good indicator of the enthusiasm about working with black issues and racism in the therapeutic context. If individuals are to feel safe to address the questions, they must be held and this means that therapists, supervisors and tutors must develop robustness in this area. The answers lie in personal, cultural and therapeutic experiences so no one should be expected to process the questions alone. They are the responsibility of training and personal development. The growing

literature on racism in therapy and the increasing interest among training organisations shows a steady movement towards healing in this area, but there is still a long way to go.

Black people in counselling and psychotherapy here rightly call for greater attention to black issues ('going all the way', as you have put it), yet these calls compete for training time with those from other minority groups. How can we overcome this problem, or is it partly defensiveness?

That is the nature of racism: due to defensiveness and denial, it is rarely given enough attention in training. Instead, a hierarchy of oppressions emerges. The emotions evoked by black issues get far more attention than constructive, empathic ways of celebrating black and Asian cultural issues and supporting cultural concerns and experiences of racism. Competing oppressions often block the openness needed to address these issues, and this exacerbates marginalisation.

I believe male trainees on most counselling courses remain few in numbers, and correspondingly there are few black male trainers. What are your views on this?

Yes, all male trainee therapists, including black trainees, are scarce. I see the training of therapists as very whitewashed and feminised, and black men in particular may not have their training needs adequately taken into account. The profession needs greater awareness of male trainees as a minority group. We need greater input and acceptance of black males as tutor role models and an important resource for trainees. The large number of black boys failed by the school system and incarcerated in penal and mental health systems in the UK is tantamount to failing black men's psychological welfare.

Roy Moodley, among others, has argued that non-Western therapeutic methods need to be honoured and included alongside traditional (psychoanalytic, humanistic, cognitive behavioural etc) psychotherapies. Do you think this is happening in the UK?

Openness to non-Western methods is increasing and contributes to greater access and equality in service provision. But there is a difference between accepting and informing about non-Western approaches and actually practising them. Many of today's therapies have built their practice on the back of non-Western approaches. Dance, music and art as therapies, group therapy and body therapies are all used in traditional societies. They have been given new terminologies and gained validation because they are systemised in the West. In Europe, Westernised approaches dominate service provision, so space is needed in training to explore the integration of non-Western methods in their true sense.

Courtland Lee suggested in a previous interview (*Therapy Today*, September 2013) that black citizens in the UK suffer from having no 'Barack Obama factor' – no example of pride and hope. Do you share this view?

From the outside it may look like this and we may never have our own Barack Obama. There are many people in whom we have pride – Linda Bellos, Bernie Grant, Diane Abbott, Stewart Hall, Paul Gilroy, to name but a few. But progress is slow and the trauma of our past is deeply embedded in our communities. It is an uphill struggle to get the voices of black people in the UK heard. Many individuals are working at grass roots level to unpick the effect of Eurocentric dominance and racial injustice. BAATN is an example of this in the therapy professions. Black people in the UK have demonstrated that we do not need a Messiah. We have opened black-led nurseries and schools and we continue to campaign for justice. In the long term we need greater support from the majority to counteract racism and build hope.

We see continuing demographic changes, including a greater increase among the African British population than the Caribbean British, an increase in Muslims from many parts of the world, recent significant immigration from Eastern Europe and refugees from Syria and elsewhere. What effect does this changing tapestry of multiculturalism have on black African and Caribbean UK citizens?

The increase in migrant populations from African and European countries means we have to consider wider inclusion and perspectives about therapy provision. The needs of refugees and ESL (English as a second language) individuals are of primary concern in current approaches to trauma, mental health support and healing. Psychotherapists are becoming more open to understanding specific spiritual and cultural aspects of today's migrant populations. One concern is the loss of focus on white racism towards asylum seekers and their needs and the different concepts of racism in European countries. Work on eliminating racism is not finished and the needs of black African and Caribbean UK citizens are at risk of being marginalised because of the myth that our statutory systems are in a post-racism period.

The huge respect expressed for Nelson Mandela seemed palpable. Yet at the beginning of 2014 we have seen mistrust inflamed by the verdict in the Mark Duggan case, and we have Steve McQueen's film *12 Years a Slave* underlining historical racism. Do you foresee further tough times ahead or are you hopeful that the UK is making real progress in community relations?

Nelson Mandela left a message for the world about how we can heal the hurt of racism. His legacy of 'Umbuntu' says it all: 'I cannot be fully me until you are fully you.' This means victims and perpetrators of racism must both know our histories and the intergenerational impact of slavery and colonisation. The media is awakening to the reality of slavery and our 'long road to freedom', which may evoke recognition trauma. Slavery is very much alive across the world. The Mark Duggan verdict, alongside the verdicts on black people who have died in the penal and mental health systems, reminds us that institutional racism is still firmly in place. With the economic decline and fewer resources, there are likely to be tough times ahead but also great achievement as we face the truth about the past and the present.

You divide your time between the UK and Tobago, and yet you still manage to conduct online supervision groups and workshops. What are your current projects and next steps in the therapy world, and personally?

I now spend the winter months in semi-retirement in Tobago. I'm working on another book to support the practice elements of engaging with the impact of racism and multidimensional oppressions. I started the online practice and supervision so that I could communicate with individuals and groups who want my support. I get my own therapeutic and professional support online too. I run the workshops and conference presentations (see www.i-mckenziemavinga.com) during the summer months or early autumn when I am in the UK. I am involved with the international co-counselling community so my personal development is ongoing in Tobago. This year, besides the book, I am planning to lead an ongoing co-counselling class in Tobago, and my second Reiki and writing workshop. In between I am re-connecting with my poetry writing and art work. ■

How I became a therapist

Sally Ingram

As Director of Durham University's counselling service, *Sally Ingram* feels privileged to be able to help these young people grow into their potential

It was only when I was invited to write this column that it dawned on me that my pathway to counselling was to a great degree influenced by events that took place before I was even born. Both my parents grew up in impoverished, neglectful and, on occasions, abusive environments. Their families often resorted to criminality, and sometimes violence, to cope with poverty.

My parents worked hard to ensure my siblings and I were never exposed to this. Our childhoods were the antithesis of everything they knew as children. But they encouraged us to regard those who had taken the criminal path with what Anton Chekhov called 'compassionate observation'. I see now that they cultivated in me an enduring ethos of respect that continues to guide all my professional and personal interactions.

My journey to becoming a university counsellor and service manager started in the Midlands in the early 90s when I was working in a family assessment unit for parents who had harmed or neglected or failed to protect children in their care. Many had already 'lost' a child and this was their last opportunity to prove they had the capacity to parent safely. I learned there how easy it is to pathologise clients. The common starting point was suspicion: clients were to be feared; they were seen as constantly trying to hoodwink and deceive us. This was true for some, but most were desperate to keep their children and undo as much of the past as they could.

I realised that working at the end of the parenting journey was deeply fatiguing and that I needed to be at the

start of a supportive process that kicked in earlier, before these parents' problems became entrenched. A postgraduate diploma in humanistic counselling developed my ability to see my clients' view of the world and what had led them and their children down this dreadful path.

I observed a great deal of poor practice at the assessment centre and finally decided to speak up. I left voluntarily, if abruptly! However it was one of the best professional decisions I have ever made. I learned that, if you put integrity first, it will never let you down.

I next worked at a small but passionate counselling charity that supported male and female survivors of rape and sexual abuse. During my time here I trained as a child and adolescent counsellor. The training changes your perception of your own childhood and I found that it changed my relationships with my siblings and my parents – mainly for the better but not always.

I next joined a local Relate counselling centre. The resilience of the young people I met never ceased to amaze me. They would be living in the most dreadful conditions, experiencing emotional and physical neglect and abuse, and yet they still made their way to school, and to counselling, often having got their siblings up too.

This was when I was invited to join the executive of BACP Children & Young People. I would encourage any BACP member to do the same. I made some excellent personal and professional connections, gained skills and confidence as a manager and practitioner and was able to help influence policy and practice at a national level to support frontline counsellors fighting passionately for the therapeutic needs of children and young people.

During this time I trained as a counselling supervisor and still hold a small supervisory caseload today. Supervision training teaches you so much about being a supervisor, but it teaches you an awful lot more about being a supervisee, and how to get the best from your supervisory relationship.

For the last 10 years I have had the privilege of working with some of the country's brightest young people, running a counselling service in higher education. It is fantastic that so many more young people are now able to attend university, but not all have come with the emotional resilience to cope with university life. Counselling services are working with more young people year on year and also with greater severity of problems. That said, I feel I have found my professional home. On a good day my heart swells with pride when I see our (mainly) young clients grow from shy and awkward freshers into confident and intelligent contributors to society.

