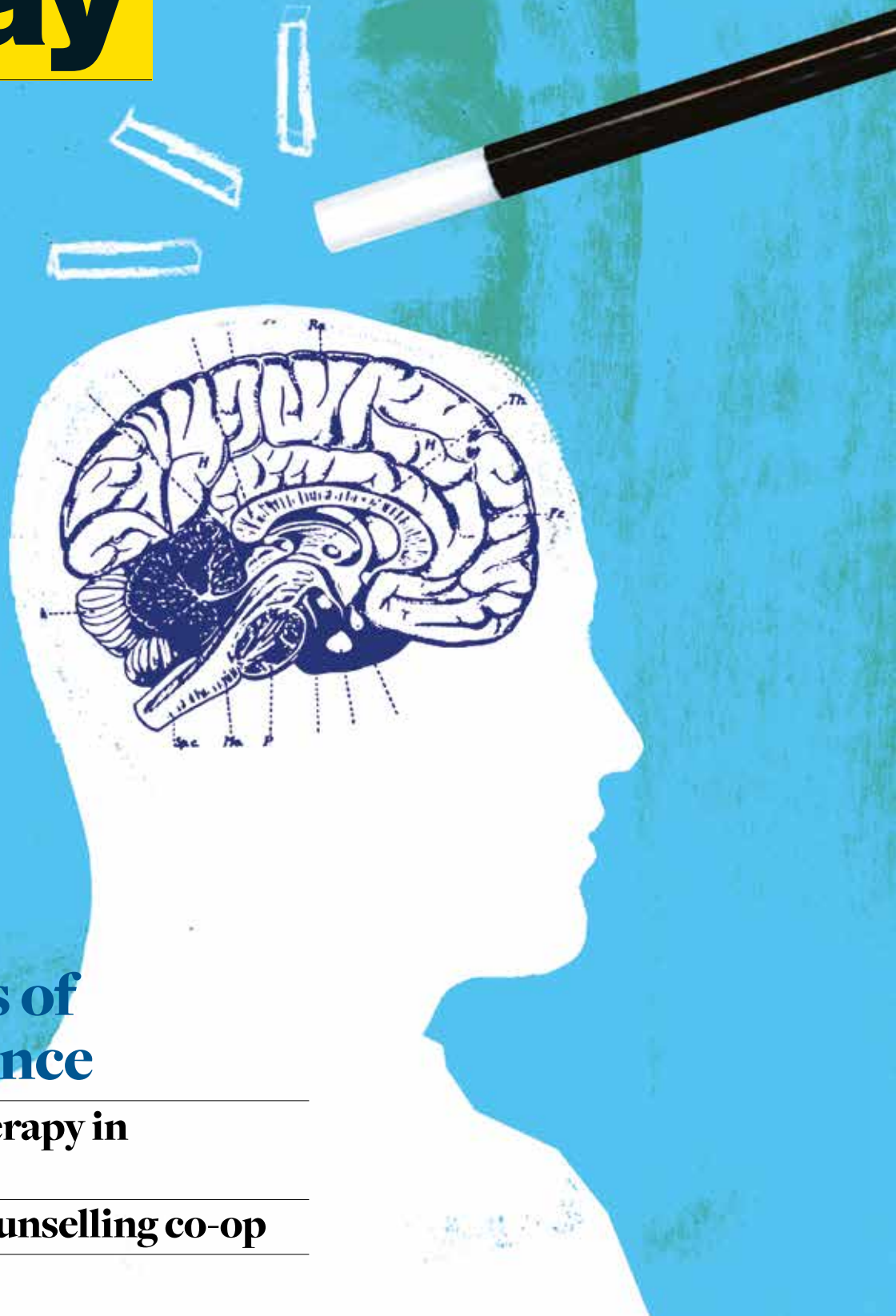


# Therapy Today



## The limits of neuroscience

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**Mandatory therapy in Jobcentres**

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**Setting up a counselling co-op**

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## Beyond neuroscience



Cover illustration by Gary Sawyer

To what extent is neuroscience really a friend of psychological therapy? Kenneth Gergen argues in our cover feature this month that we should be very concerned about the way in which neuroscience is increasingly being used to support the biomedical model. Where the neural basis of ‘psychological disorders’ can be pinpointed by research and brain imaging, this provides strong support for ‘the diagnostic categorisation of mental illness, the development of pharmacological treatments for such illnesses and the efficient dispensing of treatment to the afflicted’. But this presupposes that what is happening in the brain is the cause of the symptoms of the mental disorder. In the case of depression, for example, a scan might reveal dopamine and serotonin metabolism in the brain, but it doesn’t take into account that brains are essentially plastic and that they are in bodies and bodies have a history and inhabit a particular social-economic and cultural context. Do the chemical processes in the brain give rise to the depressive symptoms or does individual experience lead to changes in the brain’s neural pathways?

