Therapy Today

For counselling and psychotherapy professionals

July 2010
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Understanding the kinky client

Rapport in cyberspace: how to build empathy online

A day in the life of the BBC Academy's head of coaching

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

I was staggered when I realised recently that this is my 100th issue of *Therapy Today*. Some of the debates that were raging a decade ago, are still with us. For example, one of my first tasks when I began working for the journal was to write an article (a rather naïve one at that) about how regulation was sure to be in place by 2003 – at the very latest!

We have covered many topics in the past 100 issues but have not to my knowledge touched on the subject of sadomasochism. One study has reported that 14 per cent of men and 11 per cent of women have personal experience of sadomasochistic sex so the chances of someone walking into our consulting room who identifies as kinky are quite high. Unless we have personal experience of the world of kink, we are unlikely to be confident to work with a client who discloses in therapy that they are exploring this aspect of their sexuality. Su Connan argues that offering therapy to those who identify as kinky raises questions for the therapeutic community such as those that have been raised by the gay community around the need for awareness, training, ethical practice and supervision. Clients need therapists who are not going to be shocked or make them feel judged or indeed who will categorise them as pathological or sexually deviant and in need of treatment and cure. In order to be able to offer ethical therapy to these clients, Su argues, practitioners need to deepen their own knowledge and understanding of the kink experience and of the meanings that sadomasochistic sex has for those who incorporate it into their lives.

The hunt is on for some new columnists as we say goodbye in this issue to our client Emma Munro who has shared her therapy journey with us for the last 18 months, and Martin Halifax who has reached the end of his counselling and psychotherapy diploma. If you know people who might fill either of these roles, please get in touch.

Features

Cover illustration by Emmanuel Romeuf

Regulars

BACP

PTSD treatment U-turn

A government plan to provide more help for mentally ill soldiers has been thrown into doubt weeks after it was announced by the Ministry of Defence. The scheme, unveiled by the MoD in May, was aimed at early diagnosis of post-traumatic stress disorder and other conditions affecting combat soldiers. But a defence minister has told the BBC he opposes screening. Veterans' charities say the Iraq and Afghanistan conflicts alone will cause thousands of cases of mental illness.

Defence minister opposes screening for mental health problems

Andrew Robathan, minister for personnel, welfare and veterans, told BBC *File on 4*: 'I think most expert opinion is that you should not screen people for mental health issues because first of all there is no scientifically robust way that you can do that. Indeed the downside of suggesting that people have mental health problems, when actually they do not have, is actually quite immense and of great concern.'

The MoD had been responding to research published by the Centre for Defence Medical Health at King's College London, which found that 40 out of 1,000 services personnel were suffering from PTSD with the figure rising to 70 out of 1,000 for those who had served in combat zones. Previously, government data published by the National Audit Office had stated that the figure was one in 1,000.

Former Coldstream Guardsman Ben Close, who has been diagnosed with PTSD, told the BBC he had never been screened. He claimed the only help for troops returning from Afghanistan was a day and a half in Cyprus where a doctor gave a short talk. Mr Close said PTSD and other mental illnesses carried a stigma in the army.

The MoD's mental health expert, Surgeon Commander Neil Greenberg, told the BBC: 'We have some very strong evidence that stigma within the military does exist but it is at exactly the same level as in the civilian sector and also the same level as in other forces such as the US.

'What I can absolutely assure is anyone who is in the armed forces who has a mental health problem and who goes and seeks help, be it from a GP, chaplain or anyone else, will get evidence-based treatment based on National Institute for Health and Clinical Excellence guidelines.'

BBC

Help for bereaved children in schools

More than 11,000 UK teachers are to be given free guidance on how to support suddenly bereaved children, following a study highlighting a lack of support in this area. The announcement by the Amy & Tom Project – an initiative by road safety charity Brake, and the UK's leading funeral director, The Co-operative Funeralcare – follows research by the two organisations which showed that only one in five UK schools have a written policy on helping bereaved children in the classroom. The two organisations have launched a guide 'Helping suddenly bereaved children' aimed at teachers, parents and carers of children who suddenly lose a close family member. The guide is designed to give an insight into children's understanding of sudden death, how they may express their grief, and how teachers and carers can provide help.

Amy & Tom Project

Psychological therapies: roll-out continues

Psychological therapies will continue to be rolled out across the NHS in the coming year, health secretary Andrew Lansley has announced.

Visiting a psychological therapies service in Berkshire West with care services minister Paul Burstow, Lansley outlined plans to take forward the Government's commitment to increase access to services by pledging £70m over the next year. This will ensure that services can continue to run for the next year and new services can be established. Lansley said: 'Our Coalition Programme set out our intention to ensure greater access to talking therapies. We want to offer long-term solutions to people with mental health problems and psychological therapies do that... We will broaden the geographical coverage of services and also the range of therapies available. This will help us deliver more choice and give people better access to the right psychological support.'

Charles Waddicor, NHS Berkshire West chief executive, said: 'The announcement that psychological therapies will be expanded is good news for patients. In Berkshire West we are developing a successful Talking Therapies service which is delivering positive results, helping to improve the health and wellbeing of patients. We welcome the fact that this service had a good outcome: since 1 April 2010 it has helped get 64 people off benefits and back to work, which has contributed to improving their health.'

Department of Health

Brief interventions as effective as usual GP care for depression

Brief interventions that deliver counselling, problem-solving therapy (PST) and cognitive behavioural therapy (CBT) in general practice are equally effective as treatments for depression and anxiety, a study shows. The latest research evidence in support of psychological therapies comes days after the Coalition Government committed itself to 'broaden the range of therapies available', in the light of growing concerns that CBT was being invested in at the expense of other clinically useful therapies.

The meta-analysis published in *BMC Medicine*, found six sessions in all three forms of psychological therapy were equally effective in patients with either depression or mixed anxiety with depression. UK researchers analysed 34 studies involving 3,962 patients – 22 of which were conducted in UK primary care. Of these, 13 trials delivered CBT, eight counselling and 12 PST. There were small effects favouring brief CBT over usual GP care for both depression and mixed anxiety and depression. There was a larger effect for brief CBT for anxiety disorder. All differences were statistically significant.

The effect sizes for CBT for anxiety and depression translated to a 2.3 point difference between groups offered a brief intervention and those given usual care on the Hamilton Rating Scale for Depression, and a 7.2 point improvement on the Hamilton Rating Scale for Anxiety. But other therapies also showed benefits. Counselling was effective for mixed anxiety and depression. The effect size was smaller for PST for both depression, and mixed anxiety and depression.

Lead researcher Dr John Cape, head of psychological therapies at Camden and Islington NHS Foundation Trust, concluded: 'Our meta-analysis suggests that brief CBT, counselling and PST were all effective in treating depression and mixed anxiety and depression. No significant difference was found between CBT, counselling and PST.'

The results came as health secretary Andrew Lansley pledged to continue the Labour Government's commitment to provide 3,600 extra psychological therapists by 2011 and pledged a £70m investment over the next year. However, Paul Farmer, chief executive of Mind, warned: 'CBT is just one of a host of therapies that can be prescribed for mental health problems, and many people are still stuck on waiting lists struggling to access other therapies that are absolutely fundamental to mental health care, such as counselling. The new Government should use this as an opportunity to expand IAPT to include the full spectrum of treatments that huge numbers of people need urgently, and many are currently kept waiting for.'
Pulse

Antidepressant use rises as recession feeds wave of worry

The number of antidepressants prescribed by the NHS has almost doubled in the last decade, and rose sharply last year as the recession bit, figures reveal. The health service issued 39.1m prescriptions for drugs to tackle depression in England in 2009, compared with 20.1m in 1999 – a 95 per cent jump.

Doctors handed out 3.18m more prescriptions last year than in 2008, almost twice the annual rise seen in preceding years, according to previously unpublished statistics released by the NHS's Business Services Authority.

The increase is thought to be due in part to improved diagnosis, reduced stigma around mental ill-health and rising worries about jobs and finances triggered by the economic downturn. But doctors warn that some people are being put on the drugs unnecessarily, especially those with milder symptoms of depression, partly because there is too little access to talking therapies. 'I'm concerned that too many people are being prescribed antidepressants and not being given counselling and cognitive behaviour therapy, because access to those therapies, while it is improving, is still patchy,' said Professor Steve Field, the chairman of the Royal College of General Practitioners.
The Guardian

39.1m prescriptions of antidepressants given in 2009

Ban on gay conversion therapy

More than two-thirds of doctors at the British Medical Association's annual meeting in Brighton have approved a motion backing a call for the Royal College of Psychiatrists and other mental health standards bodies to reject so-called 'gay conversion therapies' and ban their use in their codes of practice.

They also agreed that health departments should investigate alleged cases of conversion therapy being funded by the NHS.

The vote follows a year-long undercover investigation published in *The Independent* in February. Patrick Strudwick, a journalist and campaigner, posed as a 'patient' to reveal how evangelical therapists – some operating within the NHS – tried to 'reorient' homosexual men and women using techniques developed in the US. One of the people Mr Strudwick interviewed described his treatment as 'psychological torture'. Mr Strudwick described the vote as a 'watershed moment in the struggle for gay equality'.

Doctors reject gay conversion therapies

He said that his undercover investigation for *The Independent*, which prompted this motion, highlighted the fact that not only are psychiatrists and psychotherapists still peddling these 'abhorrent techniques', but that in some cases the NHS is paying for it.

Tom Dolphin, vice-chair of the BMA's junior doctors committee who proposed the motion, said: 'Sexuality is such a fundamental part of who a person is, that attempts to change it just result in significant confusion, depression and even suicide. You can't just wish away same-sex attraction no matter how inconvenient it might be.'

But Cardiff consultant neurophysiologist Gareth Payne said there was no 'gold standard' evidence that conversion therapy did not work and was harmful. He said it was important to respect the wishes of patients who asked for the therapy.
The Independent

Speak to your father – secret to happiness

Children who regularly talk to their fathers are happier than those who do not, according to new research. Young people who talked seriously to their dads 'most days' gave themselves an 87 per cent score on a happiness scale compared with 79 per cent for those who said they hardly ever spoke to their fathers in this way. The findings, from an analysis of research from the British Household Panel survey into 1,200 young people in Britain (11-15), were released by The Children's Society. The charity said they were 'highly significant' as research has shown a child's wellbeing later in life depends on their teenage relationship with their father as well as their mother. It has launched a Fatherhood Commission with children, experts and the public invited to submit evidence on barriers to fathers' involvement with their children.
The Telegraph

Postnatal depression clues found

Scientists believe they have found what triggers postnatal depression, leading to a possible treatment to prevent the baby blues. Nearly three-quarters of new mums feel down shortly after birth, complaining of sadness, mood swings, anxiety and loss of appetite. In around one in 10 new mothers this continues and is classed as postnatal depression.

A sharp drop in oestrogen levels after birth has now been found to coincide with the release of an enzyme in the brain which blocks 'feel-good' chemicals. Previous research has shown that in the first three to four days after giving birth, oestrogen levels drop by up to 1,000 fold. The new study published in the *Archives of General Psychiatry* shows that in proportion to this oestrogen loss, levels of an enzyme called monoamine oxidase A increase dramatically in the brain. This enzyme can break down serotonin and dopamine, which are known to cause contentment. If levels of these are low, it can lead to a risk of becoming depressed.

The team, headed by Julia Sacher from the MPI for Human Cognitive and Brain Sciences in Leipzig, found that levels of the enzyme in women who had just given birth were 43 per cent higher than those in a control group. The levels peaked on the fifth day after birth – the day new mothers often hit their lowest point. Certain drugs can be used to lower levels of this enzyme, and also to increase levels of the chemicals it breaks down.

Dr Sacher said: 'Our results have the exciting potential for prevention of severe postpartum blues. It comes after earlier studies suggested that women could be screened for postnatal depression while they are still pregnant.'
The Telegraph

A pile of dead leaves

Kevin Chandler

2 June

Three hours between clients. The sun is shining and it's a shame to be indoors. The tall front hedge needs trimming and even with my new extendable battery-powered hedge-trimmer it's a job I don't relish, fearing one day I'll over-reach and topple off the ladder. Besides, I hate the clearing up afterwards. I toy with putting it off, settling down to write another column, or just lazing in the back garden. In the end the protestant work ethic wins and I strap on the trimmer and climb the stepladder. Meanwhile, unbeknown to me, 150 miles away in Cumbria, a man of similar age has just made the same decision and it will cost him his life, innocent victim of a taxi-driver on the rampage. On such minor decisions and accidents of geography do our fates hinge.

Of course, most of us like to think we have more control over our destinies. Our parents urge us to do the right thing; our teachers tell us to think before we act – as if a little care and consideration will keep cancer, murderers and mayhem at bay.

3 June

The teams of counsellors have been sent in, journalists and film crews flood the area and everyone seems to be asking the same question: 'Why?' Would knowing why somehow make the awfulness easier to accept or do we think that understanding one crime (or 30) will give us the knowledge or tools to prevent another? I find myself asking a different question: 'Why not?'

Anger, rage, hatred, destructiveness, even murderous feelings are part of our human make-up. They're necessary, and can work to our benefit, empowering us to escape danger or repel enemies bent on our destruction. The skilled surgeon knifes the bastard cancer cells or zaps them one by one with his laser gun. The trouble is sometimes the wiring goes wrong, our sense of value and perspective goes awol and a neighbour loses his life over the height of a conifer hedge, or a stranger is stabbed over a stolen parking space. Hardly worth it, most of us would argue. Sometimes there's not even a peg to hang it on, as a lifetime's helplessness, frustration and impotence are expunged at the squeeze of a finger, as pop-pop-pop goes the serial killer. Result: Taxi-Driver 12, The World Nil, until his own-goal suicide brings the final whistle.

What stops me losing my temper when the person ahead of me at the checkout can't find their credit card, or someone nicks my parking space, is that I know I'll look stupid and my outburst won't remedy the situation. But I also know that on another occasion it could easily have been me inadvertently holding everyone up, or opportunistically pushing in. 'Think how you would feel if someone did that to you,' the primary teacher urges the bully, in an attempt to instil a modicum of empathy for another's feelings.

Empathy works against our abusing others, but so too does our ability to anticipate the consequences for self of our own actions. And yet there are times, even for the best of us, when we really haven't got it in us to consider the feelings of others, and our immediate emotional needs seem so urgent and compelling that we give no thought to the consequences of our behaviour, until it's too late. Or perhaps we are simply so far down the road of hate, we no longer care.

'Anger, rage, hatred, destructiveness, even murderous feelings are part of our human make-up'

A conclusion no regular watcher of the news media can avoid is that, in the main, it is men who go on the rampage, and men who murder their estranged children and/or spouses. 'If I can't have you/them, then no-one will!' They thereby project all their own hurt and victimhood onto others.

A client turned up late and distressed, explaining his lateness and condition was due to a not uncharacteristic act of road rage, having chased, for several miles at breakneck speeds, a driver who had cut him up on a country road. I recall the old adage, 'Don't get mad, get even.' This client had done both and with gusto. He also happened to be a medic. I guess the man, or rather the little boy inside, was trying to protect his fragile sense of self. Sadly, and worryingly, he did it in a way that undermined his sense of self, not only in the world's eyes, but his own, for when he came to, parked by the side of the road, he hated himself. To his credit, instead of topping himself, or tracking down the other driver to wreak revenge, he found the courage to confess his shame, and look it in the eye. Too many women cry rather than get angry; too many men get angry when they really should cry. We men would do less harm that way. We'd also heal better.

Somehow, bagging up my pile of hedge-trimmings today doesn't seem so onerous. After all, I could be in Cumbria. ■

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

Walking alone

Emma Munro

On Tuesday my friend Rachel sent me a text; she was in need of urgent advice. She had had three sessions of therapy following an initial assessment. She had left the last session early, convinced that the therapist was not for her. And the therapist had told her that she didn't seem ready or committed to dealing with the issues she presented with. Later, as I listened to her doubts and complaints, I smiled inside. I had experienced all of these issues during my therapy journey. First with CBT, then psychodynamic psychotherapy and now my sessions of cognitive analytic therapy are at an end. I feel like an old hand at this now.

In the last session my therapist and I had both prepared letters that we read to each other. My therapist's piece was insightful; it summed up where I'm at and gave me a couple of pointers for the future. The documents represent an end to the hand-holding and the start of me walking alone. This is not daunting, I just fear I won't be alert enough and will fall back into my old ways. But I think I've done some good work that gives me confidence.

Now, I haven't sworn any non-advice-giving pledge, so I'm going to give Rachel the benefit of my experience and anyone else who asks me about therapy. Obviously it is different for everybody. Therapy is as varied as the number of client/therapist relationships. And so perhaps it is impossible to prepare at all for what happens to you while you are in therapy. However, some of the same issues seem to come up with a number of people I've talked to. This is a relationship like no other and, for many, that is hard to grasp. It is a relationship that may not feel comfortable to begin with as the person is not on your side as a friend would be. This person is not your mate. Rachel says that she feels that her therapist just doesn't get her and she wonders whether a woman would be better. A rotund middle-aged man doesn't work for her. She questions whether he is intelligent enough. I'd say to this, put aside your prejudices based on age, gender and appearance. The lumpy and old or the painfully young, lithe and beautiful can all make good therapists armed with a personal aptitude and some well-honed skills.

> 'It takes a propensity for truth, open-mindedness, courage and hard work and no small measure of faith to get the most out of the experience'

I feel I am able to reassure Rachel that the therapist may not get her in a very short space of time, but that this does not matter. Whether what he reflects back is right or not, it gives you the chance to really think about who you are and how you behave. The process of correction and discussion enhances your understanding and that is what matters.

I also tell her that what she does in relationships is likely to be played out with the therapist. Do you usually become defensive and flounce out because you fear being rejected? Yes, she says. I advise her to pull her neck in and give this guy another chance.

I am sure there are some therapists who are better, more empathetic and more skilled than others. I am sure that there are some types of therapy that are more suited to one person than another. It's a lottery win if you do find the ultimate therapy experience, and the odds are long. What I advised my friend is that most of the work has to be done by her. What therapy gives you is the time and space to explore. To get the most out of it, it is best to do homework. By this I include leaving time before the sessions to prepare yourself and afterwards to get over the emotional trauma it can be. I found it important to read and think around my issues, using self-help books to supplement the work I was doing. You won't become a concert pianist if you just go to lessons and never practise in between. Therapy is no different.

Most people want to be liked. You have to get over this. You will feel judged as the therapist is challenging you and making you face difficult aspects of your personality. But after a while you get over this and you stop caring what the person thinks of you. It is irrelevant.

We go into a therapy room a squirming bundle of genes, conditioning, prejudices, baggage and assumptions. It takes a propensity for truth, open-mindedness, courage and hard work and no small measure of faith to get the most out of the experience. And when it's all over, you have to put what you've learnt into practice. I don't expect to be a healthier person overnight and I am not going to give myself a hard time when I fall at the first hurdle. I know myself and like myself a lot better. And I am thankful for the presence and commitment I was given by the therapists I have had the honour of working with. ■

Some details have been changed to protect identities.

Endings and beginnings

Martin Halifax

Life has acquainted me in the past with ends. I have torn enough pages off the calendar to have marked the passing of close relatives, to have waved goodbye to workplaces and work colleagues, to have shared dinner with them and thanked them for the mantel clock. I have sold and left behind houses full of memories and left the cities where my children were born, but until I became a counselling student, I had never negotiated or fine tuned any of these experiences into an 'ending'. Endings though, are the stock in trade of the counsellor.

During the course we have scrutinised the dynamics of ending the therapeutic relationship, discussed the impact of separation for client and practitioner and, some weeks ago, opened the sensitive debate about how we would manage this for ourselves. What did we want from our ending? How were we going to manage?

Ultimately our last teaching day turned into a smorgasbord of ending options. We gathered in sub-groups as peer supervisors, as 'skills groups', as review partners, and said our nuanced goodbyes, not so much wearing different hats, more wearing the same hat at different angles. We then gathered in our final circle for what felt like a grand finale of feelings aired and shared.

All of this fairly formalised leave-taking was punctuated, though, by trappings and rituals familiar from that former life. We posed for group photos, snapped by a generous spirited and amused passer-by (thanks Jeff); we ate cake and drank coffee and hung about the student lounge discussing our plans for the long holiday; and, when the final circle dispersed, it was only for as long as it took to find out who knew the way to the restaurant we had booked for lunch.

Inevitably, as is the way of these things – ends, as distinct from endings – lunch was less formal, less predictable, a bit loose: the seating plan *evolved*, people mingled; some of us had trains to catch, others settled in for the long haul. In places, even the boundaries, at one time sacrosanct, became bleary. Were we colleagues or friends now? Tutor and student or just counselling buddies? It could be argued that this was an object lesson in being centred on the person; each individual choosing the appropriate pace to travel at and mode to travel in, and at which point to leave.