My own past is a constant reminder to me that our futures do not have to be dictated by our pasts. It is this inheritance from my parents that I seek to pass on to others in my work. ■

Letters

Sudden death in epilepsy

I was shocked to see that Sudden Unexpected Death in Epilepsy (SUDEP) is not mentioned in 'Counselling and Epilepsy' in the March issue of *Therapy Today*. The author explicitly says, as most of the general public believe, that the risk of epileptic seizures is only 'pain and injury'. But people with epilepsy and their families have to live with far more than that.

I agree with so much of the article and it's very helpful. But the omission of SUDEP is important. Three people in the UK die every day from epilepsy – to put it in context, more than cot deaths and HIV deaths combined. Around half of epilepsy deaths are from SUDEP.

The 2012 NICE guidelines on epilepsy say that all patients should be given information about SUDEP, but this is not universally put into practice. Unlike cancer and heart disease patients, people with epilepsy are often not told about the risk of dying. Families struggle to talk about the issue, so counsellors and therapists need to be informed and open to support clients' thinking about their condition and their lifestyle choices.

Research shows that people with epilepsy and their families want information early on,[1] but their main source is the internet,[2] which has many misleading websites. It is important that counsellors working with people with epilepsy have this in mind as a vital part of understanding the anxieties and pressures on their clients.

Most deaths occur in young adults, so school and college counsellors particularly need to be aware. Although not everyone with epilepsy will be at risk, some deaths can happen with the second or third seizure, some after many years, even in people who are taking medication as advised and living healthily.

SUDEP Action (www.sudep.org.uk), the main charity involved in this area, has set up a register for all epilepsy deaths, to collect data that can help research into how to avoid the deaths. While not nearly enough is known, there are known risk factors, and there is information about the risks and how to try to avoid them, for people with epilepsy and for professionals.

Epilepsy is still surrounded by stigma and ignorance. I'm not suggesting counsellors should necessarily be responsible for pointing out risks but, by knowing about the bigger issues, they could enable their clients to talk about a taboo subject. The article addresses the emotional effects so well, but it is important that we have the full picture if we are to support people properly.

I have personal experience. My son Benn died in November 2010. He was 37, fit and healthy, working in London and living happily with his partner. The impact on our family, as on all families affected, is enormous and continuing. I am currently writing a book about experiences of traumatic grief after epilepsy death, to support families and raise awareness.

Maxine Linnell
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We need to know about ADHD

I read with immense empathy the letter written by Jane Gould in the March issue of *Therapy Today*. I too have a son with ADHD and I have received unhelpful and unsupportive views from teachers, GPs and even friends. It takes a paediatrician with expertise in ADHD to give an accurate diagnosis and to fully understand the science behind the complicated set of behaviours with which a person with ADHD presents.

People without children or people who have little understanding of the condition can often be judgmental and cause great distress to parents and the child or adult with the condition. As counsellors, I believe we owe it to ourselves and to our clients to develop our understanding of this and other conditions that are most often considered to be genetically predetermined. In this way we can offer appropriate support to parents and people with these conditions.

Sue Jones

Are we paying to work?

In the February issue of *Therapy Today* there is a classified ad for 'diploma qualified counsellors... with a least 100 hours... needed to *volunteer* (my italics) in Lewisham GP surgeries'.

This reminded me of the recent experience of several colleagues at a surgery near

Contact us
We welcome your letters. Letters that are not published in the journal may be published on TherapyToday.net subject to editorial discretion. Please email your letter to the editor at therapytoday@bacp.co.uk or post it to the address on page two.

my home. In this instance the counsellors at the surgery were also unpaid and, when the surgery decided that it could no longer afford to pay their supervision, a number of the qualified counsellors left, leaving trainees on placement to work with the clients. I made a few casual enquiries of other counselling acquaintances and their answers suggest that this is not unusual.

I saw the ad in the same week that I had a conversation with a non-counselling friend, whose views were that if one went to a voluntary counselling agency one would be seen by 'an amateur' (his words), whereas at a surgery he would be seen by a qualified professional employed by the NHS. The reverse would seem to be more likely – at a surgery he is likely to be seen by a not-yet-qualified trainee, whereas at a voluntary agency he would be more likely to be seen by a qualified, probably accredited counsellor of several years' experience. I work in a voluntary agency, with 10 counsellors, eight of whom are qualified and accredited or registered, some with a private practice; the other two are trainees on placement.

And so I have several questions. The first, and most obvious, is: since the GPs are themselves paid, how is it OK to expect qualified fellow professionals (ie counsellors) to work for free? Or, more accurately, to pay to work at the surgery since, even if the surgery pays for supervision (and the Lewisham surgery does provide supervision), there is still the cost of membership of a professional body and ongoing CPD?

Second, I suspect that many clients, like my friend, will assume that the counsellor that they see at the surgery is both qualified and employed (paid) by the NHS.

What does it say about the GPs' attitude to counselling? Is it seen as an unpaid hobby? And how does that feel to the patient/client?

I am ignorant of the workings of the NHS and IAPT but the big, elephant-in-the-room question for me is why, as a profession, do we seem to be going along with this?

Caroline Crabtree
Registered MBACP

Keeping up with technology

Where is the standard setting to ensure counsellors and therapists who provide online video counselling (such as by Skype) are doing so ethically? BACP provides ethical advice for online counselling but specific advice on the use of online video media is limited and is now several years old.

It is a positive step that the BACP is updating the *Ethical Framework* to include the use of new technologies but are more detailed guidelines on the use of digital counselling now necessary?

There are clear differences and challenges when working via video as opposed to face-to-face counselling and yet, when Facetime Consultancy speaks with counsellors and supervisors who work via Skype, we continually hear that our profession is 'working it out as we go along'. The cost of this attitude is most likely borne by our clients; the safety and care of our clients seems to be seriously neglected and proceeding in such a fashion feels profoundly unethical.

As technology continues to develop apace, and more clients expect and are at ease with the use of mobile video technology, the therapeutic community appears in danger of getting left behind. For those counsellors and supervisors who are internet migrants (ie those of us who have not been brought up from infancy with the internet and smart technology at our fingertips), it appears that the fear of technology may also inhibit us even considering how it could enable us to reach a broader range of clients.

We are, as a profession, in real danger of being left behind, both in terms of ensuring we are able to use the developing technology ethically and in the best interests of our clients, and also in terms of failing to meet our clients' growing expectations and need to be able to access counselling via online video in a safe, ethical and effective way.

Is there too little interest in this topic among the therapeutic community? Should the therapeutic community be doing more to set standards, to push this new, but already neglected agenda and wake up to this as a potential threat to the integrity and standing of our caring profession? Are we in real danger of sleepwalking into some misadventure that will further strengthen calls for government intervention and control of counselling?

We fear the answer to all these questions is yes. As a community we need to be picking up this agenda with some real urgency and raising its profile and visibility. Associations such as BACP and UKCP need to be taking a more proactive role in providing our community with the leadership to drive this agenda forward, before others, with less benign interests, decide they must intervene.

Facetime Consultancy is undertaking an online survey of counsellors' attitudes to online video counselling. If you would like to take part please contact us at enquiries@facetimeconsultancy.co.uk

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IAPT quality and value

A report in the News section in the February issue of *Therapy Today* ('UKCP prices mental health') highlights a report produced by the UKCP suggesting that good mental health is worth 10 times more than good physical health. The report also refers to Improving Access to Psychological Therapies (IAPT) outcomes data. This has struck a powerful chord for me as a senior mental health practitioner/psychological therapist working for a large combined primary care mental health/IAPT service.

I am a registered mental health nurse with qualifications in CBT, counselling and psychological therapies. I have been very privileged and lucky to have been funded and supported in achieving these qualifications by my strategic health authority and my NHS employers, and over recent years I have seen the benefit

in the depth and breadth of my increasing theoretical and clinical knowledge and experience in the brief focused work I am able to contribute as a senior mental health practitioner.

Currently I am also undergoing training in dynamic interpersonal therapy (accredited by IAPT as a step 3 intervention for people suffering with depression).

At the same time that I and, I hope, the clients I work with, are benefiting from this investment in practice, I have been noticing with deep concern that the more recent financial constraints imposed on the NHS seem to be leading to monetary over caregiving bias as a priority for the service. I am mindful of the triple constraint model of project management,[1] which proposes that services can either be quick, cheap or good but cannot be all three.

I have decided to write to *Therapy Today* because I feel it is so important to speak up for practitioner/therapists who have built up experience and expertise over the years in working with people who experience mental health problems in a flexible, integrative way that at the same time relies on the evidence of theory applied in good practice.

In general, senior mental health practitioners work with people who have moderate to severe mental health difficulties and we can work with people for up to eight to 12 sessions.

As one of those senior mental health practitioners, I have the opportunity to be flexible in what I provide. After 10 years in this job, I have honed my skills and therapeutic knowledge to the point that I almost feel I have developed my own model of brief integrative therapy for common mental health problems.