Another worrying development that you may have read about in the media is the possibility of compulsory therapy

in Jobcentres. Lynne Friedli and Robert Stearn, members of boycottworkfare.org, write about this in Your Views, highlighting the way in which being unemployed is fast becoming a diagnosis requiring treatment with psychological therapy. BACP Chair Andrew Reeves made a statement earlier this month: ‘Benefit claimants shouldn’t be expected to have therapy under the threat of their benefits being stopped – it is unethical and potentially harmful.’ We explore this issue in depth in this month’s news feature. All the main professional bodies question how practitioners could ethically take part in something so coercive and the recently-formed group Psychologists Against Austerity urges psychologists to think very carefully about how their work is being used and to what ends: ‘The workfare approach positions unemployment as a problem of the individual when it’s actually a structural problem. It’s pernicious.’

Sadly I have to announce that Catherine Jackson will be leaving us at the end of this month. I’d like to thank her for her enormous contribution to *Therapy Today* over the last three and a half years.

Sarah Browne  
Editor

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‘Without doubt, many parts of the NHS maintain a culture shrouded in negative and contracted attitudes but, thankfully, others are making positive change’  
*Linda Crossland (p5)*

‘There is still a long way to go before society is open to helping reduce the risk to the public by helping offenders reduce their own risk’  
*Ellie Myers (p35)*

‘If we learn anything from working in the field of grief, death and dying it is the importance and joy of cherishing life.’  
*Val Humphreys (pp22–25)*

## The significance of first dates

### Jeanine Connor finds similarities between first dates and new clients

Ten years ago I arranged to meet a woman I didn't know in an unfamiliar part of town. A mutual friend set us up and thought we'd get along. I remember the trepidation as I decided what to wear for our first meeting and the nervous anticipation as I rang her doorbell. During the hour we spent together I gradually relaxed. The conversation flowed and she seemed interested in getting to know me. She encouraged me to open up in a way that nobody had before. We were a good match and our relationship thrived for five years. Did we fall in love? Perhaps a little.

Choosing a therapist can be like choosing a lover and a first session is much like a first date. The introduction might be arranged by a well-meaning friend or the date self-selected from the internet. It's a risk; it's anxiety provoking. And it can be ever so slightly exciting.

I remember Stanley, an outwardly confident 18 year old, full of swagger. He announced his arrival at our first session by hammering so loudly on the door I thought he might punch a hole through it. Once inside he relaxed onto the couch without waiting to be invited and started chatting almost immediately. Stanley talked about his college course, family, aggression, scrapes with the authorities and the hour flashed by. When he left he shook my hand enthusiastically and swaggered off. I'd found him intriguing and looked forward to us working together. The following week I waited as the minutes ticked by, until the realisation struck me that Stanley wasn't coming. I tried to contact him. He didn't reply to my messages. On reflection, that first session had been the therapeutic equivalent of a one-night stand. He'd charmed me with his stories and faux intimacy but it had all been bluster, and our relationship had no future. He wasn't ready to commit.

Samantha was in her mid-teens and, like Stanley, engaged enthusiastically in our first session. She had many questions: what therapy is for, how long I'd been a therapist and what I enjoy about my job. I was delighted she had the confidence to be so openly curious. The following session she arrived a few minutes late and with much less gusto. She responded monosyllabically to my wonderings about her week and after about seven minutes she fell asleep, and stayed asleep for the remainder of the session. During our first meeting Samantha hadn't told me anything about herself at all. Instead she'd employed a sophisticated form of defence disguised as engagement. Her catatonic state was less subtle and her communication loud and clear. Samantha was testing out levels of intimacy and control that would feel comfortable to her, and I needed to respect these if we were going to have a meaningful therapeutic relationship – which we did, for about a year.

First sessions, like first dates, offer a wealth of information about how the relationship is likely to pan out contained in our feeling response to the other person in the room. It's mostly a gut instinct that experienced therapists (and serial daters) learn to trust.