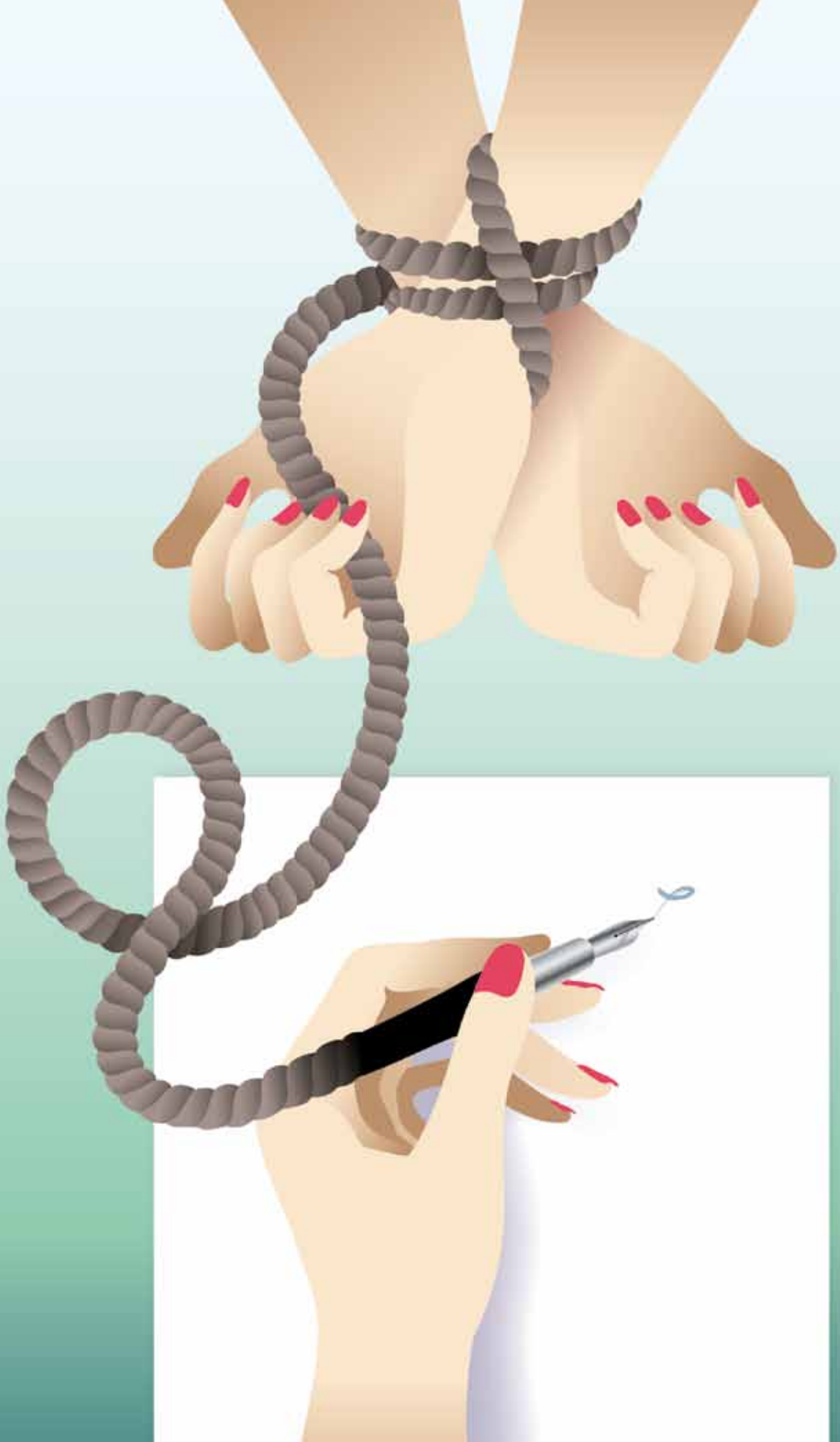
Lunch developed into pudding. Pudding was followed by coffee, then a significant fraction of the whole group, still not ready to part ways, walked on to the pub. The die hard core (or leftovers, depending on your view) sipped their martinis long enough to endure a desultory performance from their national football team before embracing in the street and going their separate ways.

It is laudable and useful to acknowledge the problems and pain attached to the end of anything. It is good – and this is counselling mantra – to face such things honestly and head-on, but there is also something charming and human in the way that endings can become ragged at the edges. Our several attempts at our own ending (and we really knew what was coming) seemed to reflect what it might be like for the client. The truth is that although the final session of counselling does mark the end of the therapeutic relationship, the end of the weekly or fortnightly ritual, the emotional aches and pains that launched the relationship in the first place will not have evaporated but may have been reduced or adjusted. The client must carry this adjustment back into 'real life', use his/her own devices, lean on the pre-existing support group, and yes, remember how the adjustment was made possible. Similarly, as we walked away from the pub, trailing a little melancholy perhaps, we also carried mobile numbers and promises to keep in touch.

> 'There is something charming and human in the way that endings can become ragged at the edges'

We started as study colleagues but have strayed into the border country between the professional and the personal, and in many ways, we are conscious that this period of time must accommodate an adjustment in approach. For now we face the new challenge as fledgling graduates in search of further placement or employment. In facing that challenge, we will phone one another, use each other for support and advice, and admit that despite all signs to the contrary, despite calling a halt to the weekly trip to university, what we are looking at is hardly an ending at all but bears all the hallmarks of beginning. ■

Some details have been changed to protect identities.



A kink in the process

Sadomasochistic sex is arguably one of the least understood and most demonised forms of consensual sexuality. How able are we to offer ethical therapy to kinky clients when there is so little awareness of the kink experience?

By Su Connan
Illustration by Emmanuel Romeuf

There are a lot of kinky people out there. An American study reported '14 per cent of men and 11 per cent of women have had... personal experience with sadomasochism',[1] and further studies reveal a much higher incidence of BDSM (bondage and discipline, dominance and submission, sadism and masochism) fantasy. Many of us are confident in our kinky sexuality and celebrate our exciting sex lives, but some of us feel shame, guilt or confusion around our desires. Yet we struggle to find a counsellor or therapist with whom we can feel confident and comfortable. As kink-identified therapists are rare, what we need is someone who will not judge us or be 'freaked out' if we disclose our kinky identities or practices.

Sexual sadism and masochism have been conceptualised as deviant, labelled as pathological and are currently listed in the *DSM-IV* (Diagnostic and Statistical Manual of Mental Disorders) and *ICD-10* (International Statistical Classification of Diseases) as paraphilias. 'Like homosexuality some 20 years ago, sadomasochistic sex is considered alongside rape and child sexual abuse as individual sexual pathology in need of explanation, treatment and cure.'[2] Yet, encouragingly, recent research has turned to the BDSM community in an attempt to understand the meanings it holds for those who incorporate BDSM practices into their sex lives or experience BDSM as integral to their sexuality.

As counsellors and therapists we need to be reflective of our own personal values and beliefs around sexuality and how they are informed by our cultural, political or religious heritage. We need to be aware of how our therapeutic models approach the issue of sexuality and be prepared to question those who pathologise BDSM sexual expression. The key to working ethically with this diverse community is through understanding the world of kink and the meanings held by BDSM practitioners.

Increasing BDSM awareness

BDSM is a term which covers a wide range of behaviours, generally involving the use and exchange of power in an eroticised relationship. Informed Consent (www.informedconsent.co.uk), the leading website about BDSM in the UK, defines BDSM as 'a catch-all phrase'. I use 'BDSM participant' or 'SMer' to describe those who identify with BDSM as a lifestyle or as an activity, and 'kink' and 'kinky' to describe both BDSM practices and practitioners.

Many of the words used to describe kinky activity refer to its often highly theatrical nature: it may take place as part of a 'scene' or in a dungeon; participants or players who identify as dominant are referred to as 'dom/me', 'master/mistress' or 'top'; submissive players use 'sub', 'bottom' or 'slave'. Those who enjoy both roles use the term 'switch'. The use of a safe word ensures the physical and emotional safety of both sub and dom/me. Kink practitioners often refer to non-kinky sex as 'vanilla'.

This article is an extract of a paper I wrote for my Pink Therapy Certificate in Sexual Minority Training and following my own experience of diversity awareness during my counsellor training. In response to my peer group's lack of knowledge of sexual diversity, and the homogenous, heterosexual nature of

'Many of us are confident in our kinky sexuality and celebrate our exciting sex lives, but some of us feel shame, guilt or confusion around our desires'

the group, I disclosed my kink identity. I wondered how these counsellors in training would respond to me, should I (or someone like me) walk into their consulting room in years to come. Happily my disclosure was not met with overt expressions of hostility or rejection. The prevailing response from those prepared to engage with this new challenge was a good-natured attitude of curiosity, though I felt my peers perceived my sexuality as exotic. The experience left me wondering how able we are to offer ethical therapy to sexual minority groups when training is delivered from such a heteronormative approach and there is so little awareness of the kink experience in particular.

Finding a kink-aware counsellor requires dedication. Knowledge of the gay or kink scene is helpful. For an individual who may be conflicted and anxious about their sexual desires or practice, looking for a counsellor who will be knowledgeable and non-judgmental is no mean feat. Clients unable to identify a suitable kink-friendly therapist may feel a need to 'test out' their counsellor in an attempt to assess their attitudes towards BDSM practices. This can be a risky and expensive business, especially for an individual experiencing conflict around their sexual desires or practice, and may lead to the prospective client covertly or (perhaps less likely) overtly interviewing the therapist.

My own experience bears this out. In an attempt to reduce my costs in emotional expenditure, time, and money, I drew up a set of what were effectively interview questions which I posed when approaching each potential therapist over the telephone. This resulted in some rather disconcerted counsellors who, to their credit, handled the experience with generally unflappable good humour.

Safe, sane and consensual

Moser and Kleinplatz[3] offer a warning to those attempting to understand the motivations of BDSMers: the individual meanings, hopes and desires of each participant will be unique, and apparently similar behaviours may have entirely different meanings as each player seeks diverse experiences. I would add that even the same individual in similar scenes may, at different times, desire and achieve a varied range of emotions and sensations.

People often get caught up on the issue of pain and may not understand the full meaning of consent. Consent is fundamental to SM – without consent, it is abuse. A complex scene is often preceded by a period of discussion and negotiation, including what is off limits – what is a turn-on for one person will be a total turn-off for another. The kink slogan 'safe, sane and consensual' counters assumptions that kink is dangerous and crazy. It emphasises that even when 'playing hard' there is a commitment to avoiding actual harm, and that individuals do not play when angry or otherwise unable to maintain boundaries or assess risk. There is an ongoing debate within the BDSM community regarding the issue of risk, with some arguing for 'risk aware consensual kink' in response to 'safe, sane and consensual' in recognition of the risks inherent in any activity, and as a rejection of what can be constructed as an ongoing need to 'prove' one's sanity.[4]

Power and transcendence, bondage and humiliation

By adopting dominant and submissive roles, a deliberate and temporary ritual exchange and play with 'power' is enacted. Easton describes this as providing a safe context for the giving and receiving of intense physical and emotional experiences – the opportunity to play out the rebellious child, experience a range of emotions or release from daily responsibilities.[5] A number of researchers have identified a state of 'transcendence' achieved through the practice of BDSM.[6] Bridoux quotes from an SMer describing their SM sexual encounter as an 'openness, which is often the key to a truly profound and personal psycho-sado-sex experience, opens the psyche in ways it is not "normal" to operate in'.[7]

The act of binding and being bound is a major theme within BDSM and carries with it many and complex meanings. It may involve an act as delicately restricting as binding another's thumbs, to using rope to 'hog tie' and even suspend one's partner. Simply commanding another not to move can have a powerful effect, relying as it does on the willingness of the 'sub' to obey, the consequences of disobedience and opportunities for the thrill of 'punishment'.

'What is devastatingly humiliating to one person is not humiliating at all to the next,'[3] which leads Moser and Kleinplatz to conclude that this is one of the most difficult aspects of kink play to describe. Being referred to as 'slave'; being 'forced' to wear certain items of clothing; or being utilised as a footstool in a play club may all provide the cues and scenarios

'By adopting dominant and submissive roles, a deliberate and temporary ritual exchange and play with "power" is enacted'

in which satisfying humiliation can be experienced by the 'sub', yet offer few explanations as to why an individual would find satisfaction in such experiences. However, Moser and Kleinplatz note that as certain activities lose their culturally proscribed status (eg fellatio and cunnilingus), so they lose their power to 'confer a particular feeling state',[3] which may provide some clues to understanding this aspect of BDSM.

Pain, joy, humour and creativity

It may seem difficult to understand and find empathy for individuals engaged in the giving and receiving of pain, yet risk and pain are culturally sanctioned within the world of sport and in the pursuit of beauty. The pain experienced during SM scenes is context specific; an SMer is unlikely to welcome painful experiences outside a BDSM scene. Studies have shown that the body releases endorphins in response to pain which produce a 'natural high' and increase tolerance for pain. This 'rush' may be helpful in accounting for why some SM practices are tolerable. Yet SMers' accounts do not always fit this picture,[8] nor does it fully answer the questions a therapist may have when working with clients. Neither does this theory help in understanding the meaning of pain for the individual.[9] A research respondent said, 'It's like people think that because I'm a masochist I must enjoy going to the dentist... bizarre.'[10]

While it is apparent to academic researchers that BDSM offers participants an intense experience, what is often missed in their analysis is an appreciation of the delight in the sheer creativity involved in role play and scenes. Coupled with this is the inventiveness borne of intimate knowledge of one's play partner(s) and what produces the desired feelings and experiences. There can be a ready acknowledgment of the absurd and at times a scene may need to be 'paused' while clothing and dignity are readjusted or giggles brought under control.

SM and the law

While it is not illegal to be an SMer, there are activities which may put the BDSM practitioner in conflict with the law. It is interesting to note that following the infamous Spanner case (R v Brown), in which a group of gay men were jailed for engaging in consensual SM practices, there was a review of a previous case, R v Wilson. This case involved the branding of a woman (at her request) by her husband. Bridoux reports the House of Lords judged them 'not guilty and declared it a strictly private matter: consensual activity between husband and wife, in the privacy of the matrimonial home, is not, in our judgment, a proper matter for criminal investigation, let alone criminal prosecution'.[7]

This apparently contradictory ruling illustrates the different positions accorded to different groups, the confirmation of heterosexual privilege, and the difficulties society experiences when pain and injury are associated with sexual pleasure. Sissons notes that such cases have 'raised two intertwined issues: whether consensual S/M interactions constitute assault, and whether an individual can legally consent to assault'.[11]

The academic perspective

BDSM is arguably one of the least understood and most demonised forms of consensual sexuality – and these beliefs carry over into the therapeutic community.[12] One of the difficulties in challenging the psychoanalytic theory that BDSM is linked to psychopathology lies in the data, as it is sexual offenders who have been most commonly studied. In a damning assessment of the English analytic perspective, Denman states: 'The tone of discussion by the analysts is so relentlessly hostile, contemptuous and denigratory that all of the patient's sexual and other life is at once pre-judged as hopelessly pathological and contaminated.'[8]

An alternative approach to considering SM is offered by Denman through her construction of 'transgressive' sex (that which attracts social disapproval or legal sanction) and 'coercive' sex (that to which one party has not consented). Denman states: 'Linking perversions with other psychiatric disorders is important to psychoanalytic theorists because it helps to establish that transgressive sex is pathological.'[8] Much attention is paid to the causes of an interest in BDSM. Theories include Money's vandalised 'paraphillic love map' through which he proposes a segregation of affectionate love and erotic lust,[8] and a history of childhood abuse, though these are not borne out by research. Barker, Iantaffi and Gupta challenge the myth of childhood abuse as a possible cause of interest in BDSM and the perpetuation of these myths within the therapeutic community.[12]

Indicating an integrated experience of what Money describes as 'affectionate

'People often get caught up on the issue of pain and may not understand the full meaning of consent. Consent is fundamental to SM – without consent, it is abuse'

love and erotic lust', and thus countering his position, Denman writes, 'Thompson (1994)[13] reports that the participants have straight sex far more often than they have SM sex and that they mix these two forms of sexual expression freely.'[14]

Clinical issues and implications for training and practice

We frequently encounter attitudes and behaviours in our clients that challenge us as individuals and therapists, and managing our own responses and working with these challenges are part and parcel of the work. Exploring where our experience of our own sexuality intersects with BDSM takes that commitment to the next step.

In adopting a non-pathologising approach, it is important to remain alert to possibilities of abuse. Kolmes, Stock and Moser's research identified that 'therapists also acknowledged the dangers of assuming that all BDSM clients are healthy, emphasising the need for therapists who can recognise the complexity and presence of both abuse and BDSM in some BDSM relationships.'[15] Useful questions for the therapist to hold in mind are:

- How aware is the client of their own boundaries, limits and needs?
- Is any of the behaviour experienced as self-destructive?
- What do you know of what the client is doing to make sure their BDSM practice is safe?
- Is the behaviour nourishing or experienced as diminishing?
- What does the behaviour 'do' for the client?
- What might it release the client from?
- Is client discomfort limited to or associated with specific practices, scenes or words?
- What does the client enjoy or value within their kinky relationship?
- When thinking about voicing concerns, consider which part of the practice is the bit that does not feel 'OK'.[16]

When working with issues of BDSM practice, whether the therapist is a kink practitioner or not, it is likely there will be elements of the client's behaviour or favoured activities that may provoke a strong response in the therapist. Nichols refers to the term 'squicked' as used within the BDSM community to describe a 'strong negative emotional reaction to an activity while knowing that you do not actually "judge" the activity as "wrong" or "bad".'[17]

Nichols suggests that these feelings may provide useful information for the counsellor around aspects of their own sexuality which may be 'repressed or disowned', and offers a model for processing such feelings.

In considering the need for counsellors to deal with their own responses to BDSM, Barker et al invite therapists to engage with the 'broader concept' of 'reflexivity': 'Curiosity turned inwards, towards our own beliefs, stories, feelings and thoughts…' So the therapist may avoid becoming fixed on 'one particular story or interpretation of meaning'.[12] In this way, we do not need to be comfortable with every kink practice but will be working in awareness of our levels of comfort and discomfort.

Kolmes et al carried out research into BDSM clients' experience of therapy. Drawing on this information, they made suggestions for creating a set of guidelines for working with this client group. Some of the themes which emerged, including practices reported by the (few) therapists who responded, were:[15]

Beneficial

- The therapist being open to reading/learning about BDSM
- Showing comfort in talking about BDSM
- Being able to ask questions about BDSM
- Helping the client to overcome associated shame and stigma
- Open-mindedness and acceptance
- Not expecting the client to provide all the education for the therapist
- Understanding and promotion of 'safe, sane and consensual' BDSM
- Being able to understand the distinction between abuse and BDSM
- The counsellor who practises and identifies with the BDSM lifestyle
- An ability to appreciate the complexity of BDSM play
- Understanding that some clients may need help to explore and establish if they are using BDSM in a positive way.

Harmful

- The counsellor not understanding that BDSM involves consent
- 'Kink aware' therapists who lack appropriate boundaries
- Therapist assumptions that 'bottoms' are self-destructive and acting from a history of abuse
- Therapists who abandon clients who engage in BDSM
- Counsellors who try to 'fix' the client on the sole basis of their interest in BDSM
- Breaking confidentiality because the therapist assumes others are at risk

'For an individual who may be conflicted and anxious about their sexual desires or practice, looking for a counsellor who will be knowledgeable and non-judgmental is no mean feat'

from the BDSM activities
- Assuming past abuse has 'caused' the interest in BDSM
- Expecting the client to teach the counsellor
- Having a prurient interest in the client's BDSM lifestyle
- Therapists who shame or judge their clients
- Therapists who adhere to theoretical approaches that offer pathological explanations for an interest in BDSM.