Within this model, a maximum of the first four sessions of therapy are used to get to know the person and to develop an understanding of their difficulties. A breadth of knowledge of mental illness and mental health will be drawn on to identify the impact on day-to-day life, and to work out when someone can tolerate opening up issues therapeutically, or whether they need to focus on coping strategies and more practical support.

Another purpose of those early sessions is to draw out the developmental narrative to identify repeating patterns in relationships and attachment patterns, and to develop an understanding of the social circumstances and their impact on mental and psychological wellbeing. This understanding of the situation will be shared with the client so that the next step can be to work on finding an agreed focus for the work.

The clinical work can entail a repertoire of different foci: it may be a counselling approach working at developing understanding and bringing changes to what, up to this point, has been an unwitting repetition of thoughts, feelings and behaviours, or it may be offering the client help in beginning the pathway of change and then considering the next steps. Or it may entail CBT and mindfulness interventions to teach the person more effective ways to manage emotional responses. Or, again, the sessions may be used to look into which longer-term, more supportive services would help the person with their distress, unhappiness or uncertainty about living conditions.

I know my colleagues offer a similarly flexible approach to mental health care and we offer each other valued support and insight into the care we provide as a team within a larger service, thereby increasing the breadth and depth of knowledge and experience available to us and to the people we are working with.

What I feel is important to emphasise is the level of skill, flexibility of approach and clinical value a senior mental health practitioner is able to offer. This accumulation of knowledge is neither cheap nor quick to gather. I feel, however, it is good. Personally I would choose 'good' as a priority of service provision. I hope that in the long term good quality can also be equated with good value.

Isobel Quirk

REFERENCE:
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Professor Robert Burden

21 January 1940 – 22 March 2014

What first comes to mind in thinking about Bob are his warmth, kindness and integrity. I am just one of the many students whom he supervised through their PhDs. He was always generous, supportive and available. He continued this role when an Emeritus Professor of Education, after he had supposedly retired. Bob's work was his passion and retirement was not an option for him. He remained Director of the Graduate School of Education's Cognitive Education Development Unit.

During his career, Bob Burden followed a wide range of research interests with the underlying theme of the application of psychology to educational issues in real-life settings, specifically schools and families. His teaching covered all aspects of teacher education and professional training of educational psychologists. For many years he was Course Director of the M Ed (Ed Psych) programme and he held management positions on secondary PGCE and undergraduate programmes and taught extensively on the Doctor of Education programme, which he was instrumental in creating.

Bob had both national and international recognition as an applied educational psychologist. He edited an international journal and was on the board of a number of others.

From 1999 to 2002 he was Head of the School of Education at Exeter University. His colleagues from the university have noted: 'His influential "Myself as a Learner Scale" revealed the importance of how children think about and respond to education. Bob's work on the self-image, as learners, of dyslexic children was cited by the Rose report of 2009 and led to positive change in government policy.'

In addition to four books on educational psychology, Bob produced a number of chapters in other books, plus many articles in peer reviewed journals. Bob was external examiner in many universities, both in the UK and abroad, including Australia, South Africa and Ireland. He received academic honours worldwide.

Bob was instrumental in introducing the work of Reuven Feuerstein to the UK in the 1980s and spent considerable time working with Feuerstein and his colleagues in both Israel and the UK. He supervised numerous doctoral studies in the area of cognitive education and was still teaching an undergraduate course entitled 'Learning to think: thinking to Learn'.

Throughout his career, Bob maintained close links with the British Dyslexia Association, producing a highly regarded book on this field: *Dyslexia and Self-Concept* (2005). He became a Vice President of BACP in 2007. His knowledge, friendship, commitment and enthusiasm will be sadly missed by all of us who got to know him.

Despite giving so much energy to his academic life, Bob's family was very important to him. I recall how, when a member of his family was ill in 2003, he ran the London marathon (much to my horror!) to raise funds for the charity that supported people with that disease. Yes, Bob excelled in many fields and was a role model in so many ways. May he rest in peace.

Dr Faith Stafford

Meg Taylor

June 1952–March 2013
(**Dawa Khandro**)
Midwife, psychotherapist, mother and writer

Meg Taylor had been disabled with multiple sclerosis for many years and since 2005 was dependant on carers 24 hours a day. Her quality of life became unbearable and she made the decision to take her own life in the only way that was open to her without implicating others. On 16 February 2013 she stopped eating and three days later stopped all fluids. Her dying process was not physically painful and she died peacefully at home in the early hours of 1 March 2013. She was 60. Meg died as she had lived, with great integrity and honesty. In life and in death she was an inspiration to all of us who knew and loved her.

I met Meg in 1987 on the South West London Counselling course that in 1989 transferred to the Institute of Education. She had previously studied at the Institute of Psychoanalytic Psychotherapy and Social Studies with John Rowan. Meg's first degree was in social psychology and she then studied for her Master's in Psychopathology at LSE. In 1978–1980 she trained as a midwife and practised midwifery for seven years, both in hospital and in the community.

Subsequent to the award of a Diploma in Counselling and Interpersonal Skills she became the staff counsellor at the London Hospital in Whitechapel, before working for nine years in private practice. She was accredited with BACP from 1990.

Meg combined a forensic intellect with a depth of compassion and insight. She had a great love of language and was always precise in her use of words. Her website (www.midwifery.megtaylor.co.uk) includes a number of published essays with such titles as 'Labour and Spirituality', 'Psychoanalysis and Midwifery', which demonstrate both the breadth of her intellect and the depth of her insight and reflection. There are also translations of many of the poems of the German poet Hilde Domin, which Meg, who had studied German, made in collaboration with her friend Elke Heckel.

Before she stopped eating she made a video setting out the reasons that informed her decision. This can also be viewed on her website.

Meg is survived by her partner of 30 years, Garry, and by her two sons. She is buried at Epping Forest Woodland Burial Park.

Linda Green

Tony Williams

July 1939– January 2014
Psychotherapist, lecturer, editor

How sad to learn of Tony's death. How awful and poignant to learn it almost by chance, nearly two months after his passing, only thanks to a magazine article. Awful because life can be so fragmented in the city that you can lose touch with and drift away from a dear friend. Years go by without seeing each other and, before you know it, the beloved friend is gone for good. Poignant because the article in question was part of a special edition he curated on psychotherapy and the arts, making the case movingly and convincingly between therapeutic healing and artistic catharsis.

To me, Tony embodied the teachings of his favourite psychologist, Alfred Adler – community feeling, belonging, empathy, solidarity, social justice and responsibility – aligning them in a unique way with Sartre's philosophy and an encyclopaedic knowledge of literature, theatre and films – a knowledge he wore casually, with no ostentation.

To my earnestness for all things deep and philosophical and intense, he responded with a suggestion: 'Read less Dostoevsky; watch some *Coronation Street*.'

I owe him a great deal, including my current profession as a therapist. For one day, during one of our regular conversations in his Notting Hill flat, he casually remarked, 'You know, you'd be good at this business of therapy.' He made riotous fun of the magniloquence some of us (me included) are prone to: 'Ontic, ontological,' he'd say, 'Why don't they talk in plain English?'

Thus his psychological/philosophical metaphors often came from football as well as from novels, from biographies as well as TV programmes. An eloquent lecturer, yet informal in his delivery, for years he chaired meetings and discussions with passion and panache. One of the things I liked best about Tony was his natural reluctance to tribalism and parochialism – the all-familiar attachment to schools, parishes and orientations. He preferred the genuine article – human encounter, human exploration.

An older brother, a substitute father, a mischievous and wise companion, so many guises with one constant theme: encouragement, a quality of the heart which only a brave heart knows.

His descriptionof our relationship was: 'I'm Tenzing Norgay, you are Edmund Hillary. I may suggest to you the terrain, but you've got to do the climbing.'

I always thought of Socrates as over-rated, but Tony made me think again. He had that most Socratic of attributes: midwifery. He attended to our conversations with an open mind and a generous heart.

Manu Bazzano

When your digits do the talking

Cyberpsychology and new media: a thematic reader
Andrew Power, Grainne Kirwan (eds)
Psychology Press, 2014
242pp, £24.99
ISBN 978-1848721661
Reviewed by Phil Topham

Cyberpsychology is the study of interaction between people and digital technology – phones, computers, internet, gaming, virtual reality and artificial intelligence. This book, a collection of research reports by MSc students rather than peer-reviewed papers, is a welcome sampler.

Following an introduction to cyberpsychology by the editors, the reports are themed under the headings of 'Communication', 'Personality and internet use', 'Internet interventions and therapies' and 'Internet and education'. The studies have a suitably exploratory feel about them that reflects the nature of our current understanding. They are clearly written and presented, with summary, background literature, description of methods and discussion of results, into which the reader can delve or skip as they wish.

