Therapy Today

For counselling and psychotherapy professionals

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Recession depression

Counselling in the US and the UK

Transpersonal therapy and the soul

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- Maintain and raise standards of training and practice
- Provide support for counsellors and those using counselling skills, and opportunities for their continual professional development
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Contents

Sarah Browne
Editor

For months now, when I've been doing my supermarket shop and flinching at the price of an apple or a loaf of bread, I've been wondering and worrying about how families on very low incomes are surviving. Researching the feature on recession depression has opened my eyes to the world of foodbanks and suicide statistics connected to unemployment. I realised that things are a lot worse than I had imagined. I had no idea, for example, that there are two new foodbanks opening every week in towns and cities across the UK and that thousands of people are using them to feed their children. Nor did I know that a one per cent rise in unemployment equates to a 0.79 per cent rise in suicide.

Talking to counsellors in different sectors, a picture emerges of hugely increased demand for services by people affected by the recession in different ways: young unemployed people, people who have lost their welfare benefits in desperate financial situations, huge increases in relationship breakdown due to financial stress, increases in suicidal ideation and alcohol addiction.

Over the years I have heard various ministers at the New Savoy Conference pledging that they will not abandon the unemployed; that they will not let them sink into depression, never to return to the workplace etc etc. This year's conference was no exception. The promises were there but the disconnect between policy and what is happening on the ground seems to be getting wider. Everybody recognises that huge progress has been made in the last four or five years in terms of trying to improve access to psychological therapies on the NHS, but currently clearly only a fraction of those who could benefit are getting any kind of a look-in. Judging from the comments from GPs in *The Austerity Report 2012*, many of them are not even bothering to refer people for counselling because the waiting lists are so long. When we know the difference that counselling can make, this is disappointing indeed.

Features

Cover illustration by Shonagh Rae

Regulars

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This month online: Colin Feltham in conversation with Caro Bailey; Shonagh Rae discusses the ideas behind her illustrations; our 'From the archive' article by Mike Shooter explores counselling in the context of poverty; the new episode of Chris Rose's fictional series 'The Wednesday group'; and the latest news.

Minister hears IAPT plea

Care Services Minister Norman Lamb has pledged to do his utmost to ensure the survival of IAPT when the new clinical commissioning groups and the NHS Commissioning Board take over from PCTs in April 2013.

Speaking at the opening of the Psychological Therapies 2012 conference, 29–30 November, Norman Lamb praised IAPT's successes since its launch in 2008.

But he expressed concern that in some areas progress with the continued roll-out of the adult programme is slowing down. 'I am doing everything I can to get it back on track but there is nothing in the system to force commissioners to give equal priority to mental health services as to physical care,' he admitted. He said the new NHS Mandate (see p50) would bring 'parity of esteem' and help remove the institutional disadvantage that has kept mental health services underfunded.

He said he was aware of the concerns about the future of the national IAPT team. 'The transition will present challenges but, whatever the programme looks like, I have been absolutely clear about what I expect [the NHS Commissioning Board] to deliver.' He said the NHS Mandate target for 15 per cent of all those eligible to receive psychological therapies will allow the Government to hold the NHS Commissioning Board to account.

Cutting services 'is not the answer,' he told delegates. 'We must not allow the absolute need to make more efficient use of resources to impact on quality... There is so much potential to get people back into work and help with a whole range of conditions. In many ways we are only at the beginning of the journey.'

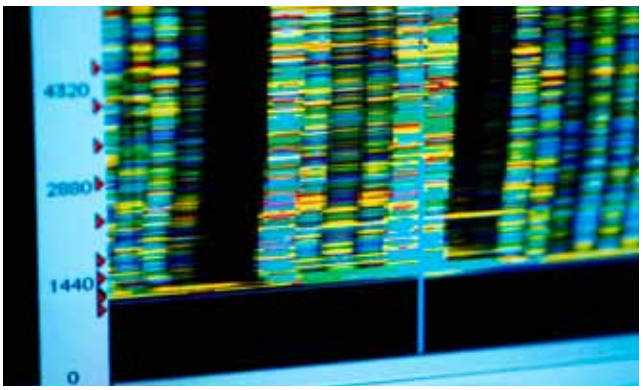
Speaking at the close of the conference, Professor Sir Richard Layard, founder of the IAPT programme, also raised concerns about its future. Only a little over half the training places for which the programme has funding are being taken up, and in some areas expansion of IAPT services has halted or services have been cut, he said. 'We have to get that moving.'

Responding to criticism of IAPT's focus on CBT and family interventions, he called for more research into other therapies and for funding for psychotherapy research to be quadrupled. 'The lack of research monies into psychological therapies is a scandal, given its major importance for the future of the NHS,' he said.

Genes may predict risk of child depression

Scientists have identified a way to detect children at higher risk of depression and anxiety disorders, using genetic testing, family background assessment and a simple, computerised emotional processing test.

The study is reported in the *PLOS One* online journal. Cambridge University researchers tested 238 boys and girls aged 15 to 18. Those with two short versions of the 5-HTTLPR gene, which helps regulate serotonin in the brain, were more sensitive to adversity; those with two long versions were more resilient; those with one of each were in between.



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Children with two short versions of the gene who grew up in violent homes where there were frequent arguments scored lower on the emotional processing tests and were more likely to become depressed in the following year. The researchers say the test would allow early treatment of children at greatest risk.

Report reveals child sexual exploitation

Thousands of children in England are at risk of sexual exploitation by gangs and groups, a report by the Office of the Children's Commissioner (OCC) for England says.

The interim report of the Child Sexual Exploitation in Gangs and Groups (CSEGG) Inquiry, set up by the OCC in October 2011, says that at least 16,500 children were identified as being at risk of child sexual exploitation in the year April 2010 to March 2011 and 2,409 children were confirmed as victims from August 2010 to October 2011.

But the Inquiry report says actual numbers may be much higher, as there is no standardised process for recording sexual offences by multiple perpetrators and signs of possible abuse are frequently overlooked. The majority of victims were female; victims were aged from four to 19 with the highest number aged 15, and over a quarter (28 per cent) were from black and minority ethnic groups. The majority of the perpetrators were male and white.

The OCC says information on warning signs of child sexual exploitation should be circulated to all professionals who come into contact with children and young people and steps taken to ensure they act on them. 'This report is a wake up call. Every one of us owes it to all victims to be vigilant, to listen and to act to stop the sexual exploitation of children,' Maggie Atkinson, Children's Commissioner for England, said.

Student mental ill health is 'under-treated'

Just one in 20 students with mental health problems are getting help, new research in the *British Journal of Guidance & Counselling* reveals.

The study assessed 1,197 first, second and third year undergraduates at a large, modern university in north west England. The overall rate of mental ill health sufficiently serious to require treatment was 17.3 per cent, comparable with the UK general population rate of 17.6 per cent. However, the rate varied significantly across years: from 12.9 per cent at the start of the first year to 11.9 per cent six months later, to 23.1 per cent at mid-second year and 18.6 per cent at mid-third year. There was also a significant gender difference: rates of mental ill health were 24.2 per cent among female students and 12.5 per cent among male students. Yet only 5.1 per cent were receiving treatment for their mental health problems.

Anxiety was more common (97.1 per cent of those with mental illness) than depression (46.4 per cent).

Ann Macaskill, Professor of Health Psychology at Sheffield Hallam University, who carried out the research, says students are facing much greater financial pressures and higher student numbers make it harder for them to establish friendship and social networks. High student numbers also mean there is less support available from university staff. 'The mental health issue is a largely unacknowledged aspect of widening participation. It seems as if the stressors have increased while the opportunities to develop protective factors have declined, putting students more at risk of psychological problems,' she said.

Humility trumps good technique

Therapists with good relational technique are less successful than those who are more self-questioning, a study in *Psychotherapy Research* suggests. The study, of 70 therapists and 370 clients, explored which elements of therapists' relational skills contributed most to improved client outcomes. 'Professional self-doubt' had a positive influence; 'advanced relational skills' were 'unhealthy'. Acknowledging one's shortcomings as a therapist is integral to professional maturation and growth, the researchers say.

Life (mostly) is sweet

Thousands of young people can't find work, one in eight of us struggles to manage financially, but over two thirds of the UK population are broadly happy with our social lives and jobs, and more than four in five are happy with our family life, the first report from the Office for National Statistics (ONS) on national wellbeing reveals.

Measuring National Well-being: Life in the UK 2012 brings together a wide range of data on the national economy, personal finance, health and wellbeing, the environment and more. The ONS National Wellbeing Programme was established by the Government to report measures of the nation's wellbeing other than economic productivity.

The Government commits £15 million to relationship counselling for new parents

The Government has announced contracts worth some £15 million to roll out relationship counselling to new parents over the next two years.

The Department for Education is fulfilling a Coalition commitment to provide relationship counselling to 2.5 million people up to 2015.

Counselling organisations will offer information and advice for new parents, training in communication and partnership skills for marriage and specialist counselling for relationship breakdowns.

Research by the Department for Education has found that most people would welcome professional advice and

problem-solving strategies when their relationship is in trouble. In a survey, over 80 per cent said that they would like help to improve couple communication, 60 per cent were interested in relationship-building courses, 78 per cent of separated people were interested in courses on problem-solving and 74 per cent were interested in conflict management courses.

The organisations awarded national contracts include Marriage Care, One Plus One, Tavistock Centre for Couple Relationships, Relate and Contact a Family.

Hearing their voices

Catherine Jackson asks why people with severe mental illness are still not offered talking therapies, despite NICE recommendations and government pledges

People with severe mental illnesses are being denied access to talking treatments, despite NICE guidance and government promises, an independent inquiry into the care and treatment of people with schizophrenia has said.

The Schizophrenia Commission was launched by the charity Rethink Mental Illness last November to look at ways to improve outcomes for people with schizophrenia.

The final report, *The Abandoned Illness*, published last month, describes the inadequate care and treatment that the Commission says many people with psychosis receive, which can exacerbate their distress and reduce their chances of recovery. It describes psychiatric wards as 'frightening places where the overwhelmed nurses are unable to provide basic care and support'; it criticises poor primary care for people when they are discharged into the community, and highlights cuts in early intervention in psychosis services, whose integrated care model has been shown to be very effective in preventing people embarking on a life-long 'psychiatric career'. It also reports positive stories where the headlong trajectory that too frequently follows a diagnosis of schizophrenia has been reversed 'by a nurse, doctor, peer or therapist who took the time to listen and understand'.

One of the report's main criticisms is the continued failure by secondary mental health services to act on the recommendations of the 2009 NICE guidelines on schizophrenia that cognitive behavioural therapy (CBT) should be offered 'to all people with schizophrenia' and family interventions to all families who live with or care for someone with schizophrenia. Rolling out CBT and family therapy to people with severe mental illness is also one of the main objectives in the Improving Access to Psychology Therapies (IAPT) programme's four-year plan.

In a survey conducted for the Schizophrenia Commission, CBT was mentioned most often (43 per cent) by people with psychosis and their families when asked what treatments they most valued apart from medication; family therapy was listed by 20 per cent (but only 10 per cent of people with psychosis) and creative therapies (art and music) by 17 per cent. Yet, says the Commission, just 10 per cent of people with psychosis have been offered CBT, and three per cent of families are getting family therapy.

This is unacceptable, says Alison Brabban, a member of the Schizophrenia Commission panel and Clinical Lead with the Early Intervention in Psychosis service with Tees, Esk and Wear Valleys NHS Trust. 'I think there is still a view that people with severe mental illnesses don't respond to psychological therapies and a lack of understanding about who can benefit from CBT, despite the NICE guidelines. But I also think there is a sense that psychological therapies are a bit of a luxury and that the priority is medication – the two don't get parity.'

Brabban is herself a cognitive therapist and has been using cognitive therapy (CT) with people with severe mental illness for 20 years. 'CT is about helping the person make sense of what is going on, what is behind the emergence of their symptoms – the life events, early experiences. In fact a lot of people who come for therapy don't want help to deal with their voices. For them, their priorities are relationships, having a job or a decent place to live. CT also helps people attain their goals in life,' she says.

'People who are distressed by their voices often see them as threatening and all-powerful; they feel they have no choice but to give in to them. CT aims to change their beliefs about the voices, so they feel they are in charge.'

Brabban is also the SMI National Advisor for IAPT, which means she is leading the work to deliver the IAPT objective to improve access to talking therapies for people with severe mental illness. She says the main barriers are lack of confidence and competence among mental health professionals to deliver psychological therapies, lack of access to good supervision, lack of ring-fenced time for the work, and lack of genuine commitment in secondary mental health services to delivering psychological therapies.

She has funding of just £1.5 million for the IAPT severe mental illness programme and is aiming to embed provision within existing services, rather than establish a whole new service. The first phase has been to identify NHS trusts that are successfully offering evidence-based psychological therapies to patients with severe mental illness, and then to disseminate what enabled these sites to provide a good service and how they overcame the barriers.

The other crucial focus is training. 'Practitioners are sent on the equivalent of a five-day training course and then think they can deliver CBT. That is completely inadequate. Often clients have been told they have had cognitive therapy when they have had nothing of the sort. It's been an awful experience that has given CBT a bad name,' Brabban says. The programme is developing competence frameworks and training curricula for delivering evidence-based therapies for people with psychosis, bipolar disorder and personality disorders, so more staff in the existing workforce can be trained, 'and trained properly', Brabban says. 'Services need to see psychological therapies as important. Service users definitely do. It's dreadful

What people with psychosis need is time – treatment needs to continue for as long as it is needed, psychotherapist Brett Kahr says

to hear of people who have had the most horrendous traumas in their lives and haven't been given the opportunity to talk about or make sense of them and have only been offered medication.'

Jan Wallcraft is a member of an alternative independent inquiry into the care and treatment of people with schizophrenia, the Inquiry into the 'Schizophrenia' Label (ISL), which was launched at the same time as the Schizophrenia Commission. She says CBT treatments are too short and too goal-oriented to be an adequate response to people with severe mental illnesses: 'Having a diagnosis of severe mental illness is effectively preventing people getting access to any therapy except CBT and family therapy. CBT can be a waste of money and it can also make the problem worse for the client. You need to assess people properly, find out what they need, explain the therapies available and work out with them what is going to work for them. It has to be individualised. Sixteen sessions of CBT is not a panacea for a life that has gone wrong since childhood or teenage.'

Psychotherapist Professor Brett Kahr has been working with people with severe psychosis throughout a professional career spanning some 30 years. He is delighted by the Schizophrenia Commission's stand on access to talking therapies: 'To have any kind of talking therapy recognised is a step in the right direction,' he says. But what patients with severe mental illnesses need is time and consistency, and these are in short supply. 'We don't refuse a diabetic insulin treatment to allow life to continue. Psychotherapy is insulin for the psychotic patient. The treatment needs to go on for as long as necessary; it doesn't mean it isn't working. There is a difference between being listened to for eight hours and 800 hours.'

Nor, he says, is this approach unaffordable or without an evidence base. There are several longitudinal studies – notably work by Bertram Karon and the Michigan State Psychotherapy Research project[1] – demonstrating that psychoanalysis is both effective and, in the long run, cheaper than drugs, he argues. Likewise, there is a body of some 1,000 case studies. 'We don't read the literature. There is this mistaken view that there is no evidence base for psychotherapy with psychotic patients. Not true. And psychotherapists come very cheap. Counselling is not an expensive activity when you think of the billions that have been pumped into pharmaceutical research.'

But, he says, psychotherapists are themselves partly to blame: 'I think there is a very real terror among psychotherapists of spending an hour regularly talking to a psychotic person. If a patient's opening gambit is, "My head is exploding and snakes are coming out of it," what does a psychotherapist say? We are often unskilled in engaging with the very exotic and rich material that people can bring to therapy. I think that terror is preventing psychotherapists from learning to make more sense of the process.' ■

Reference

1. Karon BP, VandenBos GR. Psychotherapy of schizophrenia: the treatment of choice. Northvale, NJ: Jason Aronson; 1981.

Therapists in denial

Alice King

Are we a nation in denial? A report by Dame Sally Davies, Chief Medical Officer, suggests 'Yes'. Deaths from liver disease in the UK have risen by over a fifth in the past decade, yet fallen by the same amount in the rest of Europe.

Many people mistakenly think liver disease only affects the heaviest of drinkers. Andrew Langford of the British Liver Trust says GPs need to work harder to explain this to patients.

I would go further. I think the Government needs to communicate the facts about drinking and alcoholism to the public at large – namely, that alcoholism is a progressive disease (yes, *disease*, as defined by the World Health Organisation). A glass or two can turn quickly into a bottle or two.

Rather than focusing on the arithmetic of units drunk in a week (many patients halve their true consumption anyway when talking to their GPs), we need to be encouraged to look more honestly at how our drinking affects our ability to cope with everyday life – work, wellbeing and relationships, never mind physical health. These are the areas where denial is most insidious.

The Government would do well to dispel the alcoholic myths, the most widespread of which is that the alcoholic is the stereotypical park bench drunk. Potential and practising alcoholics are all around us – the binge-drinking teenager, the tippling mother at home, the City executive propping up the wine bar... and (dare I say it?) the odd therapist. Alcoholism is indiscriminate. It crosses all boundaries of class, gender, profession and age.

What has this to do with therapy?

I believe that, as counsellors, we are poised to play a pivotal role in breaking down clients' denial. But this can only happen if we engage with and include active addicts among our clients.

In my role as a therapist at The Brooklyn, an addiction and stress clinic in Bath, I have come across clients who have been turned away by counsellors and agencies when they revealed their ongoing addiction.

There are therapists who choose not to work with people in active addiction – but I urge them to think again.

Velleman[1] points out that agencies dealing with depression or bereavement do not require clients to be un-depressed or un-grieving before they help them. Yet people with drinking problems are often required to be abstinent before some agencies are prepared to help. This puts clients in a Catch 22 situation. They want help to stop drinking but cannot get help until they stop.

I am not suggesting that a counsellor treats a paralytic client. But it is my experience that, if you ask a client to try to be as abstemious as possible before a session, they will comply. I agree with Bryant-Jefferies,[2] who believes that the counsellor can be in psychological contact with the alcohol-affected client in 'maintaining a consistent and committed presence'.

'Therapists can help clients to unravel why they drink so much, peel back the layers of denial and get to the true emotions that addicts work so hard to obliterate'

People drink for a plethora of reasons. We therapists can help clients to unravel why they drink so much, peel back the layers of denial and get to the true emotions that addicts work so hard to obliterate. Perhaps by helping clients to relax that notorious – and potentially fatal – stiff upper lip and encouraging them to be more open with their emotions, we can play our part in decreasing liver deaths in the UK.

What gives me the right to rant so passionately? I must declare my (no longer shaking) hand. I was an actively alcoholic wine writer until finding sobriety eight years ago. I subsequently retrained as a counsellor. My own therapist ignored her supervisor's advice to stop seeing me until I had stopped drinking, and worked with me for five years until I was ready to stop. As a result, I have an inner understanding of how it feels to have worked with someone adhering rigorously to Rogers' core condition of unconditional positive regard.

I am grateful she did; if she had not, I probably wouldn't be here today. Bryant-Jefferies' observation is poignant: if a client with alcohol problems is turned away 'an opportunity for change is lost'.[2]

And it is change that is needed from therapists, the public and Government if we are to cease to be a nation in denial. ■

Alice King is an integrative, humanistic therapist specialising in addiction counselling in her own practice and is a director of The Brooklyn Clinic in Bath. She is author of High Sobriety: confessions of a drinker *(Orion, 2008). Please email alice-king1@hotmail.co.uk*

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1. Velleman R. Counselling for alcohol problems (3rd ed). London: Sage; 2011.
2. Byrant-Jefferies R. Counselling the person beyond the alcohol problem. London: Jessica Kingsley; 2001.

Making measures human

Barry McInnes

Some years ago, in a small town in rural England, I was subjected to a rather unpleasant roughing up. There were about 25 of them and the ordeal lasted about five hours. I managed to put up a valiant defence and came away with no lasting psychological damage – or none, at least, that wasn't there already.

In a way I brought it upon myself. It's not that I'm given to hanging around provoking groups of disaffected youth, or anyone else, come to that. No, the perpetrators were rather closer to home. These were therapists.

At the time, I worked with an organisation that supports a well-known system for quality evaluation in therapy. My job involved travelling the UK providing training and support for practitioners and services to implement and use routine evaluation.

I was running a workshop for a medium size service delivering therapy in primary care. Most of the therapists at the event worked for the service on a contract basis. Most of them didn't much like the message I had come to deliver and let me know it from the outset. They were being required to implement a system for measuring their outcomes by the service's commissioners, and they were as enthusiastic as a herd of lemmings who have just been invited to the seaside.

I couldn't blame them. They were fearful and suspicious, and I embodied much of what they feared. For me, at that time, this was not an unusual experience. Times have changed.

To my mind, the main challenge of routine outcome measurement has never been deploying the right tools and processes; rather, it is

> 'Some would say that it was the first reflective time that they had spent with themselves for as long as they could remember'

mindset. Therapists don't mind conforming to rules, just so long as we can own them and bend them a little from time to time. So, in the process of honing my delivery over time, I began to try to consciously notice what made a difference to the attitudes of my audience.

One thing I noticed was how few participants, whether in Inverness or Ipswich, Belfast or Brecon, had actually ever picked up a standard outcome measure, let alone attempted to use it with a client. Also, it was often these participants who were the most vocal in their objections, and sometimes aggressively so.

So, rather than challenging the foundation of their objections, or suggesting that they were in danger of emulating King Canute by standing against the prevailing tide, I would simply invite them to complete a measure in the workshop. I would invite them to 'spend a few minutes with yourself, working through the 34 statements in front you, and ticking the box that most closely corresponds to how you have been over the last week'. As they did so, I would discreetly observe how they engaged with the statements – exactly as I did with clients.