The argument for sexuality training

The research by Kolmes et al revealed that simply being willing to work with, or practising and identifying with, the kink community is not sufficient to ensure that therapists working with kinky clients can do so safely and ethically. It was concerning to note that one research respondent described her experience of working with a kink-identified therapist as one in which the therapist 'seemed more interested in sharing stories about fun S/M stuff we'd both done than in acting as my therapist'.[15]

Davies makes a case for addressing sexuality issues in counsellor training in his article for *Therapy Today*, 'Not in front of the students'. As he asserts, 'The attitude of, "I've got a friend who's gay", is not actually a good enough prerequisite to ensure one is going to be able to offer competent therapy to sexual minority clients. Neither, as it happens, is being a member of a sexual minority.'[18]

A powerful tool in working with student assumptions around BDSM has been developed by Barker, in which group participants are offered a series of 'scenes' and invited to consider what, if any, concerns they may have. The majority of scenes are taken from culturally accepted activities (the stag night, pubic waxing, a trip to the cinema), while a small number are real SM scenes drawn from her research. Barker notes, 'But these are almost never the ones that are picked out as problematic.' This approach encourages 'students and trainees to reflect critically on their existing constructs before making other alternatives available to them'.[19]

In conclusion

It is encouraging to find academics and researchers increasingly turning their attention away from pathologising and towards BDSM communities. This offers a fresh approach to exploring the experiences and meanings of BDSM practitioners which can inform therapeutic work in the consulting room. Supported by knowledge, with a willingness to examine and reflect upon one's own values and therapeutic models, and holding an openness and receptiveness to the experiences and meanings of the other, more therapists may find they are able to offer non-pathologising and ethical therapy to members of the kink community. As a client said to me recently, 'It's great, I can bring all of me here.' ■

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Rapport in cyberspace

Online therapy is a huge growth area. *Jethro Adlington* offers practical advice for making good connections with our clients online. *Illustration by Emmanuel Romeuf*

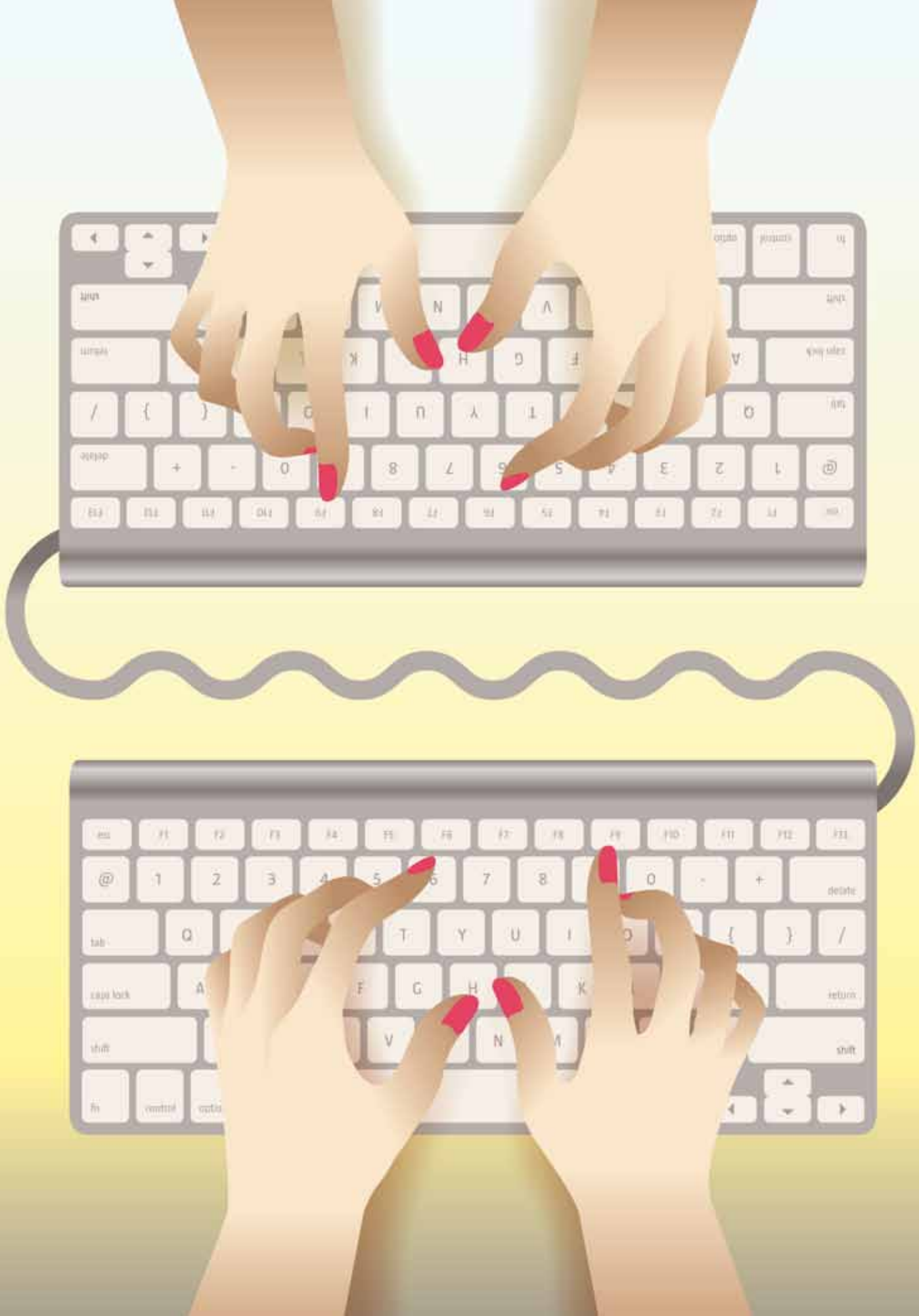
Good face-to-face therapeutic work can be very difficult unless a state of rapport exists. The same is true for work conducted in cyberspace.

Traditional communication is based on a combination of body language, tone of voice and the actual words said, and both therapist and client – providing they have the relevant sensory acuity – will experience these elements of communication, often at the same time. The elements are constantly being transferred each way, with some elements more overt, others more subtle. Body language can have varying degrees of subtlety: an arm can move a little or a lot, skin tone can change. Voice tone also has degrees of flexibility: it can rise and fall in both volume and pitch. I call these elements of face-to-face communication 'analogue', because of this unlimited built-in variance – like a dimmer switch on an electric light. In the digital world, we only have the equivalent of an on-off switch.

When a counsellor works online using email exchange (asynchronous communication) or Internet relay chat (synchronous communication), there are no body language movements or shifts in vocal tonality for the counsellor and client to connect with to build rapport. All they have is the 'digital' text itself: 100 per cent of the communication is connected to the on-screen words. However, the therapist still needs to build rapport with the client to be able to have a relationship, a sense of trust, and to engage with the client. Techniques for achieving this are the focus of my article.

Matching, pacing and leading

Face-to-face models of building rapport often focus on the concept of matching or pacing, followed by leading. The basic premise for rapport-building in a face-to-face setting is to start by matching the client's body language, speech, posture, and breathing rate. Once you feel you have achieved a reasonable state of rapport, you can carry out a test. This involves 'leading': carrying out a specific body, linguistic or tonality shift and seeing if the client follows the lead. If the client adapts and starts to follow the lead, then the level of rapport is likely to be increasing. This, however, is a very simple explanation for a much more complex set of face-to-face interactions that lead to rapport-building. It is possible that there is a much more complicated dynamic at work that is based on synchronous patterns of movements and how all these patterns interact. And yet, within that complicated synchronicity, there is still



a mixture of matching, pacing and leading, with the matching being a significant player in building rapport in online work.

Matching basics

Online clients, particularly when working in email exchange, will start by introducing themselves. This is the first opportunity for the counsellor to start building online rapport. Let's consider the following introductions:

Dear John
Hiya John
Hiya

By matching your own introduction with a parallel response, you stay within their model:

Intro	Reply
Dear John	*Dear Zoë*
Hiya John	*Hiya Zoë*
Hiya	*Hiya*

And some replies that may not aid rapport building:

Intro	Reply
Dear John	*Hello*
Hiya John	*Good morning Zoë*
Hiya	*Email number 1*

This concept also applies at signing off. Of course, a client may use no introduction or sign-off. If that occurs, I tend to still respond to them by using their name in the introduction and my name in the sign off, but keep the two as neutral as possible at that point. Perhaps 'Hello Zoë' and 'Regards, Jethro'. Part of building rapport is to recognise the 'presence' of both the client and the therapist online and therefore to communicate 'I know you exist, and you know I exist too'. This can be important when there are so few clues to the identity of the users.

When working face to face, a gesture such as a simple head nod can say 'I have heard what you say'. Of course, online, there are no head nods, and so a counsellor wanting to build further rapport needs to bear this in mind by letting the client know that not only do they exist but that they have been heard. The simplest way to do this is to use paraphrasing, as you might offline.

Here is an asynchronous example of how paraphrasing can work in an email:

Dear Therapist
I know that I cannot think about my schoolwork but that's because I have so many probs with my mum and dad. They are on the phone to each other all the time when dad is away and then when he's back they fight a lot.
Jane

Dear Jane
When I read over your email I started to realise what may be happening in your life. It sounds as if you would really like to do your schoolwork but the way your mum and dad behave is making it hard for you to do your schoolwork. It must be very hard for you to think about your work when your mum and dad are either on the phone or having a fight...

The above response does not look at problem solving or how the client may want to move on from the issues stated. Instead, the response, at this stage, is concerned with letting the client know that she is being heard by the counsellor in order to build rapport.

Of course it is also possible to let the client know they are being heard in other ways. One is to use brackets to let the client know your response:

(*I found myself nodding in agreement with what you wrote*)
(*Taking my time to think about what to write next*)
(*Looking puzzled here...*)

As the only way that the client can communicate their presence to you is via the text, then the client may use text choices to help communicate with the counsellor. For example, the client may use a specific type of font. I use Verdana, as I see this as a neutral text style when compared to others such as comic sans, which seems less formal, or *(Lucida Handwriting,) which gives the appearance of being handwritten.* As I use Verdana when writing to clients, I will occasionally interpose the client's own text style if I want to feed back to them something they have written to me. It's my way of saying 'this is your stuff' and I recognise it as such. In a way, I am saying to the client: 'I am Verdana text style and you are not, and yet I respect that.' Here's an example:

Hello Asha
I noticed in your last email that you said that you were feeling sad, low and lacking bubbles. *I wonder if you could have a think back and let me know what was happening just before...*

There are other options that the client may use, such as *text size.* This may be an

'Text colour can also be used in communicating. For example, red can be used for anger, green for envy. In online communication, the use of all capital letters is perceived as shouting'

issue for the client when he or she is partially sighted. It is wise to check that out if you receive a large-text document and there has been no disclosure in their application. Text colour can also be used in communicating. For example, red can be used for anger, green for envy. By matching the text colour the client has used, the counsellor is working in an environment that is supporting the rapport-building process.

In online communication, the use of all capital letters is perceived as shouting. This may not be the client's intention: if the entire email or text exchange is carried out in capital letters, it may just be the client's preferred style, but the counsellor can usually get some indication that shouting is intended by the context of the text in which capital letters were used. A client may use images, perhaps from clip art, or emoticons ☺ ☹ to indicate elements of their experience, or to show how they are feeling. Working online, you can use such images and emoticons to build rapport by matching them in the text reply:

So, that's my email completed for the week. I hope you can cope with having to write about all my problems.
Regards
Paul ☺

So, Paul, I hope that you can give some thought to my email before you reply to me next week.
Regards
Therapist ☺

You should also consider the impact that a smiley ☺ emoticon may have on the receiver. As a smiley emoticon is so often sent out in email or text exchanges, the power behind the smiley – ie its ability to lead to a response – can be diminished. On the other hand, if a frowney ☹ is sent out, because this is sent out to a lesser extent, then the response could be more powerful when it is received. This pattern also shows itself in mobile texting between friends. Often a sender will add a kiss, in the form of an 'x', as a matter of routine at the end of a text communication. The receiver may not consciously notice it, as it is always there. However, they will have a negative response if a routine text is sent and the 'x' is missing.

Further matching

Matching a client's experience can also play a role in rapport-building, provided that you are happy to move into an area where there is some self-disclosure on your part.

Tess
Well I decided to meet him after he sent me the text but when I got there he just didn't turn up at all. I sent him a message and he said that he couldn't be bothered to go out, as it was cold.

Therapist
Oh I can understand how you might feel, as I remember it once happened to me and I was angry at the person that 'stood me up', but also angry at myself. How did you feel at the time? How do you feel about it now?

Tess
Well at least it's nice to hear that I'm not the only one that gets stood up. Yea I was soooooooo angry!!!

The process of matching to build rapport can be extended further by considering the option of matching the sensory predicates of language that are used in the client's text. Most, but not all, people have five senses: sight, hearing, smell, touch and taste. I like to think of these sensory predicates as 'train lines' that the client's narrative runs along. Here's an example of a client using many *visual* predicates:

*I have tried many times but I just can't **see** my way out of this problem. If I leave home and end up on the streets, my future will be **very dark** for me and I so want to **focus** on how to get out of all this. My thoughts are **blurred** all the time.*

When building rapport, it's good to consider that by matching the sensory predicates when replying to a client, your response will stay within the same 'train tracks' that the client has initially laid down.

If you use other sensory predicates, then you will be 'jumping tracks' and this may affect how the client relates to your ability to be alongside them, to be in rapport.

Coupled with the concept of matching is something else that can often be used with young people: the idea of using a clean language response to match the actual words they have used. Younger clients may not often use words like 'anxiety disorder' and 'depression', but words that are right for them:

Hector
I just hate it when I have to go to school on Monday morning.

Therapist
I wonder what it is you hate about going to school on Monday.

'Online counselling has a level of anonymity that can lead the client to think there may not be a real person at the other end of the computer'

Hector
I'm not sure but when I'm walking there I go into a fuzzy bubble.

Therapist
I wonder what you might be doing that gets you into that fuzzy bubble.

Matching environment and behaviour

Another aspect of matching to build rapport is connected with the concept that 'people like people who are like themselves'. In other words, people will probably relate to others if they share similarities and connections. Young people will often form social groups based on how they look and the clothes they wear. This matching allows them to send signals to each other that they also share the same interests, and they use this 'code' as a way of speeding up the process of rapport-building. The clothes a person wears and the objects that surround them are that particular person's environment.

Another option is to match the client's behaviour. If you are working synchronously, using chat, you can match the client's typing behaviour. The client may type fast or slow, respond quickly or take a while before replying. By matching how the client behaves when typing, and matching it, you are likely to send the message that says 'I behave like you here' and that can help build rapport. By doing this, you are also matching their keyboard and typing skills.

So, to recap, we are essentially using a process of matching in order to gain a level of rapport with the client online. At the start, I mentioned that, in face-to-face counselling, a test of rapport was to try leading gently with, for example, a certain body movement, or a shift of posture in the chair, and to see if the client 'follows'. Could such a technique be applicable when working online? Could the counsellor add a smiley emoticon at the end of the email and see if the client responds with a match? Of course, there may be technical reasons, other than a lack of rapport building, why the client doesn't use the emoticon in their response. They may not have the emoticons available on their computer.

Questions: avoiding a rapport glitch

In the face-to-face world, asking questions in order to discover aspects of your client is part of your everyday toolkit – to gather information about your client's model of the world, to expand any limitations they may have, and to change the meaning of their world. The normal sequence of behaviour is that you will ask the question, and the client will ponder and then reply. However, this does not always happen that way, and you may not receive the information from the client that you initially wanted. In face-to-face therapy, you can ask the question again: either the same question or modified so that your client understands it more clearly. The client may then respond with so much information that you feel they have forgotten the original question you asked! This type of behavioural response can be reduced if you have the ability to remember the original question and diplomatically gain a less full reply from the client. You may even resort to the sentence 'Could I just stop you there for a moment?' to allow the client to know they have 'gone off track'. Sometimes, as well, a delicate question may have to be nested carefully in other questions, so that the client will feel comfortable enough to explore around the subject before tackling the issue head on.

Such behaviours are commonplace in the face-to-face world, but in the online world, particularly when asynchronous communication (email exchange) is being carried out, a whole set of different 'rules' apply. And it's important to get this technique right to reduce the possibility of a break in rapport.

When working asynchronously, a counsellor may ask a question in the form of a line in an email, and the client will not respond to the question in their reply. This can lead to the therapist either ignoring the fact that there was no response, or having to rephrase the question. As the mode of communication is asynchronous, there will be an inevitable delay caused by the counsellor having to ask again. Here is an example of an email from a counsellor, where the counsellor asks a number of questions:

Hello again Jane

I understand from your recent email that you are not happy with the way your teacher behaves in class. I wonder what your teacher is doing that you don't like. I felt a little saddened when you told me that your friends laughed at you when you told them you were nervous about going to school when you had that teacher. What is it that makes you nervous about your teacher? It did sound very positive when you emailed me and said that you wanted to talk to your mum about how you feel at school. Have you decided that you will do that? I wondered how you felt about talking to your mum about it?
Counsellor

If you consider the above example, there are a number of questions in the

'The process of matching to build rapport can be extended further by considering the option of matching the sensory predicates of language that are used in the client's text'

text body, and yet the receiver may not actually perceive all the questions listed as ones that require a response back to the counsellor:

I wonder what your teacher is doing that you don't like.

This does not end with a question mark and so may not be a question.

What is it that makes you nervous about your teacher?

This question does have a question mark but is embedded in the text body, and so may not be easily recognised as such, and therefore overlooked.

Have you decided that you will do that? I wondered how you felt about talking to your mum about it.

This question, likewise, does have a question mark but is embedded in the text body. It is also nested directly next to another possible question and so may be perceived as part of the same question. Could it be that one question requires a response and the other is hypothetical?

Rapport is maintained when there is a 'flow' between two parties and it could be argued that a series of repeated questions by the counsellor may be seen by the client as interrogation and will not aid rapport.

Therefore, when working asynchronously, it's worth considering a process whereby relevant questions are laid out so that the level of response elicitation is increased. Here is the same reply, laid out to increase a response from the client:

Hello again Jane
I understand from your recent email that you are not happy with the way your teacher behaves in class.

I wonder if you could write back to me and let me know what your teacher is doing that you don't like?

I felt a little saddened when you told me that your friends laughed at you when you told them you were nervous about going to school when you had that teacher. I have a question for you Jane:

What is it that makes you nervous about your teacher?

It did sound very positive when you emailed me and said that you wanted to talk to your mum about how you feel at school.

Have you decided that you will do that? Perhaps you could let me know what happens?
Counsellor

In the above example, the questions that the counsellor would like a response to are separated from the main body of the text with a line space and are highlighted in bold. They also indicate in the text that the counsellor would like a response. Note, too, that the line 'I wondered how you felt about talking to your mum about it' was omitted from the second example – this was a hypothetical question that was in the counsellor's head, and the counsellor decided that a response was not required at this stage.

Rapport-building when working synchronously does not have the long period of delay, or zone of reflection, that is associated with asynchronous exchanges, so the need for the above level of 'right first time' behaviour, may be less important. In synchronous communication, it is possible to lay out questions in a more immediate format, so that they resemble face-to-face communication:

Lang
I'm not really happy at all at the moment.

Counsellor
What is it that you are not happy about?

Lang
Well, my circumstances.

Counsellor
Can you tell me about your circumstances?

Lang
Which ones?

Counsellor
Well, tell me what's on your mind right now perhaps?

Lang
OK, now it's about shoplifting.

The above exchange has a conversational element to it that is not there in email exchange, so questions from the counsellor to clarify any confusion will have less of an impact on the rapport process.

However, in synchronous work, there is the possibility that more than one thread of communication can arise. This can lead to a 'rapport glitch' and if this happens, it needs to be addressed in order to get the conversation back on track. This double thread can be

'When a counsellor works online, there are no body language movements or shifts in vocal tonality for the counsellor and client to connect with to build rapport'

formed under varying conditions. For example, when the client or the counsellor adds two simultaneous pieces of text onto the text window.

Rob
I now realise what a cheat he really is.

Counsellor
Go on.

Rob
They were so secretive.

Rob
And of course when she got involved too, that made it worse.

Counsellor
Your girlfriend?

Rob
What about her?

Counsellor
Jane, your girlfriend.

Rob
Sorry, I've lost the plot here.

When working synchronously, these double threads can lead to a perception that the process has to go on hold for a few seconds so that the subject matter being discussed can be reordered. This could lead to a feeling that the process has 'jumped tracks', possibly affecting the 'flow rapport'. The occasional double thread, handled with tact or humour, can be managed, but continuous double threads could lead to the process having to be backtracked to clarify the meaning of the work.

Does disclosure equate to good rapport?

It is also possible that a counsellor may receive emails from the client that have a high degree of self-disclosure from the onset. This could indicate that the counsellor is building up rapport with the client. But clients often show higher levels of disinhibition when working online, and therefore appear to be building a good relationship, when in fact they do not actually conceptualise that they are having a relationship with anyone at all.

The reason? Online counselling has a level of anonymity that can lead the client to think there may not be a real person at the other end of the computer. This can lead to an increased level of dissociation because the client may go on to believe that their own behaviour isn't really them at all. In addition, the trappings of status, wealth and power that could be displayed by both client and counsellor are not there either. Imagine how a young client may respond in the face-to-face environment to a male counsellor wearing a pinstripe business suit. This online anonymity transcends class, gender and race, to make for a neutral environment that can either increase the building of rapport or increase the perception that rapport is building. Another thing to watch for online is that if a counsellor sends an email to a client and does not get a sense that they are building rapport, it may be due to the client being in two separate psychological states: their 'sending' state and their 'receiving' state. Consider a client wanting to send an email for the first time. It may be that they are in some form of crisis state and have a great need to get it off their chest in the email. After a few days, when the counsellor has constructed the reply and sent it, the client may be in a totally different state when they read the email. At this point, they may have dissociated from the initial 'crisis' state and perceive that the email sent from the counsellor does not actually apply to them.