Lexi was a compact, buttoned-up woman who was always prompt and didn't take a breath as she recounted her life of woe. She told me she had been let down by countless 'people like you' and had low expectations. I remember thinking, 'I'll show you. Let therapeutic battle commence!', but what I actually felt was that I really wanted to help her to have a happier and more fulfilling life. And, against the odds, I did. Lexi and I worked together for a year and she never missed a session. Ours was an intense relationship, full of passion and hate, but we survived it together and eventually love thrived. When we finally parted she thanked me for bearing with her and I thanked her for allowing me to. It's always a privilege to be chosen. *Jeanine Connor MBACP is a child and adolescent psychodynamic psychotherapist in private practice and specialist Tier 3 CAMHS and is also a writer, supervisor and trainer. [@Jeanine\\_Connor](http://www.seapsychotherapy.co.uk)*

## No work, can't work

### Lynne Friedli and Robert Stearn urge counsellors to challenge the pathologising of unemployment

Does it matter where therapy is delivered? Should therapists be concerned that 'getting a job' and 'getting off benefits' are becoming primary therapeutic goals and key indicators of a fulfilling life? The Government's decision to co-locate 350 IAPT therapists in Jobcentres makes these urgent questions for therapists and anyone working in mental health.

Billed as a package of measures to 'provide integrated employment and mental health support to claimants with common mental health conditions' (alongside access to supported online CBT), these plans featured in the Coalition Government's pre-election budget. They effectively add psychological therapies to the range of interventions applied to force claimants into work – any work. CBT becomes part of workfare, the collection of Government 'work for your benefit' programmes that not only specify what people must do to get a job (writing CVs and job applications, attending interviews etc), but how they should think, feel and behave, and subject them to financial sanctions if they don't comply.

To be unemployed is fast becoming a diagnosis that, in the words of the 2015 Conservative manifesto, requires mandatory treatment: 'People who might benefit from treatment should get the medical help they need so they can return to work. If they refuse a recommended treatment, we will review whether their benefits should be reduced.' The Department for Work and Pensions has subsequently denied that anyone will be forced into therapy or lose benefits if they refuse to participate.

But people claiming benefits are already subject to coercive psycho-

interventions. These include mandatory training and on-line ‘messaging’ designed to ‘change attitudes’ and promote ‘employability’. Claimants are being made to take part in pointless and humiliating psychological group activities (like building paper clip towers to demonstrate team work), or take meaningless and unethical psychological tests to determine their ‘strengths’.

What is striking is that the primary focus of these activities isn’t even a job. ‘Employability’ isn’t a set of job-related skills, attributes or qualifications; it’s about personality and emotions: achieving a ‘mindset that will appeal to employers’, as one course for jobseekers puts it. Positive psychology is pervasive in the growing welfare to work industry, as well as in Jobcentres. A narrow set of approved psychological and personality traits are touted as essential to getting and keeping a job: you have to be confident, optimistic, positive, aspirational, motivated, and infinitely flexible.

These developments are part of wider policy efforts to rebrand unemployment as a psychological problem, using bogus constructs like ‘psychological resistance to work’. The therapeutic value of work is being promoted more explicitly than ever – at a time when, for many people (including therapists), work is less and less able to provide either an income they can live on or emotional satisfaction.

We hope that readers of *Therapy Today* will join protests against this creeping psychological conditionality in our access to social security. Jobcentres are not neutral settings where therapy – or anything else – can be ‘freely entered into’: they are places of anxiety, distress and fear, marked by stark inequalities in power and the threat of destitution. More broadly, we hope counsellors and psychotherapists will join the resistance against workfare itself. *Lynne Friedli and Robert Stearn are members of Boycott Workfare. www.boycottworkfare.org/*. A more detailed version of their article is published in *Medical Humanities* <http://mh.bmj.com/content/41/1/40.full>

## In defence of the NHS

### Working for the NHS is very far from all bad, writes this IAPT counselling team

Having read the anonymous article ‘My year working in the NHS’ in this section in the May issue, I would like to respond on my own behalf and with the full endorsement of the counselling team to which I belong, all of whom work and enjoy being counsellors in the NHS.

I personally have worked as a counsellor for over 20 years and in this time have seen private clients, worked in the private sector, undertaken voluntary counselling and latterly worked in an Improving Access to Psychological Therapies (IAPT) team for the NHS.

I fully respect the writer’s unfortunate experience of working in the NHS, but I would like to point out that it is not like that everywhere.

I suppose I am privileged to be a clinical lead in an IAPT service – something of an anomaly in the field as I am a counsellor, not a CBT therapist (but that, as we know, is another story!). While accepting that at times each one of us may have something to moan and groan about, we can truthfully say that we all enjoy what we do and how we do it. Maybe we should consider ourselves fortunate but we don’t think that we are unique. Each NHS trust runs its services differently and, as a primary care provider within a mental health trust, we work to locally commissioned standards while adhering to NICE guidelines.

Yes, as the writer states, care is time limited; it always has been in primary care. However, it is very possible to provide care in a time-limited way, and we do and have positive outcomes from doing so. From its original commissioning levels of approximately 500 patients per month, our service is now averaging 900 new referrals per month, with a slow but steady month on month increase. To work with patients without time limits would be impossible, regardless of how much

money was spent. Yes, counsellors do have to sometimes be more creative and ‘adapt’ how we work to take into account these time constraints, but at the same time we need to remember that primary care is just that and patients with more severe and enduring mental health issues should be moved into appropriate services that are relevant to their needs.