After they had finished I would ask a couple of questions – 'How did you find that? Was there anything you noticed, anything that surprised you, anything that concerned you? How was it just spending a few minutes with yourself?'

Some participants would say – and they still do – that it was the first reflective time that they had spent with themselves for as long as they could remember. Others would say it reminded them they were ignoring long-standing issues, or that it helped them see how much better a place they were in. I came to love this part of the workshops – it was a time of real personal connection. It helped me to help them to reflect on how it might be to use such a measure with their clients – not to garner the 'truth' but as a means of getting 34 unique windows on their clients' worlds.

We can see measures as reductionist if we choose to but, before we do, don't we owe it to ourselves to ensure that our choice is properly informed?

So here's my invitation to you, particularly if you're agnostic or antagonistic. Use the web to find a global distress measure of your choice. There are plenty out there – the CORE-OM, GHQ, HADS, WEMWEBS, OQ45.

Now, spend a few minutes working through the statements in front of you and scoring them as per instructions. Be honest – no one's watching.

And, when you've finished, let me ask you how you found it. Was there anything you noticed, anything that surprised you, anything that concerned you? How was it just spending a few minutes with yourself?

We can make measurement human. ■

To get in touch with Barry, email barrymcinnes@virginmedia.com

I've got a life to live

Adam Lawton

We were on our way home from the Persian Gulf when we got the signal. We were told we were heading for the Falklands. We didn't believe war was going to happen.

I was 17. I'd been in the Navy 18 months. The Sheffield was my first ship. I loved it. You visit places you never heard of; there's that real sense of camaraderie. It beat studying for A levels at Great Yarmouth College or driving a tractor.

It was when we torpedoed the General Belgrano, then it dawned on us, this is really serious, the guns are doing the talking now.

We arrived in the exclusion zone on 1 May. On 4 May the Argentine fighters flew in below the radar. We only detected them at the last minute. The operator said, 'It's an Exocet', and three seconds later it hit the ship. I was in 2F mess, two compartments forward. The ship heeled over and it felt like she was going to capsize. Every door blew off. There was machine gun fire. A huge cloud of toxic smoke rushed in – burning fuel from the missile. There was this sound of everything shutting down and the emergency lighting went on. That's when the first casualty staggered in – he had a huge lump of metal the size of my fist in his head, and blood pumping out everywhere. I thought, 'We're going to sink and I'm going to drown'. I remember feeling ripped off: 'This is unfair, this isn't what I joined up for.' I remember thinking how upset my mum and dad and sister would be. I wasn't upset for my own death, which seems strange now.

When we got back, no one even asked, 'Are you OK?' We were expected just to get on with it.

I got my first flashback when my daughter was six months old. April 1995. I was playing with Lucy and all of a sudden, whoooo, it appeared out of nowhere. The choking smell of toxic smoke. I have no idea why. I'd moved to Australia so I'd completely removed myself from the support networks of family and friends. My wife and I weren't getting on at the time. She told me: 'Nobody gives a f***. Get the f*** over it.' We divorced late 1997.

The flashbacks would come for a bit and then go away for long periods. Then in 2000 they started coming back a lot. I was spending hours trawling the internet, going back over it, what if... all day, all night. I didn't sleep; I couldn't eat properly; I started drinking heavily. So I went to the Vietnam Veterans Counselling Service. Within two minutes of talking to the shrink, she said,'You've got PTSD.' She said she would get me in to see a psychologist and get me formally diagnosed and registered mentally disordered and I said, 'Hold on, stop right there. I'm not sitting around with a group of people saying, "My name's Adam and I'm a basket case".' I just didn't think it was for me. I suppose I thought it would be like AA, and the mental disorder label frightened me – who would employ me if it got out?

A couple of mates noticed I'd changed, told me I was being aggressive. I thought, I need to do something about this. I had heard stories of people going back to the scene of the trauma and I thought, maybe that is for me.

> 'I have never received so much hospitality and gratitude. I cried more in three weeks than I did in the last 20 years'

The following March, 2002, I flew back to the Islands. I was picked up by Terry Peck, a giant of a man. He was the Islands' police chief during the invasion. He took me to stay with various islanders. We visited Sea Lion Island, where the Sheffield memorial is. It's the most beautiful place on earth, the last frontier where nature is still in charge. I have never received so much hospitality and gratitude anywhere in my life. I cried more in three weeks than I did in the last 20 years. I went to San Carlos Cemetery. I want my ashes to be scattered there. How could such a serene place be witness to such bloodshed? I was there to unlock the demons and all this stuff, it just flowed out of me; that is what I went for and it worked.

I got in touch with the Argentine pilots. We met in Buenos Aires. I felt they were also seeking a bit of an exoneration. There was no animosity. There was mutual respect and at the end we said, 'No hard feelings. War is war. No hard feelings at all.'

When I left them I remember breathing the biggest sigh of relief – like I was taking off this massive lead overcoat. Then I thought, I've got to go home. So I got pissed and flew home the following day.

I came back to England and talked to my family about it. It had never been discussed in our house. I went to the Sheffield reunion in Portsmouth; it was the first one I'd been to. I visited the Falklands Chapel in Portsmouth and then I drove away thinking, 'I've got a life to live, a family to bring up.' ■

Further reading
Adam Lawton's book about his Falklands experiences and recovery, *Journey to Peace*, is published by Troubadour (ISBN 978-1780883182).

Encounters involving warmth

Rachel Freeth

What do we mean when we describe someone as a warm person? How do we know when we experience someone's warmth towards us? What are the behavioural gestures, large or small, that are characteristic of warm individuals and helpers?

I was recently exploring these questions with a friend, a mental health nurse, in particular in the context of our work and professional environments. We found ourselves reflecting on how much we personally value the quality of warmth and, for that reason, consciously try to express and embody it in our relating with patients.

We also found ourselves in agreement that this value is, sadly, far from universally shared in mental healthcare settings. In fact, in our experience, demonstrating human warmth towards people in mental distress seems quite often to be well down the hierarchy of valued attributes in such places where you might most hope and expect to find it.

It would take far more than a short column to explore the complex interplay of factors (organisational, cultural and political) that has led to the current state of affairs: a state where cultivating the detached objectivity of the medical model is seen as more important than demonstrating human warmth. (Whether they are mutually exclusive is another interesting question.)

Interpersonal and intrapersonal factors clearly also come into it. It wasn't long before we were discussing clinical encounters with people who challenged our capacity to feel warm towards them, and how this in turn affected our own abilities to experience and express

> 'As our clients emerge into the sunshine and warmth we need to be sensitive to their fears and impulses to retreat back into the darkness'

care and concern. The overly hostile, such as the young woman who aggressively accused one of us recently of 'not giving a shit'... the client who undermines our sense of professional competence and worth by telling us we are useless and no help... Then there are the clients who demand more from us than we can give, who never seem satisfied by our efforts to help, or who simply, for whatever reason, drain our energies. We may, at least initially, feel little warmth towards them too.

Nevertheless, despite the frequent challenge of embodying this attitudinal quality of warmth and the nature of our work and organisational setting, for both of us warmth still remains of extraordinary importance. It is, we agreed, important to explore its various characteristics and properties, and to examine the conditions that impede as well as facilitate it. Academic study and research may help towards this, as would supervision. However, in the end, while undoubtedly potentially useful, it isn't essential to read books on body language or to learn about mirror neurons, we agreed. In my friend's words, warmth is primarily about acknowledging and focusing on the humanity of the other person, whatever their experiences and outward behaviours, and whatever else may be required in the helping role.

The term 'non-possessive warmth' was an early forerunner of Carl Rogers' 'unconditional positive regard' – a phrase and concept with which most therapists will be familiar. Alongside words such as 'acceptance', 'respect' and 'prizing', another word that conveys some of the qualities of warmth is 'tenderness', about which person-centred therapist Brian Thorne has written so powerfully.[1]

However, as much as we might affirm the positive qualities of warmth, or tenderness, and regard them as having transforming, healing and nurturing properties, even beyond the client's individual experience, we must not forget that some clients may not feel able to trust these attitudes and expressions in therapists or mental health professionals. They may be regarded with suspicion, as threatening, or even dangerous.

Less extreme are those instances when individuals (friends or clients) in their acute distress ask us *not* to be nice to them. A line from Gibran often comes to my mind in these instances, when he writes of what it feels 'to know the pain of too much tenderness'.[2]

When we emerge into bright sunshine after being in the darkness for a time, we have to shield our eyes in pain. Yet the sun remains essential for life and growth. So, for me, the therapeutic task is one of empathically accompanying our clients as they emerge into the sunshine and warmth, which involves being sensitive to their fears and impulses to retreat back into the darkness. ■

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Recession depression

Counsellors across the sectors are witnessing the impact that recession is having on the mental health of the nation *Sarah Browne reports*
Illustration by Shonagh Rae

We are living through the worst recession since the Second World War. With high unemployment, static incomes, cuts to benefits and public services and spiralling living costs, increasing numbers of people in Britain are struggling financially to survive.

The Trussell Trust runs a network of 270 foodbanks across the UK. Last month it reported that it is launching two new banks every week and expects to feed 200,000 people this year, over 100 per cent more than in 2011. 'Foodbanks are seeing people from all walks of life turning to us for help,' said Executive Chairman Chris Mould. 'Every day we meet parents who are skipping meals to feed their children or even considering stealing to stop their children going to bed hungry. It is shocking that there is such a great need for foodbanks in 21st century Britain but the need is growing.'

Save the Children, the charity best known for helping children in poverty in developing countries, has launched its first ever appeal to raise money to support children in the UK. In its new report, *Child Poverty 2012: it shouldn't happen here,* over half the 1,500 children surveyed said that their parents were unhappy or stressed because of lack of money and four out of five of the 5,000 parents questioned said they had to borrow money to pay for essentials like food and clothes. Childline's recently published 25th annual report shows that economic pressures are having an increasingly powerful effect on young people's mental health. Thirteen per cent of calls to Childline last year came from children who were worried about family relationships, with many reporting that money worries were causing their parents to row.

Suicide

A number of mental health helplines are reporting huge increases in calls from people with financial worries and job insecurity. Mind has seen a surge in calls to its helplines since the start of the recession and says that calls about personal finance and employment issues have doubled since 2008. Sane has reported a disturbing increase in the number of people calling their support line with depression and anxiety due to financial uncertainty. Sane's Chief Executive Marjorie Wallace said recently: 'They report that their fears about losing their jobs and being unable to find work are making them ill. A vicious circle is being created with cuts to mental health services coinciding with increased demand, especially for psychological counselling, leaving people with nowhere to turn at times of crisis.'

Samaritans' helplines reported last December that calls about financial stress have doubled in the last three years. Now one in five calls made to Samaritans is about job concerns, housing problems, debt and other financial worries. A spokesperson for Samaritans says there is considerable research evidence to show that economic recession is linked to higher suicide rates; in 2008 there was a sharp rise in suicide that bucked the overall downward trend. 'Unemployment, job fears and financial worries lead to anxiety, depression, low self-esteem and feelings of hopelessness, which in turn increase the likelihood that someone will think that their life isn't worth living.'

Earlier this month the *Guardian* Higher Education Network reported a dramatic increase in the number of students who have taken their own lives in England and Wales since the start of the recession. Suicides by male students in full-time higher education grew by 36 per cent between 2007 and 2011 but the number of female students suicides almost doubled, according to new figures from the Office for National Statistics. Hannah Paterson of the NUS says that a combination of rising financial and academic pressures, coupled with recent cutbacks to university support services, could be partly to blame. 'Over the past five years there has been a huge increase in the amount of stress students are feeling. Being a student is a stressful time. Now finance and debt problems are adding increasing pressures. When you're paying that much for your education, coming out with a good mark matters even more.'

Michael Lilley is Chief Executive of My Time, a social enterprise based in Birmingham that provides holistic and intercultural psychological services. The service's CORE statistics show a clear correlation between increased anxiety and depression and suicide ideation and financial hardship caused by the recession. 'We have seen a rise in suicide attempts and self-harm, especially among men. Other key issues for our service users are benefit issues, increased domestic violence and higher numbers of children in child protection due to neglect, including not being fed or clothed to acceptable levels,' he says.

Recession and mental health

A wide range of studies testify to the damaging impact of recession on mental health. In 2011 the World Health Organisation published a report, *Impact of economic crisis on mental health*, that sets out the strong link between people's

mental health and socioeconomic conditions. Unsurprisingly, the report shows that people who experience unemployment, impoverishment and family disruptions are at significantly greater risk of suicide or developing depression and alcohol disorders than those who are unaffected. A one per cent increase in unemployment is associated with a 0.79 per cent rise in suicide and an increase in deaths from alcohol abuse. During times of economic adversity, men especially are at increased risk of mental health problems.

The report also stresses that social welfare and other policy measures can offset the worst mental health effects of an economic crisis. The report recommends family support programmes, higher alcohol prices and restrictions on its availability, debt relief programmes and accessible and responsive primary care services.

The WHO report compares suicide rates in Sweden and Spain from 1980 to 2005. Sweden went through a severe banking crisis in the early 1990s but its suicide rates were unaffected. By contrast, during Spain's banking crises in the 1970s and 1980s suicide rates increased as unemployment rates rose. The WHO report suggests that one of the main differences between the two countries is that Sweden made financial provision for social safety nets, such as family support, unemployment benefits and health care services; Spain did not.

Downturn in the UK

How is the UK doing in terms of social support for those who are struggling with unemployment and financial worries? At the recent sixth Psychological Therapies in the NHS conference, we were reminded of the pledges at past conferences from ministers talking about the importance of investing in psychological therapy for the unemployed. In 2008 Alan Johnson, then Secretary of State for Health, said that unemployment should carry its own health warning and he wasn't going to watch history repeating itself and let another generation of people sink into depression. The same year we heard Greg Beales, Special Advisor to Prime Minister Gordon Brown, say that 'because of the economic downturn, getting these services up and running and responding quickly to patients' was even more important. In the 80s and 90s he said, 'we left a whole swathe of people to drift out of the workplace, some of them never to return'.

This year we heard Care Services Minister Norman Lamb sounding equally sincere about the importance of psychological care in the NHS, and in particular in helping people with mental health problems return to the workplace. He made no special mention of the recession or the unemployed.

It is clear from talking to counsellors on the ground that the benefits shake-up couldn't have come at a worse time. A professional lead for counselling in an IAPT service said: 'People who have had their benefits stopped end up in our service. Half the time what is needed is social support – help with housing and help getting their benefits – not psychological therapy. You'll get clients asking counsellors and mental health practitioners to just write a letter to support them in maintaining their benefits, saying that in our opinion there is no way they are fit to go back to work. We'll do that by all means. It's something we never did in the past so we're changing the boundaries a bit.'

The Austerity Report 2012 asked 300 GPs how they felt the recession was affecting their patients' health. They were asked only to consider those instances where patients specifically linked their behaviours or conditions with financial hardship or concerns about job security during their appointment. GPs felt that worries over financial security, coupled with people working longer hours, have raised people's stress levels. Seventy six per cent of GPs believed that the economic downturn has had a negative impact on their patients' health in the last four years. Seventy seven per cent of GPs felt there has been an increase in new cases of mental health conditions in the last four years linked to the economic climate; 54 per cent said that the greatest increase was in anxiety, and 46 per cent said the greatest increase was in depression. Sixty two per cent of GPs said they have seen an increase in contacts from patients who appear to be more in financial distress than in need of help for a health condition.

One GP from Cumbria quoted in the report said: 'We really have nothing to offer people who are depressed/anxious regarding work/money. What they need is decent jobs. Pills and an eight-month wait for very poor quality counselling is not going to make any difference.' Another GP from the north west said: 'I think just letting the patient talk and if they understand that you are sympathetic to their plight they feel better. I guess we are prescribing more antidepressants; I reluctantly refer patients for counselling because the waiting times are ridiculously long now.'

The squeezed middle

As we know, work is good for mental health but that doesn't mean that people who have been lucky enough to hang onto their jobs are immune to the effects of the recession. Employee Assistance Providers (EAPs) are working with employees who statistically have better mental health than unemployed people. But, says Andrew Kinder, Chief Psychologist of Atos Healthcare and also Deputy Chair of the Employee Assistance Professionals Association: 'The employee who calls us is not necessarily stressed about losing his/her own job. It may be their friend or their partner who is losing their job. Or it may be their children who have graduated but can't get a job and have come back to live at home because they are lumbered with debt. Rents are extremely high at the moment so they have no hope of moving on until

they find work.' People are worried about what the future holds, he says. 'They may have children at university or elderly relatives in expensive care homes; they may be about to lose their child benefit...' Every month things are getting a bit tighter. So often, he says, it isn't just about how the sums add up at the end of the month; it's the psychological pressure. They talk about everything closing in on them.

Concern about debt comes up a lot in EAP work, Kinder says, and it's something his organisation has to address in the companies they work for. 'It's hard to do debt management courses in the workplace because no one wants to admit that they're in debt – if you can't handle your own finances, then how are you going to handle those of your employer?' So, he says, they run financial awareness courses instead.

'When you're holding all this together in your mind, it can feel like a monster,' says Kinder. 'When you go to an EAP counsellor, you start laying it on the table and looking at it together, seeing what is in your control, what you can change and what you can't. Sometimes a client has debts but tells you they haven't actually been opening their letters. Then they'll come back and tell you there's this other debt they've been hiding and the reason for the debt is a relationship problem... It's like peeling off the layers of an onion. Then you get to the inner layers. You can see that they've been holding onto so much on their own that it's a relief to tell someone and start doing something about it.'

Kinder's experience echoes the reports of increased suicide, particularly among men. 'I've seen organisations where there's been one suicide, closely followed in the next couple of days by another and then by a third. All men in their mid-50s. All with concerns about money and relationships.' He says there are far more suicide attempts than people actually realise because they don't get reported. 'Unemployment creates more suicidal depression but suicide is also linked to job insecurity and relationship strain, and that doesn't get talked about nearly enough,' he believes.

Couples and families

A recent Relate survey, conducted with the *Guardian* as part of its Breadline Britain series, reveals how couple and family relationships are being affected by austerity. Seventy one per cent of Relate's 2,000 counsellors said that money is becoming a more severe problem for their clients. Forty per cent of counsellors said that, compared with two years ago, they are seeing more couples splitting up where money worries are a major contributing factor. The majority of the counsellors (90 per cent) said that money worries made their clients depressed, with 80 per cent saying couples are arguing more as a result and 65 per cent saying it affected their clients' physical health.

Another issue emerging from the research was that many clients are unable to finish their counselling sessions because of money problems, despite being offered intensive courses of four to six sessions charged on a sliding scale from £6 to £45 per hour. Ruth Sutherland, Chief Executive of Relate, says the survey highlights that relationships in the UK are under increasing pressure, in part hastened by the economic climate. 'It is distressing to hear that so many people who want access to support to improve their relationships are unable to have this because of financial concerns. We know that relationships play a vital role in supporting people through periods of stress, such as losing their job, but this can also place significant pressure on the relationship. For most people, their relationship is the most important thing in their lives. Relate know that help and support can be vital to making relationships work and we are keen that people can access this when they need it.'

Another key finding of this survey was that a growing number of the 150,000 clients Relate sees each year are being forced to stay together, despite having decided to split up, because they can't afford the cost of setting up two homes. Couples with children are more likely to find themselves stuck in this position but it applies increasingly to childless couples and those higher up the income scale. 'Let's all be clear about the real cost of austerity,' says Ruth Sutherland. 'The impact of being in a relationship that isn't working is toxic. It is harmful to your children and it permeates every other aspect of your life. If the Government wanted to protect the mental health of the country, both now and in the future, they would target these cuts differently.'

Counselling and poverty

What help can counsellors offer clients with serious financial worries? What can a counsellor do to help someone trapped in poverty to change their situation? BACP member Mora Maclean was a debt counsellor working with clients from a very deprived community before she trained as a person-centred therapist. 'Many counsellors bear witness to poverty and inequality and their impact on the individual and could perhaps help outside the counselling room by speaking out about such things,' she says.

She thinks that the most important thing is that the counsellor is aware of, works on and monitors their own attitudes, prejudices, fears and beliefs around debt, welfare benefits and people living in poverty. They need also to be mindful of inequality and the particular harm that relative poverty can do – where people are excluded from and unable to participate in society and their community. 'I believe this kind of personal development work around these issues is crucial if a counsellor is going to be able to offer a genuinely empathic and prizing relationship of any depth to clients. I also feel that the importance of this can't be overstated in the context of the increasing demonisation and stigmatisation of people in receipt of benefits.' ■

Counselling's 'special relationship'

David Kaplan and Val Potter discuss the differences and similarities in the development of the counselling professions in the US and the UK

Illustration by Shonagh Rae

The year 2012 marks the 60th anniversary of the American Counseling Association (ACA). To mark ACA's milestone, *Therapy Today* brought together Val Potter, past Chair of BACP and past director of a national counselling charity in the UK, and David Kaplan, past President and current Chief Professional Officer of ACA, 'in conversation' to discuss counselling's past, present and future in the UK and US. Their discussion draws on the longstanding co-operative and creative relationship between ACA and the British Association for Counselling and Psychotherapy (BACP).

Val Potter: I have been a counsellor for over 30 years and during that time have seen counselling develop in the UK from a little known and little understood, largely voluntary activity to an established profession, with a highly developed body of theoretical knowledge and evidence-based practice. The growth of counselling in the UK is rooted in a drive for equality of access to services in welfare health and education, which gained impetus from the deep economic depression of the 1930s, followed by the effects of World War II. After years of privation and disruption to family life there was a widespread sense that a fairer, more equal society should come into being. This was the time when the National Health Service was created, free to all at the point of delivery and the 1944 Education Act gave universal access to secondary education.