Conclusion

In summary, the 'rules' that are being discovered in relation to rapport-building online can be very different from when working face to face. This article has explored some of these variables and has hopefully highlighted areas where an online counsellor needs to focus when considering building rapport with young people (or indeed with anyone) in cyberspace. ■

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'Clients often show higher levels of disinhibition when working online, and therefore appear to be building a good relationship, when in fact they do not actually conceptualise that they are having a relationship with anyone at all'

Questionnaire
Paul Gilbert

Paul Gilbert is passionate about exploring the neurophysiology and therapeutic effectiveness of compassion focused therapy

Why did you decide to become a counsellor/ therapist?
I did my first degree in economics but then got interested in psychology so did another degree in psychology, worked as a psychiatric nursing assistant, did my PhD on depression, and became clinically qualified. Then I had a mild depression myself, which taught me a lot about those states of mind.

What gives your life purpose?
Researching, understanding and promoting compassion. A compassion focus helps us recognise how little control we have had over who we have become. I am the person I am because of my genes and upbringing – neither of which I chose. But we can become much more aware of how our minds work and with practice become more compassionate and change the person we become.

What is your earliest memory?
I'm about 18 months, looking up and noticing white clouds racing across the sky and being totally fascinated.

What are you passionate about?
My family, cricket, playing guitar, and studying and promoting compassion.

Do you always tell the truth?
Good grief – no!

What has been the lowest point in your life?
I had wanted to be a researcher and had a job lined up in America in 1978. The job fell through and at the same time I had an unexpected problem with my PhD. I became depressed with suicidal fantasies (though would never have acted them out) and was having constant panic attacks. My wife saw it as a stress state that made sense and that I would get over it in time – it was nothing to feel

ashamed about. This accepting and 'don't worry about it' common-sense, validating approach was important because I became aware of how ashamed people can be of feeling depressed, when in fact many depressions are best seen as a kind of shutting down of the body when stress has got too much for it. Six months later I was over the worst of it.

What makes you angry?
The way various governments have tried to manage the NHS and have undermined the co-operative, integrated infrastructures. We are now managed through 'business units' that are constantly changing and with targets set by people who are usually very stressed and frightened. So much money has been wasted in reorganisation after reorganisation – and yet today they tell us we need cuts.

Who has been the greatest influence on you professionally?
Jung, Bowlby, the Buddha, my wife Jean, and my first supervisor Kitty Lawrence.

How do you keep yourself grounded?
Playing guitar with friends – it reminds me of a different type of life I might have had and a different version of me that might have been.

Do you fear dying?
My mother has suffered a slow decline into dementia and that does frighten me, as do serious physical incapacities.

What would you have written on your tombstone?
Please no more books!

What do you feel guilty about?
I'm afraid there are quite a few times when I have not been at my best and have been unkind.

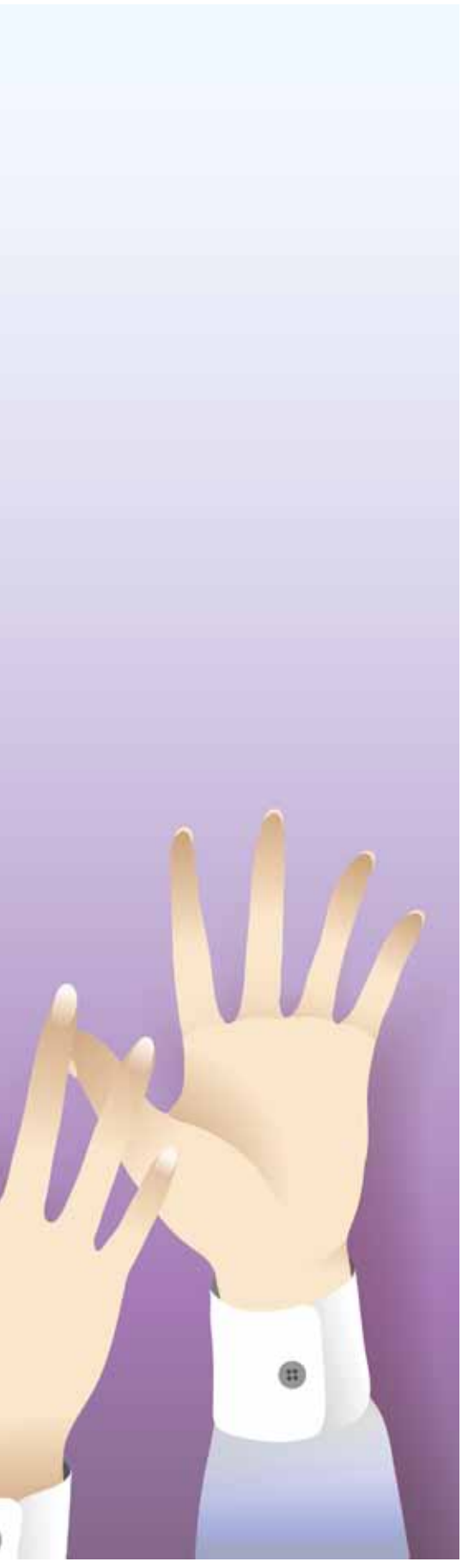
If you could change anything about society what would it be?
There are so many people in the world who are starving and desperate for resources but capitalism has ensured a lot of the world's resources go into making expensive cars, TVs and ready meals for the rich. Just imagine what would happen if we focused on more compassionate goals.

What is your idea of perfect happiness?
Being in a Greek taverna with good company after some great snorkelling.

Do you believe in God?
The version of God as creator or 'loving father' seems unlikely to me because the nature of life is so dreadful. But I do understand it offers comfort to many people. The existence of bacteria, viruses and genetic disorders, and having a brain which significantly contributes to suffering in the world because it's prone to tribalism and violence, don't seem good adverts for a loving creator – unless he or she is completely incompetent. Other versions of God as a type of greater consciousness, or the unity of all things – who knows.

What do you consider your greatest achievement?
My book *The Compassionate Mind*. It's played a small part in raising questions about developing the ability to experience self-compassion and compassion for others as part of therapy. ■

Paul Gilbert is head of the Research Unit as well as Professor of Clinical Psychology at the University of Derby.



To be born in 'interesting times' is said to be a Chinese curse. I certainly experience the current 'regulation climate' as an interesting time. As to whether these times qualify as a curse is down to us. I believe that the present regulation debate is very important and that the current climate presents a big challenge. I also think that these are defining moments and it is a time when each of us has a responsibility to fulfil. However, before saying more about aspects of responsibility, there are some observations I would like to make.

First, I want to comment on the coming together of the psychotherapeutic community. I don't think that I have ever witnessed such a collective outcry from across the spectrum of the different schools of psychotherapy. And secondly, I want to talk about what our different approaches are uniting around and why this is.

I believe the key issue that regulation exposes is one of human rights and especially justice. This is true whether you are for or against regulation. Those in favour of state regulation are concerned that clients are protected by the law and that practitioners found guilty of malpractice or abuse towards their clients can be disciplined or struck off. One of the arguments against regulation is that abusive practitioners could easily hide behind the legitimacy of registration and that regulation would not ensure the protection of clients – indeed, it may well endorse many incompetent practitioners while at the same time imposing negative limitations upon the profession.

One example used against regulation, now familiar to most, is that being a licensed doctor did not stop Harold Shipman from murdering his patients, and current control and standardisation measures, such as the Care Quality Commission, divert resources away from care and towards bureaucracy within care-providing establishments.

By introducing state regulation, which seeks to standardise all psychotherapy in a way that appears to be medical and institutional-centric, the Government is geared to limit our capacities to grow, argues *Steve Cox. Illustration by Emmanuel Romeuf*

Defining moments

'If we are to be regulated it is vital that we are regulated by an authority that understands the intricacies and dynamics of counselling and psychotherapy'

However, the bigger question seems not to be whether regulation is a good or a bad idea, but rather how regulation or non-regulation comes about – after all, as counsellors we expect process to play a central part in outcomes. Judging from the deluge of articles against state regulation in *Therapy Today*, how we are regulated and who regulates us seems to have provoked a huge outcry. Central to these questions underlies an even more fundamental question: what are counselling and psychotherapy? And I hear a resounding answer to this question, amplified in the form of what counselling and psychotherapy are not. For example, psychotherapy is not medical and counsellors are not healthcare professionals.

I have some sympathy for the Health Professions Council (HPC) which I have heard described as a 'pretty benign organisation on the whole'. They must be wondering what on earth all the fuss is about? But concerning regulation, fuss and passion are in abundance. What seems to be coming to light is a fight to preserve an emerging cultural identity, an identity that professes that counselling and psychotherapy are the antithesis of the medical model. Months before the subject of regulation hit the fan, a number of prominent articles appeared in *Therapy Today* from across the spectrum of psychotherapeutic approaches, espousing a paradigm difference between therapy and the medical model. To me at least, this issue of difference reveals an essential understanding as to why so many therapists are saying that they simply cannot and will not work under the auspices of the HPC.

The fuss, therefore, goes to the very heart of elemental principles. For a very large proportion of therapists it appears that the paradigm difference that I allude to presents an ethical issue that underpins all. The medical model is an illness-oriented perspective, whereas psychotherapy tends to be a human potential model which embraces change, growth, emancipation, and adaptation; it is not a reductionist activity.

Some differences between psychotherapy and medicine

While I do not want to restate what has already been eloquently covered by others, it does seem helpful to articulate some key aspects of difference between the medical model and psychotherapeutic approaches to distress. The medical model can be described as an 'ABC' approach, where 'A' is diagnosis, 'B' is treatment, and 'C' is cure. The patient is recognised as being sick and, according to the presenting symptoms, given a diagnosis. The sick person is in need of an expert who will prescribe treatment, and the treatment will effect the necessary cure. Dysfunction and malfunction are synonymous with biochemical disorder which is evident in the presenting symptomology.

The point here is that the way we view human distress colours our actions towards it. If we view distress as an illness or something broken, we might say that it requires psycho-technological or pharmacological intervention. However, if we see distress as a reaction to an unhealthy environment or frustrated potential, then, from a different vantage point, a certain kind of relationship offering conditions for adaptation and growth would be seen as necessary.

From a psychotherapeutic viewpoint, diagnosis compromises the possibility of successful therapy because therapy requires uncontaminated, detailed, subjective experience as a fundamental starting place. Yalom urges psychotherapists to avoid diagnosis. It has, he says, 'precious little to do with reality. It represents instead an illusory attempt to legislate scientific precision into being when it is neither possible nor desirable.'[1] Sanders makes the point that 'diagnosis requires an already vulnerable person to submit to the arbitrary, damaging "authority" of the expert diagnostician'.[2] 'Moreover,' he says, 'it is an unscientific, amoral authority borne out of historical precedent, political expediency, and maintained by professional interests.'

Regarding diagnosis, Rogers wrote: 'In a very meaningful and accurate sense therapy is diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician.'[3] Freeth states: 'Assessment, diagnosis and treatment are at the heart of the medical model. This is at odds with

‘It is vital that counselling and psychotherapy does not become a subsection of healthcare, because it offers a different philosophical perspective’

relationship-centred psychological therapies – and raises many questions for those working in healthcare settings.’[4] And Rowland points out that ‘diagnosis does not take into account the person’s process of feeling and function’.[5]

The psychotherapeutic community does not ignore the issue of biology; after all, biochemical phenomena affect and describe our every organismic action. It is well understood that environmental conditions shape and promote biological responses.[6] It could be said that the counsellor is also helping to create a biochemical solution to problems. However, the counsellor’s effect on biochemistry is environmentally caused, by way of relational interaction, rather than pharmaceuticals.

Environmental factors

Biochemical interventions are predicated on Newtonian science that specifically relate to genetic determinism.[7] However, in stem cell research Lipton[7] demonstrated that environmental factors affected the health of the cells under investigation. He showed that by (re)placing ‘sick’ cells (which he had made sick via an unhealthy environment) into a healthy environment, this caused the cells to recover. Lipton explains how this information translates to human biology: ‘Epi-genetic control is different from genetic control.’ He goes on to say: ‘Now we recognise that the nervous system is responsible for reading the environment and then selecting the appropriate genes that the organism can use to build a structure or create a behaviour that will allow it to survive in that environment.’[7]

Lipton states: ‘The reason this is important is because it signifies that you have a massive ability to modify your genes.’ However, he goes even further in pointing to the errors of medicine: ‘The problem is that conventional bio-chemists have completely ignored the role of energy fields and quantum mechanics.’ More recently he reports that bio-physicists have revealed that ‘the molecules that give us our structures and functions respond to quantum mechanical fields much more effectively than they respond to chemical information’.[8] This information is important for psychotherapy because we act as part of the interactive catalytic force that promotes the ‘energy field’. Lipton concludes that: ‘Energy turns out to be 100 times more efficient at transferring information than chemistry’.[7]

A different philosophical perspective

I am conscious of not wanting to appear as though I am ‘medicine bashing’, while at the same time I want to address the issue of disproportionate power and authority held by medicine within our current health and social services. Proportionally the importance of medicine in relation to people’s health has been generally overrated. The main improvements that have affected health in Western history have come about as a result of environmental improvements, ie improved sanitation and nutrition.[6] In part I address the current status quo or imbalance, given that the medical view dominates healthcare services. It is vital that counselling and psychotherapy does not become a subsection of healthcare, which is dominated by medicine, because it offers a different philosophical perspective.

Cooper[9] brings together an impressive body of empirical research evidence regarding a wide range of psychotherapeutic practices that demonstrate efficacy. Research findings from King’s[10] randomised control trial show that counselling is significantly more effective than conventional GP treatment (the use of antidepressants) in the treatment of depression. Cooper reveals that ‘from a wide range of controlled trials, meta-analytic studies have shown that, on average, counselling and psychotherapy have a large positive effect – greater indeed, than the average surgical or medical procedure. Put more precisely, 80 per cent of people will do better after therapy than the average person who has not had therapy.’[9]

By its very nature, medicine is expert or professional-centred and often institutional-centric. Psychotherapy, on the other hand, works via a partnership and requires the agency of the client and, therefore, it is relationship-centred. The difference in clinical philosophy is of primary importance. From quantum physics to social sciences, increasingly contemporary science accepts that

'The medical model is an illness-oriented perspective, whereas psychotherapy tends to be a human potential model which embraces change, growth, emancipation, and adaptation'

knowledge is a human creation and we must account for the effects of our participation in our inquiry.[11] Gaia theory[12] embraces the world as a living system and therefore re-incorporates humanity as part of the interwoven texture of the planet – we are in nature, not outside of it. Leicester and O'Hara claim that: 'Once human subjectivity is reclaimed as an essential and legitimate dimension of all knowledge, we can give the same kind of value to the qualities of subjective experience that we have up to now reserved for the abstractions of objective science.'[11]

Because of relational dynamics and understanding, psychotherapy moves increasingly towards wider inclusivity of interconnectedness, as Laing said: 'Human beings relate to each other not simply externally, like two billiard balls, but by the relations of the two worlds of experience that come into play when two people meet.'[13] Counselling and psychotherapy are therefore progressive in outlook and move from a self-psychology to a people- or species-centred outlook.

If we understand distress as the symptoms of a failing person, as medicine does, we enforce conditional limitations on all of humanity. Instead of encouraging people to understand and accept themselves, a label of illness such as depression invites people to disown their problems and encourages them to relegate the unwanted as discarded parts and to mask themselves with medication. Pathology implies that a certain way of experiencing equates to being ill. Therefore, these symptoms need treating to make them go away – it's not me, it's my illness – and this has a powerful and detrimental impact on all of society. In contrast, therapy encourages the application of nurturing attention and exploration. Schmid says: 'The challenge is not so much what has gone wrong, but where the possibilities are to facilitate the process of life, ie the self-healing capacities.'[14]

The limitations of evidence-based practice

Our institutions already focus inquiry on symptom reduction rather than growth as the indicator of successful therapy (for example, in CORE evaluation). Evidence-based practice (research methodology) inhibits growth because it focuses on what is already known. Rogers put forward a very different view, focusing on the process of how truth is discovered: 'It is not a confidence in truth already known or formulated.'[15] Schmid asks the question: 'How can we understand another person?'[16] He states: 'If we try to understand the other person from one's own perspective we finally end up at something we know already (this is termed "epistemology of the same").'[16] Surely we would do better by pursuing practice-based evidence. Del Loewenthal draws attention to the limitations of evidenced-based practice options by saying: '...therapies which appear to work may be privileged – particularly in public services – because they lend themselves to current notions of evidenced-based practice. There is, however, the danger that narrowly defined demonstration of effectiveness has become more important than whether or not they are necessarily better.'[17]

At present regulation provokes a collision of competing psychospheres (see O'Hara[18]). By introducing state regulation, which seeks to standardise all psychotherapy in a way that appears to be medical and institutional-centric, the Government is geared to limit our capacities to grow. This is particularly alarming because at present counselling and psychotherapy are exhibiting such vibrant activity and creative expansion. Presently, we are expanding our understanding through practice-based evidence, scholarly publications, research studies (both quantitative and qualitative), and excellence in training (from diploma to doctorate levels). There is cross-fertilisation between approaches; increased validation of therapeutic practice and theory with developments in neuroscience; and meta-analysis shows counselling and psychotherapy to be more reliable than most medical procedures.

If we are to be regulated it is vital that we are regulated by an authority that understands the intricacies and dynamics of counselling and psychotherapy, by a body that understands the fundamental differences between 'conservative' traditions such as medicine, and 'leading edge' disciplines,

'What is coming to light is a fight to preserve an emerging cultural identity, an identity that professes that counselling and psychotherapy are the antithesis of the medical model'

such as psychotherapy. It is vital that counselling and psychotherapy stand outside of healthcare in order to work alongside it. Mearns asks: 'Will the humanity of the counsellor corrupt the medical model of mental illness? Or will the medical model of mental illness corrupt the humanity of the counsellor?'[19] I realise that psychological distress can be as painful as physical pain and that pain killers in the form of psychotropic medication may well be of benefit to some people, but as Moncrieff says, it is 'better if we are honest that that is what we are doing, rather than trying to pretend that we are curing their illnesses'.[20] Surely it is time to demonstrate the competencies of a different kind of profession, a profession that can effect change, growth, emancipation and adaptation and not just manage symptoms.

Our responsibility then is to make this interesting time count. Alarming as registration might appear, it also provides a golden opportunity to give our profession the 'hard sell'. Now is the time to hit the campaign trail.

The psychotherapeutic community has within its grasp a powerful gift for a troubled world and we must be passionately proactive in 'selling' this gift. This is no time for a quiet revolution – we need to make as much noise as possible. I find myself wanting to echo Sanders' passionate cry: 'Let us campaign for the de-medicalisation of life, rather than the proliferation of new diagnostic categories for everything from relationship and sex to eating and shopping.'[21] ■

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In the absence of guidance relating to the destruction of client records in a clinical executor arrangement in private practice, *Graham Mills* considers some options

Destroying client records

In her helpful article in *Therapy Today* in September 2008 on clinical wills,[1] Sally Despenser provides a sample letter setting out a clinical will. In that letter one of the tasks agreed upon is to 'shred and dispose of... remaining case records'. This sounds a simple task but discussion with colleagues about the terms of the clinical executor arrangement I have set up with a fellow counsellor, has made clear that, for therapists in private practice, the issue of the destruction of client records in these circumstances is not necessarily straightforward.

Furthermore, there does not appear to be any specific guidance relating to the destruction of client records after death in a private practice context. There is no reference to the destruction of records in the recently updated BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy*,[2] even though it strengthens its guidance to practitioners on the keeping of records from 'are encouraged to' to 'are advised to' (clause 5). BACP produces several Information Sheets that touch on the issue[3, 4, 5] but none of them deals directly with it. And the authoritative books by Tim Bond and Barbara Mitchels[6] and Peter Jenkins[7] on legal and ethical issues in therapy do not refer to it.

So therapists in private practice making and carrying out clinical executor arrangements are currently pretty much on their own in this area. It is in this context that I set out the following thoughts and suggestions, and hope they will stimulate further discussion. I am not writing as an expert, but simply as a counsellor who has come up against these issues and tried to find a reasoned response to them.

Default position

The default position is that records need to be destroyed in a secure way to safeguard client confidentiality (eg to avoid paper records turning up in a skip or landfill site in a readable form; or computerised records being accessible to a subsequent owner of a counsellor's computer). This is embedded both legally in data protection law, where we have a responsibility to ensure the security of personal and sensitive information (Data Protection Act 1998), and ethically in the BACP *Ethical Framework*, which states, 'The professional management of confidentiality concerns the protection of personally identifiable and sensitive information from unauthorised disclosure' (para. 20, Guidance on Good Practice).