Research is presented from across the field of cyberpsychology and there are intriguing, albeit tentative, findings about online human behaviour. Victims of identity theft may be no more cautious about information they post than those who have not been targeted; in multi-player gaming, women who have a high need for achievement may present themselves as men in order to receive less help and be challenged more; psychotherapists would prefer to do therapy by webcam even though most of those surveyed had little experience of using one.

For counsellors and psychotherapists this is primarily a resource to raise awareness about aspects of cyberpsychology that have implications for the development of online and technology-supported practice. Relevant topics include trust and deception, identity and self-presentation, the role of personality and attitudes to computerised therapy. I would have liked to read more research about therapy by internet, email, smartphone apps and virtual reality but accept that this is only one aspect of cyberpsychology. As the editors note in their conclusions, academic publishing is struggling to keep up with the pace of technological change in the digital world.

Phil Topham is an independent counselling psychologist

Trauma in the family

The heart of things: understanding trauma – working with constellations
Vivian Broughton
Green Balloon Publishing, 2013
280pp, £17.95
ISBN 978-0955968341
Reviewed by Anne Gilbert

Trauma constellations is a method of working with the intra-psychic splits that result from trauma. It was developed by Professor Franz Ruppert in Germany. In this book Vivian Broughton outlines the origins of the approach and how she has developed and refined the theory in her own practice.

Although trauma constellations is not psychotherapy, it is an offshoot of Bert Hellinger's systemic family constellations groupwork, in which group members take on the roles of individuals in a client's family. Unlike psychodrama, where participants are briefed in advance about the roles they are to play, Hellinger worked in a phenomenological and existential way, treating what emerged from the group members' experience as relevant to the client's current situation.

Part one of the book explores theory. Trauma is placed at the heart of human experience, within a transgenerational model of psychological disturbance. The focus is on early attachment trauma and how the effects can ricochet through the lifespan and, if unresolved, through subsequent generations.

The second section focuses on practice issues, including individual and groupwork. Chapter eight, 'Working with constellations', encompasses diverse case studies on, for example, adoption, incest and working with children. Theory and practice are well linked although the author occasionally lapses into speculation.

The third, much briefer section explores contextual issues. Some may find chapter 12, 'Trauma constellations and psychotherapy', challenging; not all readers will agree with the author's belief that one-off sessions can bring significant relief to those suffering the effects of trauma.

This is a detailed and reflective introduction to trauma constellations work. Given that trauma is such a central issue in therapy, I welcome and recommend this addition to the field.

Anne Gilbert is a Gestalt psychotherapist and supervisor

Why we all need to play

Play: psychoanalytic perspectives, survival and human development
Emilia Perroni (ed)
Routledge, 2013
232pp, £28.99
ISBN 978-0415682084
Reviewed by Gillian Ingram

This is a rich collection of essays on humankind's essential need for play. It was first published in Hebrew over 10 years ago and three new papers have been added to this English translation. Perroni is a psychologist based in Israel, as are all the contributors, and a collective anguish about Israel's history and the current context of military conflict resonates throughout the book.

Part I has a useful essay by a psychoanalyst on 'listening' as the basis for good parenting and preparation for the capacity to play. The theories on play of Freud, Winnicott, Jung and Kohut are then summarised, followed by a stimulating self object reading of Winnicott embedded in a Jungian mindset (pp52–54).

If the child is to survive psychically, the playing space has to be protected and contained by the mother. In part II there is a searing account by a child survivor of the Warsaw ghetto(Yael Rosner) of how her courageous mother did just that, by hiding her in the cellar of an abandoned house for over two years.

Psychoanalytic theory about aggression is thoughtfully covered using Freud, Klein, Winnicott, Bion and Bollas. Sand play therapy is then illustrated from a Jungian perspective, with detailed clinical accounts of how the context of war infiltrates the subjective world of the children in treatment.

Part III examines play and fatherhood through film and classical myth and part IV looks at the realm of theatre.

This book contains some powerful and enlightening essays on the nature of and need for play, especially in time of war. Some of the contributions stray too far from the main theme to make the book easily digestible. However it remains a powerful reminder of our absolute need for play and the importance of space within which to create it.
Gillian Ingram is a psychodynamic counsellor and supervisor

Advice for supervisors

Clinical supervision made easy (second edition)
Els van Ooijen
PCCS Books, 2013
230pp, £22.00
ISBN 978-1906254674
Reviewed by Val Wosket

As the author herself points out, the title of this book slightly misrepresents its content. Van Ooijen's intention is not to imply that supervision is a simplistic activity but to help practitioners feel more 'at ease' with the process.

The book is principally aimed at supervisors new to the role and the author adopts an interactive style that is accessible and practical. Its target readership are the helping professions, with a particular focus on nurses, but the content is also relevant to counsellors and psychotherapists, although experienced supervisors and supervisees may find it light on theory and lacking in depth. Supervision is treated as staff development and the book says rather less about the restorative, transformational, research informed and quality assurance aspects of clinical supervision.

The author gives a succinct overview of a number of current supervision models, selected for their practicality and versatility, including their applicability to group supervision. She goes on to outline her own integrative, three-step model for those new to supervision, which involves: i) establishing the supervisee's needs for the session; ii) looking at how these can be addressed, and iii) considering what has been learned and what needs to happen next.

Van Ooijen writes in an informal, conversational style and her text is interspersed regularly with activity boxes to encourage reflection. I found chapter nine on creative reflection the most refreshing and engaging.

Occasionally the author attempts to pack in too much, with the danger that clarity is lost, as in the discussion of the 'shadow side' (p199) of organisations. In essence, however, the book is a useful reference guide and a versatile tool box. Ideas and strategies are clearly explained and those new to supervision will value a text that demystifies the process and gives practical examples of the benefits that supervision can bring to teams and individuals.
Val Wosket is a BACP registered, senior accredited counsellor, psychotherapist and supervisor

Self-harm narratives

Our encounters with self-harm
Charlie Baker, Clare Shaw, Fran Biley
PCCS Books, 2013
229pp, £18.00
ISBN 978-1906254636
Reviewed by Jackie Townsend

I was challenged, shocked, enlightened, outraged and at times deeply moved by the narratives in this book. I thought I 'knew' about self-harm; this book was a forceful reminder that each person's experience of self-harm is unique and different. What came across most powerfully was the importance of listening and trying to understand what the person's self-harming means to them.

It is not an easy read and at times I had to pause for breath or to wipe away tears. It incorporates narratives, poems, reflections and thoughts about self-harm by people who have self-harmed and by family, friends and professionals. The most powerful voices are those of the people who have self-harmed or are still self-harming. Most narratives end with a personal reflection on

how the contributor views their own story and the messages they would like to convey to professionals and/or others in their own or similar positions.

I cannot recommend this book enough. Written with honesty and dignity, these accounts bear witness to the sometimes monstrous failings of services ostensibly set up to offer help and support. It invites – even demands of its readers that they examine their own attitudes and practices towards self-harm honestly, without defensiveness. But the accounts also offer a message of hope and reflections on what can make a difference.

Jackie Townsend is a counsellor and supervisor

Mixing your drinks

Personal consultancy: a model for integrating counselling and coaching
Nash Popovic, Debra Jinks
Routledge, 2014
237pp, £24.99
ISBN 978-0415833936
Reviewed by Eve Menezes Cunningham

The aim of this book is to introduce Personal Consultancy, a model, and a framework for integrating counselling and coaching that draws on the strengths of both. The authors use the analogy of gin versus tequila. With gin, all the ingredients (gin, soda and lime) are mixed together in the glass; with tequila you can taste each separate ingredient – the salt, alcohol and lime. They aren't saying that practitioners who go for the gin (so to speak) are wrong; simply that a more conscious approach, keeping the ingredients separate, is more beneficial for clients. 'Every practitioner is expected to take responsibility and think carefully where and when the new element that they want to include will fit, and how it will affect everything else... there are as many variations in practice as there are practitioners!', the authors point out (p49).

The framework, which is still in development, comprises four stages: 'Being with the client', 'Authentic listening', 'Supporting' and 'Doing with the client'. The personal consultant is encouraged to re-contract with the client continuously, throughout the process, following the client's lead. The stages are fluid but 'authentic listening' is considered the 'base camp' to which the practitioner returns most frequently.

The book is in three main parts. Part one introduces the personal consultancy framework. In part two, contributors share their experience of using the model to integrate counselling and coaching in a range of settings, from organisations and addiction to working with young people and abroad. In part three a 'critical friend' offers commentary on the model, which the authors discuss in their conclusion, along with areas for development.

It is important to note that this is a snapshot of where things are at this moment; the authors make it clear that they hope more people will adopt the model and help it continue to evolve. I hope the book will be revised regularly as the field is developing so fast.

To counsellors and coaches like me, who wear many hats and want to bring all of ourselves to benefit our clients but are unsure about the best way to go about it, I'd say *Personal Consultancy* is essential reading.