Never at any time, certainly in our service, does this compromise the care offered to patients and they are never considered to be just a statistic; they are always regarded as human beings. As a team, we are creative and deliver several different models of primary care interventions and a variety of relevant therapy groups and receive a generous amount of ongoing training in order to meet the requirements of BACP membership, our personal needs and patient care.

As part of my role I oversee clinical supervision across the team and ensure that each counsellor receives 90 minutes’ one-to-one clinical supervision per month. This is in addition to line management and regular counsellors meetings where team development, training, peer discussion and reflective practice are all facilitated. All supervision, in line with trust policies, is in-house but all our supervisors hold appropriate qualifications and are not involved in line management.

In terms of not having a desk, most of our counsellors work out across the local borough, in GP surgeries and other community centres. Other than once a month when team meetings are held, we only occasionally come together collectively, so ‘hot desking’ works fine and fixed bases, while nice, are not a necessity.

Yes, without doubt, many parts of the NHS, as stated in the article, maintain a culture shrouded in negative and contracted attitudes etc but, thankfully, others are making, and evidencing, positive change, and this should also be acknowledged. *Linda Crossland is Clinical Lead and Gill, Lillian, Kathleen, Lucy, Jimmy, Chris, Sue, Kerry, Jo, Dawn, Annie, Karen and Kate are all members of the counselling team at Doncaster IAPT, part of Rotherham Doncaster & South Humber NHS Foundation Trust*

## Child exam stress warning

Pressure from continual exams and tests is causing unprecedented levels of anxiety, stress and mental health problems among children, says a report from the National Union of Teachers.

*Exam Factories?* looks at the impact of tests, exams, Ofsted inspections and ‘accountability measures’ on schools and their pupils. It includes responses from a survey of 8,000 teachers, case studies, and a review of research and other literature.

Teachers warn that low achievement in tests or exams is resulting in low motivation

and low self-esteem, that self-harm is ‘rife’, pupils are suffering eating disorders and attempting suicide, and many have symptoms of depression. The problems can be made worse by pressure from parents. Children with ADHD are being medicated because the school environment has become less suitable for them, allowing less movement and practical work, the report says.

School-based counselling can do little as it cannot reach the cause of the distress. One teacher of pupils receiving support for special educational needs said: ‘You can’t be

counselling them for what you are putting them through at school... Our clientele is going to increase and their problems are going to become – wider let’s say – because of the academic pressures that are being placed on them.’

The report calls for an urgent review of testing and school inspections. Its author Merryn Hutchings, Emeritus Professor at London Metropolitan University, said: ‘The current pattern of testing very young children creates unnecessary stress and anxiety for pupils and parents.’

<http://tinyurl.com/q5ylcp7>

## New fathers’ mental health

More than one in three new fathers (38%) are worried about their mental health and three quarters (73%) are concerned about their partner’s mental wellbeing, research from NCT has found. NCT conducted a longitudinal study of 869 first-time mothers’ and 296 first-time fathers’ experiences and attitudes during the first two years following the birth of their baby. NCT says it’s important that men are encouraged and supported to speak about how they are feeling.

<http://tinyurl.com/oqx3j8h>

## Hoarding guidance calls for fresh approach

Therapists need to work outside the traditional one-to-one relationship if they are to help people with hoarding difficulties, says new guidance published by the British Psychological Society.

The guidance says that current approaches to treatment, including one-to-one therapy, aren’t working and this is because hoarding is unlike other obsessive compulsive disorders: it doesn’t cause the same high levels of distress and people who hoard are often unwilling to engage with treatment.

Four per cent of the population are thought to have hoarding difficulties but this is likely to be an underestimate as many are reluctant to talk about it.

Therapists should involve partners and other family members/carers, and act as a bridge between the person with hoarding difficulties



and external agencies who may also be dealing with the problem, such as landlords or environment health officers, the guidelines say.

Sophie Holmes, Consultant Clinical Psychologist at Sussex Partnership NHS Foundation Trust and author of the guidelines, said: ‘Often the person with hoarding difficulties has encountered nothing but criticism. They need a therapist who doesn’t join in with the “clamour to

clear”. The work needs to happen at a really slow pace and often it will be about managing the risk, as opposed to getting rid of the problem.’

The guidelines also urge greater sensitivity from the media. ‘This is not entertainment. It is really important that TV production companies take seriously their responsibility for after-care of participants,’ Sophie Holmes said. <http://tinyurl.com/obv2nnc>

## FE student concerns

Further education (FE) colleges are reporting a significant increase in the numbers of students with mental health problems.