However, in the event of a therapist's death, the assumption that their records should be destroyed can be challenged and needs consideration. The question is whether there are any legal or ethical reasons why client records should be retained after death that would confer a benefit on clients that might outweigh the protection afforded by their destruction. Three possible reasons might be: the information needs of a subsequent therapist; a subsequent complaint by a client; or a legal action by a client. However, in a private practice context it is hard to see the first of these outweighing the need to safeguard client confidentiality, even in the unlikely event of a subsequent therapist feeling a need to see their predecessor's records. As for posthumous complaints, in the private practice context, if a therapist has died, there is no one to answer any professional complaint against him, and no complaints procedure can operate fairly if the person complained about is not given a chance to state their side of the story. Therefore, although it may seem rough on an aggrieved client that their complaint cannot be pursued, it would also be unfair to proceed against a deceased counsellor who cannot defend him/herself. It would seem likely that the same issues would apply to most forms of legal action, though this is a lay not a legal opinion.

The position is of course different where therapists are working in counselling or therapy agencies. In that case, when a therapist dies, the agency will have a responsibility to provide continuity of service to a client, and a duty to retain records in case of possible future complaints or litigation against the agency. However, notwithstanding the points made above, if one of the parties to a clinical executor arrangement in private practice is aware that there is an outstanding or pending complaint about their work, it might be prudent for them to take advice from their insurers about what should be done with the records about that case in the event of their death, and to communicate this advice to their clinical executor.

‘In the event of a therapist’s death, the assumption that their records should be destroyed can be challenged and needs consideration’

Contractual agreement with clients

There is also the question of contractual agreements with clients. If a therapist keeps client records, then the contractual arrangement with their clients should include an understanding about how and for how long these records will be kept. The information given to clients should include the arrangement that is in place for the destruction of those records in the event of the counsellor’s death. The simplest arrangement would be for the records to be destroyed after a certain length of time or on the counsellor’s death, whichever occurs first. (The issue of how long to keep client records is in itself not straightforward, and is discussed in a book by Bond and Mitchels.[6])

More complex arrangements might be for the records to be retained by the clinical executor for the same length of time as originally stated by the therapist; or for the records to be forwarded by the executor to each client who would then take ownership of them. These are clearly more onerous tasks for the executor, and the retention of records by the executor also raises questions about the legal ownership of the records that are retained. Whatever arrangement is decided upon, it needs to be agreed with the client as part of contracting, and with the clinical executor.

Destruction of computerised records

Many therapists keep client records electronically, and this raises some additional issues. To maintain confidentiality, it would probably be good practice to password protect client records held on computer (the equivalent of keeping paper records in a locked cabinet). Records can then be deleted from a computer while still being password protected. They do of course need to be deleted twice – once to the waste bin, and then from the waste bin. However, it is still possible for deleted records to be recovered using hard disk recovery software. This is because deletion does not remove the records from the hard disk, but only unlinks the file from indexes so it is not visible or accessible. So a second level of secure destruction might be to erase the record using commercially available software which overwrites it with carefully selected patterns. In the absence of clear advice about what measures are deemed reasonable to destroy computerised records, each counsellor needs to make their own judgment.

Clinical executor responsibilities in this area might be of two kinds. It might be agreed to be the responsibility of the owner of the records to specify to their next-of-kin how their computerised, passworded records are to be destroyed, and the executor’s responsibility to check that this has been done. Or it might be one of the executor’s tasks to carry out the destruction themselves with their deceased colleague’s next-of-kin providing access to the computer.

It has been a challenging learning experience to set up a clinical executor arrangement in a private practice context, and not least of the issues to be explored and addressed has been how to deal with the destruction of records. I hope I have raised some points for discussion that will stimulate further thought in this area. ■

Graham Mills is a BACP accredited and UKRCP registered individual counsellor.

My thanks to Peter Jenkins and Barbara Mitchels for their advice; to Sarah Lillywhite for proposing our clinical executor arrangement and working with me on it; and to colleagues in my local counselling network group for raising questions about the destruction of records which I had not considered. Also to Sarah Lillywhite and Mike Worrall for helpful comments on the draft of this article.

The Information Commissions Office (ICO) can offer legal advice on these matters. Helpline: 0303 123 1113 or email informationcommissioner.gov.uk

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Dilemmas
Maintaining confidentiality

Here we publish your responses to our first dilemma: how can you balance the need for confidentiality with the possibility of putting a child at risk of harm?

This month's dilemma

Khalil is a counsellor who works for a specialist agency supporting adult survivors of sexual abuse. His client, Angie, discloses abuse perpetrated by a family friend when she was eight years old. She has recently discovered that the alleged abuser has moved in with her auntie who has a child – a boy aged 11. Angie has never disclosed her abuse to her family and does not wish to do so now. The agency policy is to provide total confidentiality to clients, apart from when legally obliged not to do so. Angie minimises any current risk and states that she only told Khalil because of the agency policy to protect her confidentiality. Khalil is not sure what to do.

It's the shades of grey in any situation that can cause the most uncertainty and anxiety; the blacks and whites are often much easier to deal with, even if they seem to be more challenging on the surface. Khalil's dilemma in knowing how to respond to Angie's situation, while keeping in mind the possible safety of a child, is not necessarily helped by the policy of the agency or the contract agreed. Often the procedural or legal certainties begin to falter in the face of moral or ethical imperatives. These are much more personally experienced, and as such, resolution can be elusive. The four responses below to Khalil's situation each provide a different perspective and emphasis and point to the different ways we might reflect on this.

The next dilemma involving Suzanne's concern for her friend and colleague Michelle, is outlined at the end. I would be delighted to receive your responses to include in the next *Therapy Today*. Please send them before 6 August to andrew.reeves@bacp.co.uk

Andrew Reeves

Gail Ashton, Integrative counsellor/ psychotherapist

An agency policy that states it provides 'total confidentiality to clients, apart from when legally obliged not to do so' enables counsellors to contract with their clients more explicitly about what is deemed a 'legal' duty to disclose, such as the intention to harm self or others, the Prevention of Terrorism Act 2005, or if the counsellor is subpoenaed or summoned as a witness in a court of law. However, as there is no mandatory duty to report child abuse under British law (Peter Jenkins, *Therapy Today*, vol 19, issue 10), the risk of a rupture to the therapeutic relationship should Khalil disclose concerns without the client's consent needs to be balanced alongside concerns about a child who may be at risk of harm, and within the context of any agency policy in which the counselling relationship exists.

Khalil's uncertainty about what to do perhaps reflects the tension in such sensitive and complex cases as these, and would be taken to supervision. He will need to consider how such a disclosure would impact on Angie and the therapeutic relationship, the need to respect his client's autonomy and her need for trust and confidentiality so that she can talk about her own experience of the abuse. Also he will be considering the welfare and potential harm to the child who is now living with the alleged abuser, although his client has not stated that the child is being abused and has minimised any current risk.

Angie herself has already raised the issue of the alleged abuser now living with a child, and perhaps Khalil can congruently reflect with his client his uncertainty/concern regarding the potential risk to the child and explore this within their work. By respecting Angie's autonomy, it will enable her to decide how she wishes to proceed with any disclosure. He may also be able to share with Angie avenues for disclosure of her concern whilst protecting her confidentiality.

Angie needs to be at the centre of this relationship. She needs the space to talk about her experience of abuse and her feelings related to the alleged abuser now living with her auntie and the child. The delicate balancing of enabling Angie to stay within her experience alongside the consideration of risk to another child is a challenging one for any counsellor. The therapeutic relationship needs to drive any decisions and not an overarching set of legal rules and assumptions about what we perceive the law states 'should' be done.

Considering all of the factors above, it would seem to me that no information has been disclosed about the third party (alleged abuser) or the child, with whom he now lives, that gives enough information of intention to harm or harm happening that would mitigate going against Angie's wishes for confidence. I think that on balance, the suspected possibility of child abuse 'potential to harm' is not the same as 'an intention of harm'. In this case protecting the therapeutic alliance would outweigh a set of assumptions and possibilities, which have as yet not been disclosed or described. I would not breach confidentiality.

Kath Caffrey, Counsellor in training (person-centred)

It would have been important for Khalil to have outlined in the initial meeting with the client the basis of confidentiality, but also he would have pointed out the exceptions to the rule – legal restraints, the duty of care to the client if she was at risk of harm, and the duty of care to anyone else who might be at risk, especially children. The agency has a strict policy with regard to confidentiality but the same limitations must ethically apply.

The client has made it quite clear that the promise of confidentiality is what has permitted her to feel comfortable enough to disclose the suffering she has undergone in the past; to talk about the trauma of child abuse. The relationship with the counsellor has benefited from this clear-cut confidentiality and sufficient trust has been established for the client to discuss something that she has kept hidden for many years. Breaking this trust would have a devastating effect on the therapeutic relationship. It is important that Khalil does not put the client under any pressure to make further disclosures to other agencies, or to further add to her feelings of shame and guilt by trying to place responsibility for the child 'at risk' on her; the consequences could be enormous.

But what about the child potentially at risk? Khalil should record and discuss with the agency the potential for harm to the child to ensure he works within the agency policy and the contract agreed with the client. In this discussion and in supervision he might speculate as to the motives for Angie's disclosure (perhaps she hopes someone will act), or is she testing the boundaries of confidentiality? Perhaps this is an attempt by Angie to bring everything out in the open, including to her family? At this stage however, my priority would be to work with the client and try to empower her to act accordingly.

Kirsten Amis, Counsellor, supervisor and counsellor trainer

When I first read about Khalil's dilemma, I was initially drawn to the clause in the agency's confidentiality policy that states 'apart from when legally obliged not to do so'. This is a complicated issue due to the fact that in this case, we are considering a moral obligation rather than a legal one. In a perfect world, Khalil would already have explained this to Angie during their first session so that both were clear of the outcome if Angie were to disclose any sensitive information such as this. Unfortunately, it appears that Angie believed that anything she said would remain confidential.

The law is quite clear that the welfare of the child is paramount and should always come first if any sort of abuse is suspected, despite not being a legal requirement to forward any information. Understandably this can result in an immediate breakdown of trust with the client if they feel betrayed. To avoid this, a transparent process, which involves discussion and negotiation with Angie, would be the most appropriate next step. The BACP document *Providing a good standard of practice and care* states that 'practitioners should be aware of and understand any legal requirements concerning their work, consider these conscientiously and be legally and professionally accountable for their practice'. Khalil would need to take responsibility for his choices and actions if he does choose to pass this information on with or without Angie's consent.

As Khalil is currently unsure how to proceed, a swift consultation with his counselling supervisor would be appropriate so he can seek guidance from an experienced practitioner. In addition to this, a discussion with his line manager would show that he was seeking guidance, considering his actions and the subsequent impact upon Angie. One of the main challenges is the fact that Angie does not want her family to know

about the abuse. This suggests that she would prefer to be in control of the information that is passed on. That the abuse is still 'alleged' suggests that it wasn't reported to the authorities at the time so there is no record of any abuse allegation.

The BACP ethical principles do acknowledge the importance of autonomy, and this would seem to be a situation where Angie's informed consent would be the ideal solution. Khalil's first option would be to encourage Angie to contact the social work department directly and discuss her concerns with the Child Protection Officer. This would allow Angie to remain empowered whilst still protecting her nephew. However, if Angie was resistant to this, Khalil would contact them with Angie's knowledge, if not her consent. Additionally, the agency may wish to learn from this and reassess their clients' perception of a strict confidentiality policy so that future clients are aware there are exceptions to this.

Margaret Bradshaw, MBACP counsellor

This is always a tricky situation when the survivor of sexual abuse recognises a child (relative) is at risk, but does not want to upset the apple cart. This may be because Angie does not want to alert her family to her own history or expose her own abuse, or because she fears a backlash from her abuser who may, or may not, have a criminal record.

Firstly I feel Khalil should take this scenario to his supervisor without delay, as there is arguably a responsibility on every adult coming into contact with children, or who are responsible for their welfare, to act on their concerns. Too many errors of withholding vital information about known abusers have led to further abuse, even child deaths.

When Angie first raises the topic, Khalil could help her explore her reluctance to disclose the risk to her nephew; her feelings about him being exposed to possible abuse; her aunt's reactions if alerted; possible consequences in the family and extended family; the likely reactions of the abuser; and Angie's own fears about the alleged abuser; and how it is affecting Angie herself.

This is not something to be imposed or rushed, but safety of both client and child are important. Are there alternative ways of alerting the appropriate authority (whether it be the police, social services, child protection agencies, the school or GP perhaps) of the risk to the nephew, without risk to Angie, and maintaining anonymity? Discussion with a local NHS Child Protection Officer, keeping the client's name anonymous, would provide helpful guidance as to procedure.

Empowering Angie to take responsibility for her nephew's welfare as far as she can and to put herself in his situation may increase her post-traumatic stress and this would need to be worked with and contained in the ongoing counselling. Not being believed and the whole issue of exposure and its consequences, both past, present and future, will need to be worked with.

With support from his supervisor, Khalil could explore agency policy and how far it applies. Are there exclusions to total confidentiality that are written into the agency contract: for example regarding disclosure of terrorist intent, or intent to harm self or another, especially a child? Not that Angie has this intention: but to do nothing at all constitutes an act of omission once possible risk to a child is revealed.

September's dilemma

Suzanne has worked in a primary care counselling agency for four years and has become good friends with a colleague there, Michelle. Michelle is a highly respected and well-liked member of the team. Suzanne discovered recently that Michelle has been drinking heavily, and for some time. While she appears to be sober at work, Suzanne is fearful for Michelle's clients and her capacity to work professionally. Michelle became distressed when asked about this, and begged Suzanne not to say anything to her manager – she would 'lose [her] job and become unemployable'. Suzanne feels torn between trying to support her friend to turn things around personally, and the wellbeing of her clients, which increasingly seems to be compromised.

Please keep your responses to 500 words or less. It is important that you outline your response to the dilemma, and make your thinking as transparent as possible. A small selection of answers will be published in *Therapy Today*, with others appearing on our website (www.therapytoday.net).

Coaching at the Beeb

Liz Macann is head of executive, leadership and management coaching for the BBC Academy and juggles her working life with kids, dogs and horses

Interview by John Daniel
Photographs by Phil Sayer

I get up about 5.30am – I'm a lark not an owl, and it's the only time the house is quiet and I can have some me time. I'm based at home in the Chilterns near Great Missenden, but I travel to wherever I need to be. On the four days of the week that I don't travel into London, I meditate and, if I'm a really good girl, I'll do some exercises.

I work for the BBC Academy as head of executive, leadership and management coaching, which is a long way from where I started 25 years ago as admin assistant for Radio Solent. I arrive in the Media Village at White City by 8.30am and my first stop is for a double espresso. Then I go up to my office. I manage a team of two other full-time coaches and two co-ordinators.

After I came back to the BBC having taken time off in the 1990s to have children, I discovered coaching through the *Harvard Business Review*. It didn't exist within the BBC at that time and I presented a proposal to introduce coaching within the corporation as opposed to buying it in from outside. In the late 90s the coaching training available wasn't good, and so the BBC brought in a clinical psychologist to teach six of us some core coaching skills. I was the only one who then took it onwards.

We learned the core skills of active listening, incisive questions and also the GROW model, which a group of the very early coaches like John Whitmore, Timothy Gallwey and Graham Alexander created as a basic route through a conversation. Although the model is still used in today's training, the four-module externally accredited course trains coaches to work at a much deeper level, seeking to transform or at least develop, rather than offer quick fixes.

I often have an early client because I like coaching early in the morning. Before a session I make sure the balance of the room feels right. The session will be for an hour and a half, and straight afterwards I will write up my notes. The next thing I might do is run a shared learning group for my quota of 12 coaches. That's like group supervision really.

We have 92 coaches, 89 of whom have non-coaching day jobs. They are all employees of the BBC who want to do something in addition to their main job. We run a strenuous selection process because we don't want people who won't walk the talk. I bring in external experts to teach some of the CPD; these might cover psychosynthesis or Gestalt and some of our coaches love CBT – we don't create clones. As long as they've got the core coaching capabilities – challenging assumptions and limiting beliefs and unearthing the underpinning values, meaning and purpose as they pursue the client's agenda towards their desired outcome – they're doing a good job.

A coaching mentor supports trainee coaches and if they reach the right level of competence, they will go on to work on one of three programmes. There's the leadership development programme in which middle management learn some management theory models and practices and then work with a coach on how to apply that within their own teams. Then there is the transition programme for people who come into the BBC at a senior level from elsewhere or are promoted internally. There's a lot of research to show that your opportunity to impact and influence in a new role is going to happen in your first 90 days. And then the third programme is one-to-one executive coaching.

‘I’ve got dogs, horses and kids – not necessarily in that order. Family life is the most precious thing to me’

Each coach has three clients. We have BBC sites all over the world, and if somebody overseas wants coaching, it will be by phone. Most of the programmes span six to eight months. We give them 10 hours of coaching and they can divvy that up in whatever way suits them. They may want a half-hour phone call just before they go into a problematic meeting or they may want a whole morning before an away day. More typically it’s an hour and a half sitting in a room with the coach, chewing over something in pursuit of their long-term goal.

We concentrate on work-focussed issues, although we believe that an individual doesn’t walk through the door and shed the skin of his life. If there are personal issues which are impacting on the workplace, then we feel that it’s right to address those if the client wants to. We hold the boundary between counselling and psychotherapy and what we do. If we feel a coachee is in need of counselling or psychotherapy then we refer them on.

We sometimes have a learning break over lunch, when you bring a sandwich and a cup of coffee and we’ll have a presentation on this or that. After lunch we may meet as a team – not the whole network but the three coaches and two co-ordinators. We have this meeting once a fortnight to keep everyone up to date with every element of the work. I might then go on to supervise one of the coaches for an hour, probably face to face, depending where they are. If they are in another city or country, it would be by phone.

Everybody has a one-to-one supervisor who they are required to meet at least four times a year, or as often as they and the supervisor contract for. And then there is group supervision which needs to happen at least three times a year, although it’s offered six times. Every coaching programme starts and ends with a three-way meeting between the line manager, the client and the coach. From that meeting the organisational objectives are agreed, although the client can add personal objectives. The three meet together again at the end to compare what actually happened to what was established up-front.

In between all of these things I also have to keep up with emails. These can be from external coaches offering their services. Sometimes it’s essential to buy in to get the added expertise; that’s often where the psychological expertise comes from, because a lot of psychologists have become executive coaches and I personally think that the very best combination is a coach who has practised as a psychological therapist. If I’m talking with a senior exec and sensing that there’s a whole can of psychological worms to open, then I might suggest that it could be good to explore in a deeper way than any of the coaches can facilitate.

I log off around 6pm. I might meet friends in town for a glass of wine or I might hurtle back to Missenden where I’ve got dogs, horses and kids – not necessarily in that order. Family life is the most precious thing to me. We always eat together as a family, then at 9pm we try to sit down together and find something to watch on TV, ideally a good drama like *Spooks*. I love what I do and I’m lucky enough to have a fab family and a job I love. I’ve got a fantastic team and a truly wonderful network of coaches. This isn’t flannel – anybody who knows me would tell you that that’s what I think. ■

Letters

What constitutes a phobia?

I was interested to read about the life and work of Salma Khalid ('Embracing spirituality', *Therapy Today*, May 2010) as it offered an insight into the everyday life of another professional whose life is very different to mine, but I was troubled by some of the opinions expressed by someone who works as both a therapist and a diversity trainer.

Salma writes about delivering training in cultural competence in Oldham 'where the race riots happened not so long ago and Islamophobia, as in much of Britain, is rife'. Apart from being an unfair smearing of the British non-Muslim population, I find this statement troubling as it feels partisan and is somewhat disingenuous and reductive regarding the Oldham riots which happened in May 2001. The riots were triggered by a National Front march through the town centre, which is obviously provocative. However, that's not the whole story, some basic research (via Wikipedia) reveals that the two reports (the Ritchie Report 2001 and the Cantle Report 2006) that followed the riots both arrived at the conclusion that there was a long history of segregation between the Asian and white communities that had gone unaddressed for generations. These reports reveal that both communities had become entrenched in their isolation from each other. It seems likely that both communities had an investment in maintaining their own particular status quo. It could be argued then, that both 'Islamophobia' and what might be termed 'Anglophobia' were present in this situation – both unhelpful concepts.

> 'There are no easy answers to dealing with prejudice, other than a certainty that a partisan approach is not the way forward'

I think it is important for someone in the role of a therapist and diversity trainer to avoid setting up one side as victim, and to think more deeply about what constitutes a phobia. A quick Google search provides a useful definition of phobia as 'an intense, unrealistic fear, which can interfere with the ability to socialise, work, or go about everyday life, that is brought on by an object, event or situation' (please see www.answers.com). The same website describes how therapy 'can be helpful in overcoming phobias, the phobic person being gradually exposed to the anxiety-provoking object or situation in a way that demonstrates that no threat really exists.'

So the role of a diversity trainer would seem to be not just a one-sided education of the perceived perpetrator (the majority) but more of a community-building exercise in bringing both sides of the divide together to see that 'no threat really exists'. Of course, that's a huge task in practice with groups who are likely to be resistant or just uninterested and that's the scale of the challenge. In my view this is one important aspect of the role of therapist – in working with individuals to help them gain perspective on what troubles them. The scale of the problem might make the progress of one individual seem a drop in the ocean but my work setting of an addictions treatment centre suggests that when one client gains insight into their addiction, they support their peers in their recovery by challenging their entrenched beliefs, as for a client to do otherwise, would be to jeopardise their own recovery by colluding. The principle being that one person in recovery is the whole community in recovery.