Eve Menezes Cunningham offers a range of therapeutic mind, body, heart and soul practices (including counselling and coach-therapy).

Buddhism and cognitive science

Mind, brain and the path to happiness: a guide to Buddhist mind training and the neuroscience of meditation
Dusana Dorjee
Routledge, 2014
154pp, £19.99
ISBN 978-0415626149
Reviewed by Manu Bazzano

This book is a worthy but flawed endeavour to bring together cognitive neuroscience and the Tibetan Buddhist teachings of Dzogchen.

The author begins with a question *de rigueur* among Western Buddhists: 'What is happiness?' (p1). However, her discussion of 'kinds of happiness' (pp6–22) leads us down a misleading path. Quoting Aristotle, the author discriminates between hedonistic and eudaimonic happiness – the first associated with pleasure-seeking and external possessions, the second linked to self-exploration and wellbeing. In so doing, she bypasses the hedonic dimension, advocated by Greek philosophers Epicurus and Aristippus, the purpose of which is serenity and the appreciation of life's simple pleasures.

By conflating hedonic and hedonistic, Dorjee replicates the dualistic fallacy of most religious teachings, denigrating the humble joys of existence in the name of a spiritual ideal. This contradicts her very sincere attempt to present a non-dualistic perspective.

Dzogchen is a sophisticated meditative/ethical tradition and the very flowering of Tibetan Buddhism, yet is presented here to resemble a 'mind only', non-Buddhist doctrine: 'Such an approach to well-being can perhaps be linked to the "mind over matter" view' (p12). We also learn that 'from the Buddhist perspective, there are elements of our mind which do not cease with our body' (p13). Far from being 'the Buddhist perspective', this is the author's interpretation of Dzogchen's teachings. Similarly, there is so much more to 'western psychology' than Maslow and Frankl, the only two sources ever mentioned in the book (on pages 24–25).

The book attempts to find a synthesis between these two different perspectives of Dzogchen and cognitive science, but they are arguably two irreconcilable worlds. There is an ineffable quality to the transformative power of the Buddha's teachings that bypasses a 'science of the mind' and what some Buddhist teachers see as the 'technologisation' of

meditative practice.

That said, the book is an interesting example of the exciting project to integrate Buddhism and Western psychology.

Manu Bazzano is a psychotherapist and writer

Why therapy isn't the cure

The therapy industry: the irresistible rise of the talking cure, and why it doesn't work
Paul Moloney
Pluto Press, 2013
256pp, £17.99
ISBN 978-0745329864
Reviewed by Colin Feltham

Ours is a strange world in which most practitioners 'know' therapy works, many (but not all) clients feel that it has helped, and research 'proves' it works. Yet a minority of practitioners and many outsiders suggest or 'know' that it doesn't work, while researchers know that the simple term 'works' is fraught with difficulties.

Paul Moloney is a counselling psychologist who is affiliated to the Midlands Psychology Group, itself linked to David Smail's scepticism about therapy and a 'social-materialist' theory of distress. The book articulates many longstanding reservations about therapy in its varied forms, promoting the view that ongoing social inequalities cause most of our psychological distress. We might infer that therapy often brings comfort in an often brutal world but rarely if ever brings cure or freedom from distress or unhappiness.

Moloney writes very clearly, is passionate rather than cynical, and argues carefully with the claims of outcome research and theoretical infrastructure. He brings in philosophy and sociology when necessary, and takes on the problem of the medicalisation of distress. Ultimately though, he can offer no better solution except the hope that we can 'change the world'. I personally don't agree that our ills lie mainly in contemporary social structures, seeing David Smail's analysis as correct up to a point but neglecting an evolutionary psychological aetiology of distress.

For practitioners who have paid their way through training and are struggling to build a career, reading books that undercut belief in therapy is a challenge. The importance of this book lies in what we should not be embarrassed to call the search for truth. Moloney has written a masterly critique.

Colin Feltham is Emeritus Professor of Critical Counselling Studies at Sheffield Hallam University, and Associate Professor of Humanistic Psychology, University of Southern Denmark

Loves lost and refound

Unexpected lessons in love
Bernardine Bishop
John Murray, 2013
384pp, £7.99
ISBN 978-1848547827
Reviewed by Naomi Stadlen

Bernardine Bishop was a psychoanalytic psychotherapist who died of cancer last year. *Unexpected Lessons in Love*, one of her three published novels, is about two women – a retired psychotherapist and a novelist – who meet and become friends because they both have colostomies, following cancer treatment.

As you might expect from a psychotherapist, the focus of the novel is on relationships: between couples, friends, parents and children.

Psychotherapists often write as if love is inevitably ambivalent and does not exist without hate. Bishop clearly believes that people can love unreservedly, but she doesn't make love seem easy. Her characters struggle with one another's less attractive aspects before finding ways to accept them.

The book includes two significant themes: adoption and psychosis. Abandoned by his mother, a two-month-old baby is taken in first by his grandmother and then by the father and his new partner. Alongside, in another of the life journeys charted in the book, Bishop describes a child given up for adoption many years previously. In each case, the adoptive relationship is more loving than the biological one.

Bishop gives an equally sensitive account of the mother of the two-month-old baby. Depicted initially as bizarre and even dangerous, seen through the sympathetic eyes of the main character, the mother's behaviour emerges as both 'psychotic', in that it is dictated by voices, and understandable.

The last paragraph of the novel is a profound testament to life and love, written by the author shortly before her death. *Unexpected Lessons in Love* was shortlisted for the 2013 Costa Novel Award. That it didn't win is no reflection of its unique strengths.

Naomi Stadlen is an existential psychotherapist and author

From the Chair

Hope, loss and voluntary counsellors

It's time to tackle the issue of counsellors working for free, says *Amanda Hawkins*

My thoughts this month are with the families of the passengers on the missing Malaysian Airlines plane. It's terrible to think of so many people dying like that, and all those families who are waiting for proof that their loved ones are indeed dead. It's hard to let go of hope. Our need to find meaning in endings is so great. I can't even imagine the distress of those families. The sense of helplessness is huge. Does it make me a bad person if I give up hope? Does it mean I don't love that person enough? Do I need to let go and accept that they are not coming back? Do I grieve and move on? I just hope that some resolution will come that allows the families to find a way of honouring their loved ones.

This month I again have to report a death: of Robert Burden, one of our vice presidents. Robert served as a vice president for seven years and gave much to the Association. He was Professor Emeritus at Exeter University and specialised in researching the wellbeing of children and young people. As we have a division for counsellors working with children and young people, we were very pleased to have him on board with his particular interest in psychology in family and child issues and in schools and in education. Our VPs do a fabulous job advocating for the profession in wider circles, and Bob's particular contribution to supporting our work for children and young people was significant. We will miss his wise counsel.

At the weekend I attended the AGM of the Irish Association for Counselling and Psychotherapy in Dublin. Over 400 people attended. It's fascinating to see how universal some issues are for counsellors. One of the motions debated was a call for a better professional framework to ensure that counsellors are paid properly and fairly. There was much anger in the room that services are profiting from the use of voluntary counsellors, rather than paying them a fair wage. Personally I have no objection to people giving their time for free and I do some 'pro bono' work myself, but that should be a decision for the individual; qualified professionals providing a service have a right to be paid. Counsellor training is expensive, and many of us spend years and a lot of money in qualifying, and continue to spend a lot on CPD. Would we ask medical doctors to look after our physical health for free? No. So why do we expect this in mental health? It's an issue that we have skirted around now for years and I think it's time we tackled it. I don't have the answers but I do want the debate.

Tomorrow I attend the launch of Counselling MindEd, the online training resource that BACP has developed for counsellors working with children and young people. It's part of a bigger MindEd e-portal project and was allocated £750,000 of the total £2.9 million Department of Health funding. That we have our own section, alongside Children and Young People's IAPT, makes a significant statement about the recognition of the importance of counselling. Do please visit the website and look at what the Counselling MindEd team has created – it's fantastic. It makes counselling accessible and user-friendly and, because it's based on our new CYP competence framework, offers high quality, standardised e-learning for all counsellors working with children and young people in all contexts. Overall, MindEd itself, because it is intended for all professions (police, social workers, sports coaches, teachers and others) working with these age groups, will help combat the stigma and indeed fear that many have of reaching out to children in distress, lest they make things worse.

> 'It's hard to let go of hope. Our need to find meaning in endings is so great. I can't even imagine the distress of those families'

And last, but not least, I would urge all members to contribute to the review of the BACP *Ethical Framework* that's just been launched. It's led by Professor Tim Bond, who co-authored the 2002 *Ethical Framework*, and he very much wants members to have input. The *Ethical Framework* is central to our daily practice as counsellors so any changes will affect how you work. You need it to support and guide your professional practice today and into the future. The current *Framework* is more than 10 years old and counselling and health and social care have moved on considerably.