Over two thirds (67%) of the 127 colleges that responded to a survey by the Association of Colleges (AoC) said they had seen an increase in students with disclosed mental illness in the past three years and 75 per cent said there had been an increase in the number of students with undisclosed mental health difficulties. Colleges said they were dealing with depression, anxiety and self-harm.

Social media (75%), financial concerns (61%), exam pressure (60%) and employment concerns (41%) were all cited as chief reasons for students’ mental distress. <http://tinyurl.com/nhwa528>

# NICE workplace guideline

Employers and managers should do more to address the effects of poor working environments on employees' lives, says NICE in new guidance on workplace health policies and management; the quality of staff-management relationships is key to promoting a mentally healthy workplace.

Over a million people in the UK experience a work-related illness, NICE says. The reasons for poor workplace health include long, irregular hours, lack of control over work and discriminatory practices. In a recent survey by the manufacturing

industry association EEF, a quarter of companies reported that stress and mental health disorders were the main reason for long-term sick leave and that rates have steadily increased since 2009. Yet just one in 10 businesses said they provided mental health training for managers.

In another survey, by YouGov for Mind, 26 per cent of employees said they had developed anxiety as a result of workplace stress, and 18 per cent said they had become depressed. Paul Farmer, Chief Executive of Mind, said: 'A big part of the problem is that staff often don't feel able

to speak out about mental health and seek support before problems spiral.'

The new NICE guidance says line managers should have training in mental health awareness and wellbeing issues, and in particular how their management style can affect the psychological wellbeing of staff. Dame Carol Black, Department of Health advisor on workplace welfare, said: 'There is abundant evidence that the health, especially the mental health, and overall wellbeing of employees depends greatly on their relationships at work.' <http://tinyurl.com/np88cz3>

## CBT helps back pain

CBT can help people manage chronic low back pain and related psychological stress, new research has found. Contextual cognitive behavioural therapy (CCBT) focuses on helping people to accept and learn to live with pain that cannot be cured.

Researchers compared CCBT with physiotherapy in 89 patients with low back pain. The CCBT group reported greater improvements in disability and pain after six months than the physiotherapy group. However many patients thought the best treatment was a combination of both, and patients also expressed a preference for one-to-one talking therapy, rather than in a group. <http://tinyurl.com/ntb96qp>

## Older teens need more protection from harm

Young people aged 16 and 17 need better protection from the law against abuse, violence and exploitation, the Children's Society says.

The society has launched a new campaign, Seriously Awkward, to highlight the challenges that 16 and 17 year olds face. It says they are more likely to go missing or be a victim of violent crime than any other age group and they are at a high risk of sexual exploitation and domestic violence, yet they get less protection in law than younger children. It estimates that half a million 16 and 17 year olds face particular risk of harm because they are already dealing with multiple issues such as poverty, poor health or they lack supportive relationships.

In a survey of over 1,000 16 and 17 year olds across the UK, 34 per cent said they frequently felt anxious, 25



per cent said they often felt sad, 25 per cent said they did not feel optimistic about the future, and 69 per cent said they felt judged just for being a teenager.

The Children's Society says the law should be changed to offer young people aged 16 and 17 the same levels of protection and safeguarding as younger children, and that statutory health and social care services should always treat 16 and 17 year olds as

children, not adults, and offer them support if they need it.

A recent study commissioned by Youth Access has revealed clear links between social adversity and mental illness among young people. It found that young people who are not in education, employment or training (NEET) or who are socially isolated are at twice the risk of having mental health problems. <http://tinyurl.com/pxduw4p>

## Male suicide and alcohol

Men are turning to alcohol instead of talking about their problems, putting them at higher risk of suicide, Samaritans says. In a new report, *Men, Suicide and Society*, Samaritans says the Government should challenge the UK's unhealthy drinking culture to reduce the 65 per cent of suicides involving alcohol. It is calling for joined-up treatment locally and nationally for alcoholism, mental health conditions and suicidal behaviour. <http://tinyurl.com/q37cfw2>

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# Should counsellors work with ‘workfare’?

IAPT therapists will soon be working alongside Jobcentre Plus employment advisers to help the unemployed back into work *Catherine Jackson reports*

‘You can’t have a therapeutic alliance where one of the partners has the power to make the other destitute.’ Case closed, surely? But how real is the threat raised by Lynne Friedli and co-author Robert Stearn in Your Views (see pp4–5) that Employment Support Allowance (ESA) claimants may have to agree to have CBT or risk losing their welfare benefits? Could IAPT practitioners find themselves offering therapy to a client who is there under what amounts to duress?