Clearly, there are no easy answers to dealing with prejudice, other than a certainty that a partisan approach is not the way forward and is likely to be counterproductive and increase entrenchment. A partisan approach also raises the question of the investment in the trainer's personal bias?

Another statement that I found troubling in 'Embracing spirituality', due to its reduction to little more than a soundbite was Salma's view on spirituality, when she is talking about 'the huge separation of religion and spirituality from medicine, never mind mental health'. I worked in a hospice for five years so I know that's not entirely true and more clarity on Salma's part would have been helpful. She goes on to say that, 'There's still an airy-fairy, hippie view of spirituality and that's a real shame'. She doesn't say what she means, which is the real shame because I don't know what she's talking about. I can only hope that she's not talking about the post-organised religion phenomenon of self-defined spirituality that began in the 1960s, which can be dismissed by those who subscribe to organised religion as an 'airy-fairy, hippie' view of spirituality. It seems to me that the liberation of

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spirituality from the yoke of organised religion was one of the major achievements of the 20th century, even if sometimes it presents as 'airy-fairy'. In fairness, Salma does say that that she thinks that God/spirituality is universal which I agree with and would add that spirituality can be refracted through multiple prisms. In conclusion, I think that Salma has not been well-served by her interviewer (and editor) as it looks like she has been allowed to dig herself into something of a hole by exceeding the brief of the article format. However, I am grateful for the opportunity to review the challenge of living with diversity.

Brian Tasker
MBACP (Accred)

Salma Khalid's response

Following the very honest and open responses to the 'Day in the life' interview with me in the May issue of *Therapy Today*, I would like to thank Fauzia Gaba, Chris Jenkins and Jill Britten for their feedback and personal contributions on the subjects of diversity, spirituality and faith.

I was deeply concerned about some of the content of Brian Tasker's letter. Although I welcome challenge and openness, I found his tone and opinions worrying in terms of how he perceives diversity and the way in which he pathologises me as a 'victim'. Brian has made many assumptions about my work; the first being that the training I deliver is to a British non-Muslim, non-Asian, non-black audience. The training is delivered to a very diverse group of staff from various professions and diverse cultural and ethnic backgrounds. Although the training gives some space to discuss the background of the riots in Oldham, it is not about why the riots happened or the presence of Islamophobia, or 'Anglophobia' as Brian suggests. It is more about how we engage and offer our clients the best possible care, treatment and service in a climate where race relations have been severed and distrust and misunderstandings are present. The training aims to unpack values, beliefs and stereotypes that 'we' – including myself – may hold or may have held. I will not apologise for being partisan because I would like to meet a person who is not partisan. As Fauzia Gaba stated in her letter, 'We are dealing with individuals whose psyches are defined by a range of external and internal influences, but essentially who are human beings first.'

I am partisan because I am a woman and I believe in equality when it comes to gender. I am partisan because being British is an important part of my identity. I am partisan because I have a strong sense of faith and spirituality. I am partisan because I am committed to working with all the strands of equality and diversity (race, gender, sexuality, religion and belief, disability and class) and human rights and these commitments are embedded in my values, beliefs and experiences as a British Muslim Asian woman. Would Brian see me as partisan if I were a white middle-class heterosexual male committed to the areas of work mentioned above?

Perhaps in Brian's way of thinking I would have to talk about hatred towards men by some women before I could talk about domestic violence, rape and discrimination against women, otherwise I would be partisan and coming from a 'victim' point of view.

It is important to acknowledge the fact that social inequalities, health inequalities and the structure of power in society are not symmetrical – ie Islamophobia versus Anglophobia – but very complex and dynamic. These are shaped by collective sociological values, historical legacies, media, politics and of course individual values and beliefs. This is the context in which I deliver diversity training.

Brian's distorted view of me 'delivering a one-sided education of the perceived perpetrator (the majority)' worries me. I wonder how this black and white thinking might translate into work with potential clients if one views black people raising issues around discrimination as holding a 'phobia' and that 'no threat really exists', especially in light of the MacPherson report and David Bennett inquiry.

'Day in the life' is an article which reflects the personal, which is what I felt I was able to convey and the interviewer and editor very eloquently put together. This article is not of an academic nature and hence I will not start an academic debate in this space.

With regards to embracing spirituality, I agree that there are many examples of good practice across the country within hospices and chaplaincy services and in some cases within everyday mental health service delivery. However, I believe we are still very far from embracing spirituality from an organisational point of view (in the NHS, for example). In the assessment, treatment and recovery of clients our work with spirituality on the whole only tends to be available when the chaplaincy service is contacted. Despite the fact that the liberation of spirituality from the yoke of organised religion was one of the major achievements of the 20th century, many health and social care organisations continue to reject both. I feel that as healthcare providers and mental health practitioners we can only say we have truly embraced spirituality when it is embedded in the organisation and work we do, both at strategic and grass roots level, and of course in the learning we receive on counselling and psychotherapy training courses.

The BACP division on faith and spirituality APSCC (www.apscc.org.uk), of which I am an executive member, continues to campaign for the religion, faith and belief agenda to be taken forward in counselling, psychotherapy and pastoral care.

Salma Khalid

Accreditation, gender and sexual diversity

I am utterly disappointed and dismayed by Kate Thompson's article in the latest *Therapy Today* (June 2010) entitled 'Applying for accreditation: issues of difference and equality' where she fails to include differences of sexual orientation and

gender variance as part of the equality audit done by accreditors. Given the recent publicity around the study by Bartlett, Smith and King (2009)[1] which showed 1:6 therapists were willing to contract to reducing same-sex attractions and redirect sexual orientation (despite no evidence base for this), I had hoped the Accreditation department at BACP would be closely scrutinising applications for clear evidence of how the applicant views gender and sexual diversity.

This is even more crucial since Patrick Strudwick's[2] investigative journalism into reparative therapy found a BACP senior accredited counsellor/psychotherapist to be falsely attributing memories of childhood abuse as causative of Strudwick's homosexuality and trying to cure him of his sexual desires through prayer.

How is sexual orientation being considered by the accreditation panel? Is BACP doing anything to ensure its members are educated in this area? Was my Fellowship awarded for my 'distinguished contribution to the field' in vain? Please I expect better of you all than this.

Dominic Davies
Fellow BACP; Director, Pink Therapy; Co-editor of the Pink Therapy *Trilogy* (*Open University Press, 1996 & 2000*)

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2. Strudwick P. The ex-gay files: the bizarre world of gay-to-straight conversion. Independent; 1 February 2010. http://www.independent.co.uk/life-style/health-and-families/features/the-exgay-files-the-bizarre-world-of-gaytostraight-conversion-1884947.html

BACP's response

Kate Thompson gave several, quite general, examples of difference and equality and stated very early on in the article: 'There are of course many taxonomies of difference and many issues of equality.' She goes on to say: 'Such issues may include the visible, such as age, gender, race, physical disability; the audible, such as language; or the invisible, such as class, religion, politics or experience (none of these lists are exhaustive).'

Mr Davies misunderstands the assessors' function. They do not carry out an 'equality audit'. They are tasked to respond to what the applicant tells us about the impact of issues of difference and equality upon the therapeutic relationship they have with their clients. It would be quite wrong for assessors to attempt to make a definitive list. This is why the examples given in the article are general, illustrative and brief. The assessors are not ignoring particular or specific areas of difference and equality but respond to what the applicant offers, which must be considered in the context of their work. Neither do they direct potential applicants to possible or actual areas of difference and equality. Kate Thompson's article quite properly explained how sub criterion 8.1.3 and 8.2.3 might be approached by someone reflecting on the requirements of the criterion prior to writing an application for accreditation.

Paul Asher
BACP Professional Standards Assessment and Standards Manager

Obsolete accreditations and other anomalies

I read in the March issue of *Therapy Today* that people accredited as trainers, which has now become an obsolete accreditation, can no longer use this title. It is not enough to thank them for contributing to raising standards; BACP needs to find a way of allowing members who have striven to reach the highest standards in various categories of accreditation to continue to have this acknowledged in their qualifications in some form when it becomes obsolete.

Accreditation denotes levels of achievement and professionalism achieved after a lot of hard work. It is good for the practitioner and something to be proud of. It is also good for BACP to have its members reach this level even if there is no longer a call for the process of accreditation to continue in that form.

We have practitioner status, accredited status and retired status to accommodate what happens in practice. Can we not find a form of words to accommodate this situation and other similar situations where for some reason a member can no longer meet the requirements of the process but has not actually retired?

Outside of counselling/psychotherapy one can continue to attach the title of the qualifications – eg diplomas/cert Ed/BA/MA/MPhil/PhD etc – whether or not one is using the degree in one's work because it denotes a level of achievement. If a particular degree ceases to exist, the letters after one's name are, I believe, still licit. All denote a level of education; they also stand for a level of commitment and are part of who one is, both personally and professionally.

Doug Turner comments also in the March issue (in the Letters section, 'On being unaccredited') as someone affected by this change. What do other members think whether directly affected or not? I am not directly affected but I believe that all members are affected because it impoverishes BACP.

Dr Penny Rawson

BACP's response

Further to our comments in the March 2010 issue of *Therapy Today* regarding the closure of the Trainer Accreditation Scheme, which requested members to no longer claim this category of accreditation, we would like to clarify that as stated in our initial letter informing members personally about the closure of the Accredited Trainer's Scheme: 'In respect of advertising on business cards, letterheads, CVs etc, it will be quite acceptable to state that you were a BACP accredited trainer "From ..... until February 2010 when the scheme closed".'

All categories of accreditation are currently under review and a new category of senior accreditation for trainers/educators may be introduced,

subject to consultation and Board of Governors approval.
BACP Accreditation department

Are we in danger of devaluing accreditation?

I have just become aware that the new pilot scheme for supervisor accreditation requires that applicants have completed a minimum of just 30 hours' experience as a supervisor. The current requirement is 180 hours and I understand it used to be 250.

I'm curious to understand why what seems to me a vital part of evidencing a reasonable level of experience as a supervisor, appears to now be so much less an important aspect of attaining accreditation status. What is the current thinking around what it means to be BACP accredited?
Karen Twyford
MBACP (Snr Accred)

BACP's response

There are around 8,500 BACP accredited counsellors/psychotherapists and only 330 accredited supervisors. The reality of supervision practice is that many who offer supervision have neither specific qualifications/training or even in some cases, are they accredited practitioners. They supervise on the basis of 'experience', which in many cases is little more than having relatively recently completed a core training.

The rationale for setting the level at 30 hours is that for many apprentice supervisors with a case load of one or two supervisees, it can take a considerable time at one-and-a-half hours per month to achieve the present eligibility threshold (180 hours). To use the analogy of training for a pilot's licence and the accumulation of flying hours – the purpose of the assessment is to ascertain through the case material quality of skills, knowledge and professional practice not quantity. (Hence, training is a prerequisite of the new criteria and greater reflexivity is required to meet, for example, Criterion 9.2.3, as we require case material demonstrations rather than as previously evidence of awareness).

In summary, the criteria have been strengthened, requiring a more in-depth reflection and demonstration of practice; the outcome should, therefore, be higher quality standards and not just a greater quantity of accumulated hours. Finally, the current criteria are at the testing stage and when we have examined the applications from those participating in the pilot, we will be in a better position to judge the impact of the changes, prior to the launch of the new scheme.
Helen Coles
Head of Professional Standards

Ways of being a man

I wanted to respond to letters from the last two editions of *Therapy Today*: 'Bloke bashing' by James Hennah in the May issue and 'What makes a man a man' by David Mair in the June issue. I won't focus too much on the content because my attention was drawn to the difference in my felt experience in response to reading the two letters. When I described my response to a colleague they remarked on the irony of the two letters.

Whilst reading James's letter I experienced his humility, openness, and presence. I felt that he had lived his experience and described it beautifully and I applauded his views. I then read David's letter and my experience was of intellect, knowledge, distance and some arrogance.

My stereotyping then took me to place James as representing feminine qualities and David representing masculine qualities. I loved the idea that men can be different kinds of men and that there is a continuum of ways of being a man. I guess there is a continuum of ways of being a woman as well.

I celebrate difference and I take an analysis based upon biological science where natural selection has ensured that difference and diversity in the natural world ensures the survival of species. How arrogant to want to deconstruct millions of years of evolution, by which means we are able to engage in this process, and to want everybody to be the same. We are different from each other – that is the point.

I worry that those hell bent on the creation of sameness will mean that something that has been successful for millions of years will be lost. Oh, the boredom of one person's sameness. Of course, I am only referring to sameness and not equality or inequality, they are different matters altogether.
Christopher Murray

Alienating men

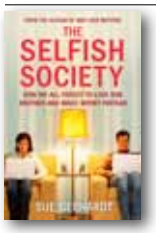
James Hennah's letter in May's issue initially evoked real sadness in me at what I also agree is a disturbing tendency in our culture to vilify men as potential paedophiles and unsafe to be around children. I agree totally with his feelings about the impact on our society and, in particular boys, as a result of this. As a lifelong feminist, I deplore bloke bashing as a way of challenging patriarchy – it does nothing for the cause and only alienates men, and very often women.

However, as I read on I also felt surprise at his apparent anger at his experience of being in a female dominated profession and have two comments to make about that. Firstly, whilst the majority of therapists are women and they too are often tutors, at a higher level and historically, most of the influential writers on therapy have been, and continue to be, men.

Secondly, until not so very long ago, all professions were male dominated and women constantly experienced what he is now feeling. Might I suggest he draws on his feelings about being in the minority to relate to what that can be like for others. I don't know much else about Mr Hennah, other than he is obviously passionate about what he does. However, I do know that in our society most men, particularly those who are white, middle-class and heterosexual, very rarely, if ever, have an experience of being in the minority and disempowered, but what a potential gift if they are truly committed to a vision of equality.
Lois Peachey

Supporting our early emotional lives

The selfish society: how we all forgot to love one another and made money instead
Sue Gerhardt
Simon & Schuster 2010, £12.99
ISBN 978-1847375711
Reviewed by Angela Cooper



Gerhardt argues that we need to overhaul our basic understanding of how society works, and find new ways to support good emotional development, whatever form this may take, in order to change social and political culture, ultimately on a global scale.

Research, she writes, shows children learn more about morality from being emotionally understood than from strict parenting. The issue of childcare provision is discussed. Gerhardt explores how childcare for under-twos can produce socially inept and narcissistic adults and advocates other childcare possibilities which still draw on the idea of social support and ultimately more effective parenting. Empathic parenting is important, but mentalising – a concept that explains how inner states motivate behaviour – is essential. This entails not just sharing the emotional experience of the other, but understanding and predicting how they will behave. Being understood in this way will lead to more co-operative social behaviour later in life, as the individual has developed emotional self-regulation, empathy, and a confident belief in themselves and the world. Rather than taking the negative behaviour of someone else personally, they will wonder why the other is behaving as they do.

Gerhardt argues that narcissism has increased in society as a result of complex social change since medieval times. In perhaps the strongest chapter, she explores the erosion of democracy in the UK and the insecurities of individual politicians (she names several!) that lie behind this. She is skilled in writing about complex subjects, drawing together psychotherapy, social history, attachment theory and neuroscience. She is clear about the challenges that lie ahead, and equally clear about the outcome if the problems are not resolved: an emotionally and materially ruined world.

Suitable both for social psychotherapists and counsellors with no experience in this field or indeed in neuroscience, many outside of the counselling profession will undoubtedly find it fascinating, albeit controversial. Gerhardt takes us out of the dark ages of good and evil and into the modern era of empathy and narcissism. This is an excellent and overdue book.

Angela Cooper is a BACP senior accredited counsellor and supervisor

The meaning of work

Object relations, work and the self
David P Levine
Routledge 2009, £21.99
ISBN 978-0415479981
Reviewed by Eileen Aird

This densely argued book is a valuable addition to the body of theory available on the workplace and the nature of work. Drawing on psychoanalytic and specifically object relations theory, Levine explores the individual's capacity to do work, which involves creative potential and the factors which impair that creative capacity. His focus is not just on organisational dynamics, although he makes many interesting observations about groups and institutions, but on the way in which our internal worlds engage with the external in our work. The external here is defined both as separate reality beyond the subjective but also as created by the projections of the internal.

He argues that three internal factors – greed, guilt and the self – are significant in any consideration of the individual's experience of work. Work, he states, takes place when we form ideas. In this it both overlaps with and is differentiated from the world of play, which has more to do with the creation of fantasy. However, those who can play in the ways discussed by Winnicott, are also likely to be able to work. Although it also exists separately as the realm of ideas, not subjective fantasies, work is seen as determined in part by the material of the inner world: 'the external world of events and interactions can be understood as a setting for the enactment of dramas originating within' (p3). Being and doing come together in work, as 'being alive is the being that requires doing if it is to fulfil its promise' (p 18).

There is, however, an interesting discussion of the distinction between playing and playing a part. The assumption of a role does not have the authenticity of being which leads to the fullest exploration of creative potential at work. This does not imply that work and personal lives are identical: there are boundaries and frustrations at work which are not required in the realm of the personal.

I found two chapters particularly illuminating: chapter two, which explores Levine's concept of 'reflective

autonomy', namely the capacity to be both involved in and separate from work and colleagues; and chapter five, which analyses the fantasies at play in not-for-profit organisations.
Eileen Aird is a psychoanalytic psychotherapist and supervisor

Clients at risk of suicide

Counselling suicidal clients
Andrew Reeves
Sage 2010, £22.99
ISBN 978-1412946360
Reviewed by Jenny Bloomer

Though 'suicide' is a word quickly articulated, it also embodies a magnitude of thoughts, feelings and emotions for everyone involved. Even today, suicide is not easily discussed. Andrew Reeves writes accessibly about the subject, successfully combining a wealth of important professional issues with insightful and empathic understanding of what suicide potential can mean for both counsellor and client.

The book is divided into seven parts: Contextual aspects of working with suicide risk; The prediction-prevention model; Policy and ethics; Organisations; The client process; The counsellor process; Key aspects of counselling with suicidal clients; and finally the author's own concluding thoughts. Case studies are presented throughout, followed by thought-provoking questions that encourage deeper thinking and personal examination of beliefs and practice.

The idea that counselling is unhelpful for suicidal or self-harming clients, and that counsellors are not equipped to handle them, is challenged by Reeves as he takes the reader through history, the medical model, trends and statistics. Whilst recognising the necessity for counsellors to understand possible risk factors and the need for thorough assessment, the author asserts that 'exploration' rather than 'ticking boxes' is vital.

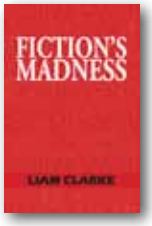
The difficulties of personal and professional ethics and confidentiality are addressed in depth and demand honest self-examination. Differences between working in organisational and private practice are focused on and counsellors are advised of the possible problems that can arise. There are useful suggestions that can help develop confidence when working with suicidal ideation. Important legal and ethical facts are presented and practical suggestions are given regarding supervision. All this valuable information can only serve to increase competence and effectiveness when working with suicidal clients.

I have worked in psychiatry as well as in private practice with suicidal people. I found it poignant and true when Reeves points out that people do not have to be mad to be suicidal and '...that assessing suicide potential fundamentally lies in engaging with the suicidal client at a deeper relational level'. So true.

This thoroughly researched book is written with passion and compassion. It will be a valuable addition to the libraries of therapists and anyone else who works with suicidal people.
Jenny Bloomer is a BACP accredited psychotherapist/ counsellor in private practice

Literature and mental health

Fiction's madness
Liam Clarke
PCCS Books 2009, £18.99
ISBN 978-1906254230
Reviewed by Kate Thompson



The apostrophe in the title is a possessive, not a contraction; Liam Clarke is an enthusiastic reader of fiction and a Reader in Mental Health. This book is a collection of essays discussing the 'madness' manifest in the protagonists of a number of works. He has made a personal selection of novels, inclining towards European 20th century literary fiction, with the addition of Shakespeare's *Richard III* and *Macbeth* (with references to *King Lear* of course).

As a champion of mental health studies, his aim is to 'initiate discussion on mental distress that would help shunt psychiatric – including psychotherapeutic – discussion away from reductionism'. Where his sympathies lie is clear (at one point he refers to the new breed of mental health practitioner currently being trained as 'band-aid' therapists).

The most successful parts of the book are those that discuss the texts themselves. Clarke here allows his knowledge of the chosen work and the history of mental health studies to structure his essays (his choice of word – rather than the more academic 'paper') and his obvious enthusiasm gives them life. There are times when the enthusiasm is perhaps over-emphasised with an excess of exclamation marks and colloquial asides. He analyses his authors, as well as their protagonists, which helps place the texts in their historical contexts, illuminating the events and ideas which are part of their construction. This makes the book accessible to readers with little or no knowledge of either literary theory or the development of psychological treatments.