We've organised three half-day webinars, on 26 April, 24 May and 5 July. Do try to attend at least one of them and contribute to the discussions. They're completely free and you can attend from the comfort of your own home! The details are at www.bacp.co.uk/efc ■

BACP membership fees for 2014–15

Membership fees enable BACP to function and carry out its range of work as well as providing benefits such as information guidance sheets, the Ethics helpdesk and its portfolio of journals.

Your fees also help BACP raise the profile of the psychological therapies at Government level and among opinion formers, and educate the public through our www.itsgoodtotalk.org.uk website.

It has therefore been necessary to increase the membership fees slightly for the next year so that BACP can continue its work. The fees from 1 April 2014 will be as follows.

Individual membership of BACP

Category	*Standard 2014-15*	*Reduced 2014-15**
Registered MBACP Accred	£174	£87
MBACP Accred	£174	£87
Registered MBACP	£156	£78
MBACP (closed category)	£156	£78
Individual Member (new)	£156	£78
Associate (closed category)	£146	£73
Student	£74	£37

Individual membership of divisions

(In conjunction with individual membership of BACP)

Division	*Standard 2014-15*	*Reduced 2014-15**
BACP Children & Young People	£20	£10
BACP Coaching	£20	£10
BACP Healthcare	£30	£15
BACP Private Practice	£20	£10
BACP Spirituality	£20	£10
BACP Universities & Colleges	£40	£20
BACP Workplace	£30	£15

Organisational membership of BACP

Category	*2014-15*
Local voluntary and charitable	£222
National voluntary and charitable	£288
Commercial	£545

Organisational membership of divisions

(In conjunction with organisational membership of BACP)

Division	*2014-15*
BACP Children & Young People	£35
BACP Coaching	£50
BACP Healthcare	£50
BACP Private Practice	£40
BACP Spirituality	£25
BACP Universities & Colleges	£120
BACP Workplace	£75

Overseas postage

Non-UK postage annual surcharge	£19

** Reduced fees are available to members who are in receipt of a state benefit, including state pensions (but not tax credits) and members who are unwaged with no personal income.*

Calling all BACP journals readers

BACP is inviting feedback from the readers of its specialist quarterly journals, which are produced by the seven BACP divisions.

The journals are included with membership of the divisions and are available on subscription to non-members.

We want the journals to reflect readers' interests and concerns. So, if you are a reader of any of the journals, we'd like you to complete a very short survey by following the relevant link below for your journal. It should only take 10 minutes.

For *BACP Children & Young People* go to https://www.surveymonkey.com/s/BACPChildrenandYoungPeopleonlinereadersurvey

For *Coaching Today* go to https://www.surveymonkey.com/s/CoachingTodayonlinereadersurvey

For *Counselling at Work* go to https://www.surveymonkey.com/s/CounsellingatWorkonlinereadersurvey

For *Healthcare Counselling & Psychotherapy Journal* go to https://www.surveymonkey.com/s/HealthcareCounsellingandPsychotherapyJournalsurvey

For *Private Practice* go to https://www.surveymonkey.com/s/PrivatePracticeonlinereadersurvey

For *Thresholds* go to https://www.surveymonkey.com/s/thresholdssurvey

For *University & College Counselling* go to https://www.surveymonkey.com/s/universityandcollegecounsellingonlinereadersurvey

Praise for Practitioner conference

BACP's new Practitioner conference has been a big success. A total of 436 delegates attended one of the paired events: 246 in London (28 February) and 190 in Leeds (8 March).

The conferences brought together four of the BACP divisions – BACP Workplace, BACP Coaching, BACP Healthcare and BACP Spirituality – for the first time in a joint event.

One of the aims of the conference was to offer divisional members an opportunity to sample other areas of specialist practice. In London more than half the BACP Healthcare delegates attended a keynote presentation outside their 'stream', while just 44 per cent attended the BACP Healthcare keynote presentation. Similarly, 75 per cent of BACP Workplace and 49 per cent of BACP Coaching delegates attended presentations outside their 'stream'. However, the majority of BACP Spirituality delegates (73 per cent) attended Isabel Clarke's guest presentation on spirituality. There was a similar pattern in Leeds.

Comments from delegates showed that many enjoyed the diversity of content: 'I enjoyed the different strands. So much food for thought to take away that will enrich my practice'; 'Possibly one of the best conferences attended in 10 years because of the variety of input'; 'Great range of subjects, appreciated the choice, also the opportunity to go to strands that were familiar and new.'

'We have all been delighted with the response from delegates. It's clear that the experiment worked. Delegates were able to stay within their field of interest or pick and mix across the different streams, as we hoped and planned,' said BACP Deputy Chair, Elspeth Schwenk.

The chairs of the four BACP divisions were also pleased with the response. Gill Fennings-Monkman MBE, Chair of BACP Coaching, reported very positive feedback from delegates: 'People welcomed the chance to "try on" coaching to see how it could add to their skill set.' Tina Abbott (BACP Workplace) said there was a 'real sense of energy' at both events and delegates appreciated being able to go to workshops across the streams: 'The only complaint was they couldn't attend more. I think it is a great way to run divisional conferences.' Melody Cranbourne-Rosser (BACP Spirituality) said there had been a lot interest among delegates in the work of the division: 'I loved the enthusiasm, generosity of spirit and general buzz in the air.' For Zubeida Ali, Chair of BACP Healthcare, the conferences provided 'the ideal platform for members to hear about the successes of their own division as well as those of others'.

New name and logo for APSCC

bacp spirituality

British Association for
Counselling & Psychotherapy

The Association for Pastoral and Spiritual Care and Counselling (APSCC) has chosen a new name and logo.

The division, which has some 1,150 individual and organisational members, is the last to adopt a new name in the BACP rebranding programme to boost membership of the seven specialist divisions.

The division's new name will be BACP Spirituality, with the strapline 'Honouring spirituality, belief and pastoral care in counselling and psychotherapy'.

Thresholds, its quarterly journal, has a new editor. Amanda Anderson takes over this month from Susan Dale, who has been appointed BACP's new Good Practice Guidance Manager. Amanda has worked in academic and educational publishing for over 20 years and is currently completing a part-time Master's course in core process psychotherapy at the Karuna Institute on Dartmoor.

Ethical Framework review

The first of three webinars for BACP members to contribute to the review of the *Ethical Framework* takes place later this month.

The review will update the 2002 *Ethical Framework* to reflect developments in counselling and the wider healthcare world in the 10 years since it was published. It is led by Tim Bond, who co-authored the 2002 *Framework* and is Emeritus Professor at Bristol University (see 'The interview' in last month's *Therapy Today*).

The webinars aim to give as many BACP members as possible the chance to input their views. 'The new *Ethical Framework* will have a direct influence on counsellors' future practice. We very much want BACP members to contribute their thoughts on how it can better reflect the realities of their practice today and the challenges they foresee in the future,' Tim Bond says.

The first webinar is on Saturday 26 April from 10am–12.30am and will focus on the core duties. The second is on 24 May and will look at supervision and line management. The final webinar is on 5 July and will be an overview of proposed changes, including a 'duty of candour', tighter record keeping requirements, protecting the rights of children and vulnerable adults, and ethical issues in relating to new technology.

The webinars are free. You can book your place at www.bacp.co.uk/efc/

Why I joined... BACP Private Practice

Trisha Fisher is a person-centered counsellor and supervisor working in private practice in Liversedge.

She qualified in 2002 and combines her independent practice with a part-time job with Leeds and York Partnership Foundation NHS Trust, supporting carers of people with mental health problems. She is a carer for a family member who has mental health problems.

'When I started the training it all just fell into place. I guess I've always had an interest in the psychology of how people work and communicate, and in human relationship, and in exploring that in myself,' she says.

She has been a member of BACP since she joined as a student and was persuaded to join BACP Private Practice by Susan Utting-Simon, a colleague and member of the BACP Private Practice Executive, who is also based in Leeds. 'For me, one of the big benefits is the journal,' says Trisha. 'My daughter is also a counsellor and we have had some really good discussions lately, sparked by some of the articles, like the one on social media in the latest issue.

'Being in private practice can be quite isolating. It's very easy to jog along in your own little world, sticking with what has always worked well for you. For me the journal brings different ways of looking at things and different ways of working into your awareness. It makes you think.'

She also welcomes the peer support from belonging to a professional peer group. She instigated the newly formed Leeds regional BACP Private Practice networking group, and organised and co-facilitated its first meeting in January. 'There was a real buzz in the room and we got some very good feedback. I think it's really useful to have a forum where you can get together with peers. You can learn a lot from each other and make links locally.

I also went to the BACP Private Practice conference last year and that was brilliant. I really enjoyed hearing how other people work and the opportunity to chat with people from all over the country. It all broadens your professional horizons.'