The issue hit national media headlines in early June when an article by Friedli and Stearn was published in the *BMJ* specialist journal *Medical Humanities*. The article, titled ‘Positive affect as coercive strategy: conditionality, activation and the role of psychology in UK government workfare programmes’, argues that psychologists, and more recently psychotherapists and counsellors, are increasingly involved in the Government’s programme to cut the welfare benefits bill by getting long-term unemployed people back into work, including those unable to work for physical and mental health reasons.

The article describes the application of ‘workfare’ methods, imported from the US, to motivate and prepare unemployed people for work. ‘Workfare’ includes job coaching, skills building and motivational workshops, training courses and unpaid work placements. Participation in these programmes is mandatory; non-compliance is punished by loss of benefits. This is ‘psycho-compulsion’, write Friedli and Stearn, and they warn that the Conservative Government intends to extend this conditionality to claimants’ health and treatment. In February this year Prime Minister David Cameron asked Professor Dame

Carol Black, specialist advisor to the Government on work and health issues, to explore the possibility of refusing benefits to people who are obese or use alcohol or drugs unless they agree to medical treatment. In their 2015 election manifesto the Conservative Party said that claimants who ‘refuse a recommended treatment’ may risk having their benefits reduced. The pre-election budget allocated funds to place IAPT therapists in 350 Jobcentres throughout England; the possibility that claimants may be required to attend a course of CBT treatment to improve their ‘employability’ or risk losing benefits has become very real.

## ESA sanctions

According to official statistics, 46 per cent of ESA claimants are receiving benefits for mental health reasons – some 260,000 people, at a cost of around £1.4 billion a year. In November last year Mind flagged up that people with mental health problems in the ESA work-related activity group (WRAG) – those deemed closest to re-entering the job market – are the most likely of all groups to be sanctioned: over 60 per cent of sanctions are imposed on this group, Mind says.

An independent study supported by Mind and published in June last year, *Fulfilling Potential? ESA and the fate of the Work-Related Activity Group*, explored the impact of the ‘workfare’ process on this group: they can be left ‘fearful, demoralised, and further away from achieving their work-related goals or participating in society than when they started’. A report by Church Action on Poverty, *Time to Rethink Benefit Sanctions*, published in March this year, found: ‘Sanctions have a financial impact on

individuals, but the personal costs of shame, demoralisation and destruction of self worth are much harder to measure. This is a system that leaves many people feeling under suspicion and valueless simply because they do not currently have work.’

Lynne Friedli, who is a researcher with the Wellcome Trust funded project Hubhub, says that therapy under such conditions can only be profoundly untherapeutic: ‘It’s a deeply coercive enterprise and it’s difficult to see how any therapist could ethically take part in that. This is about state co-option of health professionals; the client’s need and interests are being subsumed under a whole different agenda. The other problem is that it presupposes that getting people off benefits and back to work is the primary therapeutic goal. But the work these claimants are being offered is often not the kind of work that pays a living wage and respects people’s dignity and rights.’ How can that help anyone’s mental health, she asks?

It would be impossible for a therapist to detach themselves from the context in which they were offering therapy, argues Stearn. ‘The coercive nature of welfare to work services creates huge inequalities in power. However careful you are as an individual practitioner, you are plugged into that.’

## Protests

Psychotherapists, counsellors and psychologists have been among those protesting against these and other government measures to cut the amount spent on welfare benefits. In April the Alliance for Counselling and Psychotherapy published an open letter in the *Guardian*, signed by 400



## 'It's a deeply coercive enterprise and it's difficult to see how any therapist could ethically take part in that. This is about state co-option of health professionals'

psychotherapists and counsellors, condemning as 'malign' and 'totally unacceptable' the Government's austerity programme and its impact on the most vulnerable in society.

Psychologists Against Austerity (PAA) was launched a year ago in protest at what its members believe are the damaging effects of the Government's welfare cuts and the psychologising of unemployment. Says spokeswoman Laura McGrath, a lecturer in psychology at the University of East London: 'Psychologists need to think very carefully about how their work is being used and the ends it is being used for. The workfare approach positions unemployment as a problem of the individual when it's actually a structural problem. It's pernicious. People are being made to feel they are to blame for not being good enough.'

The publication of Friedli and Stearn's paper prompted statements from all the main psychotherapy professional bodies. Said BACP Chair Andrew Reeves: 'Benefit claimants shouldn't be expected to have therapy under the threat of their benefits being stopped – it is unethical and potentially harmful.' The UKCP similarly declared: 'To link either being unemployed, poor or disabled with a psychological deficit is inappropriate, unethical and deeply concerning to our profession.' The BABCP, many of whose members work in IAPT services, declared itself 'against any offer of any treatment, including CBT, based on coercion or associated with unfair or disproportionate inducements'. Said Rob Newell, BABCP President: 'It is almost certainly against our code of conduct and almost certainly likely to be at the very best ineffective and at the worst quite possibly damaging to clients.'