Literature and mental health studies have a long relationship and various practitioners on both sides have looked to and borrowed ideas and images from the other to further their understanding of their own field. Literary theorists Terry Eagleton and Stephen Heath in the 1980s examined ideas from psychoanalysis; Neville Symington took *Anna Karenina* as a starting point for his study of narcissism. Writer Blake Morrison has long championed the work of organisations like Lapidus in using fiction and poetry as a way of healing. Liam Clarke's book is an attempt to popularise the debate and encourage more people to use their reading to inform their practice. The ample references should provide enticement to follow this intriguing multidisciplinary line of thought.
Kate Thompson is a journal therapist, counsellor and supervisor

Self-help for phobias

Coping with phobias and panic
Professor Kevin Gournay
Sheldon Press 2010, £7.99
ISBN 978-1847090799
Reviewed by Jackie Townsend

This slim volume is a self-help guide for people experiencing panic and/or phobias and is based on the principles of CBT. The first half of the book defines specific anxiety disorders, with a brief chapter on the causes of anxiety. The author then discusses treatment for anxiety, and the final section of the book is a self-help programme. Gournay uses a chatty, personal style. He avoids professional jargon, explaining any terms or theories that could be unclear, and covers the main issues in a succinct and comprehensible way.

The first half of the book covers too many anxiety disorders in too little detail. If someone is seeking to use a self-help guide, it is likely that they would already have done some research into their difficulties, and the information provided in the first half of this book may not add to their knowledge.

The self-help programme may also be of limited value. Whilst it is based on sound principles, I'm unsure if there is enough detail for someone new to the ideas of CBT to be able to follow the programme. The programme is not laid out in easy to follow stages and at times veers off to cover other related areas in a somewhat confusing way.

This book may be a very helpful starting point for someone beginning to explore their difficulties and it does contain a reference list of useful organisations and publications, although its coverage is not comprehensive. However my main criticism is that the book tries to cover too much and despite its clarity and easy-to-read style, many readers will be left with more questions than answers.
Jackie Townsend is a counsellor and trainee CBT therapist

Working creatively with traumatised children

Children and adolescents in trauma: creative therapeutic approaches
Chris Nicholson, Michael Irwin and Kedar Nath Dwivedi (eds)
Jessica Kingsley 2010, £22.99
ISBN 978-1843104377
Reviewed by Cicely Gill

This book is an exploration of creative methods used in therapeutic communities for children who have been traumatised early through neglect and abuse and placed in care. As a result of reading it, I now need to re-read Mary Shelley's *Frankenstein* (insecure attachment: violent result), Robert Graves' *Goodbye to All That* (complex post-traumatic stress disorder), and to watch Hitchcock's *Marnie* (inability to regulate affect)!

In a broadly psychodynamic approach, in part one, eight contributors describe how a child becomes traumatised, the neurological effects, the resulting insecure attachment, and a treatment model used in a particular community. Part two covers working methods: story, art therapy, working with self-harmers, and working with the roots of violence. The treatment model is set out as a very clear and detailed seven-point plan, which could be used as a baseline in other settings.

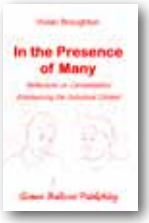
Utilising a case study, the chapter on 'story' shows us how, by extending the imagination, the child's understanding is also extended so that he absorbs a deeper, more coherent picture of how the world is in relation to himself. In the two chapters on self-harmers, we look at self-harm as an initiation rite and a recuperative, re-experiencing of abuse with a modicum of control. We see how art therapy (paper equals skin, paint equals blood) can act as an alternative place for expression, a stepping stone to recovery. Another study shows a violent boy whose 'porcupine' pencil holder becomes, over the weeks, a 'muddy mixture' and then finishes as a flat disc with a yellow smile painted on.

Lest you imagine it's all easy, the importance of the community rules are stressed: how everyone is compassionately contained and kept safe; how every aspect of day-to-day functioning must support the work. For the children whose lives have been chaotic, great skill is required to help them settle and trust in the community, to eat meals (they may not be used to that) and to sleep at night (that may have been when they were abused). The book emphasises the courage, skill and stamina of the workers, and the support they need to carry on day after day and often night after night.

A worthwhile read for all counselling practitioners and a very useful overview for those starting out.
Cicely Gill is a counsellor

Working with systemic constellations

In the presence of many: reflections on constellations emphasising the individual context
Vivian Broughton
Green Balloon Publishing
2010, £17.95
ISBN 978-0955968310
Reviewed by Anne Gilbert



The system known as 'systemic constellations' was developed by Bert Hellinger in post-war Germany as a therapeutic approach to working with individuals, couples and organisations. When working with groups, Hellinger used representatives to stand in for members of the client's family. Unlike psychodrama, where participants are briefed on their roles, Hellinger preferred to work in a more existential and phenomenological way, by allowing the representatives to be in tune with their role at a much deeper level, and treating any data they reported as a useful part of the constellation that was created. Whilst not strictly psychotherapy, the approach offers much that is of interest to counsellors and

psychotherapists. Broughton's book offers a comprehensive introduction to the topic.

The book is divided into two parts. Part one, 'Reflections on the work of constellations', explores the underlying philosophy, concepts and theoretical discussion. I was fascinated by chapter five, 'Entanglement and trauma', which presents constellations theory on trauma, and poses many questions about the transmission of trans-generational trauma, a topic neglected in psychotherapy literature.

The second part, 'The individual context', provides an innovative insight into how the concepts explored in part one may be integrated into work with individuals, couples, and small groups and also into supervision. Both sections contain plentiful practical examples of work undertaken by the author which bring the theory to life, and which illustrate the parameters of the approach.

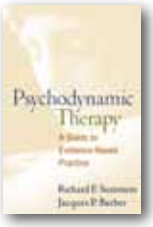
I was also very interested in one of the appendices that explores similarities and differences between psychotherapy and constellations. It is clear that constellations work can be a powerful therapeutic tool that challenges the traditional psychotherapeutic notion that clients need a regular weekly session to achieve effective therapeutic outcomes.

This is an easy-to-read and well researched book of huge interest to therapists who work in creative and experimental ways, and who might be encouraged to incorporate some of its ideas into their work. It also makes a very valuable contribution to the current literature on trauma, particularly trans-generational trauma.

Anne Gilbert is a Gestalt psychotherapist

Psychodynamic theory in action

Psychodynamic therapy: a guide to evidence-based practice
Richard F Summers and Jacques P Barber
Guilford Press 2009, £27.00
ISBN 978-1606234433
Reviewed by Els van Ooijen



The authors' combined wealth of practical experience with clients, students and research has led to the development of a useful model for practitioners, trainers and students. Refreshingly they admit that this model is rather different from the more traditional form of psychodynamic therapy in which they were trained.

The book is clearly structured in four parts. Part one includes a discussion of past and current models of therapy, including CBT. Next the concepts and techniques of 'pragmatic psychodynamic psychotherapy' (PPP) are introduced by means of a case study. PPP involves clear diagnosis and case formulation, which is shared with the client and used to agree a focus for the work. Rather than the traditional 'blank screen', an active, warm and engaged way of working is advocated. This is similar to the relational and intersubjective approaches to psychoanalysis advocated by writers such as Mitchell and Aron,[1] and Stolorow and Atwood.[2] The authors' stress on the importance of a collaborative approach is also reminiscent of CBT. Part two offers practical guidance on the building of a good therapeutic alliance, followed by a detailed discussion of core problems, case formulation, focusing and goal setting. In part three the authors deal with the middle phase of therapy, including the facilitation of 'change'. Part four discusses the importance of giving due consideration to the planning and experience of endings. Where available, evidence is offered for the effectiveness of psychodynamic therapy, other therapies and drug treatment.

However, I have two quibbles: the American use of the words 'diagnosis' and 'treatment', and the authors' apparent lack of familiarity with approaches other than psychodynamic therapy and CBT. They appear unaware of models that integrate psychodynamic therapy with humanistic and/or cognitive behavioural approaches. This is a pity, as aspects of PPP might be very useful for those of us who work integratively. I enjoyed this book. It is clearly laid out, the style is very readable and jargon is kept to a minimum. Its real strength, however, lies in the many case examples, which make the PPP model easy to engage with, as the authors demonstrate how psychodynamic therapy can be practised. Overall the authors' aim to create a concise and focused model of psychodynamic therapy has been achieved. They have managed to lift the veil of mystique that sometimes lies over psychodynamic therapy and have written a very useful book for practitioners, students and trainers alike.

Dr Els van Ooijen is a psychotherapist and supervisor

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From the Chair

This is the first of what will be a regular feature in *Therapy Today*. In each issue I will offer a Chair's update covering a range of topics, including contemporary issues and events in the field, and comments on BACP and Board activity.

In May the Health Professions Council (HPC) reconvened its Professional Liaison Group (PLG) to agree its workplan for 2010. As part of its work the PLG will invite further evidence to inform its recommendations on statutory regulation from a range of groups, including a wider representation of the client/patient/public voice. Key issues around levels of entry to the register and differentiation between counselling and psychotherapy do continue. That said, there is useful work underway between leading UK professional associations, including BACP, UKCP and BPC (British Psychoanalytic Council) to develop a model for counsellor and psychotherapist regulation that seeks to best represent the complex counselling and psychotherapy training and practice field.

Following the recent General Election, we have not detected any deviation from the former Labour Government's intention to bring counselling and psychotherapy into statutory regulation. Indeed, in a recent statement, Anne Milton, present Parliamentary Under Secretary for Health (with a brief for regulation) stated that '...professions wanting to achieve the highest standards will welcome proper regulation' (Integrated Health Care House of Commons debate, 2/6/2010). The former Government's 2007 White Paper, *Trust, Assurance and Safety*, identified the HPC as the regulator for counsellors and psychotherapists.

BACP, along with other professional associations and groups, has lobbied the HPC to deliver a regulatory framework for counselling and psychotherapy that is fit for the profession. With HPC revising its generic statements to accommodate professions that are not based in biological/physiological health, and in view of its proactive engagement with the professional associations and others to produce a regulatory framework that is fit for counselling and psychotherapy, there is clear evidence of its willingness to work positively with the profession.

As part of scoping HPC recommendations for statutory regulation, the Department of Health will scope alternative regulatory models. There are several models of regulation that have been identified as possible alternatives, should HPC regulation of the profession not proceed. Whilst BACP anticipates that HPC will continue to be the Government's chosen regulator for counselling and psychotherapy, should regulation by HPC not happen, it would be important for BACP to have a considered view of the alternatives.

We have begun looking at other forms of regulation and alternative approaches to professional accountability – including those in operation in Europe, the US and Canada. At the July Board of Governors meeting, the Board discussed ways of engaging members in these ongoing regulatory debates and developments and we will update you on this in the September Chair's column – and earlier than that on the BACP website. We will continue to keep you informed on other regulatory matters through the Chair's column in *Therapy Today*, the BACP website and in dialogue at the member events across the four Home Countries.

Lynne Gabriel
BACP Chair

BACP awards 2010

As reported in May's *Therapy Today*, if you would like to make an application for this year's BACP Counselling and Psychotherapy awards, please note that the deadline is 30 July 2010. For further information about the award categories or to download an application form, visit www.bacp.co.uk/awards or email awards@bacp.co.uk

AUCC Guidelines new edition

A new edition of the *AUCC Guidelines for University and College Counselling* has now been published (June 2010), and is an essential reference document for all practitioners working within a university or college setting.

The guidelines have been designed to outline: the role of the counselling service in further and higher education; the activities undertaken by counsellors in such institutions; and the working structures required to maintain good practice.

Copies are available to purchase at a price of £6.50 per copy for BACP members and £8 for non-members. To place your order, please contact the BACP Customer Services team on 01455 883300 or visit the online bookshop (www.bacp.co.uk/shop).

APSCC launches new website

The Association for Pastoral and Spiritual Care and Counselling (APSCC) has launched its new website (www.apscc.org.uk).

The website has news about APSCC, spirituality and counselling, conferences and journals. There is also a growing members' section with more information and links. Do pay it a visit!

Chris Jenkins
APSCC Chair

Policy and public affairs

Following the general election, Minister of State for Health, Paul Burstow MP, has been confirmed as being responsible for the mental health portfolio. Paul is Liberal Democrat MP for Sutton and Cheam, and since 1999 has worked on the older people's brief and has a special interest in social care and disability issues. Anne Milton, the Conservative MP for Guildford, who previously held the mental health brief in opposition, was given a junior ministerial role at the Department of Health, which includes responsibility for professional regulation. BACP has written to both ministers welcoming them to their posts.

The Coalition Government has produced its *Programme for Government*, which states: 'The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strategy to prevent ill health which harnesses innovative techniques to help people take responsibility for their own health.' It also makes a specific commitment to 'ensure greater access to talking therapies to reduce long-term costs for the NHS'.

Speaking about psychological therapies, in response to a survey by the charity Mind on the recession leading to an increase in work-related stress, Health Secretary Andrew Lansley said: 'The recession has left many people facing tough times. Getting the right support for those grappling with the health effect is critical to the country's recovery.

'Psychological therapies, which can be offered alongside medication, provide choice for patients. But over a quarter of local health trusts don't yet have services in place. We want to provide better access to psychological therapies and we will also look at how employers can better access support for their staff.'

A new Psychological Therapy Services strategy has been launched for Northern Ireland, which will benefit hundreds of people, Health Minister Michael McGimpsey has said. The strategy will include talking therapies, such as cognitive behavioural therapy, counselling, family support and psychoanalytic therapies. The strategy also recognises the benefits of relevant therapies in the treatment of particular illnesses and conditions, and covers a range of therapies for children, adolescents, adults and families. It emphasises the need for user-focused services which promote a recovery ethos. It also sets out how services should be developed over the next five years, the standards which will underpin service delivery and the qualifications therapists must have.

BACP responded to the Department for Children, Schools and Families consultation on 'Teenage pregnancy strategy: beyond 2010'. BACP emphasised that counsellors can provide early support for children and young people most at risk, in matters relating to sexual health, and wider support with personal skills and in building ambitions to stay on a path to success.

The Health Professions Council consulted on an amendment to the standards of proficiency for health psychologists. BACP supported the removal of the phrase '...including the use of cognitive behavioural therapy...' from the standards of proficiency for health psychologists.

For further details, please email policy@bacp.co.uk

Are you interested in joining the BACP Coaching division?

If you would like to join our new division, BACP Coaching, please visit the website www.bacpcoaching.co.uk/join.php or contact our Customer Services department on 01455 883300.

We are looking for members to get involved in organising networking/learning events for local therapists/coaches in Scotland, Northern Ireland, North East, North West, Yorkshire and the Humber, E Midlands, W Midlands, Wales, East of England, London, South East and South West, as well as sourcing presenters for seminars, workshops and conferences; setting up a new online BACP Coaching magazine/newsletter; writing coaching articles, book reviews or website copy; debates around research, coaching ethics, standards or supervision. If you are interested, please email linda.aspey@bacp.co.uk

Board of Governor Elections 2010

In line with Standing Order 8.2, nominations had to be submitted to the Company Secretary by 5pm on Monday, 7 June 2010.

The final nomination field as at 15 June 2010 is one nomination for the post of Deputy Chair, two nominations from Governors who wished to stand for re-election under Article 32, and one further nomination for a seat on the Board.

Therefore, as there is no contest for any of the vacancies, there is no need for a membership ballot. In accordance with Standing Order 8.2 the name of the Deputy Chair, new Governor and re-elected Governors will be announced at the Association's Annual General Meeting on 15 November 2010.

Laurie Clarke
Company Secretary/Chief Executive

My first experience of the annual Research Conference

As the new Research Facilitator for BACP, I was invited to attend the Annual Research Conference prior to beginning my new role. I was delighted to take the opportunity to learn more about current issues in counselling and psychotherapy research and the kind of research being undertaken at the moment, and of course to meet my new colleagues.

I arrived on the Thursday evening in time to attend John McLeod's workshop on 'Exploring the utility of systematic case studies in counselling and psychotherapy research'. Coming from a psychology background, the format of this workshop was an entirely new experience for me and was particularly enjoyable as it allowed the opportunity to discuss personal experiences, thoughts and beliefs with other delegates. Other conferences I have attended have sometimes been intimidating, particularly to students, whereas the workshop format created the chance to meet people prior to the conference the following day, which for me enhanced the whole experience.

The workshop challenged people's ideas regarding the use of case studies in counselling and psychotherapy research. I found it really interesting to note that the main barriers to this approach came from practitioners, rather than clients, and this was a theme I noticed throughout the conference. My background is as a researcher in psychology, so for me the importance of research to inform practice is essential. It was really rewarding to discuss my views with those of other delegates and gain insight into why there are concerns over gathering data for the purposes of research during therapeutic sessions with clients. Although I perceived barriers towards research, I was encouraged to hear from the majority of people I spoke to that they felt research was important in their practice.

I attended many presentations over the course of the conference, all of which I found interesting. However, there were some that really stood out in terms of establishing a research-based practice. The first of these was a 60-minute workshop with Sue Wheeler and Julie Folkes-Skinner on 'Setting up a counselling research clinic'. I was curious from this title as to what exactly this would entail, as my experience of research clinics has been to support students in how to conduct complex statistical analyses. I was intrigued to learn that this research clinic was actually a counselling service where all therapists and clients have agreed to participate in research. This is a fantastic concept and the development of this clinic alongside the implementation of similar clinics across the country could really impact on research-based practice.

I was similarly impressed by Maria Bowens' presentation on the 'Development of a client feedback tool – stage one: a qualitative study of therapists' dilemmas'. The idea of client preferences being utilised in developing the most appropriate mode of therapy was enlightening and is something that I feel ought to apply in all therapeutic settings. Gathering this kind of information on a large scale could be very useful to practitioners in developing an idea of whether there are groups of clients who have similar preferences, either in terms of their presenting problem, or their age group or gender, which could be a useful tool for determining the most appropriate mode of therapy.

Overall, the conference was a fantastic experience and a great initiation into my new job. I came away feeling really excited about the kinds of research projects I would be getting involved in and the opportunity to develop high quality research in counselling and psychotherapy that could be used to make a difference in practice. What struck me most was the enthusiasm, not only of the speakers, but also the delegates. Everybody appeared to really care about what they did and were keen to begin to develop evidence, through research, for the therapy they practise. I look forward to being a part of this and to next year's conference in Liverpool.

Jo Pybis currently works at BACP on Mondays and Tuesdays, and will start full time once she completes her PhD at the end of the summer.

BACP's 2011 Annual Research Conference

BACP's 17th Annual Research Conference 'Research and Practice' will be held next year in Liverpool. We are delighted to welcome the Society for Psychotherapy Research (SPR) as the co-host for this event.

Submissions from SPR members are encouraged, along with abstracts for papers, workshops, symposia and posters from anyone involved in research into counselling and psychotherapy.

The submission deadline is 19 November 2010, and all submissions will be subject to blind peer review. Forms and further information can be found on the BACP website (please visit www.bacp.co.uk/research/conf2011/).

2011 *CPR* new researcher prize

Are you currently doing research for your degree? Or have you completed a research project within the last 24 months? Submissions are invited for the 2011 *CPR* new researcher prize, and the deadline is 10 December 2010.

Please visit the website www.tandf.co.uk/journals/pdf/rcpr_new_researcher_2009.pdf for further information. The winner will receive £200 in Taylor & Francis book tokens and £200 in cash.

Research clinic at Metanoia

The Metanoia Institute has set up a research clinic using its existing clinical services, which both practitioners and clients are enthusiastic about taking part in

The idea for the research clinic at the Metanoia Institute started in the context of running our existing clinical services. Our low-cost clinic (MCPS – the Metanoia Counselling and Psychotherapy Service) has been established for nearly 15 years providing a service to the local community and placements for our students.

We first started to monitor the effectiveness of practice within the clinic in 1988, using the early versions of the Core system. The data provided interesting feedback to our academic committees and the students had an opportunity to learn to evaluate their practice.

We accumulated a large database over the years, but the quality of data varied. Clients dropped out of sessions, students sometimes struggled with using the forms and they were often left incomplete. However, the IAPT initiative, challenges of NICE guidelines and the process of statutory registration provided additional motivation for all involved to demonstrate the effectiveness of integrative psychotherapy and the humanistic approaches we teach at Metanoia Institute (transactional analysis (TA), Gestalt, and person-centred). It became apparent that the clinic provided a resource for research and a potential to offer a contribution to the profession.

The existing research clinics at the Strathclyde and Abertay universities provided inspiration and encouragement to contribute to what is gradually becoming a network of research clinics within the UK. John and Julia McLeod generously shared some of their experiences at Abertay University with me: what worked, how clients responded to bundles of questionnaires, when to give them out, etc. John McLeod shared his research protocol which inspired the structure and measurements we decided to use at MCPS.