David Kaplan: First, let me thank BACP for acknowledging ACA's 60th anniversary. ACA highly values our relationship with BACP and it is an honour to be able to work with Val on this article. Readers may be interested in knowing that counselors* in the United States owe our name to the British. Counseling began in the US when Frank Parsons started Boston's Vocational Bureau for juvenile delinquents in 1908. Parsons was a lawyer by trade and liked the British term 'counsellor' that was used in England for barristers. So to make it a bit different, he chopped off an 'l' and called himself a 'counselor'.

Parsons started counseling in the US for a somewhat more pragmatic reason than Val's description about the start of counselling in the UK. The industrialisation of the early 1900s meant that large numbers of adolescent boys and young men were moving from their family homes and towns to large cities to find work. This was the first time in American history that large numbers of young single men lived alone and unsupervised, and they were creating havoc in New York, Boston, Philadelphia, and other major cities (think spring break in Ft Lauderdale or Bank Holiday in Brighton). Frank Parsons started the Vocational Bureau to find these youths jobs that matched their skill levels so that they would get (and stay) hired and then be too tired after work to raise hell. So from the very beginning, the professional identity of counselors in the US was tied to vocational development and schools (since the Vocational Bureau was a part of the Boston school system).

Val mentions the effects of World War II on counselling in the UK. The war had two major effects on counseling in the US. First, as it ended rather abruptly, tens of thousands of servicemen in the US found themselves discharged and looking for work at the same time. As such, the military needed to develop group vocational tests to assist the large number of veterans exiting the military and entering the private sector. Counselors developed these tests and thus group testing and group counseling became part of our core identity. A second issue revolved around disabilities. Advances in medical treatment meant that many soldiers who would otherwise have died returned from the battlefield alive but with missing limbs or with other serious physical disabilities. Rehabilitation counseling developed in order to meet the emotional needs of these disabled World War II veterans. For most of our history, US rehabilitation counselors have not felt closely aligned with or in the same profession as school counselors, but that has recently changed with the advent of the ACA policy initiative '20/20: A Vision for the Future of Counseling' (discussed later in the article).

This brings us to the early 1950s, the era of ACA's founding (ACA was incorporated in 1952).

VP: The 1950s and 1960s were a time of profound social change in the UK. Women entered the workplace in much greater numbers. They had been employed to fill the gaps left by men on active service and, when the war ended, were unwilling to relinquish employment when they returned. Women had also become used to managing the household and the finances while their menfolk were away. This disturbed traditional gender roles and patterns of relationship. Extended families were much less likely

** In this article the US spelling 'counselor' will be used in context.*

to live near each other and so were unable to help with childcare and other forms of support. There was also a sense that we had endured a great deal and deserved a better life.

By the 60s rebellion was in the air. People were less deferential to their rulers, less likely to just accept what they were offered and more motivated to find ways to help themselves. In 1959 the Government's new Mental Health Bill aimed to close the old long-stay mental hospitals and replace them with care in the community. This meant that people with mental health problems were much more visible and in need of new forms of help. This was a golden time for establishing new charities. The National Marriage Guidance Council had been working since before the war (1938), training couples counsellors and providing counselling for low fees. They had a good deal of financial support from the Government, which was concerned about the rising divorce rate. Samaritans was founded in 1953 to support and befriend people who were suicidal. Both were founded by clergymen who saw distressed people at first hand in their work. Apart from the National Marriage Guidance Council there was very little counselling training available. There was an Association for Pastoral Care and Counselling, but it was 1970 before the first discussions took place that led to the British Association for Counselling.

DK: Change was certainly in the American air in the 1960s. The development of oral contraceptives ('the pill') meant that, for the first time in history, women were able to control the number of children they had, or whether they had them at all. And this meant that, as in the UK, large numbers of women chose to enter the workforce rather than stay at home in their traditional role. The result was an influx of counselors, since counseling in the US is a female-dominated occupation – 80 per cent of counselors in the US are women. With increasing interest in counseling came a growth spurt. Many counselors wanted to go beyond the 'normal human developmental issues' in schools and career development and focus on the more severe and clinical presenting problems that were traditionally the domain of psychiatrists and psychologists. And so mental health counseling emerged as a career path for counselors in America.

VP: By the 1970s the UK was a more confident and affluent society. Egalitarian access to health, education (including university) and social services raised expectations. Therapy in statutory education and healthcare settings was largely in the hands of psychologists and social workers. Psychodynamic theory formed the basis for much of this work. In the 1960s people went from the UK to the US to learn from the new ideas in existential and humanistic counselling developing there, especially in California. Counselling training developed from all these traditions in the 1970s, delivered in colleges, universities and independent training agencies, which were often in the voluntary (charitable) sector.

In 1970 the Standing Conference for the Advancement of Counselling was inaugurated at the instigation of the National Council for Voluntary Organisations and in 1977 membership was extended to individuals when the British Association for Counselling (BAC – the 'P', representing psychotherapy, was added in 2000) came into being, aided by a grant from the Home Office Voluntary Service Unit.

At this time counselling was a little known activity in the UK, apart from marriage guidance counselling. We spent our time explaining that we were not local government representatives (councillors) but were engaged in a new activity designed to increase the wellbeing of the community. When a group of us set up a counselling centre in Essex, we joined Westminster Pastoral Foundation, a national charity, whose founder was a Methodist minister. He had returned to his home country in the US to complete an MA in pastoral counselling, which wasn't available in the UK. He was a pioneer in the field and set up centres around the UK providing low cost counselling and training counsellors. It was an exciting time, being part of developing a new profession. At first it was a case of 'Let a thousand flowers bloom'. Many organisations developed, trainings varied and you could qualify with a counselling diploma from four years of rigorous training or from just a short course.

In order for counselling to become a respected profession it was necessary to develop guidelines and standards. Over the years working groups drawn from BAC staff and volunteers from the membership worked hard to develop codes of ethics and systems for accreditation of individual practitioners and supervisors and of training courses. The aim was to develop standards for best practice without homogenisation. There was no statutory regulation of counselling and psychotherapy then in the UK – and this remains the case –

'The growth of counselling in the UK is rooted in a drive for equality of access to services in welfare health and education, which gained impetus from the deep economic depression of the 1930s'

so nationally recognised voluntary quality benchmarks were of great importance.

BAC membership grew rapidly from 1,536 in 1982 (the first year for which statistics were produced) to 6,035 in 1990. I was interested to discover from David that 80 per cent of counselors in the US are women. BACP statistics have consistently shown that 84 per cent of its members are female. Of course women feature strongly in most of the 'caring professions'. The reasons for this have been the subject of much debate.

DK: The conventional wisdom in the US is that most professional counselors (as well as our clients) are women because counseling focuses on a behaviour that our culture assigns to the feminine gender – talking about feelings.

As noted by Val, US counselors focus less on psychodynamic theory than do counsellors in the UK. That is because Carl Rogers had a profound impact in the US and established strong and deep humanistic roots that are in many ways antithetical to the psychodynamic approach. These humanistic roots developed into a professional identity for American counselors, with a focus on wellness, primary prevention, and a strength–based approach.

Val also noted that advancing professionalism through regulation became an important focus for BACP in the 1970s. The same thing happened with ACA in a new and unchartered area: licensure as a mental health profession. As stated previously, with the emergence of mental health counseling many ACA members wanted to go beyond the traditional settings of schools and colleges and work in community mental health centres and private practice. But to do so in the US you need a mental health-related state licence. American counselors had long been certified to work in schools and rehabilitation settings, but in the 1970s ACA focused on a new frontier: obtaining counselor licensure so that members could see clients with serious mental health issues in clinics and in independent practice and obtain health insurance reimbursement. (As a general rule in the US, a licence to practice independently in one of the mental health professions is necessary to obtain funding for treatment from private health insurance companies.)

Due to the fact that licensure is a state rather than a federal issue in the US, ACA and our coalition had to lobby state by tedious state to enact counselor licensure laws. The first state to be licensed was Virginia in 1976 and the final state (California) enacted counseling regulations 33 years later, in 2009. This may sound like a long time, but it took psychologists 32 years. You can imagine the celebration ACA and our members had when all 50 states had counselor licensure – you might have heard the cheering all the way over on your side of the pond!

VP: Only 33 years! I have looked through my archive of papers on regulation of counselling/psychotherapy in the UK and found the first report to mention regulating psychotherapy (the Foster Report) was commissioned by the British Government in 1971, before BACP began. This was an enquiry into the practice and effects of Scientology[1] and came to the conclusion that 'there is a case for legislation in the United Kingdom to control the practice of psychological medicine'. The recommendations did not lead to government action. Since then negotiations have waxed and waned, partly as a result of changes in government and political attitudes to regulation and the role of government and sometimes because of difficulties in reaching agreement across the range of professional interests involved. In 2000 BAC became the British Association for Counselling and Psychotherapy (BACP), to recognise members who designate their training and practice under either title. The first report on regulation to include counselling was published in the early years of this century.

To bring this up to date, since its inception BACP has worked to establish ethics and standards for counselling, including accrediting practitioners and training courses and developing a voluntary register of its members. This month (December 2012) the Professional Standards Authority for Health and Social Care (the PSA), a Government regulatory body, is launching a scheme to accredit voluntary registers for unregulated health and social care professions and occupations. BACP has been involved in this development and hopes that the BACP Register will be one of the first to be accredited. So, at last, after over 40 years of debates, committees, working groups and reports, we may have a form of national registration for counsellors.

Not all counsellors are thrilled at the prospect of any kind of regulation. A minority fears that their practice could be restricted to a set of 'manualised' techniques and, as a consequence, the profession will be in danger of losing the creative freedom we cherish. There is no sign of this

'ACA and our coalition had to lobby state by state to enact counselor licensure laws. The first state was Virginia in 1976 and the final state enacted counseling regulations 33 years later'

happening at the moment. Since BAC(P) was established, it has led the way in developing the four cornerstones of best practice: research, accreditation, ethical guidance and complaints (professional conduct) procedures. All are vital and need constant review and revision to keep them fit for purpose. The importance of research is increasingly recognised. For 18 years BACP has hosted an international Research Conference, in conjunction with a range of co-hosts. This is a forum that I know attracts the participation of researchers from the US.

The UK Government has recently acknowledged the toll that psychological disorders take on the wellbeing and life prospects of the population and the important contribution of psychological therapies to alleviating these disorders. On World Mental Health Day 2007 it launched the Improving Access to Psychological Therapies (IAPT) programme to expand access to talking therapies for depression and anxiety through the NHS in England.[2]

The main approach used is CBT although, as time has gone on, some 'manualised' forms of counselling and psychotherapy have been added to the repertoire, and many counsellors have undertaken training to enable them to deliver IAPT services. As I write the scheme is being rolled out to include services for children and young people.

Counselling in the UK has come a long way since I saw my first client in 1974. Theoretical understanding has been enriched by cross-fertilisation between psychodynamic, humanistic (especially person-centred) and behavioural approaches (especially CBT). Practice techniques have benefitted from knowledge handed down by experienced practitioners through their work as trainers, clinical supervisors and authors. In the UK it is standard practice to continue regular supervision throughout a counsellor's professional life. Research is enabling us to develop evidence-based practice. Counsellors are to be found working in the statutory, independent (commercial) and voluntary (charitable) sectors. Whether paid or unpaid, they all aspire to work to the high standards maintained by BACP, to which the vast majority (around 38,000 at the last count) belong.

As a closing statement, let me say that during the years I served as Deputy Chair (1999–2002) and Chair of BACP (2002–2005) I gained a great deal from visits to the ACA conference, which I attended each year. I have enjoyed this opportunity to work with David Kaplan on this 'hands across the sea' article. I know when I attend the BACP Research Conference that our organisations benefit from sharing knowledge and experience. Long may it continue.

DK: Val lists an impressive number of accomplishments, and BACP is to be congratulated on all it has done. ACA's most recent professional focus has been on unifying the counseling profession. We are a co-sponsor of '20/20: A Vision for the Future of Counseling', an ongoing effort by 31 counseling organisations to proactively and strategically position professional counseling in the US. '20/20' has accomplished two historic achievements to date. The first is the *Principles for Strengthening and Unifying the Profession*.[3] This document delineates one vision for advancing the counseling profession and is the first time in the history of counseling in the US that virtually every major organisation within our profession has endorsed the statement that they are part of a single, unified profession.

The second historic accomplishment for '20/20' has been the promulgation of a consensus definition of counseling that can be used with the public and legislators.[4] It took two years to agree and the resulting definition, endorsed by 93 per cent of the participating organisations, states: 'Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.' We are now seeing this consensus definition appear in textbooks, journal articles, practitioner websites, business cards and graduate class syllabi.

In closing, let me reflect Val's statement and say that it has been an absolute pleasure to work with both her and with BACP. ACA truly values our relationship with BACP and we have learned much from your great organisation. I will be attending the 2013 BACP Research Conference and would very much enjoy meeting BACP members who have graciously taken the time to read this article. ■

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'Since BAC(P) was established, it has led the way in developing the four cornerstones of best practice: research, accreditation, ethical guidance and complaints procedures. All are vital'

How I became a therapist

Nick Totton

Nick Totton came to therapy in search of a way to foment social change and says he is still in the business of changing the world, one person at a time

I trained as a psychotherapist in the early 1980s, when dinosaurs still roamed the earth. The idea of therapy as a 'profession' was pretty much unknown, at least in the circles in which I moved; none of us saw it as a way to make money. In a way that I suspect is no longer possible, it was simply about the therapy.

In fact, when I began training in Reichian therapy I had no conscious intention of becoming a practitioner. I had been attending experiential workshops with the same leader for a few years; this was his first training intake and it was priced to include individual therapy, which made it a very cheap way for me to work on myself. It was only around halfway through that I realised I was quite good at this, and started to consider taking clients. This seamless progression from client to therapist still strikes me as exemplary, especially when compared with trainees who barely tolerate receiving therapy in order to be allowed to practise it.

I also experienced my training, and my whole involvement with therapy, as a progression from one mode of political activism to another – which may seem equally odd in the current context. I was 31 when I started training. I had spent my 20s in London involved in a series of radical political activities – a local alternative newspaper, claimants unions, squatting, a bookshop, situationist interventions – and had reached the point of realising that none of this was going to work, in the sense of fomenting revolution. A social revolution had seemed a genuine possibility in the late 60s and 70s; by the early 80s it was clearly unrealistic. Asking why most people were

so completely uninterested in social change led me to the radical therapy movement – people like RD Laing and David Cooper in this country and Claude Steiner in the USA – then back to Wilhelm Reich, who tackled this very issue in pre-war Germany. I left London for rural Yorkshire, and discovered at almost the same time that someone in Yorkshire was actually offering Reichian workshops.

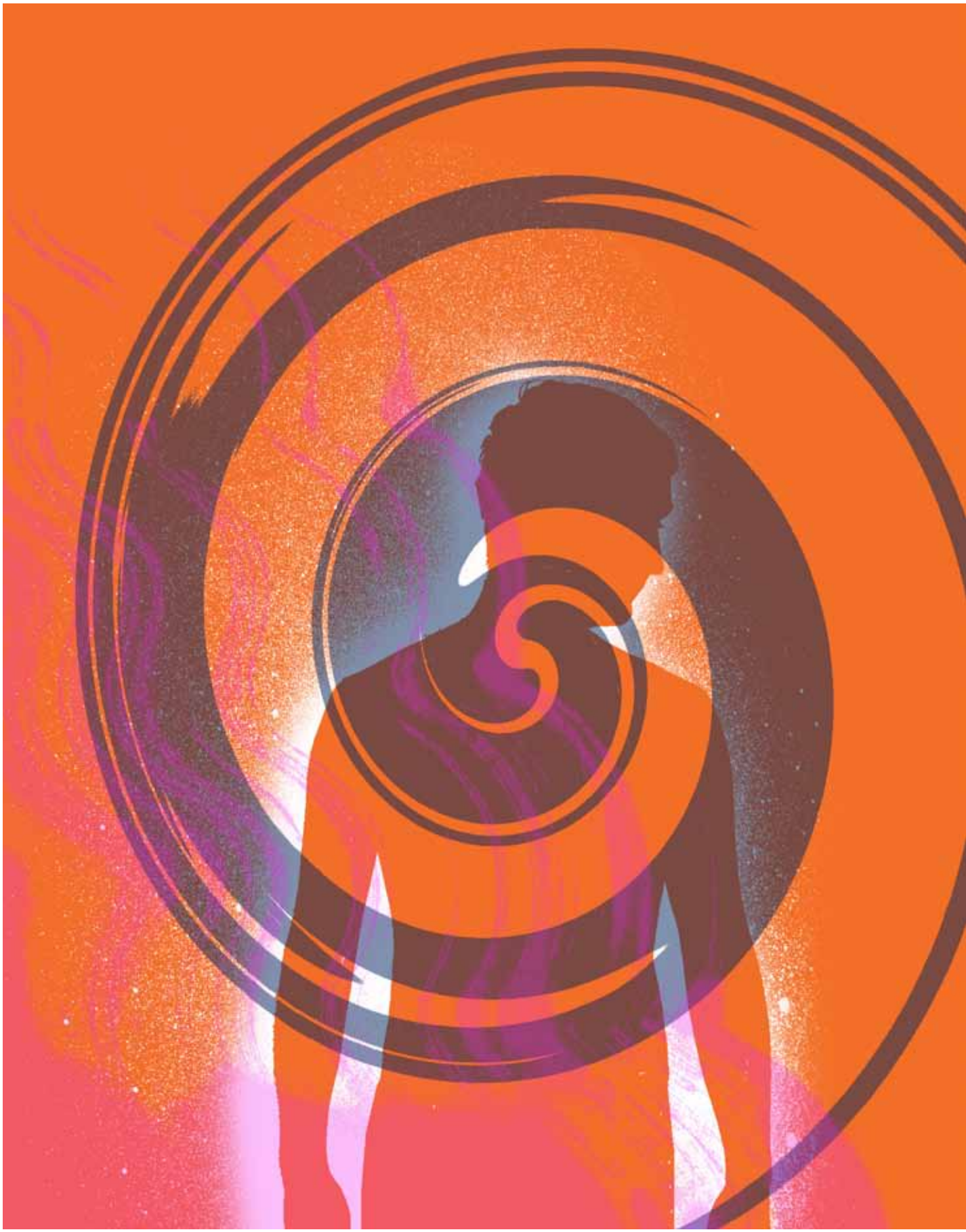
I was one of several political activists who around this time took refuge in the practice of psychotherapy. Some are now quite eminent in the field. It was, I think, both about taking refuge, in the sense of finding a niche where, at that time and for some while afterwards, no one interfered with what one chose to do, and about seeking a new and more effective way to help people empower themselves. Reich argued that therapy led people to become less passive and more self-actuating in their work and relationships and harder to push around – constructively stroppier, one might say. I still think there is a lot of truth in this.

It's important, of course, that in the last sentence I mentioned relationships. Looking back, I was a refugee not only from political defeat but from relational defeat: how could love turn out so wrong? Thirty years later, I think therapy – receiving and giving it – has improved both my theory and my practice of relationship, but I have some way to go.

So have my motives changed over that time? Not fundamentally, I think. Earning a living has inevitably created its own imperatives. Up until the recession of the early 90s I pretty much did exactly what I wanted and managed to earn a living, but the collective tightening of belts meant that I had to think about what would *sell*. Interestingly, this hasn't happened in the current financial squeeze. Like many colleagues, I've found work still abundant, which probably says something about how the social role of therapy has changed.

But although words like 'career' and 'profession' certainly mean a lot more to me now than they did when I started, and although helping to alleviate individual suffering is an important motivation, my central reason for doing the work is still the same: trying to facilitate social change. Though by no means all therapists agree, I still feel that therapy implicitly fosters the same values that I embrace politically: self-regulation, distribution of power, questioning authority, standing up for one's own needs and desires, loving and respecting the other-than-human. The sheer technical fascination of the work can sometimes take over but I'm still in the business of changing the world one person at a time – starting of course with myself. ■

Nick Totton is a body psychotherapist, supervisor and trainer. His most recent book Not A Tame Lion: Writings on Therapy in its Social and Political Context *is published by PCCS Books.*



Mind, body and soul

It has become unfashionable to acknowledge the transpersonal in counselling today, but to ignore the spirit is to ignore a huge chunk of a person's being, argues *John Rowan. Illustration by Shonagh Rae*

In all the ferment about different therapies, empirical evidence, relational approaches and which therapy is the best, one issue is conspicuously absent. No one is talking about the transpersonal. This article is my attempt to remedy that.

Why should we bother about the transpersonal? Not many clients mention it, or want it or need it, it seems. Isn't it a luxury, only of interest to the well heeled and the curious?

I argue that if we are interested in the whole person – as most therapists claim to be – then we must not leave out that huge chunk of the person that is spiritual in nature. In particular, we must not leave out the soul or the spirit.

The soul

Some people instantly bridle at this point. They have rejected the religion of their youth, and the soul was just part of that junk. It went with the doctrines of Heaven and Hell, and was liked by the wrong people. In their circle, they just don't use that kind of language. We are all now scientific and rational and have abjured superstition.

There are two answers to this. One is that we don't have to use the word soul, even though it is the best known word for the part of us that is in touch with the divine. There are many other words, including higher self,[1] inner teacher, deep self, heart, transpersonal self, genius, daimon,[2] guidance self, higher intuitive self, archetype of the self, guardian angel, wise being, bliss body, *savikalpa*, luminosity and psychic centre.[3] There may well be many more possible names for the same thing. It is the part of us that is in touch with the spiritual realm through images and symbols, through concrete representations of the divine. We get in touch with it through ritual and ceremony, or through personal intimations of the spiritual, or through art or music, or through experiences of nature. It is the realm of the typical peak experience, where we experience ecstasy in some form, or other glimpses of the spiritual order of things.[4]

This is the realm of surrender, where we see creativity and intuition and insight not as personal possessions but as voices from outside. As James Hillman in particular has argued,[5] it is a polytheistic world, where there are many sources rather than one but they all speak of the divine.