BACP Private Practice regional networking groups meet in Leeds on 26 April, Ashford (Surrey) on 10 May, Nottingham on 10 May and Edinburgh on 28 May. Details are on the website at http://bacppp.org.uk. To join any of the BACP divisions, email divisional@bacp.co.uk

New Lead Advisor for Coaching appointed

Veronica Lysaght has been appointed BACP Lead Advisor for Coaching. Veronica will be responsible for internal and external liaison and supporting BACP's work on behalf of members who coach. 'Veronica's role is ambassador, advisor and advocate for coaching. She is a very welcome addition to our Sector team and will greatly enhance the support and leadership we offer to our coach members,' BACP Senior Lead Advisor, Karen Cromarty says.

Anne Calleja, BACP Coaching Network Group Organiser (NGO) for Oxford and a member of the BACP Coaching Executive, has been elected Chair Elect of the division. Anne will work alongside the current Chair Gill Fennings-Monkman and will take over as Chair when Gill completes her period in office.

Eve Menezes-Cunningham has joined the Executive as Executive Specialist for Communications.

BACP Workplace

BACP Workplace is looking for a new member to join its Executive Committee to work on its website. No special expertise is necessary as full training will be provided. For more details, contact BACP Workplace Chair, Tina Abbott: abbottta@cardiff.ac.uk

BACP Universities & Colleges

Full details of the 2014 BACP Universities & Colleges conference have been confirmed. Bookings for the event are now being taken.

The conference takes place at the University of Exeter from 24–25 June. Its theme is 'Being present: exploring process and practice in our counselling services'.

For full programme details and to book your place, go to www.bacpuc.org.uk or call BACP Customer Services on 01455 883300.

BACP CYP conference

New technology and its influence in the lives of children and young people and on counsellors' clinical practice is the focus of this year's BACP Children and Young People conference. 'Technology: Friend or Foe?' takes place in London on Saturday 21 June. Speakers include Jim Gamble, former Chief Executive of the Child Exploitation and Protection Centre (CEOP). To book go to www.bacp.co.uk/events or call 01455 883300.

Supporting women offenders

BACP has published a new report on the role of counselling in helping women offenders stay out of prison.

The report, *Mental health provision in women's community services*, is based on a survey of the 48 women's centres in England and Wales that provide community-based support for women offenders and those at risk of offending.

BACP is campaigning with the Centre for Mental Health and the charity Women's Breakthrough for more such alternatives to prison for women offenders. They argue that prison is damaging for women and their children and that in many cases women can be better supported through community sentencing to deal with the issues that led to their crime.

Nearly three quarters (34) of the women's centres responded to the survey. Three quarters (76 per cent) offered some kind of mental health intervention and 71 per cent offered psychological therapies. Centres often also offered a range of other support, including psycho-education, art therapy, mentoring and confidence and self-esteem building.

Counselling was the most frequently provided type of psychological therapy offered (by 20 centres)and 12 provided mindfulness.

Waiting times for in-house therapies were less than two weeks in most cases, but longer if the woman had to be referred off-site. The most common problems treated in-house were anxiety, relationship issues and anger management. Offsite referrals were mainly for psychological therapies and substance/alcohol misuse treatments.

'The survey shows that women using the centres are benefiting from a very broad range of services including counselling,' BACP Chair Amanda Hawkins says.

'Women leaving custody have very complex needs and, without a very different form of support, outcomes are poor. Women's community centres are at the heart of this different approach,' Jackie Russell, Director of Women's Breakout, says.

Currently women's centres are not available nationwide. 'We now need to find out more about what support women need, what outcomes can be achieved and how it can be delivered in all parts of the country,' Sean Duggan, Chief Executive of the Centre for Mental Health, said.

The report cn be downloaded free from www.bacp.co.uk/research

New CYP framework

BACP's new competence framework for counselling children and young people is now available online.

The framework is based on a comprehensive review of the research literature and was produced by BACP's Professional Standards team and an expert reference group led by Tony Roth, Professor of Clinical Psychology at University College London.

The framework sets out the competences needed to deliver effective, evidence-based humanistic counselling for young people aged 11–18. It can be used by colleges and universities when developing their curricula and will bring greater consistency in standards of education and training. It can be downloaded from www.bacp.co.uk/research/resources/cyp_competences.php

New CfD textbook published

Sage has published a new textbook on Counselling for Depression (CfD). Written by Pete Sanders of PCCS Books and BACP's Head of Research Andy Hill, *Counselling for Depression* is the first book to explain the theory and practice of this person-centred/experiential approach to counselling depression.

CfD is recommended by NICE for treating depression and is offered through the national IAPT programme.

The book's chapters include evidence-based practice and person-centred and experiential therapies, the CfD competence framework, the CfD therapeutic stance, in-depth case studies illustrating CfD in practice and training, supervision and research. It also includes lists of CfD competences, research data supporting the approach, and sources used to develop the humanistic competence framework

This will be vital reading for counsellors taking CfD training or a humanistic counselling and psychotherapy course, as well as for those already working in the NHS wishing to enhance their practice.

The book costs £22.99 (pb: ISBN 978-1446272091) and is available from all good outlets now.

Research enquiry of the month

This month's research enquiry of the month was: 'What research is available that has investigated Eros in the counselling room?'

We searched our internal abstract database and Google Scholar using the search terms 'Eros' or 'erotic (counter)transference' and 'counselling room'.

Much of the published literature draws on case studies. Many of the practitioner-researchers working in this field believe that erotic transference and countertransference can be damaging to the therapeutic relationship. However, they also believe that it has the potential to enhance their therapeutic work.

Most of the research conducted in this area is limited to very small samples so the results cannot be generalised to the therapeutic community as a whole. Furthermore, psychodynamic psychotherapy is grounded in theory, rather than empirical data, and this should be taken into account when appraising the research literature.

If you would like help with any counselling and psychotherapy research query, or would like the list of references used to compile this response, please email research@bacp.co.uk

BACP Research Conference

The full programme for the 2014 BACP International Research Conference has now been finalised.

The conference takes place 16–17 May in central London and is co-hosted with the American Counseling Association (ACA).

The conference starts with a preconference workshop on Counselling for Depression on Thursday 15 May. Keynote speakers are Professor Louis Castonguay, Professor of Psychology at Pennsylvania State University (16 May) and Dr Miranda Wolpert, Director of the CAMHS Evidence Based Practice Unit (EBPU) at University College London and the Anna Freud Centre (17 May).

With 46 papers, five symposia (a further 22 papers), four workshops and 28 poster presentations, the conference is the biggest event in the international counselling calendar.

You can download the full programme and book your place at www.bacp.co.uk/research/events/index.php

Research surgeries

Do you have a research problem or dilemma?

The BACP Research department holds regular telephone advice 'surgeries' with Andy Hill (Head of Research) and Jo Pybis (Research Facilitator) .

The sessions are 30 minutes. The next surgery dates are from 2–4pm on 16 April and 28 May. To book, please contact Stella Nichols on 01455 883372 or stella.nichols@bacp.co.uk

Calling all PhD students

The BACP Research department wants to hear from all BACP members who have completed doctorates in the last five years.

We would like to know the subject of your research and what you are doing now.

If you have completed a PhD or professional doctorate in counselling and psychotherapy in the last five years, please get in touch by emailing us at research@bacp.co.uk

Newly accredited counsellors/psychotherapists
Jan Albertsen
Sidika Alkan
John Anderson
Amy Barnes
Linda Best
Francine Bracken
Pam Brown
Benita Carter
Rakhi Chand
Piers Clifford
Kerri Crewe
Victoria Cuming
Sarah Curran
Catherine Davies
Judith Davies
Brian Dennis
Julia Disney
Sarah Eaby
Bupp England
Linda Eshag
Tara Evans
Jodi Ferris
Marie Fillbrook
Linda French
Jayne Gabriel
Marilyn Gaudencio
Katherine George
Paula Gerrard
Romilly Gregory
Susie Hewitt
Catherine Howbrook
Russell Kendall
Atoosa Khosravi-Noori
Lynne Marjoram
Lorraine Martin
Hilary O'Neill
Catherine O'Rourke
Jo Ounstead
Jane Ryder
Shirley Share
Sara Speakes
Julie Steele
Gillian Strutton
Jenny Sutherland
Valerie Tavares
Margaret Tonge
Tracy Walker
Susannah Wheller
Fiona Whiteman
Peter Wyatt

Newly accredited service
The Arts University Bournemouth Student Counselling Service

Newly senior accredited counsellors/psychotherapists
Penelope Davis
Glenna Demeter
Christine Martin
Garath Powell

Newly senior accredited counsellors/psychotherapists for children and young people
Jane Chambers