In 2008 we were part funded by the Ealing PCT to set up a research clinic within GP practices, at multiple sites, as a part of their Well Being service. This became the first stage of our research clinic.

A research clinic within the PCT

The aim of this project was to evaluate effectiveness of TA and integrative approaches in time-limited counselling in GP surgeries. We were funded to offer the service to 90 clients within the research clinic. The project started in 2008 and is now in the last stages of reaching the required client numbers. Patients taking part in the research reflect the routine GP assessment practice, and therefore represent the actual population within this area.

Practitioners are senior counselling and psychotherapy students using TA and integrative theoretical approaches. Both of these approaches are relational, non-manualised treatments. So, how could we show that therapists were adhering to them? To answer this question we devised 'adherence' questionnaires for each of the orientations, using the defined core skills, theoretical knowledge and attitudes used to assess students within their training at the Metanoia Institute. The adherence to the theoretical approach is then assessed in supervision on the basis of sessional recordings and supervision discussions.

In order to evaluate the effectiveness of practice we decided to use a number of different measures.

Pre and post measures show the overall impact of treatment and we decided to use Beck's Depression Inventory (BDI) and CORE 34 at the beginning and at the end of therapy.

In order to show the impact of individual sessions as well as clients' process during the week, we decided to use the following measures after each session: Patient Health Questionnaire (PHQ-9), General Anxiety Measure (GAD -7) and CORE 10.

Therapeutic relationship, as an essential component of both approaches, is evaluated using the Working Alliance Inventory (WAI) at each session.

What next?

The early outcomes at this stage are positive and interesting. They show that both practitioners and clients can engage in evaluation of practice and even be enthusiastic about it! We have a high rate of compliance from clients with the measurements, and the data will give us enough information to analyse and publish.

Based on this experience we are now planning to expand the research clinic to cover the whole of the service at MCPS, which currently numbers 72 practitioners, and all the theoretical orientations practised here. This will give us an opportunity to develop an insight into the effectiveness of integrative, TA, Gestalt and person-centred psychotherapies and counselling in a medium-term setting (six months to a year), publish regular reports and compare our findings with other research clinics. We hope that it will also raise interesting questions and debates about how we work and teach, as well as meet the statutory requirements of evaluation.

Dr Biljana van Rijn is head of clinical services at the Metanoia Institute, London. For further information about the research clinic, please email biljana.vanrijn@metanoia.ac.uk

Training counsellors and psychotherapists in research skills: a manual of resources

Training in counselling and psychotherapy has not always included a substantial syllabus in research methods, nor have research skills featured significantly. In recent years, the demand for evidence-based practice, service evaluation and the political imperative to collect practice-based evidence have grown, together with a shift towards training being provided or validated by higher education institutions.

For these reasons, the general shape of counselling and psychotherapy curricula is changing. If research is to be routinely taught in counselling and psychotherapy training courses, the lecturers and trainers need to ensure that they are competent in research methods and understanding research themselves.

In 2007, having recognised the need for staff development to equip therapy trainers to feel more confident and competent at teaching research methods, BACP, in association with the University of Leicester, was successful in a bid for funding from the Research Development Initiative programme, sponsored by the ESRC. There were five elements to the project that was undertaken: one-day workshops to introduce research in the core curriculum for counselling and psychotherapy; a summer school to enable lecturers and trainers to enhance their skills in teaching research methods; a website publicising research methods training opportunities; and a research methods training resource manual, with an accompanying DVD containing PowerPoint presentations and other materials.

This manual contains a wide range of research training resources that can be used for teaching counsellors and psychotherapists. There are lectures, PowerPoint presentations, information handouts and leaflets and experiential exercises. Some of these resources may be used in routine counsellor and psychotherapist training sessions and others specifically for research methods training. The manual is organised in 11 sections, each with a different theme. It is not designed to be a specific course in research methods. It is not a comprehensive guide to all possible research methods, but reflects the interests and expertise of the authors. It is not expected that trainers will use all of the materials. A broad range of materials is provided to enable course tutors to design their own syllabus and choose from the resources provided as appropriate.

While much of the material has the academic level of a master's degree in mind, many of the resources have wide applicability, from doctoral study to undergraduate level. The manual takes an experiential approach to research training, encouraging students to learn by doing rather than by listening. It is also firmly rooted in the belief that all counsellors and psychotherapists need to understand and be involved with research in some way.

This manual is a tool for empowering trainers and students to enter into the world of research, demystifying it and going past pre-existing stereotypes of emotional disengagement and white coats. We hope to help trainers and students to discover for themselves, first-hand, that research can be as exciting (and scary) as practice, and that the best research is not so very different from practice.

This manual will be an essential teaching aid and contains the work of established figures in the counselling and psychotherapy field, including Professor Sue Wheeler, Dr Kaye Richards, Professor John McLeod and Professor Robert Elliott.

This training resource will be available shortly. If you are interested in the manual, and would like to be placed on the mailing list, please email jack.rogers@bacp.co.uk

Shift from 'counsellor' to 'counselling researcher'

A new study by Ann Dalzell and colleagues published in *Counselling and Psychotherapy Research* (*CPR*), and presented at the BACP research conference this year, suggests that a new approach to counsellor training can implement an important shift from 'counsellor' to 'counselling researcher'. High quality research in counselling and psychotherapy is becoming more important in order to inform practice and improve counselling services. Therefore, the need to train new counsellors in the skills of conducting research is paramount.

However, it is not always clear how the practice of conducting research 'fits' with the practice of counselling. Dalzell and colleagues suggest counsellors often use and are taught using creative and imaginative techniques. Therefore, to encourage counsellors to conduct research and to think like researchers, emphasis ought to be given to more creative research methodologies, which can complement traditional approaches. The importance firstly ought to be to engage counsellors in the process and benefits of conducting research. The use of creative approaches could be one way to aid this.

In their paper Dalzell and colleagues use collective biography practices to create data that could be used in research. Collective biography practices require participants to retrieve memories and use those memories to create data that can be analysed. The authors of this paper went through a process of story-telling, listening, responding critically, writing and re-telling

stories specifically around the theme of becoming a counselling researcher. Through a process of challenging explanations, the authors were able to explore the collective biographies in order to uncover 'discursive imperatives at play'.

From individual stories, which were challenged and reconsidered, the authors developed a collective biography of commonalities observed in their individual stories regarding their experience of moving from 'counsellor' to 'counselling researcher'. The process of telling and re-telling stories to form one collective voice was by itself a form of data analysis.

The authors state how the process not only led to new ways of understanding how to research but also created new and deeper meanings for them as individuals and as a collective. By researching in this way the authors were able to move easily between being counsellors and being counselling researchers.

Dalzell and colleagues advocate if used carefully, and with attention to ethical issues, collective biography practices could readily feature in counselling practice. The ability to refrain from rules on 'how to do research' allowed the authors to embrace this new approach.

The authors propose counselling courses ought to make room for creative research methodologies. Research training ought to be integrated into the heart of most counselling training courses in order for new practitioners to see themselves not just as counsellors but also as counselling researchers. If research is simply a 'bolt on' to training, then it is easy for many newly qualified counsellors to leave training and not see themselves as researchers and practitioners.

More creative approaches to research methods could help counsellors become counselling researchers. As engagement with personal histories is at the heart of therapeutic work with clients, the authors state that there is a place for collective biography within core modules of counselling training courses. In this way, many counselling students who may otherwise feel intimidated, or perhaps even uninterested in conducting research, may embrace this type of approach through which they may come to embrace more traditional research methods.

The take home message from this paper is the benefit of using more creative approaches to engage counselling students in research. Although research is taught with more emphasis in counselling courses than in the past, many practitioners do not see themselves as researchers, often believing research to be separate to their therapeutic practice. Research is an integral part of evidence-based practice, used to inform practice and change policy. Thus, if counsellors and psychotherapists do not begin to incorporate research into their practice as standard, they may fall short, compared to other disciplines (eg psychology) and find it more difficult to provide evidence for the benefits of the services they offer.

Training students not only as counsellors but as counselling researchers can only be of benefit to the practice of counselling as a whole, particularly as this paper comes at a time when the importance of developing counselling and psychotherapy as evidence-based practices is becoming more important.

BACP Professional Conduct Hearing

Findings, decision and sanction

Relate Basingstoke & District
Reference No 108440
Basingstoke RG21 4AF

The complaint against the above organisation was taken to adjudication in line with the Professional Conduct Procedure.

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

The focus of the complaint, as summarised by the Pre-Hearing Assessment Panel, is that the complainant, a counsellor in training at Relate Basingstoke, allegedly experienced specific problems with a supervisor there; he alleged that Relate Basingstoke failed to provide adequate and appropriate supervision; and that the supervision allegedly promoted and encouraged unethical practice. Further, the complainant alleged that when he attempted to deal with these problems by raising his concerns with Relate Basingstoke, the organisation failed to respond satisfactorily and appropriately to his concerns. The complainant alleged that Relate Basingstoke did not provide a formal complaints procedure, which led to frustration of his alleged attempts to raise a formal complaint.

In accepting this complaint, the Pre-Hearing Assessment Panel was concerned in particular with the following areas:

- Relate Basingstoke allegedly did not respond appropriately to the concerns raised by the complainant and refer him to a formal complaints procedure or other formal means of addressing his concerns
- Relate Basingstoke allegedly did not make available or did not adequately communicate to the complainant any formal complaints/grievance procedure which applied to him as a trainee counsellor on placement
- The alleged actions and behaviours of Relate Basingstoke, as described by the complainant, suggested a contravention in particular of paragraph 33 of the BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy.*

Findings

On balance, having fully considered the above, the Panel made the following findings:

- The complainant had two informal meetings with the agency manager, at which he stated that he raised various concerns about the quality of his supervision. No notes were made of these meetings by the manager. There was some dispute as to whether the complainant had raised his concerns; nevertheless, an email sent from the complainant to the manager made reference to the fact that his 'serious issues

about supervision' had been raised 'informally in discussions over the past few months' with the agency manager

- The complainant raised his concerns directly with his supervisor but remained dissatisfied. Relate Basingstoke did nothing to resolve the difficulties in supervision other than referring the complainant back to his supervisor
- The agency failed to inform the complainant about concerns expressed by the supervisor about some aspects of the complainant's response to supervision
- At his End of Placement Interview, the complainant was as 'open and honest' as he could be regarding his concerns around the supervision, when the subject was raised by the End of Placement Panel, adding that he and his supervisor were working at improving their relationship. The Professional Conduct Panel did not consider such an interview an easy or appropriate place for the complainant to reveal more detailed concerns about the perceived quality of the supervision
- Concerned about his approach and the use of supervision, the End of Placement Panel offered the complainant a six-month trial period as a volunteer at the centre
- The complainant wrote, expressing his concern about the offer of a 'trial' period; that he was expected to continue in supervision with the same supervisor; that he found this difficult when he had raised what he considered to be ethical issues about the supervision which had not been addressed; that the onus appeared to be entirely on him to resolve the issues of/in supervision; and that he was required to 'trust their [supervisor's] judgement and advice'. Furthermore, that the offer of a six-month trial period meant that he would fall short of a small number of hours (approximately 30 of the total of 240) required to become a qualified Relate counsellor
- There was ongoing correspondence on the matters raised but to no avail, resulting in a letter of resignation from the complainant accompanied by a detailed report of the ethical concerns raised in supervision, as experienced by the complainant
- Relate Basingstoke made assumptions about the complainant's references to 'unethical' practice, and did not make any further enquiries of him to establish precisely what these were or what steps he should take to have his concerns addressed. Unbeknown to the complainant, the agency was seeking to address the concerns with others, but this was never communicated to him. The agency admitted that it would have been appropriate to have communicated these ongoing discussions with the complainant at the time and to have kept him informed
- Relate Basingstoke did not offer the complainant any opportunity to detail his ethical concerns, and/or have them considered, either informally or formally. Whether or not his concerns had any substance, they should have been addressed, by making further enquiries of him
- In his letter of resignation, the complainant listed in detail nine concerns that he believed to be unethical issues. While some of the concerns listed were considered by the Panel to be allegations of questionable remarks rather than unethical issues, there was, nevertheless, sufficient reason to enquire further into the allegations made. There was no attempt by Relate Basingstoke to do this with the complainant
- While the complainant's letter of resignation was acknowledged in writing, the allegations of unethical practice were neither acknowledged nor referred to
- There was some confusion about the right channel for making a formal complaint by a student who had completed a course and was not yet formally accepted as a volunteer. Nevertheless, there was at the time no formal grievance procedure for volunteers in the agency, and information about complaints to the national body were not spelled out specifically in the agency's literature; nor was it mentioned to the complainant by anyone from Relate Basingstoke at any time
- Dissatisfied that he had not received any response from Relate Basingstoke to his complaints, the complainant forwarded his complaint to the national body. As a result, Relate Basingstoke terminated his training placement earlier than scheduled and refused to allow him to complete the period of ending with a client on the grounds that his complaint had breached the confidentiality of a third party. The Panel could find no breach of confidentiality in his letter of complaint and decided therefore that this action was ill-advised and unnecessary in the circumstances
- There was insufficient attention given by Relate Basingstoke to promote good working relationships and communication between the parties concerned, as evidenced in some of the findings above
- It was confirmed that there were no particular concerns about the complainant in his counselling practice, only about his response to the particular supervision offered. Nevertheless, the lack of response to his concerns and/or to offer any other opportunity for him to complete his required number of client contact hours, eventually frustrated his ability to qualify as a counsellor
- As a result of these events, Relate Basingstoke has now produced a draft grievance procedure for volunteers, which was due to be approved imminently. The agency admitted that this complaint process had revealed a need for such a procedure
- Accordingly, the Panel found that:

i. Relate Basingstoke did not respond appropriately to the concerns raised by the complainant, nor refer him to a formal complaints procedure or other formal means of addressing his concerns

ii. Relate Basingstoke did not make available or adequately communicate to the complainant any formal complaints/grievance procedure which applied to him as a trainee counsellor on placement

iii. Relate Basingstoke did not respond promptly or

appropriately to the complaints received from the complainant.

Decision
Accordingly, the Panel was unanimous in its decision that these findings amounted to professional malpractice, on the grounds that Relate Basingstoke did not adequately or appropriately manage the complainant's grievances.

Sanction
Accordingly, the Panel imposed the following sanction.

Relate Basingstoke must submit a copy of its Grievance Procedure, when approved by the Trustees, together with evidence of how it will be disseminated to volunteers (and any others to whom it applies) within the agency. Furthermore, Relate Basingstoke must also submit a report in which it demonstrates its learning from the issues raised in this case, and its understanding of the effect that the lack of communication and response had upon the complainant.

The report must be submitted to the head of professional conduct within three months of the date of imposition of this sanction and will be considered in full by a Sanction Panel.

Sanction compliance
Samantha Gray
Reference No 601765
London W6

BACP has received reports that verify the requirements of the sanction reported in *Therapy Today* (October 2009) have been met. Thus, the sanction has been lifted. The case is now closed.

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

Newly accredited counsellors/ psychotherapists
We would like to congratulate the following members on achieving their BACP accredited status:

Marie Adams
Jocelyn Ashton
Violet Baker
Jane Balls
Sophia Barton
Clare Bate
Claire Bessant
Herginder Bhangoo
Nerma Biscevic
Rebecca Black
Christine Bonsmann
Virginia Bowley
Lesley Brewerton
Peter Burgess
Jessica Calvo
Pamela Collins
Fiona Cook
Hanya Czepkowski
Helen Daly
Myriam Day
Traci De Marco
Jo De Vries
Anne Devine
Sandy Doyland
Gillian Evans
Sally Fisher
Diane Frewin
Amanda Georgiou
Gerard Gillespie
Allan Gois
Rochelle Gould
Andrea Grahame
Charlotte Harding
Guy Harrison
Marianne Hewson
Darlene Hughes
Luitgard Hunter
Leonie James
Heather Janakiraman
Trinder Jaspal
Sue Jeppesen
Taj Kaur
Stefan Kelly
Jane Kill
Kathryn Kinmond
Patricia Lamb
Susan Lees
Barbara Lewis
Susan Lewis
Aifat Mahmood
Carole Mandeville
Parveen Marrington-Mir
Teresa McAllister
Eilis McFadden
Lauren McWhirter
Anna Miles
Linda Miles
Janet Neal
Kathleen Nisbet
Julie Parker
Gill Pascoe
Magdalena Powell
Margaret Preston
Sharon Ramsden
Jo Ridley
Jill Ross
Jean Rowan
Lindsay Schofield
Julie Scott
Robert Smith
Robert Sookhan
Tricia St Clair
Andrew Treacher
Epameinondas Triantopoulos
Penny West
Melissa Whitelaw
Jane Whitman
Colin Williams
Evette Williams-Beckford
Susan Wintgens
Sally Wood
Catriona Wrottesley
Kathryn Zimmer

Newly accredited counselling/psychotherapy supervisor of individuals
Helen Lill

Newly accredited counselling/psychotherapy services
University of Reading 'Time to Talk'
The What? Centre
Mind in Barnet

Successful counselling/ psychotherapy service re-accreditations
Croydon Pastoral Foundation (CPF)
Hertfordshire & Bedfordshire Counselling Foundation (HBCF)
Relate Leicestershire
Relate Greater Manchester North (GMN)
Wimbledon Guild

Members whose accreditation has been reinstated
Salwa Ibrahim
Mahnaz Razavi
Howard Straughen-Simpson
Foluké Taylor Muhammad

Members not renewing accreditation
Whether it is through retirement, illness or perhaps moving on to a different career, we would like to thank the following for their contribution, to offer our good wishes for the future, and to confirm that they may no longer describe or advertise themselves as BACP accredited members:

Robert Berzins
John Brazier
Sue Brown
John Dagleish
Pat de Sylva
Beryl Hopkins
J Alison Jones
Caroline Kennedy
Kathryn Key
Joy Lovelock
Pat McMinnies
Anthony Morrison
Matis Nimetz
Ian Osler
Jacqueline Price
John Price
Eileen Regan
Carolyn Rushforth
Pamela Saunders-Ward
Sara Scott
Hilary Shaw
Peter Slater
Cherry Stainforth
Sandra Stellavato
Kirsten Toland
Myrna Van Der Zee

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

Applying for accreditation: using the *Ethical Framework*

In the sixth of our series of guidance articles about completing the accreditation application form, assessor *Patience O'Neill* considers the use of the *Ethical Framework*

Let's imagine that you are halfway through compiling your application for accreditation. Perhaps you have already completed the 8.1 section. You are contemplating the requirements for the 8.2 section – Practice – in which you present case material that provides an example of your work as a practitioner.

Criterion 8.2.4, 'Use of the BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy*', is one of the four elements within the 8.2 Practice section. Here is the first opportunity within the application to comment on how your practice is informed by ethical awareness. At the beginning of the application form, there is the benchmark statement: 'Standard for Accreditation – to demonstrate the capacity for independent, competent, ethical practice', against which the whole application is measured. Then, for criterion 1, you confirm your membership of BACP, and so your agreement with the *Ethical Framework*. So you are reminded of the *Ethical Framework* from the start.

As we know, the *Ethical Framework* provides a set of principles and guidance on good practice, recently updated. It replaced a Code of Conduct which set out 'rules'. As practitioners we now take on the responsibility of interpreting these principles within our own practice, which is perhaps more of a challenge than it first appears.

So, to meet criterion 8.2.4, what are you being asked for? To provide relevant and specific examples of your use of the *Ethical Framework*, as part of the case material which you are presenting for section 8.2. In other words, you need to identify the ways in which your case material is informed by the principles and guidance given in the *Ethical Framework*, and to refer to these in the case material. Given the breadth of the *Ethical Framework*, you are in effect providing a snapshot of your own ethical practice by giving specific case examples.

Here are some signposts to typical themes:

- The client group or groups with whom you work are likely to link with specific principles and guidance points. For example, young people, vulnerable clients, clients at risk to themselves, therapeutic family or group work. If you work with young people, for example, it is important that you make clear your understanding of the relevant *Ethical Framework*, guidance point 15, for example, in your case material

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- The context in which you work is likely to link to specific principles and guidance points. For example, accessibility of the counselling provision, the way contracting is conducted, how confidentiality is managed, if a team approach is involved, how the integrity of the counselling is maintained
- The principles and personal moral qualities, and the relational dimension of your therapeutic work. For example, competence, respect and keeping trust.

In other words, there are many aspects of the *Ethical Framework* that relate to a piece of case material. So, your task is to select specific examples which you think are the most relevant and best illustrate your own ethical awareness. Most importantly, you need to include the key principles and guidance points that relate to your particular client groups, to show that you are competent to work with those kinds of clients.

To help with preparation for counsellor accreditation, BACP organises workshops and surgeries around the UK. Workshops cover all application criteria. Surgeries are short, individual sessions, appropriate for people who are concerned about one or two particular criteria. They are popular, so early booking for either is advised. For further details, please visit www.bacp.co.uk or call our Customer Services department on 01455 883300.

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