And here is another barrier that affects many people. British people tend to avoid any mention of concepts like 'surrender', because there is an air of irrationality about them. What we have to take on board is that there is more than one form of rationality. The most basic form of rationality is called formal logic, and was laid down by Aristotle. Under the heading of Boolean logic, it is at the heart of the

‘Those who have experienced this level of ecstasy speak of an undeniable awakening. When used in therapy, it can lead to sudden deep insights’

way in which computers are designed. Its basic tenet is that ‘A is A’. But there are other forms of logic, such as fuzzy logic, many-valued logic, intuitionistic logic and so forth. Perhaps the most important of these is dialectical logic, whose basic tenet is that ‘A is not simply A’. In recent years there has been a much better understanding of how useful and important this is, through the work of people like Basseches[6] and Laske.[7] Dialectical logic, sometimes called vision-logic, is capable of embracing contradictions and enlarging our sensibilities. It enables us to see the use and value of the exceptional, the contradictory, the negative. It is well illustrated by the yin-yang symbol of Taoism.

If we want genuinely to do justice to transpersonal psychology, we have to get our head round these ideas; we have to move on from the received wisdom and everyday prejudices of our scientific establishment.

And this is not just a conceptual matter – it affects the whole way in which we work. I often say to a client, ‘What does your soul say about that?’ when a difficult decision has to be made. Occasionally the soul actually speaks, as when a client said he was considering two houses to buy and could not decide between them. When he sat on the ‘soul’ chair, he said, ‘Don’t assume it is either of them, and keep looking.’ He did, and the house he eventually bought was neither of them.

The spirit

But this is not all. If the level of the soul is the beginning of the transpersonal, it is not the end. Further on along the path of psycho-spiritual development, according to Wilber,[8] is the spirit. Again we meet with the prejudice against this language – the language of the old religions we have left behind. But again, there are plenty of other words we can use, if we reject that one. Words like divine spark, void, ‘O’, essence, transpersonal self, God within, no-self, the ineffable, the absolute, the one without a second, *neti-neti* (not this, not that), universal mind, overmind, *kether*, emptiness, *gnosis*, *nirvikalpa*, one mind, cosmic consciousness, all-self or big mind, big heart.

This is the realm spoken of by the mystics, and not much cultivated in our society. It requires too much effort, too many years of meditation, to reach that stage of development. Yet all of us have the possibility of experiencing it briefly at any time.[9] This kind of ecstasy has no content, unlike the previous level, the level of soul. Soul is full of colours and lights and big experiences – this level has nothing of that kind to demonstrate. But those who have experienced it speak of complete freedom, of a total opening, of an undeniable awakening. When used in therapy, it can lead to sudden deep insights, or sometimes to a session where little or nothing is said in words. It may also lead to a session where something that has been struggled with for years is just dropped, all at once.

There are certain words it is better to avoid in this field. One is spirituality. The reason is that there are all sorts of spirituality: in particular, there can be pre-personal, personal and transpersonal spirituality.[10] Pre-personal spirituality includes things like the narrowest fundamentalism, magical thinking, superstition and so forth, and can sometimes be dangerous. Similarly, it is better to avoid the word God, for much the same reason.

Therapy

But what has all this to do with us, I hear you cry? Just this – if we all have these riches within us, how dare we ignore them? And if our clients have these amazing resources inside, how dare we underestimate them and regard them as poor suffering victims? David Matteson has a deep and sophisticated account of these matters, when he says (p355): ‘Approaching therapy as a creative act need not inhibit our studying the process scientifically, just as other aspects of the creative process have been usefully studied. We can use the scientific method to check our work, so that dogma and superstition don’t prevail, and at the same time recognise that we are dealing with a process that is human and mysterious and can’t be reduced to medical or mechanical schemas.’[11]

Also the transpersonal gives us a very useful key to working with other cultures and social groups other than our own. An excellent book on multicultural working is *Integrating Spirituality into Multicultural Counseling* by Mary Fukuyama and Todd Sevig.[12] The authors deal with both the positive and negative aspects of spirituality. They quote Battista[13] in distinguishing between ‘true or transformative, or false or defensive’ spirituality. They also make the point that, while some people need to develop their spirituality more, others need to draw back from an excessive concentration on spirituality and be more grounded.

One of the most moving aspects of the transpersonal is the way in which it enables us to go with the client into the deepest holes in their experience. Kate Maguire has written about this in a way that certainly speaks to me. She makes important links between

‘If we want to do justice to transpersonal psychology, we have to move on from the received wisdom and everyday prejudices of our scientific establishment’

the transpersonal and the metaphorical, showing how metaphors have the power to straddle different levels of discourse with ease. She says: ‘[Metaphors] help the individual to live with his or her experiences, to own them; they help to communicate pain which is one of the most difficult things to do; they help the listener to listen without being traumatised; they prevent the listener from stealing the experiences for themselves, being the voyeur; they convey so much in such few words; they are bounded by form but boundless in interpretation; they can bring beauty out of horrific pain… they will be the bridge between your souls. They are disarmingly spiritual.’[14]

One of the great pioneers of the transpersonal is Stanislav Grof, who has written book after book exploring different aspects of this vast realm. He is not afraid to go into very deep areas, which sometimes lead to experiences of catharsis. He says: ‘For abreaction to be fully effective, the therapist has to encourage its full development. This frequently leads far beyond biographical traumas of a psychological nature to memories of life-threatening physical events (childhood pneumonia, diphtheria, operations, injuries, or near drowning), various aspects of biological birth, and even into past life experiences and other phenomena from the transpersonal domain.’[15]

Examples like this show us that the transpersonal is a vast resource, ignored at our peril, and offering great riches to our practice. I hope I have indicated some of its riches in this short article. In my latest book,[16] I have given some details of how it can be explored very directly using the concept of I-positions.

Research

In keeping with our emphasis on the respectability of transpersonal psychology, it may well be wise to finish with a brief discussion of research. From the standpoint of dialectical logic, the forms of research that have been most acceptable have been the qualitative. In 1981 I co-edited with Peter Reason a big book entitled *Human Inquiry: a sourcebook of new paradigm research* – now out of print.[17] This was a huge compendium of wisdom in this area. More recently there have appeared excellent books such as those by Braud and Anderson[18] and Bentz and Shapiro,[19] which push the practice of research further forward again. Peer-reviewed journals such as the *Journal of Transpersonal Research* and the British Psychological Society’s *Transpersonal Psychology Review* have published many research papers that carry the work forward. Two new journals have been launched in Spain and in Italy during the past year.

Here then is an approach to therapy that is well based and that cannot be dismissed or played down. It is an essential part of the attempt to deal with the whole person that is so characteristic of therapy today. ■

John Rowan has been a member of BACP since it began, and is now a Fellow. The second edition of his book The Transpersonal: Spirituality in Psychotherapy and Counselling *came out in 2005. He has conducted workshops in 27 countries, and is holding one in London in March 2013.*

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Nurturing reflective space

In a quick-fix culture, surrounded by myriad distractions, therapists can help their clients access and draw psychic nourishment from reflective space, argues *Mark Emery*

We live in a culture of distraction. Western 21st century culture is awash with instant solutions to complex problems and ready-made answers that promise a quick-fix solution to our troubles. We therapists are consulted by people who regard us as experts who will be able to help them resolve their dilemmas. But what if we don't have the answers? What if we are as perplexed as the person in front of us?

Perhaps we need to rely less on our personal knowledge and life experience, avoid the temptation to offer off-the-peg solutions and strategies and draw back from applying our own knowledge and life experience to their problem. Rather, we should seek to work with the unique complexity that the client brings to us, endeavouring to create a reflective or 'psychic' space that is open and fluid and contains no expectations of conformity to cultural notions of normality.

For the artist this would be like working with malleable clay, with no fixed shape in mind, as opposed to constructing an Airfix model that comes with precise instructions and creates an instantly identifiable end product that knows its place in the scheme of things. Many of you will say this is what you do. But in an era when some therapies are becoming more prescriptive about how people should live and feel, I suggest there is a need to explore and embrace the infinite world of personal complexity and that this is a rich vein from which significant and authentic personal resources are waiting to be mined.

The psychic apparatus

The philosopher and psychoanalyst Julia Kristeva suggests: 'Modern man is losing his soul, but he does not know it, for the psychic apparatus is what registers representations and their meaningful values for the subject. Unfortunately that darkroom needs repair.'[1] The metaphor of the darkroom is helpful. In the days before digital photography, an image recorded on film would only reveal itself when processed in the darkroom. The image that then emerges has the potential to amaze the viewer in what it reveals. There is an unexpected and unpredictable element to the experience. The image may or may not conform to our expectation; it may surprise us by what it reveals. Similarly, it may be helpful if the therapist has no preconceived expectation of what direction the therapy should take or what its content and nature should be.

Put simply, this is non-directive therapy, but even therapies that lack overt proscription may still be marked by the therapist's personal agenda or cultural influences. Quick-fix solutions promising a fast road to happiness and success can be like applying sticking plaster to deep wounds. They hide the trauma but do not treat the underlying damage or foster the slow, steady, natural pace of organic repair. Van Deurzen suggests that we need 'an openness and readiness to explore human existence without thinking in terms of the normal and the pathological and without aiming for happiness or cure.'[2]

Before I go any further I would like to establish the use of the term 'psyche' as my mode of reference. I find it a useful concept as it embraces the unique complexity of each person and the contexts, past and present, from which they come and in which they exist. For me it is more useful than the term 'personality', with its categories that label people and the extreme polarities of negative and positive traits often attached to them. I would even move away somewhat from the term 'self', as this may be seen to propose an independently constructed state of being. Jung is helpful here: 'By psyche I understand the totality of all psychic processes, conscious as well as unconscious.'[3]

The truth is that, like it or not, we are intersubjective beings. Our identity is formed, sustained and sometimes broken down in direct relation to others. Without others we could not acquire identity in the first place. To quote Leader: 'My relationship with myself is constructed from the outside. I learn who I am because others tell me.'[4] Not only is our identity intersubjective; it also occurs within a culture with its own values and definitions of normality, and these impact on us, for good or ill.

Alchemy of experience

Most therapies support a reflective dimension: some provide more structured direction; others endeavour to facilitate a fluid but supportive process with no set agenda. Traditionally, religion and meditation have recognised the value of a protected space, free from superficial distractions, in which we can become aware of who we are and how we are at a given time. Contemplation has long been a feature of monastic communities, with some devoting themselves purely to a contemplative life. The Quakers' main weekly meeting is dominated by silence and the wait for inspiration to arise. Meditation is probably more popular than ever, helping people learn how to be comfortable with themselves and the world. But why do this? Why not just get the latest self-help book with a step-by-step list of how to conduct your daily life? For me there

is infinite value in the notion that each person has an innate creativity, a capacity to understand and resolve their issues, and a unique psychic structure, capable of transformation, with which they perceive and process experience and through which they can acquire meaning and purpose.

My own approach to therapy is that each person can become their 'own centre of initiative'.[5] This is the foundation of any work that I do and I would call it a supreme optimism of the human condition. There is a wonderful creativity at the heart of every person: a capacity to process experience and transmute it into something useful, much in the way that the alchemist takes base metals and seeks to turn them into gold. But this approach is about working with the challenging aspects of our emotions, as well as the easier and more readily acceptable: it is not about cherry picking the superficial niceties that produce an instant lift, a psychological sugar high. 'The lesson is that creating a smooth and utopian way of life, which only allows for pleasantness and positive feelings, invariably leads to disaster. Negativity not dealt with or expressed accumulates till it explodes back in our lives in a different guise.'[2]

In support of the belief that each person can become their 'own centre of initiative', I need to call on the assistance of Jung. Carl Jung suggested that the psyche is self-regulating: 'The psyche strives to maintain a balance between opposing qualities while at the same time actively seeking its own development or... individuation.'[3] I interpret this as meaning that, left to its own devices and placed in an open and fertile environment, the psyche has the capacity to transmute all of its experiences into something creative and enhancing. This space might be a good therapeutic relationship but, more importantly, it needs to be a facility that we can create and access outside formal therapy sessions.

In her book on Julia Kristeva, Noelle McAfee talks of creating 'an inner garden, a place to keep alive, nurture and tend a meaning to our existence'.[6] This leads me back to the idea of a reflective space in which we discover and explore our psyche. So what prevents us from accessing and being comfortable with this process? Kristeva draws attention to the distracting and numbing manifestations of modern culture. 'If drugs do not take over your life, your wounds are healed with images, and before you speak about your states of mind, you drown them in the world of mass media. In such a situation, psychic life is blocked, inhibited and destroyed.'[1]

The average household today is packed with televisions, games consoles, laptops and mobile phones. There is something deeply worrying about the multitudinous methods whereby we avoid encounters with our psyche. As well as unrelenting access to commercially driven mass media, there is the widespread use of recreational drugs and alcohol, offering oblivion rather than clarity, not to mention mood-altering medication prescribed by GPs with ever greater frequency, promising short cuts to some kind of happiness. Is filling our spaces with a plethora of images and sensory experiences, often provided by others as consumer experiences that have to be paid for, a distraction that impoverishes us? Yes, we all need to switch off and relax, but perhaps this can be achieved through silence and reflection, rather than by cramming our mental space with sensory overload and blocking our capacity for perceptive awareness.

The inner garden

I first came across Jung's idea of the psyche as self-regulating when I was training and it has informed my personal journey and my therapeutic work ever since. It is lived experience. It is a deeply personal and authentic evidence base. I adore its optimism but, like all seeds of hope, it needs a fertile place to grow; it needs an 'inner garden' that we protect and nurture; a garden with variable seasons, with times of aridity and decline and times of lush growth and beautiful flowerings.

In my past life I spent a year in a monastic community. Here I learnt the creativity of silence and the illuminations that can occur within it; the value of an uncluttered space that facilitates awareness of the subtleties of our moods and our thoughts that can easily be missed if we fill that space with distractions or anaesthetise ourselves with substances. This approach does not provide quick and simple solutions to a fixed deadline. Rather it facilitates a journey of discovery into our unique complexity and the possibility of becoming intimate with ourselves.

With such knowledge comes understanding and with this understanding come control and determination in how we manage ourselves. Without personal awareness we are victims of our own ignorance. We will be constantly wondering why we do what we do and may feel powerless to take control and effect change. This is where simple solutions may sometimes be more of a hindrance than a help. To use a gardening analogy, it could be compared to lopping the head

off a dandelion and leaving the root in the ground: in time the plant will re-emerge to produce yet another identical flower.

Where the psyche leads

Jeanette Winterson, in her recently published autobiography, wrote: 'I often hear voices, I realise that drops me in the crazy category but I don't much care. If you believe, as I do, that the mind wants to heal itself, and that the psyche seeks coherence not disintegration, then it isn't hard to conclude that the mind will manifest whatever is necessary to do the job.'[7] Her fictional books frequently explore the nature of personal and gender identity and are full of characters who transgress and disturb conventional notions of normality. Her characters have a unique and uncensored complexity and are often subversive and outrageous.

In describing her personal breakdown, Winterson acknowledges that sometimes we unravel and fall apart for a reason, that a certain process needs to occur to liberate us from past shackles and allow us to undergo a metamorphosis whereby we transmute our problematic experiences and create something liberating and precious. Winterson also deconstructs cultural notions of reality. 'By unravelling the word "real" I hope to show that it contains in itself, and without any wishful thinking on my part, those densities of imaginative experience that belong to us all and that are best communicated through art. I see no conflict between reality and imagination. Our real lives hold within them royal lives; the inspiration to be more than we are, to find new solutions, to live beyond the moment.'[7] Instinctively Jeanette Winterson has tapped into the capacity of the psyche, when allowed the freedom to explore and develop its complexity, to produce its own solutions. She discovered, through her experience of mental disintegration and the unfettered expression of her own imaginative processes, her capacity to reflect on and reshape her identity, recognise past traumas and reduce their power over her.

Writing is another means of exploring and externalising aspects of the psyche, be it as a writer of fiction and poetry or by keeping a daily diary or journal. It is an effective way of becoming acquainted with ourselves and writers often say that they have no idea where some of what they write comes from. Staying with the authenticity of how you feel at a given moment requires openness and courage. Our emotions are not necessarily irrational, even when chaotic with anxiety, subdued with depression or fragmented with psychosis. They can be a natural response to known events and past traumas; they can be a message that needs to be understood rather than immediately eliminated as an undesirable negative thought.

Kristeva proposes that identity is not fixed and stable but open to significant change and development: our identity is constructed through and so open to change by intersubjective relationships, as well as from unexpected revolutions from within. 'Instead of a model of the self that is stable and unified, Kristeva offers us one that is always in process and heterogeneous.'[6] This fits well with Jung's concept of individuation and the self-regulating psyche. If we are not predetermined and fixed like an Airfix model, if we are not chained to an essentialist view of human identity and experience, we are more like pliable clay that we can nurture and shape within the expansive realms of reflective space. For Kristeva we are 'subjects in process': there is no blueprint or predetermined destination; there is only an evolving journey of discovery, a genuine adventure.

Reflective processes require cultivated spaces free from external distractions and proscriptive expectations. It might be a time of simple silence each day, a walk in the countryside, an hour working in the garden or listening to a piece of reflective music or reading poetry or literature or writing something yourself. When we become acquainted with the unique and variable topography of our psyche and how it operates in relation to others, we move towards being more in control, more able to accept our often contradictory complexity and better able to experience life as a revelatory process of exciting discovery. ■

Mark Emery is a psychodynamic counsellor in private practice in West Sussex. He is also involved in systemic family work and works for the NHS providing support to people with psychoses. He has a special interest in the ideas of Julia Kristeva and their potential application in therapeutic work. Email choracounselling@btinternet.com

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'There is a wonderful creativity at the heart of every person: a capacity to process experience and transmute it into something useful'

Questionnaire
Stephan Natynczuk

Adventurer and therapist *Stephan Natynczuk* is passionate about helping young people make the most of their potential

When did you become interested in psychological therapies?
Around 1994 I was working as a teacher and adventure instructor when I realised I could augment the work I was doing with young people in crisis by training in counselling.
What gives your life purpose?
The people who matter to me, doing my best to live a meaningful life and doing my best to spread a little happiness.
What is your earliest memory?
Possibly going to an old red phone box with my mother when my parents were buying a house.
What are you passionate about?
I founded a social enterprise, My Big Adventure CIC, which works to re-engage young people who have given up on the whole education, skills, knowledge and learning system. I firmly believe that the ability to look after yourself and care for others and to have confidence that you are in charge of your own future is a life-long gift. Education is key to this so I'm passionate about equality of both opportunity and aspiration. I don't use 'passionate' in a business speak sense either; it has been a challenging, interesting and rewarding journey that has been expensive for me in many ways.
Do you always tell the truth?
Honesty is crucially important, especially with oneself. The truth often ends up being negotiated.
What has been the lowest point in your life?
A temporary loss of hope and power to effect change in my life. Getting myself through that taught me the

value of hope and informs the solution-focused approach I take with my work today.
How do you relax?
I like to read Russian fiction and to watch films in good company – most important. A glass of wine is always welcome too.
What keeps you awake at night?
I can get to sleep pretty quickly in most places. A sharp nudge in the ribs is pretty effective at waking me.
What makes you angry?
I don't get angry much; I'm generally very calm and measured. Any form of discrimination or intolerance upsets me, bigotry especially.
Which person has been the greatest influence on you professionally?
Recently it's Harvey Ratner.
How do you keep yourself grounded?
Good supervision and good mates. Being able to laugh at myself seems to work well.
What are you reading for pleasure right now?
John Shuttleworth's *Honed Lyrics*. Top chuckle therapy!
Do you fear dying?
No, that'll be a really big adventure, to quote Peter Pan. Meanwhile there's so much to do, things to learn, people to see, places to go...
What would you have written on your tombstone?
Here lies Stephan Natynczuk at thermodynamic equilibrium.
What do you feel guilty about?
Nothing.
What makes you laugh?
Spontaneous ridiculousness.
Where will your next holiday be to and why?
I'm off canoeing across Scotland as soon as I've typed these responses. It's a staff training expedition and a timely dose of wilderness that will do me good.
If you could change anything about society what would it be?
I'd like the joy of learning to be a stronger feature of education, with more exploration and self-directed learning. I think many things will change themselves as a result.
What is your idea of perfect happiness?
A meal shared with my children.
Do you believe in God?
A supreme creator of absolutely everything in the universe? No, though I do realise that this is very important to many people.
What's your most treasured possession?
A Swiss Army penknife I bought when I was 14, on a school trip to Switzerland. I paid for the whole experience by doing paper rounds and other jobs.
What do you consider your greatest achievement?
Helping to raise four independent and confident young people. A close second is keeping a social enterprise alive, thereby creating jobs and opportunities for young people to lead better, fuller lives that contribute to our community. ■

Stephan Natynczuk is the founding director of My Big Adventure CIC. His keen interest in adventure therapy comes from his background in scientific research, education, adventure activities, exploration and talking therapies.

Do we need supervision?

Caro Bailey questions the unquestioned acceptance that supervision in counselling is a good thing

How does supervision work, and how do we know it? To me these are perfectly legitimate questions that we might ask of any activity we undertake, and particularly a mandatory one. But how often do we ask it? And do we always feel in a position to do so? In my green years as a counsellor, I never thought to question what felt to be part and parcel of practice; to me, it was a given. Back then I had an idea that supervision was a way of monitoring me, checking that I was doing 'it' right. Time and practice have altered that perspective; I now believe that what we need, what we want and what we offer from supervision changes as we become more experienced.