BPS President Elect Peter Kinderman told *Therapy Today*: 'It is a very basic principle of medical ethics that services should not be provided under compulsion, other than in very extreme circumstances. If the Government were to go down this route it would be wrong.'

He argues that the Department for Work and Pensions (DWP) could be making much better use of the skills and support psychologists and psychotherapists can offer in the package of measures to help the jobless back into work. As to the ethics of participation, he says: 'Individual psychologists will have to make their own decisions about working in this way, bearing in mind that so many professional bodies, including the BPS, have made it clear that it is ethical to offer people therapy only in the context of a free and informed choice.'

Says Andrew Reeves at BACP: 'There are, of course, people out of work experiencing mental health difficulties who would benefit from psychological intervention and should be offered the choice.' But he says the ethics of involvement are clear; the BACP *Ethical Framework* states unambiguously: 'The principle of autonomy opposes the manipulation of clients against their will, even for beneficial social ends,' and that BACP members should 'seek freely given and adequately informed consent' from clients.

The UKCP likewise raises a caveat about the ethics of coercion: 'We understand that some people may benefit from being offered therapy whether they are employed or out of work. But imposing it in this way is a badly thought out approach...Therapists involved in such work may wish to bear the ethical dimensions in mind.'

### Not in our name

Others disagree that offering therapy in such a context could ever be appropriate. Psychotherapist Del Loewenthal, a signatory of the Alliance open letter and Director of the Research Centre for Therapeutic Education at the University of Roehampton, believes the talking therapy professions have been co-opted into the Government's neoliberal political agenda. 'What the Government is proposing is a perversion of what we understand to be counselling. Their agenda is to get these people back

to work whether they are ready to go or not. To confuse that agenda with counselling or psychotherapy is just abusive. They should at least be called "compliance clinics",' he argues.

He doesn't think counsellors and psychotherapists should be involved at all in DWP welfare-to-work programmes, and that it is a slippery path down which the profession is too eagerly stepping. 'You can see the pressures. There are therapists who would like more work and you can see the way they can frame this as doing good within the system. But therapy has to be voluntary.' He also objects that most people accessing this therapy through IAPT will be offered CBT; here too, participants should have a genuine choice of therapies, he says.

It is, says Loewenthal, part of a wider and worrying trend towards increased state intervention in the psychological therapies. 'There is a danger that psychological therapists are becoming part of the problem rather than the solution. At what point does therapy become a form of social control? Some say psychologists and psychiatrists have already become agents of the state, and now psychotherapists and counsellors are being invited in, having been on the outside before. The prospect of the state entering the therapeutic space is very frightening.'

Loewenthal, with fellow critical psychotherapists, has just launched a Council for Critical Psychotherapy ([criticalpsychotherapy.wordpress.com](http://criticalpsychotherapy.wordpress.com); email [criticalpsychotherapy@outlook.com](mailto:criticalpsychotherapy@outlook.com)) that will, they hope, provide a forum for informing and influencing public debate and alerting psychological therapists to what they perceive as the growing influence of neoliberalism in the therapy room.

Psychotherapist Paul Atkinson, also a member of the Alliance and of the Free Psychotherapy Network, agrees. 'I think the talking therapies profession has been too keen to get on the gravy train. There has been an excitement about being recognised by the state as a profession.

## 'We have to become more politicised. We have turned ourselves into a group of experts in the psyche and now society is taking hold of that expertise and using it for its own ends'

Even our professional associations have become brands in competition with each other to get their piece of the pie. I think this issue of coercion is a red line. It's time we stood our ground and declared that certain psychotherapy values really need to be upheld.

'We have to become more politicised,' he argues. 'We have turned ourselves into a group of experts in the psyche and now society is taking hold of that expertise and using it for its own ends. I hope this issue wakes people up to the fact that what we do has been put to political use and abuse and that we as a profession have a responsibility to stand up and state what we think about that.'

### Partnership programmes

Getting people back to work has always been a major part of IAPT's remit, and one of the main arguments that Professor Lord Richard Layard used to persuade the Government to provide funding in the first place. It has so far failed to achieve much impact in this respect. While the joint IAPT/Jobcentre Plus pilots are still some way from being implemented, there are a number of other government-funded pilot programmes exploring different models of collaboration between the DWP and IAPT services. NHS England is currently involved in a pilot collaboration with Work Programme providers in eight sites evaluating the effectiveness of offering ESA claimants talking therapies through IAPT. NHS England's view is that people with mental health problems on ESA are very likely to include those least likely to be able to access talking therapies, and that placing IAPT therapists in Jobcentres is no different to placing them in other community sites that are more accessible to target groups, and is already common practice in IAPT services.