Newly senior accredited supervisor of individuals
Meriel Pinkerton

Service accreditation term renewals
PSS Spinning World & Women's Turnaround Counselling
The Maya Centre

Counsellors/psychotherapists not renewing accreditation
Fiona Ablett
Charlotte Ansell
Catherine Bradbury
Lynda Brandish
Hermione Bridges
Erica Buckmaster
Rachel Burns
Elizabeth Campbell
Christine Cook
Lynda Dale
Catherine de Wolf
Rosemary Evetts
Lynda Godden
Stephen Golden
Sylvia Harwood
Elizabeth Higgins
Sally Holligan
Melanie Hopkins-Womble
Joy Jeffrey
Judith Jones
Deirdre Long
Margaret Malcolm
Sally Mathews
Hazel McEvoy
Margaret Miller
Jacqueline Mo-An
Graham O'Neil
Teresa Onions
David Phillips
Richard Provis
Alison Rosenthal
Andy Rushton
Jessica Salomone
Alexandrina Scarbrough
Marie Simmonds
Martin Simpson
Rosaleen Simpson
Valerie Smith
David Tann
Steve Vincent
Marcella Walsh
Susan Widlake
Lynn Wood

Counselling/psychotherapy services not renewing accreditation
Ezer North West Counselling

Members whose accreditation has been reinstated
Jan Kristian
Patricia Barden

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

Around the Parliaments

Lack of Parliamentary time prevented Labour and Co-operative MP Geraint Davies' Counsellors and Psychotherapists Bill receiving its second reading on 28 February 2014. The second reading of this Private Members' Bill has now been scheduled for 6 June 2014.

BACP's Policy team is already preparing for next year's general election. We have had a meeting with Lord Storey, Chair of the Liberal Democrat Parliamentary Committee for Education, Families and Young People, to discuss school-based counselling. The Liberal Democrat Conference passed a motion in 2011 calling for a counsellor to be available in every secondary school in England. This is one of several meetings BACP has held with the Liberal Democrats to discuss taking forward this policy commitment.

Children's wellbeing and child and adolescent mental health services (CAMHS) have been hot topics in the parliamentary committees in England and Wales.

BACP contributed written evidence to the Welsh Parliament's Children, Young People and Education Committee's inquiry into child and adolescent mental health services.

In the UK Parliament BACP contributed to the Education Committee's inquiry into 'Child Well-being in England' and to the Health Committee's inquiry into 'Children's and Adolescent Mental Health and CAMHS in England'. We also contributed to a number of partner organisations responses to maximise our message.

BACP attended the second evidence session of the All-Party Parliamentary Group for Mental Health inquiry into parity of esteem between mental and physical health. This session focused on the quality of mental health emergency care. The APPG heard evidence from the Rt Hon Damian Green MP, Minister for Policing, Criminal Justice and Victims, about efforts to keep people with mental health problems out of the criminal justice system, including the recently launched Crisis Care Concordat, street triage trials and the liaison and diversion pilot scheme. The third and final evidence session, on mental wellbeing as a public health priority, is in May.

BACP launches parity of esteem initiative

BACP has launched a major policy initiative to explore the implications for psychological therapies of the Government's commitment to 'parity of esteem' between mental and physical health.

The initiative was launched on 3 April at a breakfast meeting in central London, where a panel of speakers and an audience of invited guests from third sector and mental health stakeholder organisations debated how parity of esteem could be made a reality in relation to psychological therapies.

The event was chaired by Jane Dreaper, BBC Health Correspondent. The speakers included Professor Dame Sue Bailey, President of the Royal College of Psychiatrists; Paul Farmer, Chief Executive of Mind; Dr Clare Gerada MBE, Chair of the London Primary Care Clinical Board at NHS England; Julie Stone, Healthcare Ethics and Law Consultant, and BACP President Dr Mike Shooter.

Participants debated whether the goal should be equality in waiting times, choice, access, service funding and research funding or if parity would be better achieved by creating an entirely integrated health and social care service. They also discussed how these could be realistically achieved.

Panel speakers highlighted the obstacles, opportunities and drivers for improving access to talking therapies. Paul Farmer pointed out that IAPT has 'improved access to psychotherapies' but only to some therapies and for some groups.

Julie Stone challenged the argument that some therapy is better than none. 'Parity is access to safe, effective treatments provided by a properly skilled workforce. Saying some therapy is better than no therapy at all doesn't cut it. They wouldn't say that about surgery,' she said.

BACP will be publishing a final report in the autumn. 'This was an opportunity for leading stakeholders to contribute right from the outset,' Mike Shooter said.

BACP backs cuts protest

BACP has backed a joint campaign by six leading mental health organisations against cuts in funding for NHS mental health services in England.

The NHS and Monitor, the NHS economic regulator, have ruled that non-acute health care services, including mental health trusts, will have their funding cut by 1.8 per cent. This is to raise the £150 million needed by acute hospital trusts to improve staffing levels to comply with the recommendations of the Francis report on Mid Staffordshire NHS Foundation Trust. But acute health care services will have their funding cut by only 1.5 per cent.

In a letter to *The Guardian*, Mind, Rethink Mental Illness, the Royal College of Psychiatrists, the Mental Health Foundation, the NHS Confederation Mental Health Network and the Centre for Mental Health said the decision sends 'a disturbing and deeply disappointing message, and is likely to have far-reaching consequences for people with mental illness'.

Responding to the statement, BACP said the cuts 'show that [the Government's] message that mental health must no longer be the poor cousin in the NHS is not getting through even to its own senior managers'.

BACP is calling on the Department of Health to review its decision and 'make good on its promise to treat those with mental ill health as equal to those with physical health problems and avoid the necessity for more costly interventions in the future'.

Couple relationships 'critical'

On 11 March BACP attended a joint meeting between the All-Party Parliamentary Groups (APPGs) for Conception to Age Two, Sure Start Children's Centres and Strengthening Couple Relationships at the Houses of Parliament, chaired by Andrea Leadsom MP.

Speakers debated the importance of couple relationships in the period from conception to age two and the role of children's centres in supporting couple relationships.

Anne Longfield OBE, Chief Executive of 4 children, gave the introductory speech highlighting the reach and work of children centres, which are used by one million families and a quarter of which provide relationship support. Honor Rhodes from the Tavistock Centre for Couple Relationships spoke of her training work with children's centre managers to raise their awareness of the importance of a couple's relationship and the effects on a child when their parents have a poor relationship. Bev Miller, Director at Relate Derby & Southern Derbyshire, emphasised the central role of children's centres in providing counselling and warned that this work was under threat because of cuts in funding.

BACP has since provided the APPG for Conception to Age Two with information for its submission to the Health Committee inquiry into Children's and Adolescent Mental Health and CAMHS in England.

Support EDM 1063!

Last month we told you about Greg Mulholland's Early Day Motion 1063 on improving access to psychological therapies. We still want members to contact their MP to support the motion.

Guidance on how to contact your MP, including a pro-forma letter and email you can use, can be found at www.bacp.co.uk/policy/edm1063.

Get involved. Ask your MP to support the motion and let us know how you get on!

Support for school children with special medical needs

Access to school-based counsellors could be an important source of support for children with special medical needs in mainstream education, BACP has said.

In its response to a Department for Education consultation on new guidance on 'Supporting pupils at school with medical conditions', BACP says access in every secondary school to school-based counsellors could help schools achieve many of the Department's objectives, including reducing school absences due to health problems, enabling children with medical conditions to fully engage with learning, and ensuring they enjoy the same opportunities at school as any other child.

BACP says counsellors can promote understanding in the school community of the impact of a medical condition on a child's ability to learn, and can work with children to increase their confidence and promote self-care.

BACP Professional Conduct Hearing
Findings, decision and sanction
Paul McGinley
Reference No: 568810
Barking IG11

The complaint was heard under BACP Professional Conduct Procedure 2010 and the Panel considered the alleged breaches of the BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy*.

The Panel made a number of findings and the Panel was unanimous in its decision that these findings amounted to professional malpractice in the provision of inadequate services, as Mr McGinley's service fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill.

Mitigation

Mr McGinley states that he now has a psychodynamic supervisor, which helps him to see things differently. He further stated that he had changed his practice and now provides his clients with a written information sheet containing the terms and conditions of his service, a copy of which was contained within his written evidence. Mr McGinley further stated that he was reviewing his process regarding note taking.

Sanction

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

Within six months of the date of the imposition of this sanction, Mr McGinley is required to provide a written report detailing his learning and understanding of the parts of the complaint that have been upheld, which should be countersigned by Mr McGinley's psychodynamic supervisor. Further, Mr McGinley is required to evidence how his practice with regard to note taking has changed, given his written evidence that he is reviewing the way in which he takes notes.

These written submissions must be sent to the Deputy Registrar and Deputy Director of BACP Registers by the given deadlines, and will be independently considered by a Sanction Panel.

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