To me, the role of supervision is to help and support the supervisee in all the different roles that are evoked in the activity – educator, guide, mentor, assessor and so on – to be an ethical, humane and competent practitioner in the service of her work with clients. But where is the evidence that supervision is a good and necessary thing, regardless of age, stage and experience? What evidence exists to demonstrate its usefulness?

In brief, there is not a lot and not enough to reach any conclusion that it is essential and it works. To put this into context, while supervision has existed for the *training* of psychoanalysts since the 1920s and was *de jure* in place for trainee therapists, the first Code of Ethics and Practice for Supervisors was not produced by BACP until 1992. Arguably, it is only in the past decade or so that an interest in supervision in its own right has occurred. In the wider scheme of things, it is a relatively recent arrival on the research front.

Over the past 10 years BACP has commissioned two scoping searches: 'Research on supervision of counsellors and psychotherapists in the English language'[1] and a systematic review of the literature on 'The impact of clinical supervision on counsellors and therapists, their practice and their clients'.[2] From these, and extensive consultation with BACP members, there emerged only one study – of the working alliance – that demonstrated an enhancement of treatment outcomes to which the skills and process of supervision had contributed. Most evidence related to the impact of supervision on trainees and there was nothing about the needs and wants of experienced practitioners.

We might conclude from all this that there is little evidence to support continuing supervision, yet we carry on and I'd like to believe it is not because we all toe the party line. Taking a wider perspective on the whole thing, I think there is more to this than measuring client outcome and satisfaction; to me, that is about accountability.

This brings me to the second part of my argument, which is that, if we wish to provide the best possible service to our clients and supervisees, we can do no other than seek consultative support from our fellow practitioners. Might, then, the supervisory exchange be seen to exist for the benefit of *both* parties, client and therapist, in the therapeutic relationship?

To assume we are doing all that we can and should be doing in supervision *by our selves alone* is to court the narcissistic within us. Surely this is hubristic and ignores a fundamental aspect of being human? We are existentially alone, but we are at the same time 'incorrigibly social' – our humaneness depends on our relationships and interactions with others. We can get things wrong; we have blind spots. Human beings are messy; what goes on for us, as supervisors and counsellors, will inevitably affect our work both with clients and supervisees. We need to be able to discuss our work with others to ensure, at the very least, that we are not becoming too entangled and confused.

Why not supervision?

Maybe we should ask the obvious question: 'Why not have supervision?' Our answer lies, perhaps, in the example of all those professions who do not have supervision integrated within their practice. Medical doctors experience high alcohol and suicide rates, and burnout. Soldiers returning from war report a high prevalence of PTSD and divorce, and many homeless people are former members of the Armed Forces. This might suggest that having supervision is, at a basic level, economically a very sound proposition. Moreover, to carry high levels of distress without regular opportunity to explore and examine it is to ignore fitness to practice and care of self, both fundamentals of the BACP *Ethical Framework*.

Let us look at the notion of self in relation to other. Adam Phillips and Barbara Taylor, in their book *On Kindness*,[3] tell us of John Donne's belief that we all belong to the great 'community of reason'; that the Stoics were famously self-reliant but this notion also relied on a sense of community – the self in relation to other; how Jean-Jacques Rousseau wrote that 'our sweetest existence is relative and collective and our *true* self is not entirely within us'.

Another thread is to develop, maintain and expand the *internal supervisor*, which is both reflection *in* and *on* action. Penny Henderson and I wrote a chapter called, 'The internal supervisor: developing the witness within'.[4] But this is still self-referential and, however rigorous, does not allow in the light of other perspectives or perceptions.

I have a terror of blind spots when driving on motorways; I experience it also in both therapy and supervision. I may for example have a sense that something else lurks outside my field of vision and may sense also that I would rather not know about it; indeed, I may work quite hard to ignore and conceal it. Bringing this discomfort to supervision may bring to light what we are otherwise hoping to bury. I would suggest that blind spots are even more likely in supervision, where we are working not only with the visible presence of the supervisee but also with the invisible presence of the supervisee's clients. We cannot know what is not within our vision at the time so we need and, I suggest, *need to depend on* our interaction with another or others to help us to widen and extend our vision.

I can occasionally feel quite frightened by the degree to which we supervisors are dependent on our supervisees telling us not only who they are seeing but what they are doing as well. Effective supervision relies on our developing and maintaining a strong working alliance from the very start, in which trust and honesty are twin pillars holding up the supervisory edifice. But what about the sheer difficulty of owning up to what we might feel ashamed or guilty about or simply have not been aware of but later realise we should have been? A rigorous light cast on what we do during supervisory conversations can be infinitely illuminating through parallel process or simply *talking about it*.

So far I have attended to one-to-one supervision. Group supervision, in my view, can be the most rigorous, rich and truly inspiring experience of all. Light can be shed from so many different perspectives. It can be a ghastly battleground for power or a scrabble to be heard; so much depends on the leadership of the supervisor and her skills in supervision.

There are occasional flurries in the profession about whether we are an art or science. I like to think we are both an art and a craft, both of which used to demand an apprenticeship. Mediaeval craftsmen would have apprentices who evolved into journeymen and so became Master Craftsmen in their own right. I believe the analogy holds good for therapy and supervision.

Held up to the light

But what is relevant to the apprentice may not have the same relevance for the more experienced practitioner. Sheer familiarity may lead to jadedness, and faulty memory may cause additional problems. The research that Penny and I have carried out among practitioners with more than 20 years' experience indicates a consensus that we welcome new perspectives and need more challenging. We may have become more set in our ways and harder to shift. In our profession, we cannot hold the finished product up to the light and examine it for flaws: we have instead to put ourselves into that position. We should not feel afraid to do so. As Leonard Cohen wrote: 'Forget your perfect offering/There is a crack in everything/That's how the light gets in.'[5]

And finally, there is the question of *quid custodiet custodies*? Who guards the guardians? I believe supervisors are the guardians of our profession. We have a responsibility to the wider community to try our best to work ethically and to a high standard. Rules and regulations cannot eliminate rotten apples. However, as group dynamics explains, that which occurs in a group, community or system needs to be resolved within it. I am not at all sure we can ever prove conclusively that supervision works but a system that monitors everyone's process in the service of others feels a good enough check and balance to me. ■

Caro Bailey has worked as a counsellor, supervisor and trainer for over 30 years. She was a trainer on the CASCADE diploma for individual and group supervision until November 2012. This article is based on a talk to TAP, the Taunton Association for Psychodynamics, in January 2010.

If you would like to submit an article to Therapy Today *about supervision, please email bernicesorensen@googlemail.com*

Therapy Today.net

Visit www.therapytoday.net to read Colin Feltham 'In conversation' with Caro Bailey.

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In pursuit of awe

Journalist and author *Oliver Burkeman* talks to *John Daniel* about happiness, positive thinking and the self-help industry *Photograph by Jeff Mikkelson*

I've been writing the weekly psychology column 'This Column Will Change Your Life' in the *Guardian Weekend* magazine for six years. It's broadly about self-help books and self-help culture but I also write about economics or philosophy – wherever my random interests take me.

I've always had an ambivalent fascination with self-help, which I brought to writing the column. On the one hand, as someone who thinks of himself as a sceptic, I have plenty invested in not falling for all that corny nonsense; on the other hand, I'm honest enough with myself to know that I'd quite like some of the things that those books promise.

So writing the column has been an exercise in walking the line between scepticism (crucial) and cynicism (corrosive and ultimately boring for both writer and reader). As the column has evolved, far less of it is devoted to exposing nonsense and charlatanry, though I still enjoy that when it arises. Much more, it's become a means to explore psychological ideas, writings and research that fascinates me.

Some classically cheesy self-help books are actually surprisingly good. Susan Jeffers' work is a good example. The cover designs, language and approach are mainstream but the message of books like *Feel the Fear and Do It Anyway* is quite radical. More recently I've been impressed by books on acceptance and commitment therapy, like *The Happiness Trap* by Russ Harris, which really crystalised some thinking for me about the sort of assumptions underlying the horribly simplified, bastardised CBT that forms the majority of most self-help.

On the spiritual side, as a modern restatement of some timeless insights about what we take selfhood and reality to be, *The Power of Now* by Eckhart Tolle had a very big impact on me. What all these books have in common is that part of their function is to distance you just a little bit from assuming that they are the truth and conclusion to everything. They ask you to take a more oblique stance, which I think is key.

I've had two books published. *Help! How to become slightly happier and get a bit more done* is a collection of my columns, so I've only had to face the challenge of writing one: *The Antidote: happiness for people who can't stand positive thinking*.

For me, the writing-about-happiness and the trying-to-live-it aren't really separable. Writing *The Antidote* forced me to think these things through in a much more rigorous way, but that resulted less in any answer to the question 'What is happiness?' than to a recognition that to a large extent it's just a placeholder word: the real challenge is acknowledging the absence of any ultimate definition and somehow continuing to pursue it anyway.

Beyond that, I think it's just clear to me that it's a multi-faceted thing, when positive thinking insists on it being a uni-dimensional thing, a kind of one note, constantly upbeat excitement. I love the psychologist Paul Pearsall's word 'openture' as an alternative goal to 'closure' – being open to the highs and the lows, feeling not so much 'excitement' or 'cheerfulness' but rather 'awe' – a mixture of wonder and fear.

What I refer to as 'the antidote' is simply that family of approaches to happiness, going back to the ancient Greeks and Romans, via all sorts of spiritual and psychological schools, through to contemporary approaches

'Positive thinking is fundamentally an exercise in struggling to eliminate half the human emotional repertoire – the result is usually to make things worse'

like Acceptance and Commitment Therapy, that urge us to reconsider the role of those feelings and situations we tend to consider 'negative' and do all that we can to escape – insecurity, failure, uncertainty, pessimism, sadness, the awareness of mortality, and so forth. From the perspective of these approaches, positive thinking is fundamentally an exercise in struggling to eliminate half the human emotional repertoire, and the result is usually to make things worse, not better. Trying so hard to be 'happy' is what causes the unhappiness, in other words.

I've tried positive thinking techniques, like using positive visualisation to motivate myself, or setting incredibly ambitious goals for the next month or year in an effort to achieve great things. The appeal is obvious: these kinds of things feel like they ought to work because you're taking action to replace negative thoughts and feelings with positive ones. The problems are a) that, even if they do work, they work only in the short term and require constant, effortful replenishment and vigilance, which isn't actually enjoyable, and b) they rarely do work, as a growing body of research demonstrates. This is part of the business model of motivational speakers and seminars, of course: you go, you get pumped up, it fades, you feel obliged to go back for more.

I have had therapy in a couple of small, brief periods. It helped me get my bearings, quite a few years ago, after a relationship went off the rails. My interest in pursuing it further, now that I'm not in a particular crisis, is partly one of intellectual curiosity. It's also partly knowing so many people who credit it with making such a difference to them.

I also went on a week-long silent retreat once. I'm enormously glad I did it and I'm desperate to find time to go and do one again. Undoubtedly the hardest thing is precisely what you're doing the whole time you are there – attempting to remain present and aware, regardless of the tenor of the emotions and thoughts that arise. This is hard! The first unpleasant shock was how incredibly noisy it was inside my mind, once outside noises and distractions were eliminated; the second was about halfway through, when those thoughts turned from irritating song lyrics and random nonsense to self-berating, hostile thoughts. But the way out of this was through it. By the end of the retreat, I'd changed not so much my thoughts as my vantage point on them. I was observing them more than 'being' them, and it was this distinction that was easily my biggest lesson from the experience.

I moved to New York four years ago to be part of the *Guardian* newspaper's American operation. I love it here. But there is an ultimate individualism quite deep in the core of what makes America America. Work on the self is your responsibility, so you're thrown back on your own resources in ways that can be good but also, in many ways, aren't. If you're at the bottom of the socioeconomic ladder, you're more on your own in America than you are in the UK. America produces the best and the worst. Some of the greatest modern Buddhist, psychological, and psychotherapeutic writing comes from here, and so does the most harmful and stupid examples of positive thinking. ■

The Antidote *is published by Canongate Books (ISBN 978-1847678645).*

Dilemmas
Historic sexual abuse

This month's dilemma

Sally is a counsellor in a small voluntary organisation. Last week she met a new client, Kevin. He has come to counselling because his relationship has just broken up and he is very unhappy about it.

Kevin tells Sally that 25 years ago, when he was teaching, he instigated several relationships with 14-year-old pupils. He says he is now deeply ashamed and would never do anything like that again, but at the time many other teachers were doing much the same thing and he just got 'caught up' in it.

What should Sally do?

Jayne Godward
Person-centred practitioner and senior lecturer

On reading this dilemma I felt anxious, uncertain and under pressure to suggest a course of action that would match the current public condemnation and outrage over recently uncovered child sexual abuse. I think the real danger here is of Sally doing something prematurely.

Stepping back from the situation, I realised that, even if I am keen to protect children from exploitation, and am disgusted and shocked by child grooming, what has this got to do with Sally's role as a counsellor?

Kevin is her client, not the young people from 25 years ago. Kevin is very upset, has sought counselling for his relationship breakdown and is expecting to be listened to in confidence. Is he now to be judged, interrogated and reported? Sally is not a social worker or police officer – her code of ethics and, possibly, her voluntary work setting do not demand that all possible child protection issues are reported. Divulging any information about her client's past at this stage could cause a lot of harm to Kevin, his family, the pupils involved and other staff and their relations. A breach of confidentiality like this that possibly involves a false accusation could lead to Sally being sued or at least reported for professional malpractice.

Sally does not know what actually went on at the school – what does 'instigated several relationships with 14-year-old pupils' mean? This could be anything from flirtatious behaviour on one or both sides and going out for coffees and drinks to full blown sexual relationships,

> 'The public interest in reporting potential child abuse, current or historic in nature, tends to outweigh the duty to keep such information confidential'

but none of this is clear and it is unwise to presume. There is a big difference between the sorts of abuse we have heard about recently and relatively harmless romances that sometimes occurred between young teachers and pupils, even though these could still be seen as a misuse of a position of power and trust.

It is likely that recent events have made Kevin aware that what he did was unacceptable, even though it may have seemed the norm at a time when today's emphasis on safeguarding young people did not exist and societal attitudes and behaviour were considerably different.

Sally needs to be there for her client in his current crisis and possibly work with him to explore his shameful feelings. Supervision is the place where she can voice her own fears and anxieties. Sally may need to check out what her client means in order to prevent any further presumptions becoming a barrier to their therapeutic relationship. It might be a different matter if Kevin was definitely sexually abusing his pupils then, or is still doing so, but at the moment there is no evidence of this, so being non-judgmental and accepting of him is a priority – and very easy to say, but not necessarily easy to do.

William Johnston
Person-centred counsellor in private practice

The paucity of information here suggests that Sally has gone into panic. What was the nature of these relationships? How many? Even if they were inappropriate, were they necessarily sexual? People can experience shame for many different reasons. Sally must not leap to conclusions.

Sally's first responsibility is to her client. The break-up of his latest relationship may be the trigger that has brought him into counselling, while his real reason for coming has been precisely so that he can deal with the shame of past actions. He may ultimately want to take restorative action. At present what matters is that he has taken the courageous step of talking about them. If there are actions that need to be taken, Sally will need to discuss these with Kevin at length, and only when he has got a proper perspective on events that he clearly finds very disturbing.

There is an indication that Kevin may be trying to evade responsibility by blaming events on the culture of the time. I suspect that, given his level of shame, it will not take him long to find the relief of taking responsibility for his actions.

If Sally cannot see Kevin through the barrier of her own reactions, then this is something to be discussed with her supervisor and probably in personal therapy as well. If she still cannot see past her own reactions, then it might be that she cannot work with Kevin and will need to refer him to someone else. Under these circumstances, she will need to proceed with enormous sensitivity. Kevin, having revealed these facts

about himself, is likely to be in a very vulnerable state. We live in a society where it is extraordinarily difficult to talk about relationships with young people. The fact that he has raised the subject with Sally suggests that, on some intuitive level, he trusts her. It is essential that she does not betray that trust by rejecting him. She must make it clear that her inability to work with him has to do with her failings, not those of her client.

Above all, Sally needs to take a deep breath and remember that these events are not current. If 25 years have passed, then a few more months are not going to make a great deal of difference.

Another issue that is not mentioned is the policy of her organisation. The need to raise the alarm is normally only activated when abuse is current. Unless they have a peculiarly strict set of policies, then I would hope that this need not be of immediate concern.

Bob Froud
Counsellor and supervisor

Given that no specific contractual requirements around sexual abuse of minors were given to Kevin at the outset, at this present moment there appear insufficient grounds to consider any break in confidentiality. There are no specific legal grounds for such a breach (see BACP G2 information sheet: 'Breaches in confidentiality'). Kevin has given no details and appears, initially at any rate, to be in need of a confessor. I would be wondering why something of such severity has been disclosed so early in the relationship, particularly in the light of recent media attention to such issues. What is Sally picking up from Kevin's mood and mode of confession? What did she feel towards Kevin prior to this disclosure and what followed for her?

However, an immediate, gentle but clear response is paramount, regardless of whether Sally feels able to continue working with Kevin or not.

Kevin may yet give a clearer and more worrying picture of what happened. He has already commented that 'many other teachers were doing much the same thing' and Sally may well consider whether any of those other teachers might continue to be a threat to children.

This reflects another very serious aspect to what Kevin has disclosed and requires an immediate response to clarify the extent of Sally's confidentiality. Sally might, for example, say: 'What you have just said seriously concerns me yet, at this moment, I do not feel I have any right to break our confidentiality. However, while this was 25 years ago, part of my concern is because of what you've also said about other teachers and that there may be a continuing threat to children. If you tell me any further details of what happened, I might feel they should be disclosed to the police although I would try to talk this through with you. I will need to discuss this with my supervisor.'

If Sally feels able to continue for the moment, she might explore Kevin's thoughts and feelings generated around the seriousness of his disclosure and then arrange another session, which gives her the chance to contact her supervisor at the earliest opportunity.

If Sally feels strongly that she is unable to continue working with Kevin because of this disclosure and/or other factors, then this has to take priority. Sally might explain the professional and ethical considerations that prohibit her from such work and Kevin's need for a more appropriate counsellor, before ending and contacting her supervisor.

Vernon Cutler
Accredited psychotherapist/counsellor and supervisor in private practice

The nature of the relationships is not made clear and, without a lot more information than is contained in the brief description given, there are insufficient grounds for Sally to break confidentiality. In our current fearful, sex-obsessed society, 'relationship' has become a loaded word, to be uttered in lowered and hushed tones. Having taught for 20 years before retraining as a therapist, I am fully aware that 14 year old girls in particular will be exploring the nature of different relationships, where a male teacher will become the father figure one minute and the idealised male partner the next, and where 'flirting' will be an inevitable product of those subconscious feelings. It is, of course, the duty of every teacher to manage those projected feelings so that the child or young person's explorations do not result in hurt. On the basis of the information given, it is implied that perhaps Kevin did not manage those boundaries very well. Perhaps, therefore, given the presenting problem he has brought to therapy, Sally may usefully help him to explore those feelings and how they may have been a part of his failed relationship now.

What Sally cannot know is the effect of Kevin's badly managed boundaries on the 14 year olds in question. In the absence of that knowledge, Sally's clear responsibility is to her client. She cannot take responsibility for the psychological welfare of people whom she has never met, who by now are approaching middle age and therefore responsible for reporting the past relationship themselves if they are of the belief that Kevin broke the law. For Sally to report what she does not know to be a crime could cause harm to a number of people – not least her client, who has trusted her sufficiently to relate this in the first place.

If any of these incidents were reported and Sally was questioned by the police, she might consider the place of professional confidentiality at that point. Even then I would understand that my first responsibility must be to my client and that the only things I may not do are to wilfully obstruct the police in their enquiries or to disobey a court order seeking access to my notes.

In all such cases, therapists need to be clear whom we are protecting by reporting. In this case it is not the client or, from the information available, the wider public. Rather, I would hope that Sally will be able to build on the trust already established and help Kevin explore his feelings around that, as it is likely to have relevance to the work. I respect that Sally may experience a conflict of interests in her responsibilities to the agency and her client and I would encourage her to seek independent supervision if she does not already have

this in place. Sadly, in this litigious age, agencies may sometimes feel that their first responsibility is to protect themselves.

Peter Jenkins (who was invited to comment on the above responses)
Integrative counsellor/ Director of MA Counselling, University of Manchester

It seems to me that the responses above are in danger of minimising the ethical, professional and legal options available to the counsellor, in wanting to avoid any premature or hasty action by the counsellor.

Jayne Godward states, correctly, that the BACP *Ethical Framework* does not '*demand* that all possible child protection issues are reported'. However, there is clear provision *permitting* a counsellor to break client confidentiality, if there is a perceived risk to a third party (paras 10, 14 and 22). The ethical principle of non-maleficence tends to prioritise the need 'to mitigate any harm caused to a *client*' (p3), but it certainly does not exclude the need to protect or mitigate harm to *third parties*, such as potential alleged victims of historic child abuse. The counsellor's ethical responsibilities do not stop at the counselling room door. The voluntary work setting may or may not *require* her to report all child protection issues – again, this would not *prevent* her from doing so, if it was judged to be consistent with the BACP *Ethical Framework*.

More generally, all the respondents seem to take a broadly minimalist approach to the counsellor's ethical and legal responsibilities towards potential third parties. There is a clear body of law and guidance, not mentioned here, that would enable the counsellor to take a more interventionist approach, if desired. Admittedly, this more proactive response by the counsellor may well be at the expense of undermining, or fatally damaging, the therapeutic alliance with this particular client, but we have already seen that this should not be the sole or even over-riding ethical consideration.

The disclosure lacks crucial detail, and this might be disclosed in a later session with the client. The fact that the potential abuse is historic again does not preclude the counsellor from reporting it to the authorities, as the recent flurry of self-reports following the publicity about Jimmy Savile demonstrates. Sex with a child under the age of 16 would have been a criminal offence 25 years ago, regardless of media fluff about 'a different culture at the time'. Sex between a teacher and a child under 18 years in the same school is specifically prohibited as a 'breach of trust' under s.16 of the Sexual Offences Act 2003, indicating that this is seen by society as a particular criminal offence that is worthy of special attention in the eyes of the law.

The voluntary agency may have a specific policy or protocol relating to reporting potential child protection issues. The counsellor may or may not have specified the reporting of alleged abuse as part of the original contracting process with the client. Again, neither of these factors would necessarily preclude the counsellor from taking action on their own behalf. Many voluntary agencies follow the requirements for statutory organisations set out in *Working Together*.[1] This states: 'Where there is a clear likelihood of a child suffering significant harm, or an adult suffering harm, the public interest test will almost certainly be justified.' Translated, this means that the public interest in reporting potential child abuse, whether current or historic in nature, tends to outweigh the duty to keep such information confidential.

For the respondents to say 'There are *no specific legal grounds for a breach*' (BF); 'I do not have *any right to break our confidentiality*' (BF); 'For Sally to report what *she does not know to be a crime*...' (VC) is potentially misleading to readers, in my view. Any citizen, regardless of whether or not they are covered by agency protocols derived from *Working Together*, *can* report potential crime 'in the public interest'. If this is done 'in good faith', and 'without malice' (ie with the appropriate legal grounds for doing so), it is very unlikely that they will be sued for breach of confidence or for defamation.

No doubt, the counsellor would need to take proper legal advice from their professional association and professional indemnity insurance society, in order to ensure that the decision to report was *legally*, as well as ethically and professionally, defensible. This scenario firmly reminds us, however, that our therapeutic work does *not* operate in an ethical bubble, sealed off from responsibilities towards the outside world.

REFERENCE:
1. Department for Children, Schools and Families. Working together to safeguard children. London: DCSF; 2010 (p140–141).

February's dilemma

Augustus is about to complete his counselling diploma. His counselling placement has been in a voluntary organisation where counsellors offer their services free, or for very little pay once they are qualified (clients pay a small fee to the service). The counsellors in the organisation are expected to undertake supervision in their own time and at their own expense. However, some of them have told Augustus that they cannot afford supervision and do not undertake this element of their professional practice. Augustus is himself experiencing financial hardship and is considering ending his own supervision when he finishes his course, even though he intends to go on working for the organisation.

What are the issues inherent in this dilemma and what should Augustus do?

Email your responses (500 words maximum) by 28 January to Heather Dale at hjdale@gmail.com. Outline how you would manage the dilemma and make your thinking as transparent as possible. Readers are also welcome to send in their dilemmas for consideration for publication, but these will not be answered personally.

Letters

Short-changing supervisors

On pursuing the 'Changes to the BACP Register', as advised in a letter from BACP to each of us dated 31 October, we looked at the supervision requirements in *A Registrant's Guide to Supervision*. Before the more detailed clarification of what this might be, there is the following telling sentence: 'The main aim of the Register is to protect the public by providing access to counsellors and psychotherapists who are trained, qualified and dedicated to *high standards*' (our emphasis).

We have no quarrel with this and are delighted to see that BACP uses Inskipp and Proctor's definition of supervision to follow. However, we are appalled and dismayed to read further on, under 'Who can my supervisor be?', that the 'high standards' mentioned at the beginning of the paper do not seem to be carried through in terms of supervision – supervision that is not only mandatory but, as stated in the earlier definition, intended to 'give best possible service to the client'. The guide states: 'Supervisors should be sufficiently experienced in counselling and psychotherapy or a closely related field, *ideally with some training and qualification in supervision*' (again, our emphasis).

Sufficiently? Ideally? Where is the rigour and high standards in this worse than sloppy statement? It has been a long slow journey to establish supervision as a branch of the profession in its own right, and 20 years since the first Code of Ethics and Practice for Supervision emerged. There is now a huge range of supervision trainings on offer across the country, leaving little excuse for therapists to have supervision with untrained supervisors.

We urge the BACP Board and all those involved in drawing up this document to reconsider urgently the requirements for supervisors. Just because a counsellor is 'sufficiently experienced', that is not tantamount to her being an effective supervisor. She may well be and that is a well- recognised route, but the journey does not or should not end there. Without question, the two professions are allied but are in no way the same. Not to recognise these differences and aim for a similar level of training in supervisors that is expected of counsellors not only short-changes supervisees but demonstrates the inconsistencies of BACP's thinking on the matter.

Caro Bailey, Jane Dawson, Jill Hunt, Melanie Lockett, Angie Shiress and Bernice Sorensen
Cascade Training Associates

Response from BACP

The 2007 mapping of supervision training in the UK identified 117 supervisor training courses offered in the UK and, within these, found great disparity in content, duration and academic level of training providers.

In addition, there was no evidence to show what the standard of these courses might be. As a result, in 2009 BACP commissioned an evaluation of the Roth and Pilling supervision competence framework. The resulting report made recommendations for additional competencies. This work has resulted in the development of a competency-based curriculum and training programme, which will be launched in 2013 and quality assured through the accreditation process.

At present, therefore, there is no common standard for supervision training. The same is true of counsellor training: there is no common standard and the QAA benchmarks for counselling and psychotherapy are applied only to courses with higher education awards. Much training is delivered in the private sector, with no formal qualification or quality control.

The Register's current guidance on supervisors of registrants is consistent with the current guidance notes for counsellors/psychotherapists seeking accreditation: 'We don't require your supervisor to have specific qualifications or be a BACP member or accredited. However, we do expect your supervisor to be adequately qualified and/or experienced to supervise your work.' And with the criterion for supervisor accreditation: 'Supervisors achieving supervisor accreditation are required to demonstrate how they have acquired the knowledge base in order to work with supervisees (criterion 9.2) but this may be acquired through training, experience or a combination of both.'

This recognises the disparity in the ways in which people acquire the skills and knowledge of supervision. BACP Professional Standards has recognised the difference in the two professions and the change of supervisor accreditation to senior status requires

Contact us

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initial accreditation as a counsellor/psychotherapist prior to applying for supervisor accreditation.

BACP has therefore gathered information about the provision of supervisor training and decided to develop a competency-based curriculum for delivery as an accredited programme. It is hoped that, in future, it will be possible to require such training for supervisors in the context of registration and accreditation.

BACP Professional Standards

Insight in the mud

I enjoyed Manu Bazzano's letter regarding integrating meditative practice and therapy (*Therapy Today*, November 2012), and particularly his reference to a 'reductive understanding of meditation' in which meditation simply becomes synonymous with control, and 'means' suppressing the passions and becoming calm. This very specific, very limited, goal-oriented approach brings to mind the Zen tale of the keen young fellow who eagerly asked his teacher, 'How long will it take me to get enlightened?' 'Oh, 10 years,' replied the teacher. 'Ah, but what if I practise twice as hard, spend twice as many hours meditating? How long then?' 'Twenty years.'

Rather than this all too common cultivation of meditation, rooted in teleology and thus accompanied by sometimes desperate notions of success and failure – 'I've been good this week! I've been really positive!' – it seems to me that an insight meditation approach works far more congruently with therapy. By this, I mean sitting and noticing, with curiosity and kindness, whatever comes up, and seeing the process, the coming and going that is our life experience in all its mixed up, interconnected glory; the lotus growing out of the mud as the Buddha mentioned or, indeed, the flowers in the dustbin that The Sex Pistols referred to.[1] The 13th century Persian poet Rumi probably expresses this idea of equanimity better than Buddha or Johnny Rotten, in his poem *The Guest House*.[2]

This being human is a guest house.
Every morning a new arrival.

A joy, a depression, a meanness,
some momentary awareness comes
as an unexpected visitor.

Welcome and entertain them all!
Even if they're a crowd of sorrows,
who violently sweep your house
empty of its furniture,
still treat each guest honourably.
He may be clearing you out
for some new delight.

The dark thought, the shame, the malice,
meet them at the door laughing, and invite them in.
Be grateful for whoever comes, because each has been sent
as a guide from beyond.

Andy Darling
MBACP (Accred)

REFERENCES:
1. The Sex Pistols. God save the Queen. A&M Records; 1977.
2. Rumi. The essential Rumi. Translated by Coleman Barks with John Moyne, AJ Arberry and Reynold Nicholson. San Francisco: Harper Collins; 1996.

Let down by our employers

I would like to stand up for a supervisor who is standing up for counsellors like me. I have no personal knowledge of Davy Hutton. However, having read his article ('Standing up for counsellors', *Therapy Today*, October 2012), I already like/admire him.

I am one of those counsellors who work in the community/voluntary sector in Northern Ireland. Unfortunately, after 17 years in this sector, I see how I and many of my counsellor colleagues in this sector are treated and in particular how this has worsened in the past few years. We have had our hours significantly reduced; we have had no pay increase for up to four years; proportionate to the number of hours we now work, we are forced to see more clients, irrespective of the nature of the organisation, the complexity of the client caseload or the distances travelled to get to the counselling venues.

How do they manage to do this to us who, in our work role, help other people work through similar situations? There are, I believe, several factors. First, we are in this profession because mostly we are people who care and we tend to put the needs of clients over the organisational abuses that occur. Second, like everyone else, we are people with bills to pay and we need an income. Third, the organisations remind us regularly how fragile funding is and that, every March, with little or no warning, they can make us redundant. Fourth, there are a lot of us in our organisations, mostly working part-time hours in a wide range of venues. So we have no forum, we rarely meet and we have no common voice. We are isolated, which makes us easy to control. Finally, we are very replaceable and they know it and remind us of it.

Personally, I do a difficult job working with a deeply damaged client group who are mostly vulnerable; many regularly present with issues giving rise to concerns over risk. (Many of my counsellor colleagues in agencies across Northern Ireland do the same.) I love my job and I believe I do it well. With many supports, including good supervision, I can manage the work with clients. Burnout for me will come from the organisation, not from my work with clients.

I know that, in difficult times, organisations and management have it difficult with funders, red tape and all they have to deal with. My great sadness is that I don't think an article entitled 'Standing up for counsellors' could have been written by a director of our voluntary sector organisations. I doubt that any will have replied to this article. As I have written this, I have realised how angry, how sad and how tired I am. Fortunately that is limited to my work environment. There is much in my life outside of work to mitigate the damage that organisational abuse is doing.

Just a thought – maybe when organisations are seeking or renewing accreditation some of their counsellor staff should be asked to provide references from the employee perspective.

Thank you, Davy Hutton.

Name withheld

Standing up for survivors

Christine Sanderson's article (Talking point, *Therapy Today*, November 2012) on the need for counsellors to speak out to ensure that survivors of child sexual abuse (CSA) are heard and given access to open-ended counselling resonated strongly with me.

As a counsellor in a university, I have frequently worked with survivors of CSA. Sometimes I am picking up the pieces that have resulted from receiving short-term therapy that, in my view, just 'plasters over a crack' that is likely to open up again. I do not deny the usefulness of short-term therapy, and acknowledge the increasing pressure to look at ways of keeping the waiting lists down and giving clients across the board a fair chance of accessing counselling. But I cannot condone the restrictive way of thinking that suggests that 'one coat fits all'. We have a responsibility to ensure that our clients who are brave enough to face the past (painful though it is) are given the time in therapy that they need and deserve.

I consider myself fortunate to work in a higher education setting where managers and colleagues alike recognise the importance of providing a service that considers the time needed for therapy on an individual basis. I agree with Sanderson's concern that the voice of survivors needs to be heard. If we as a society fail these brave survivors, then I feel strongly that, as professionals, we need to stand together to at least voice our concern and help to protect future clients. To fail these survivors and deny them their right to a future would be in essence repeating the abuse from the past.

Linda Barnsley
Counsellor and supervisor

Beauty of holism

As a counsellor for 21 years, an acupuncturist for 27 years and a lazy yoga student for 40 years, I was absolutely delighted to read the letters from Turiya Gough and Manu Bazzano (*Therapy Today, November 2012*) about the article 'Yoga as therapy' in the October issue. Turiya explained so eloquently and beautifully the lifestyle that is yoga, and for me that includes acupuncture and counselling too. Her letter highlights how ineffective it is to cherry-pick parts of a way of being, like yoga or acupuncture or counselling, and shows how vital (in all senses of the word) it is to embrace the whole, and not the parts we think work independently or the bits we like. A call to those who believe that following the western medical model is an appropriate path to regulation, please think again about the beauty and integrity of holistic models.

In response to Manu Bazzano, I have not found yoga to diminish my affect in the least – on the positive side it has given me an island in the week (I said I was a lazy yoga student) where I can reconnect with all of myself – not just the pretty bits – and feel whole for a while.

Thank you for such intelligent and affecting writing!

Debbie Collins
MBACP (Accred)

Angry and unemployed

I am angry. Fourteen months after graduating I remain unemployed. Not only unemployed but apparently unemployable, for two simple reasons. First, I have effectively changed career – a well-considered risk, rooted in the belief that all I have learned and experienced to date would remain a credible context to any potential employer in any field. Second, given my enduring deadlock, I simply cannot afford to spend any more money on yet further training.

The subtext here is that a single initial qualification is apparently wholly insufficient to progress in this ambiguously defined field.

Whatever happened to the more pragmatic arguments for regulation of our 'industry'? That's exactly how it appears to me: a complex and dangerously self-serving example of pyramid selling. Prescribing 'standards' for attainment and enhancement of core capabilities is, after all, about providing a structure that effectively defines attainment for the middle of a normal distribution, leaving scope for all comers to critically reflect on professional development. Teachers have certainly survived to tell the tale; I hope that BACP will take genuine lessons from the ensuing reductionist culture.

Name withheld

A journey into self

Reflective writing in counselling and psychotherapy
Jeannie Wright and Gillie Bolton
Sage, 2012, 205pp, £20.99
ISBN 978-0857023285
Reviewed by Linda Watkinson

This is an engaging, accessible and practical book that takes the mystery out of reflective writing. It deserves to become a constant companion to the student and practitioner of counselling and psychotherapy.

Reflective Writing is an exploration of how reflective writing can be built into psychodynamic, humanistic and CBT practice and training. The joy of the book is that it takes the reader on a journey into self, while also providing insights into and bringing alive research and theory by the use of personal testimony, references to literature and poetry and through the voices of three fictional student characters, whose training it follows.

The book does not provide 'navigation equipment with precise instructions, nor a musical score' (p3), but it does lay down clear foundations while gently and persuasively encouraging the reader to develop their own sense of direction and to trust their inner voice.

The book is in three sections. The first explores what the book is about and how to use it, explains the rationale for journal writing and offers practical guidance on how to start writing. This section usefully concludes by looking at culture, assumptions and stereotypes.

Section two engages with the writing experience, exploring past, present and future, and the merits of writing alone, in groups, online or to an imagined audience. This section will be of particular interest to people in transitional states. Section three covers how to deal with writing blocks and 'stuckness', the use of reflective and reflexive writing in preparing for supervision, the assessment of personal development writing and the contribution of journaling to continuing professional development.

Underpinning the whole book is the importance of therapist self care and how the practice of reflective and reflexive writing can contribute towards this.

Paradoxically, while some of the strength of the book is its range and diversity of subject matter and its commendable consideration of different cultural backgrounds, this is also its Achilles' heel. There were times when I felt I might have benefitted from a bit more depth and a little less breadth.

However, this is a small point and does not detract from the book's overall impact. I would warmly commend it both to students and practitioners.

Linda Watkinson is a BACP senior accredited counsellor and an associate editor for groupwork for Therapy Today

Why men will be men

Men, addiction and intimacy
Mark S Woodford
Routledge, 2012, 217pp, £19.95
ISBN 978-0415871006
Reviewed by Olivier Cormier-Otaño

This is a short but rich book that seeks to bridge the gap between psychotherapy, neurobiology and addiction in men and boys. As Woodford points out, men outnumber women two to one in the addiction field. But, he argues, while gender-specific approaches are seen as fundamental to the treatment of female addicts, men's gendered selves and the influences of their upbringing and socialisation are often overlooked.

Woodford takes a developmental lifespan approach to explore the social contexts and socialisation of men and boys and how the therapist can help male clients realise their emotional potential and overcome drug and alcohol addiction.

The first three chapters explain the theory and thoughts that underpin Woodford's approach and the following five demonstrate the theory in practice, using meticulously reported case studies for the different age groups: 12 to 18 years, 18 to 24, 24 to 34, 34 to 60 and over 60.

The theory chapters are based on attachment theory and interpersonal neurobiology, drawing on Dan Siegel's ideas about brain, mind and body connection. Woodford presents some very interesting propositions about the difficulty some men have connecting with or talking about their feelings and offers some useful practical suggestions. He suggests, for example, that explaining to male clients how the brain operates will allow them to understand the recovery process that psychotherapy attempts and empower them to explore their emotional self.

The book also covers intimacy and the role of emotions as sources of information. Citing Fogel's work, the author suggests therapists could encourage their male clients to scan their bodies for sensations and work on their

'conceptual' or 'embodied' self-awareness.

The case studies cover some interesting aspects of intersectionality and particularly the development of men and boys in the context of their spiritual/religious beliefs, sexual orientation, ethno-cultural identity and age, among other identities.

Overall, Woodford's biopsychosocial approach offers some constructive ideas for working with men and boys whose socialisation can prevent them realising their intimacy potential and expressing their emotions.

Olivier Cormier-Otaño is a relational and integrative counsellor and a psychosexual therapist

Accessing inner healing

Healing intelligence: the spirit in psychotherapy – working with darkness and light
Alan Mulhern
Karnac, 2012, 164pp, £20.99
ISBN 978-1780490397
Reviewed by Els van Ooijen

According to Mulhern there is little discussion today about what constitutes healing in psychotherapy, which he links to an ever-increasing emphasis on rationality and efficacy. However, people yearn to be healed, hence the huge growth in alternative therapies in the West.

Jung suggested that we all possess an instinctive healing intelligence. Although many emotional wounds (such as the death of a loved one) will heal naturally, this largely unconscious mechanism can become blocked through overwhelming trauma or repressive mechanisms. Mulhern sees it as the task of the therapist to help create the right environment so that this natural healing process can be released.

He identifies four levels of healing. For many clients, he says, the first two are sufficient and form the bulk of the work in which most practitioners find themselves engaged. Regrettably, Mulhern does not discuss these levels in much depth; in his view, they are sufficiently described elsewhere. His focus, and the main part of the book, is concerned with levels three and four. At these levels, therapists need to be able and willing to enter deep into the client's inner world, attune to their unconscious processes and facilitate the expression of complexes and emotional pain. The client also needs to be helped to abandon negative attitudes, such as self-pity or depressive temptations, so that the healing energies that lie buried deep within them can become available.

The final stage involves a process of integration, which is essential for the healing to last. Mulhern sees the entire process, particularly the latter stages, as including a spiritual or transpersonal dimension where the client feels no longer alone but connected to others as well as themselves.

The book's chapters provide a clear account of Jungian therapy and are illustrated with many case studies and helpful techniques such as active imagination, dream and chakra work and focusing. Although the book's focus is on the dynamics of emotional healing and how this process can be facilitated within Jungian psychotherapy, practitioners, trainees and trainers from other schools will find much that is of interest here too. The last chapter's question and answer format is particularly useful for stimulating discussion.

Dr Els van Ooijen is a psychotherapist in private practice at the Nepenthe Consultancy

Attachment and trauma

Shattered states: disorganized attachment and its repair
Judy Yellin, Kate White (eds)
Karnac, 2012, 219pp, £20.99
ISBN 978-18557558315
Reviewed by Andrew Barley

Shattered States brings together five pioneering papers on trauma viewed through the lens of attachment theory: its impact on early attachment, its links with mental illness later in life and its treatment with attachment-based therapy.

The papers were presented at the 14th John Bowlby Memorial Conference, held in London in March 2007, which focused on the contribution of attachment theory and psychoanalysis to understanding and treating people with severe mental and emotional distress.

After a short introduction to attachment theory and John Bowlby's work, the book launches into Brett Kahr's epic paper on the role of trauma in schizophrenia. Taking up more than half of the book and couched in academic and medically technical terminology, including a whole page listing all the medical terms used to describe schizophrenia, it is a mountain to climb, but worth the effort.

Kahr's care and attention to detail that is evident in his research is very much there in his therapeutic work too, when he touchingly describes a piece of long-term therapy with Steven, who has schizophrenia. This tenderness goes to the heart of the approach and evidences the value of relationship in healing shattered minds.

The next paper, by Giovanni Liotti, examines disorganised attachment and the therapeutic relationship. He sets out the various phenomena of trauma and how they can manifest in the therapy room and influence the therapeutic relationship. For example, presented with a 'shattered patient', it is common for a therapist to switch off in the relationship.

Shame, the topic of the paper by Judith Lewis Herman, also plays an important role in severing interpersonal connection and, Lewis Herman argues, in the development of traumatic disorders. In her work too there is much evidence of the painstaking care these contributors take in their attempts to resolve immense interpersonal and intrapersonal damage.

Shame features in the final paper, by Rachel Wingfield Schwartz, titled 'You can kill me with what you say'. The story of Alice made me think a lot about skin, the interplay

between our inner and outer worlds and the metaphorical and literal place of self, which can be a battleground. Again, the need for tenderness is paramount when you are working with someone so damaged that even your words 'can kill.'

The book left me feeling more optimistic about the treatment of traumatised people and glad of the existence of the Bowlby Centre, whence so much of this work derives.

This is a hugely thought-provoking, rich and rewarding book, and I spent a good chunk of an afternoon debating it with colleagues.

Andrew Barley is a UKCP psychotherapist and supervisor working in higher education

Researching psychoanalysis

The significance of dreams
Peter Fonagy, Horst Kachele, Marianne Leuzinger-Bohleber, David Taylor (eds)
Karnac, 2012, 294pp, £29.99
ISBN 978-1790490502
Reviewed by Ann Bowes

This book comprises a large collection of papers given at the 12th annual Joseph Sandler Research Conference, held in Frankfurt, and is part of Karnac's *Developments in Psychoanalysis* series, edited by David Taylor.

Its focus is research into dreams and psychoanalysis in the 21st century – both neuroscientific research in the laboratory and reports of clinical use of dreams in contemporary psychoanalytic practice. Its subtitle explains its aim, to 'bridge the divide between clinical and extraclinical research'.

This was for me an exciting book to read and to review. My excitement lies in its demonstration that such high quality, well presented research is being undertaken into psychoanalysis when many assume there is none and that the only research of any note or value comes from CBT and NICE guidelines.

The book has five parts, all of which are of interest and relevant to the non-psychoanalytic practitioner who is interested in research. The content ranges from a very detailed synopsis of coded research – of interest to those specialising in this approach, but less so to the general reader – to more qualitative studies illustrated with detailed case studies. Space allows me to highlight only a few of the chapters.

An early chapter is a fascinating review by Margaret Rustin of the impact on dream work of taking into analysis children with more severe developmental delays. Another chapter reminds us that patients of a Freudian (or Jungian) analyst tend to bring Freudian (or Jungian) dreams, but that the longer a patient is in analysis, the more their dreams express their inner world in their own, unique ways. Another chapter reports how the dreams of a traumatised chronically depressed patient changed as the psychoanalysis enabled, over time, a release from this stuck place. Finally, important links are made between psychoanalytic research, scientific research and neuroscience – a vital understanding in today's climate of scepticism.

This is an important book for course libraries and those interested in research and developments in the evidence base for psychoanalytic approaches.

Ann Bowes is a psychoanalytic psychotherapist, researcher and supervisor

Meditations on manhood

Thirteen ways of looking at a man: psychoanalysis and masculinity
Donald Moss
Routledge, 2012, 150pp, £22.99
ISBN 978-0415604925
Reviewed by Nick Duffell

This collection of Moss's papers is complex. I reread and rewrote my review many times.

His studied pluralism gives an inconstancy of style and presentation that will delight some readers. The energetic anecdotal writing is engaging, recalling Philip Roth, and is often touching. Sometimes a Zen insight twinkles, recalling Adam Philips. At others, the language can jar, as in 'inserting the analyst's desire into the conceptual slot vacated by axiomatic heterosexuality' (p99), which carries echoes of early 90s gender studies.

There are moments of brilliance, such as Moss's meditation on a Kelvin Klein poster, and excellent vignettes of men stuck in disappointment, having lost unproblematic desire. Yet Moss prefers to hint at rather than build on men's vulnerability to narratives of masculine identity, which I see as but a starting point for development. Castration anxiety doesn't wash as a theory about men; fear of vulnerability, rejection and exclusion does.

Despite naming the ambivalence he detects in his mentor, Freud, Moss the analyst sometimes seems to lose his patient between undifferentiated identity and relationship issues.

Based on a heady mix of drive theory and Lacanian symbolism – scant models of health let alone development – Moss' mental athleticism is the dominant force. I sometimes wanted him to ground some of his elegant thoughts. But his Neo-Freudian plastic approach to sexuality is consistent and compassionate and he is most intelligent on homophobia and precise and gentle on cross-genderism.

In the end, the title of this well-crafted, literary book tells all: it is more about psychoanalytic 'looking at' than about men; its flaw perhaps is that it risks, like *nouvelle cuisine*, over-celebrating its creator. I wondered if the men I see in groupwork – hungry for support and guidance on how they experience and express themselves – would feel satisfied by it. Psychoanalysis is able to offer shape and tenderness; reading works by Harold Searles, I longed to sit with him. Moss's mind really impressed me, but his 'place of blurred boundaries and endless remembering' did not have that same effect on me.

Nick Duffell is co-founder of the Centre for Gender Psychology, author of The Making of Them *and co-author of* Sex, Love and the Dangers of Intimacy

Raised in violence

Understanding adult survivors of domestic violence in childhood
Gill Hague
Jessica Kingsley Publishers, 2012, 192pp, £22.99
ISBN 978-1849050968
Reviewed by Jeannette Roddy

Domestic violence affects many families and, while not every child who witnesses domestic violence will go on to experience emotional/mental problems as an adult, the author is clear that for those who do, the suffering is real, significant and potentially life-threatening.

This unique book brings together research, testimony and practitioner experience to help others understand what life is like for a child witnessing male to female adult domestic violence, and how that can affect their development into adulthood.

The book is a well-written, accessible overview of the topic presented in a mix of academic and first-person writing. The author uses the first chapter to introduce and explain her method and what the book is attempting to do. Three chapters follow, each with a personal story (two female and one male) of living through domestic violence as a child, providing tremendous insight into the experience and its impact.

These are followed by chapters reporting research findings relating to domestic violence and its effects on children. This academic work is interwoven with poems by adult survivors, who poignantly share the feelings these experiences evoked.

Chapter eight provides some good ideas on how to work with adult survivors and resources for survivors seeking to help themselves. The final chapter gives an excellent summary of the main points.

The book would be of interest to practitioners and to anyone who experienced domestic violence as a child. Although the author warns that reading the book may trigger forgotten childhood memories, there can also be benefits in realising that your experiences are not unique and that recovery is possible. My only criticism is the exclusive focus on male to female domestic violence, without allowing for the possibility of a female abuser, which weakens this otherwise valuable resource.
Jeannette Roddy is a BACP accredited psychotherapist/counsellor and PhD student

Not-knowing the answers

What will you do with my story?
Elizabeth Meakins
Karnac, 2012, 140pp, £16.99
ISBN 978-1855757929
Reviewed by Mary Neave

This book is a real pleasure to read, beautifully written and hard to put down. The warm and honest voice of the author really draws you in.

Elizabeth Meakins is a psychoanalyst and psychotherapist who, for many years, wrote a popular column, 'Tales from the Therapist's Couch' in *The Independent* newspaper. The columns explored the experience of therapy through the stories that her patients brought to her. Some of these stories feature in the book.

The stories are vividly described and often moving. Key themes in Milner's work are a deep trust in the unconscious and its creativity, being open, being able to bear doubt and uncertainty in the struggle for truth and, above all, being able to wait and watch and tolerate not knowing. She writes that, after considering this issue for many years, she came to realise that the pressure to know all the answers 'is invariably a way of defending oneself from the pain of someone else's experience... and being a therapist is about being able to emotionally engage with the difficult and uncertain process of struggling for change' (p125).

Meakins draws on a wide range of psychoanalytic writers, including Freud, Jung, Bion and Winnicott, as well as poets and philosophers. She deals with a number of important aspects of therapy. I particularly valued the chapter titled 'The Angel in the House', which considers the cultural conditioning of girls and boys and how this links to the particular emotional difficulties of many women.

The analyst and writer Marion Milner is a continuous presence throughout and, in an appendix, we encounter the 92-year-old Milner interviewed by Meakins.

This engaging and thought-provoking book would be useful to trainees, experienced practitioners and anyone interested in therapy. Throughout, Meakins does not avoid the hard and sometimes painful nature of therapy, but also she conveys the excitement, hope and enrichment that it can bring.
Mary Neave is a psychodynamic counsellor

Update on the BACP Register

Sally Aldridge explains the different routes open to members to join the BACP Register

Earlier this year, the UK Register of Counsellors & Psychotherapists (UKRCP) changed its name to the BACP Register of Counsellors & Psychotherapists (the Register) to make clear its link with BACP.

The change was part of a series of strategies for BACP to develop the Register, both for its own quality improvement purposes and to meet the public protection requirements of a new accreditation scheme by the Professional Standards Authority for Health and Social Care (the Authority).

The Authority's accreditation scheme sets standards for the quality assurance of professional organisations' registers within the field of health and social care and is a significant development for public protection. The registers will provide access to professionals who are committed to providing good care. This will be a valuable way for the public, employers and commissioners to choose professionals who are competent and behave in an ethical manner.

BACP was delighted to be part of the Authority's pilot accreditation scheme for Assured Voluntary Registers and put in its full application in early December, when the scheme was officially launched. A decision on whether accreditation has been granted is expected early in 2013.

The BACP Register is now in the process of informing eligible members how they can sign up to the new Register terms and conditions. We have invested in a fully automated system so that eligible applicants can go onto the Register website, read and sign each of the 15 terms and conditions and provide an electronic signature to confirm their acknowledgement and agreement. There are different routes to make you eligible for registration.

Accredited members

You are eligible to remain or go onto the Register by signing the Register terms and conditions. If you have not already done so, please go to prospective registrants' area of the Register website at www.bacpregister.org.uk, click the 'Check your status' button and enter your details. The site will confirm your eligibility and ask you to continue to a page where you can sign the terms and conditions. You will be sent an electronic copy for your records. Please note current accredited members should sign the Register terms and conditions by 31 January 2013.

MBACP who have completed an accredited course

You are eligible to go onto the Register by signing the Register terms and conditions. If you have not already done so, please go to the prospective registrants' area of the Register website at www.bacpregister.org.uk, click the 'Check your status' button and enter your details. The site will confirm your eligibility and ask you to continue to a page where you can sign the terms and conditions. You will be sent an electronic copy for your records. Please note that if we do not have details about your accredited course, you may be asked to upload a certificate, which we will then need to verify before you proceed.

MBACP Certificate of Proficiency holders

You are eligible to go onto the Register by signing the Register terms and conditions. If you have not already done so, go to the prospective registrants' area on www.bacpregister.org.uk, click the 'Check your status' button and enter your details. The site will confirm your eligibility and ask you to continue to a page where you can sign the terms and conditions. You will be sent an electronic copy for your records.

MBACP who have not completed a BACP accredited course and/or are not BACP accredited

If you have MBACP status but have not completed a BACP accredited course and/or you are not BACP accredited and wish to go onto the Register, then you will need to take the BACP Certificate of Proficiency (COP). This is an online, case study-based assessment to assess ethical decision-making, skills and knowledge. We are holding invigilated COP events around the UK.

To find out more, visit the prospective registrants' area of www.bacpregister.org.uk ■

You can find out more about the Register and its work at www.bacpregister.org.uk/faq/. If you need further clarification, please call 01455 883300 or email enquiries@bacp.co.uk

Sally Aldridge is Registrar and Director of BACP Registers.

From the Chair

A new year to come

Amanda Hawkins looks back at a year of major achievement and forward to 2013

I can't quite believe it's been a year since I became Chair. Sometimes it's felt more like 30 years; at other times the time has just flown by.

Last month's BACP Annual General Meeting was, for me, a time to pause to take stock and reflect on what BACP has achieved on behalf of the profession, our clients and its members.

In this past year BACP has done much to help improve mental health and wellbeing – there is space only to single out some of the highlights.

You have read a lot about the registration process in this column over the last year, so I won't go through it again. It has involved a root and branch review of BACP, its staffing and its processes. As therapists, we all know the impact of change and uncertainty on people – staff and members alike have endured much. I want to thank two people in particular: Laurie Clarke, our Chief Executive, for his leadership during this process – without his strength and courage I am not sure we would have arrived at this destination – and, of course, Dr Sally Aldridge. Sally, still battle weary from the negotiations with the Health Professions Council, picked herself up and led us through unchartered territory, often sitting with huge unknowns that are inherent to new schemes. Sally has worked tirelessly for us over the last two years and I want publicly to acknowledge that.

We are fully committed to ensuring that children have access to counselling. As you know, in Wales we were a key partner in helping to gather the evidence that has led to legislative change and there is now a statutory duty for counselling to be provided

> 'The AGM is for me an important point in the annual calendar to pause and reflect on what BACP has achieved'

in all Welsh secondary schools. While we are not at this point yet in England, we have been successful in winning a bid that will provide e-learning opportunities for school-based counsellors. As part of this bid we now have a National Advisor for Schools-based Counselling at the Department of Health – Professor Mick Cooper, with whom BACP has worked closely and fruitfully for many years. We have also been successful in setting up a practice research network (SCoPReNet) for schools counsellors, to help us develop a robust and significant evidence base for the work in schools.

Our policy and parliamentary work continues apace. A number of parliamentary questions were initiated by BACP in the UK and Scottish Parliaments, the Northern Ireland Assembly and the Welsh Government. We have also maintained a stream of correspondence with ministers, civil servants and opinion-formers on issues relevant to our members and the profession.

Another important area of work has been our representation on many external working groups, where we have been able to influence policy development. These included the Joint Commissioning Panel for Mental Health, the Mental Health Alliance and the Improving Access to Psychological Therapies children and young people's expert reference group. We also achieved membership of the UK Parliament All Party Parliamentary Group for Mental Health.

All this work was achieved above and beyond BACP core activities – communicating with our near-40,000 members; upholding standards via the *Ethical Framework*; running in excess of 67 events; answering over 50,000 telephone calls and 6,000 email enquiries; publishing our portfolio of publications.

We are very sad to be saying goodbye to our President, Cary Cooper. Cary has been such a great asset to BACP and we thank him for every door he has opened. He has been both a support and an inspiration. But with loss there is gain, and in this particular loss our gain is Mike Shooter as our new President. Mike has been a loyal and incredibly supportive Vice President over the past few years. He brings with him different skills and talents that feel right and relevant to the strategic direction of BACP today. His wisdom and his understanding and experience of the power of working with human beings through being in relationship with them is immense. When you couple this with his connections and the respect with which he is held in the field for his work as a psychiatrist and as past President of the Royal College of Psychiatrists, you get some understanding of my excitement about the gifts he brings into BACP.

At the end of a momentous year, I am immensely proud of BACP's achievements and equally excited about what is to come. Thank you to all who made it happen; I hope that you share my pride. ■

Engaging with the spiritual

Editor *Susan Dale* discusses *Thresholds*, the journal of the Association for Pastoral and Spiritual Care and Counselling

About APSCC

APSCC is committed to understanding and working at the interface between counselling, pastoral care and psychotherapy on the one hand and spirituality and religion on the other. For further details about joining the division, please email julie.camfield@bacp.co.uk

How would you describe yourself and your professional background?

I live in beautiful Mid-Wales and have worked for 15 years as an independent counsellor, supervisor, trainer, researcher and writer. Initially I took a pastoral counselling diploma. Later came more specialist knowledge, a master's degree in counselling and a doctorate in education. Always, however, the constant has been a passion for people, for listening, and for enabling the voices of those marginalised by experience, prejudice or pain to be heard.

Who is the journal for?

Thresholds is read mainly by counsellors, psychotherapists and professionals offering pastoral care. All have an interest in spirituality. This could be in the form of a specific religious tradition, such as Christianity, Judaism, Islam, or through a more transpersonal or existential sense of spirituality that is not attached to a religious belief. What all *Thresholds* readers seem to have in common is the passion to engage with a spiritual dimension in their lives and therapeutic work.

What is in the journal?

There are articles from a wide spectrum of professional and spiritual backgrounds. The Autumn 2012 issue includes an article by Caroline Brazier, a Buddhist psychotherapist and trainer, about her experience in practice and of training psychotherapists, founded on a system of thought grounded in the spiritual. Avigail Abarbanel writes of her spiritual transition from a secular Jew growing up in Israel to a new discovery of her relationship with God and the effect this has had on her psychotherapy practice. Researcher Lorna Marquès-Brocksopp shares research about wellbeing, visual impairment and existential spirituality. Other articles come from Christian and Muslim perspectives.

As editor, what have been your priorities?

I aim to include a wide range of authors from different spiritual backgrounds and approaches. I have also been keen to enable people who are expert practitioners but not expert writers to share good practice and ideas by publishing letters and giving feedback on articles and offering different ways to engage with the journal.

Are there any particular challenges for your journal?

I recognise that inter-faith and inter-spiritual conversations are sometimes difficult to manage. Authors fear they will offend, that they won't understand enough about others' viewpoints, or others will not understand theirs. There is also a fear of criticism from the wider therapeutic community, which often champions the secular over the spiritual. For me there is also the fear of being so politically correct that the words on the page become bland. Authors have to be prepared to speak about deeply held beliefs, not just about their counselling skills and theories. This takes courage, and I am really heartened that so many contributors are prepared to rise to the challenge.

'What all *Thresholds* readers seem to have in common is the passion to engage with a spiritual dimension in their lives and therapeutic work'

Are you actively looking for readers to contribute articles?

Yes, yes, yes....

What has given you greatest satisfaction in the role?

Several things. Working with authors and seeing sometimes fragile ideas turn into fully formed articles that speak to others; receiving feedback and discussion about specific articles – it shows people have opened the journal and engaged with the material we publish; working with an editorial team who are very skilled at supporting and enabling divisional editors to produce professional journals of repute, and learning so much from the authors about my own relationship with spirituality and how this affects my work.

Could you sum up in three words what you hope the journal provides for readers?

Resource – it should be a resource for practitioners enabling good practice to be shared and learning encouraged. Voice – it should give a voice to the membership of APSCC in order that they can encourage wider inclusion of spiritual practices within therapeutic work. Invitation – it should provide readers with an invitation to explore their own spirituality and how this connects with their work and therapeutic training. ■

Susan Dale is the recently appointed editor of Thresholds. *You can contact her at thresholds.editorial@bacp.co.uk*

Thresholds *is published four times a year and is mailed free to members of APSCC. It is also available on subscription to non-members. To subscribe, please contact BACP Customer Services on 01455 883300.*

New BACP President and Deputy Chair elected

BACP has a new Deputy Chair and a new President to take the Association forward into 2013

Congratulations to Elspeth Schwenk who, as announced by BACP Chief Executive Laurie Clarke at the AGM, has been elected Deputy Chair of the Association. Congratulations also to Fiona Ballantine Dykes, who was elected Governor for a first three-year term of office. Faith Stafford is welcomed back onto the Board of Governors for a further three years.

The full list of Governors of the Association is Amanda Hawkins – Chair; Elspeth Schwenk – Deputy Chair; Fiona Ballantine Dykes, Alan Dunnett, Anna Hamilton, Caryl Sibbett, Faith Stafford and Mhairi Thurston.

Sadly BACP has had to say goodbye to Cary Cooper, President for the past six years. As Amanda said at the AGM, Cary has been a great support and inspiration during that time and he will be much missed in that capacity. We have also lost Linda Bellos, Vice President, who has completed her term of office. Linda's energy and commitment, particularly in the area of equality and diversity, will equally be missed. The Association's thanks and appreciation go to both Cary and Linda and we hope they will maintain their contact with, and support for, BACP.

We are, however, delighted to welcome Dr Michael Shooter as our new President. Mike will be known to many members already, through his years as a Vice President. His particular skills and expertise will be very relevant to BACP's strategic direction going forward.

Current BACP Vice Presidents are John Battle, Robert Burden, Robert Burgess, Bob Grove, Lynne Jones, Martin Knapp, Juliet Lyon, Glenys Parry, Pamela Stephenson Connolly and David Weaver.

To contact any of the Board or Governors, please address letters c/o Jan Watson at the BACP Lutterworth office or email jan.watson@bacp.co.uk

BACP Private Practice annual conference

BACP Private Practice, the BACP specialist division for independent practitioners, will be hosting its 2013 annual conference in London on 9 February

The theme of the conference is 'Depression: what's therapy got to do with it?' It will explore different cultural, sociological, and psychological perspectives on working with depression in private practice and the role of the private practitioner in providing therapy for clients who present with depression.

The conference will be opened by keynote speaker Darian Leader, a founder member of the Centre for Freudian Analysis and Research, President of the College of Psychoanalysts UK and Visiting Professor at the School of Human and Life Sciences, Roehampton University. He has published a number of books on psychoanalysis and is also author of *The New Black: Mourning, Melancholia and Depression* and *What is Madness?* Darian will explore the experiences of loss and separation that lie behind the diagnosis of depression and how the therapist can help its treatment.

The other keynote speaker is psychotherapist Benjamin Fry, who set up Get Stable, a social enterprise offering NHS-funded talking therapies, and also works in private practice and runs a residential clinic.

Workshops include transcultural approaches to depression, depression and bereavement, antidepressants and depression, and working in private practice with military veterans.

The conference is open to BACP Private Practice members and non-members.

Full details can be found on the BACP Private Practice website at www.aiponline.org.uk/Conf%202013/index.php or telephone 01455 883300.

BACP Coaching update

BACP Coaching, one of the BACP divisions, is looking for people to join its Executive

In particular, BACP Coaching needs members to take on the voluntary roles of Executive Specialist for Research and Executive Specialist for Communications and Engagement.

Executive Specialists are co-opted onto the Executive for a fixed period. The time commitment for the posts is two to three days a month (or equivalent evenings), including at least four Executive meetings a year in Lutterworth or London.

Further information can be found at www.bacpcoaching.co.uk/opportunities.php or please email the Chair, Jo Birch, at jo@jobirch.co.uk to arrange an informal chat.

BACP Coaching is also looking for members willing to set up and run local coaching networks in their area, and to co-ordinate existing networks in Scotland and the East London/UEL network. If you are interested, please email Trish Turner, BACP Coaching Executive Specialist for Networks, at trish@trishturner.co.uk.

All BACP members can attend a local coaching network group for a 'taster evening' even if they haven't joined the coaching division yet. More details about the BACP Coaching local network groups can be found at www.bacpcoaching.co.uk/Localgroups.php

BACP summit to debate 21st century therapy

BACP has confirmed the speaker line-up for its 2013 summit conference on 5 February in central London to discuss the future of counselling/psychotherapy

The conference follows the Evening with Yalom event on 4 February, also at the Queen Elizabeth II conference centre in Westminster, which is now fully booked. The conference theme is 'Your Profession in the 21st Century', with a focus on ethical practice, building an evidence base for talking treatments, and new ways of talking therapies using new technologies.

Gregor Henderson, Public Mental Health Lead at the Department of Health, will discuss the role of psychotherapy in public mental health. There will be three panel discussions/debates: Dr Alistair Ross, Chair of BACP's Professional Ethics and Quality Standards Committee, will lead a panel discussion on the relevance of ethical frameworks in today's changing social and political environment; John McLeod, Emeritus Professor of Counselling at the University of Abertay Dundee, will lead a discussion on evidence measures and building an evidence base for counselling and psychotherapy, and Jenny Hyatt, founder and Chief Executive of The Big White Wall online therapy service, will introduce a panel debate about the future of therapy in an increasingly pluralistic, online and globalised society.

For more information, please visit www.bacp.co.uk/events or ring 01455 883300.

Making Connections dates booked for 2013

The first 2013 BACP Making Connections event is in Oxford on 30 January

Making Connections is an opportunity for BACP members to network, meet BACP staff and find out about developments in the world of psychotherapy and counselling and within the Association.

Speakers at the Oxford event in January include Sir Richard Bowlby, son of John Bowlby, who will be talking about his father's legacy; psychotherapist and drama therapist Andrea Parry, who will be discussing the use of creative arts when working with loss and bereavement, and Maxine Ashton, who will talk about counselling people with Asperger syndrome.

Making Connections visits Cardiff on 19 March. Speakers booked for the Wales event include Gill Fennings-Monkman, who runs the Counselling for a Change service and was awarded an MBE in 2010 for services to women in business; Stuart Walkley, Director of the Oakridge training and development consultancy, and Professor Tim Bond, Professorial Teaching Fellow at the University of Bristol.

For more information, please visit www.bacp.co.uk/making connections or ring Customer Services on 01455 883300.

BACP commissions cost-effectiveness review

BACP has commissioned Martin Knapp, Professor of Health Economics at the Institute of Psychiatry, to review how counselling can cut costs to the NHS and public expenditure more widely by improving people's mental health and wellbeing. Professor Knapp, a BACP Vice President, will be working with Gregor Henderson, Public Mental Health Advisor to the Department of Health.

The aim is to produce a report that will support counsellors to make a case to local commissioners of the benefits of their work.

BACP members wishing to contribute can contact Suky Kaur, BACP Policy and Public Affairs Manager, at suky.kaur@bacp.co.uk

Coaching lead advisor appointed

BACP has appointed Laura Bennett to the new post of Lead Advisor, Coaching

Laura was previously Learning and Development Manager with North East Lincolnshire Council, where she devised and implemented its in-house staff coaching service. She will be working two days a week in her BACP role and continues to work part-time with the council.

Laura is herself a qualified coach and person-centred counsellor and volunteers with her local branch of Cruse Bereavement Care.

'We were one of the pioneer councils introducing in-house coaching and I am looking forward to the new challenge of influencing the development of the coaching profession at a national level with BACP,' Laura said.

Professional conduct

Sanction compliance
Relate Leicestershire
Reference No 108427
Leicester LE2 7LL

BACP has received reports, which verify that the requirements of the sanction have been met. As such, the sanction reported in the June 2012 edition of this journal has been lifted. The case is now closed.

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

NHS mandate published

The first mandate between the Government and the NHS Commissioning Board was published on 13 November

The mandate sets out the ambitions for the NHS for the next two years, reaffirming the Government's commitment to a comprehensive and universal NHS.

The publication of a mandate means that, for the first time, the NHS will be measured on how well it achieves its commitments to the delivery of healthcare to the public. This includes a commitment to putting mental health on an equal footing with physical health, meaning that everyone who needs mental health services will have the same right to timely access to the best treatment available. Other important commitments outlined in the mandate are improving standards of care, not just treatments, especially for older people, and better diagnosis, treatment and care for people with dementia.

Commenting on the mandate, BACP Chief Executive Laurie Clarke said: 'BACP welcomes the Secretary of State's pledge to give mental health parity with physical health as a vital step towards providing appropriate and timely treatment to those affected by mental illness, but urges the Government to facilitate this by providing patients with a choice of psychological therapies, carried out by appropriately trained, experienced practitioners.'

BACP comments on Assisted Dying Bill

BACP says specialist counselling should be available to people considering assisted death and their families, if a law to allow assisted dying is passed by Parliament

BACP Policy attended a meeting of the All-Party Parliamentary Group on Choice at the End of Life on 17 October. The meeting, chaired by Heidi Alexander MP, was part of the ongoing consultation process to discuss a draft Assisted Dying Bill. The Policy Unit followed up this meeting with a letter to Heidi Alexander reiterating that, while BACP does not have a view on assisted dying, if such a Bill were to be introduced, access to independent counselling should be included.

In its response to the consultation, BACP stated: 'BACP does not have a view on a change of law to allow assisted dying and our comments are not intended as support for legislation. However, if the Bill were to go through, BACP would suggest that people considering assisted death may require independent counselling prior to making a final decision. Access to an independent counsellor (one who is a member of a professional body with an ethical framework such as BACP), as part of the mental health assessment process and the patient's decision-making process, could provide specialist support to the patient (and their family), and could reduce fears of coercion – whilst continuing to leave the ultimate decision with patients and doctors.'

The consultation on the draft Bill closed on 21 November and received almost 500 responses. These responses will be fed into a report and an Assisted Dying Bill, which Lord Falconer is expected to table in the New Year. Speaking after the consultation closed, Heidi Alexander said: 'I am delighted to have received such an overwhelming response to the consultation. I am confident that, with the input we have had from the general public, healthcare professionals and other experts, we will be able to provide the best legal framework possible to make safeguarded assisted dying for terminally ill, mentally competent adults a reality.'

The Policy Unit has also been in contact with Margo MacDonald MSP, who is leading a similar Assisted Dying Bill through the Scottish Parliament. We again highlighted the need for access to independent counselling for people considering assisted death, to make available specialist support to patients and their families, should they want it.

For the full response, please visit the consultations page at www.bacp.co.uk/policy

Current consultations

Fees for Registered Health and Social Care Services
Consulting body: Care Quality Commission
Nation scope: UK
Deadline for comments: 19 December 2012

New Service Framework for Older People's Health and Social Care Services
Consulting body: Department for Health, Social Services and Public Safety
Nation scope: Northern Ireland
Deadline for comments: 19 December 2012

Strengthening the NHS Constitution
Consulting body: Department of Health
National scope: UK
Deadline for comments: 24 January 2012
Consultation scope: Changes to the NHS Constitution, including ensuring parity of esteem between physical and mental health; a new responsibility on staff to treat patients with the highest standards of care, compassion, dignity and respect, and a new pledge to patients that NHS staff must be open and honest with them if mistakes are made or things go wrong.

BACP consultation responses

NICE Quality Standards for Children and Young People with Depression
Consulting body: National Institute for Health and Clinical Excellence

Safeguarding Choice: a draft Assisted Dying Bill
Consulting body: All Party Parliamentary Group for Choice at the End of Life

To view BACP's full response to these and all other consultations, visit www.bacp.co.uk/policy

Around the Parliaments

It has been a busy month in Parliament, with the Government announcing its Mandate for the NHS and with it the NHS Outcomes Framework (see news report on p50).

The Policy team at BACP has also been active. We met Graham Stuart MP (Conservative), Chair of the House of Commons Education Select Committee, to talk about school-based counselling. Another meeting on school-based counselling was held with Chris Ruane MP (Labour), who has an active interest in mental health, particularly mindfulness-based therapy. We also met former Care Services Minister and now Chair of the Liberal Democrats Paul Burstow MP, who is keen to continue an active interest in mental health, despite leaving his Government post.

BACP was invited by Heidi Alexander MP to attend the All-Party Parliamentary End of Life Group to hear about developments on a Private Members' Bill on Assisted Dying. While BACP takes no position on the subject of assisted dying (see the news report on p50), we acknowledge that, should legislation proceed, the benefits of counselling support needs to be part of that ongoing debate. BACP also attended its first meeting of the All-Party Parliamentary Sustainable Relationships Group. The Group's aim is 'to promote and develop marriage and relationship skills and support, identifying best practice within the UK and internationally to help reduce family breakdown'.

The Policy team has also written to Diana Johnson MP (Labour) to follow up a question she asked about the future registration of psychotherapists. BACP also followed up the Labour Party leader Ed Miliband to welcome his speech on mental health (see News, November *Therapy Today*). Other letters were sent to Oliver Colville MP (Conservative) and Rebecca Evans AM (Labour), who both raised the subject of students' mental health in their respective Parliaments.

For further information about BACP's Parliamentary work, please contact Martin Bell, Parliamentary and Public Affairs Advisor, at martin.bell@bacp.co.uk

Newly accredited counsellors/psychotherapists
Kirstie Adamson
Moira Aitken
Debbie Almond
Sarah Armstrong
Jan Baker
Amanda Barge
Ellie Bentley
Lesley Benzie
Christopher Berry
Julie Birchall
Morag Borszcz
Dianne Bowden
Angie Bradley
Margaret Bryant
Nicola Burch
Kevin Burrows
Sheila Cartwright
Gillian Darby
Carolyn de Ferrars
Janet Dee
Terry Deehan
Majella Doherty
Judith Eccleston
Judith Edge
Maria Ferguson
Petra Friesner
Orla Gardam
Rachel Gardner
Jaeda Goodman
Lesley Grice
Lesley Heath
Catherine Henshall
Ruth Herrtage
Julia Hill
Jill Jarvis
Victoria Joyce
Giles Kendall
Sharon Kerry
Niki King
Deborah Knight
Alison Leftley
Lynsey Lowe
George MacDonald
Imelda Maguire
Iulia-Ligia Manastireanu
Laura Mann
Leighton Marjoram
Colette McBride
Bernadette Mccullagh
Anna Mills
Veronica Moore
Sinead Mulhollhand
Hilary Newbrook
Lynn Newport
Veronica Norman
Jill Parnham
Michael Randall
Rowena Rheinberg
Janice Rogers
Michael Rouse
Janet Royle
Jessica Salomone
Wendy Savage
Britta Schuessler
Sarah Seymour
Yvonne Shelmerdine
Claire Sparrow
Caroline Stancer
Jennifer Sykes
Joanne Turner
Sarah Urwin
Gillian Warin
Amanda Webbon
Sian Welch
Samia West
Nicola Wheeler
James Wilson

Newly senior accredited counsellors/psychotherapists
Karen Cook
Gail Knight
Priscilla Sparks

Newly senior accredited counsellors/psychotherapists for children and young people
Allison Brown
Pauline O'Keeffe

Newly senior accredited supervisors of individuals
Julie Bithell
Karen Collins
Christine Ojera
David Smith

Members not renewing accreditation
Brita Andrews
Sandra Bigg
Richard Bury
Norma Clark
Karen Dale
Karin Dosani
Martha Emeleus
Ann Fiander
Carolyn Higgins
Kathleen Howes
Marion Lynch
Mel Mackay
Gary Mayhew
Marian Mycock
Delphine Ruston
Lil Stanley
Jennifer Williams
Elizabeth Woolman

Member whose accreditation has been reinstated
Sue Grant

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

Evaluating Counselling for Depression

Peter Pearce and colleagues report the headline findings from an evaluation of the first wave of Counselling for Depression (CfD) training

Feedback from the evaluation will inform adaptations to the training

As reported in February's *Therapy Today*,[1] BACP has, with partners in the higher education sector, developed a continuing professional development (CPD) training programme in Counselling for Depression (CfD), for counsellors working in Improving Access to Psychological Therapies (IAPT) services. The training is currently being rolled out and we now have a network of accredited providers covering most of England.

CfD is a competence-based person-centred/experiential (PCE) therapy for people with depression. It is recommended by NICE as a high-intensity intervention for persistent sub-threshold depressive symptoms or mild to moderate depression.[2] The training programme is designed for experienced counsellors who already hold an initial qualification in person-centred or humanistic counselling/psychotherapy.

The CfD training programme and its associated competence framework, together with the person-centred and experiential scale (PCEPS)[3] that is used to assess adherence to the CfD model, are important steps towards the recognition of PCE counselling as an evidence-based therapy. BACP is also funding a CfD textbook to support the training programme and is commissioning a full randomised controlled trial (RCT) comparing CfD with CBT. Establishing strong links between research, training and practice will help secure evidence-based status for CfD and support choice for people using NHS psychological therapy services.

So far the NHS has funded over 160 places for IAPT counsellors to undertake the CfD training and further places are being negotiated for 2013. Geographical coverage has been variable, with some strategic health authorities investing heavily and others less so. An estimated 30 per cent[4] of IAPT therapists are counsellors and BACP believes it is vital that they are funded to complete CfD training, both to increase their own job security and to ensure a continuing choice of therapies in IAPT.

CfD has been generally well received in the counselling field although, as with any new initiative, there are improvements to be made. This article reports on the evaluation of the first year of CfD training to assess trainees' responses both to the training programme and the competence framework.

The evaluation consisted of a questionnaire about participants' experience of the training, and follow-up telephone interviews with six individual participants. The questionnaire asked about sense of self as a practitioner pre-training, expectations of the CfD training, experience of the five-day taught CfD training programme, the CfD competence framework, experience of supervised practice, experience of the assessment of counselling practice and the impact of CfD training on practice.

Thirty of the 60 counsellors who took part in the first round of CfD training completed the questionnaire online. The majority worked as high intensity therapists in an IAPT service, many in part-time roles, and all had a minimum of two years post-qualification experience and had completed an initial person-centred or humanistic training.

Findings

Most respondents to the questionnaire felt that they had a good understanding of PCE theory and practice pre-training. Very few felt that they had equal status to therapists from other modalities (eg CBT) in their service context. Most viewed training in a set of competencies as positive and useful. For most, enhancing their status was a significant motivator for participating in the training. There was broad agreement that the CfD competence framework accurately described both PCE therapy and how to work with depressed clients from a PCE perspective. A large majority of participants agreed that the CfD supervision provided throughout the assessed practice period as part of the training helped them to align their practice with the CfD competence framework.

Opinion was more divided about participants' experience of the evaluation of their assessed practice recordings. This was anticipated: external assessment of competence is always going to raise anxiety levels and a number of the participants' practice recordings struggled to meet adherence to the competence framework. However, there was still very high agreement that the feedback received on assessed practice was clear and supported participants' development as CfD therapists.

Overall, 60 per cent of participants reported being more confident to work with depressed people since completing the training. Half the participants felt that participating in CfD training had enhanced their status as a therapist and around three quarters felt that using an adherence scale had been a positive experience. For 60 per cent of participants, the CfD training had changed how they practised and had deepened their understanding of how to work with depressed clients.

Opinion was more divided about whether their practice had become more PCE as a result of the CfD training. Nearly half reported that it had, a quarter reported that it had not and the remaining quarter didn't comment.

What we have learned

The evaluation provided evidence that high-intensity counsellors in IAPT services often do not feel they have equal status to their CBT colleagues. This may be reflected not only in attitudes and perceptions but also in levels of pay. It would appear that training in CfD might help to address some of these perceptions and reduce this lack of equity by putting all high-intensity interventions on a more equal footing:

'This training has empowered me. And in the setting of our trust, I'm now respected more.'

The evaluation also seemed to affirm that counsellors are generally positive about working with a competence framework; that the CfD training helped them to return to 'aware practice' within the orientation in which they trained, often after having lost their way through trying to follow the demands of their IAPT context. There was also a perception that the CfD framework is a valid and accurate articulation of the PCE model.

It was significant that not all trainees found it easy to adhere to the competences. This suggests that, in some cases, there may be a gap between a counsellor's professed theoretical orientation and how they actually practise. The CfD training appears to provide a useful means to realign these two. The significance of this for the PCE community is that the framework provides both a basis for clarity about the theory and practice of PCE counselling, and a way to ensure the model is implemented faithfully by practitioners.

As IAPT services roll out a wider range of therapies, it is important that clients receive clear, consistent descriptions of the approaches available, and that therapists deliver the therapy as described. Without this there is no genuine choice for IAPT clients.

The evaluation highlighted a number of problems in relation to the training itself. Some participants felt that, at five days, the course was too short and they needed more time to assimilate the material. Some encountered practical problems in relation to the assessment process: recording therapy sessions and sending these to assessors outside their primary care trust presented issues of confidentiality and data handling.

In some cases supervisor expertise was also raised as a problem. The availability of a team of appropriately trained supervisors is, of course, prerequisite to rolling out a training programme. We had to train supervisors very rapidly in the CfD model, which was not ideal and led to critical feedback from some trainees. As the training becomes more established, this issue is being addressed and a nationwide network of CfD supervisors is being established.

Other critical feedback related to the teaching of the more experiential competences that derive from emotion-focused therapy (EFT). There seemed to be quite an interest in this aspect of the training, which for many counsellors represented a 'developing edge' to their practice. Perhaps inevitably in a CPD training programme, some trainees felt that the course didn't allocate enough time to this and were left wanting more.

A final negative point raised related to a sense of frustration among trainees at not being able to implement what they had learned on the training programme when they returned to practice in their IAPT services.

'The minute the course was finished, it was back to normal, back to try and get clients you know patched up in four or five sessions... I didn't really get a chance to... really engage in what I'd learnt.'

The key issue here seemed to relate to the number of sessions counsellors were allowed to contract for with clients. This highlights a wider problem. NICE recommends between eight and 10 sessions of CfD for mild to moderate depression and up to 20 sessions for more severe presentations.[2] Despite this, participants reported that some services are restricting the number of sessions to a maximum of six.

On a more positive note, a number of trainees experienced the training as empowering, as helping them to reconnect with the PCE model and, interestingly, as equipping them to work with clients in greater emotional and relational depth.

'It was going home to a way of working that I had somewhat, not strayed from, but somehow, because of working in a very pressurised environment, I'd actually lost some of... the spirit of it.'

The challenges now for BACP and its partners are to adapt the training in the light of further feedback from trainees, to lobby the Department of Health for more funding for CfD training places, to evaluate the model and to improve access to CfD training while maintaining quality standards.

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Does CBT for anxiety work?

A US-based study of CBT for adults with anxiety disorder is claiming long-term effectiveness

The aim of this study was to examine the long-term effectiveness of CBT for patients with a wide range of anxiety disorders, treated in a naturalistic, fee-for-service setting. Patients were categorised as being either responders (those who identified themselves as 'very much improved' or 'much improved' compared to pre-treatment) or non-responders, and as remitters (those who identified themselves as 'normal/not at all ill' or 'borderline ill') or non-remitters. Between post-treatment and follow-up, 29 per cent of patients began psychotherapy or counselling with other treatment providers and 12 per cent started seeing a psychiatrist.

The authors report only on those patients who were categorised as either 'responder' (n=113, 62.4 per cent) or 'remitter' (n=26, 14.4 per cent) at the post-treatment stage. However, an additional 23.3 per cent of patients were neither responders nor remitters. Hence, for over 20 per cent of patients, the CBT intervention had no immediate effect.

At one year follow-up, 78 per cent of patients who were either responders or remitters at post-treatment maintained this status. The results of this study indicate that, in the short-term, over 75 per cent (n=139) of patients with anxiety respond to CBT. However, in the long-term it is effective for only 60 per cent (n=109), meaning that for 40 per cent of patients CBT is not effective in helping their anxiety. Furthermore, at post-treatment, only 14.4 per cent of patients were in remission (n=26), dropping to 12.2 per cent at follow-up (n=22). Thus, over 80 per cent of patients receiving CBT still experience symptoms of anxiety.

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DiMauro J, Domingues J, Fernandez G, Tolin DF. Long-term effectiveness of CBT for anxiety disorders in an adult outpatient clinic sample: a follow-up study. Behaviour Research and Therapy 2012. DOI: 10.1016/j.brat.2012.10.003.

SCoPReNet e-bulletin

The first e-bulletin of the School-based Counselling Practice Research Network (SCoPReNet) was sent out to its members in November.

The quarterly e-bulletin was developed by BACP Research and includes details of new and ongoing research in this area, as well as policy news and upcoming events.

Membership of SCoPReNet is free and open to members and non-members of BACP. SCoPReNet members have access to a networking discussion forum and receive the quarterly e-bulletin. The SCoPReNeT webpages are also regularly updated with relevant research news.

Visit www.bacp.co.uk/schools

A big thank you from the BACP Research department

BACP Research would like to thank the many people who have contributed to our work in 2012.

Over the past 12 months we have had the pleasure and the benefit of working closely with many people who have kindly given their time and expertise to further research at BACP, for which we are very grateful indeed.

We would like to mention the people below for a special thank you, although the list is not exhaustive, and please forgive us if we have missed anybody out unintentionally.

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And a huge thank you also to all those who presented and chaired sessions at our annual research conference in May; it was very much appreciated.

Debate over open access to research

Over the last few months there have been various debates, discussions and statements regarding the issue of open access to research papers

Currently, most academic journals work on a subscription basis and some are calling for a change in this, particularly for research funded by the UK's seven Research Councils.

Options for open access are 'Gold', where authors of accepted manuscripts pay to cover publishing costs and then the article is freely available for anyone to read, or 'Green', in which authors do not pay and articles become freely available after a set period of time of up to 24 months. The BACP journal *CPR* (*Counselling and Psychotherapy Research*) offers a 'hybrid' model, which means that authors can choose to make their article open access, for a fee, after it has been accepted following a rigorous peer review system.

Research Councils UK has recently announced grant funding to aid open access to research that the Research Councils fund. In the first year (2013/14), RCUK will fund 'Gold' open access to some 45 per cent of Research Council funded research papers, rising to over 50 per cent in the second year and 75 per cent by the fifth year (2017/18). The remaining 25 per cent of papers reporting Research Council funded research will be delivered through the Green Open Access model.