Separately, in December last year the Cabinet Office confirmed £12 million funding for four other pilot programmes – in Blackpool, Sunderland, Greater Manchester and West London. Three

will offer IAPT therapies in parallel with Individual Placement and Support (IPS) – a model of intensive, individualised employment support that has been pioneered successfully with people with severe mental health problems. The Greater Manchester programme is based on a very similar model, 'Working Well', that the Greater Manchester Combined Authority has been trialling independently.

In these and the NHS England/Work Programme pilots, participation in any talking therapy is voluntary. But the experience of an earlier IAPT/IPS pilot suggests the issue is not so clear cut for participants. The Centre for Mental Health (CMH) led this pilot, which ran for six months at four sites. Participants were referred by local Jobcentre Plus work coaches, and the employment support and therapy were provided in IAPT or other premises. The aim was to offer the therapy and employment support in parallel. However the local IAPT services already had waiting lists and got no additional resources, so many participants started the IPS without the therapy and some never got therapy at all.

They recruited only 240 participants, of whom just 15 found paid work (although one participant got two jobs). The pilot was given too short a timescale, says Jan Hutchinson, CMH Director of Programmes. But what was clear was that participants really valued the intensive, personalised one-to-one employment support. The IPS employment specialists had maximum caseloads of 20, rather than the more usual 100–200 of Jobcentre Plus work coaches. 'Participants got much more time with the employment specialist and a more responsive service. It was very unlike the conveyor belt process they were used to at the Jobcentre,' she says. 'It wasn't me being forced into anything. It was just talking about some things I might be able to do,' said one participant.

A small number didn't want the therapy, and resented having to accept it if they were to get the employment support. Many more did want the

therapy but they wanted it first, so they would feel more able to make the most of the employment support. Overall the feedback was positive and, even in that short time frame, participants' mental health improved.

Some of the IPS specialists and managers did feel that the participants' decision to take part was inevitably clouded by the context in which the help was offered: 'As soon as you put the Jobcentre's stamp on it and turn it into Jobcentre provision, it has an immediate negative effect on the claimant's perception of the service,' a Jobcentre work coach said. Critics have pointed to the high drop-out rate (roughly half dropped out after expressing an initial interest and failed to attend their first appointment) as evidence that the pilot was unsuccessful. But, says Hutchinson: 'My feeling was that people attending Jobcentres just feel it's not a good idea to say no to anything that's offered, even if they don't necessarily want it. They feel that if they then don't engage with the offer they haven't actually said no in front of their work coach.'

Hutchinson believes this model is a winning formula because it offers individualised, intensive support from caseworkers with specialist expertise and small caseloads. 'We know that people with mental health problems generally want to work but need more help and more personalised support. IPS has the ability to get 50 per cent of participants back into work. It sounds expensive but if it works that is what it costs.'

But, she points out, participation in IPS is essentially voluntary. 'I'm aware that critics fear this kind of collaboration is the thin end of the wedge to mandatory therapy, and there is always that possibility. Participation in IPS is voluntary and we have absolutely no reason to believe it would be effective for people who didn't feel ready to go back to work.' ■

*The Friedli and Stearn article is at <http://mh.bmj.com/content/41/1/40.full>*



# The limits of neuroscience

*Kenneth J Gergen* questions the faith placed in neuroscience to explain the causes of mental illness  
*Illustration by Gary Sawyer*



While resistance to the biomedical model of mental suffering has long been robust, recent decades have dramatically shifted the momentum. Relying on various developments in brain-scanning technology, research consistently reveals what appear to be the neural bases of wide-ranging behaviour. To the extent that such research can pinpoint the neural basis of what are commonly viewed as psychological disorders, strong support is provided for 1) the diagnostic categorisation of mental illness; 2) the development of pharmacological treatments for such illnesses; and 3) the efficient dispensing of treatment to the afflicted.

Perhaps the most dramatic cultural transformation favoured by the biologising of human suffering is the shift from 'talking cures' to psychopharmacology. Some 30 years ago there were relatively few antipsychotic drugs available, and drug treatments were typically limited to the severely impaired. In 1970 there were approximately 150,000 mental health cases treated pharmacologically in the US. By 2000 the number had jumped to between nine and 10 million. More than half of those treated with psychotropic drugs were schoolchildren. At the time of writing, Amazon lists more than 3,000 books on the subject of psychopharmacology; only a handful

are critical – or even cautious – about the use of drugs in psychiatric practice.

Putting aside the increasingly vast literature on the failure of such drugs to promote positive change (for example, see Kirsch<sup>1</sup> and Moncrieff<sup>2</sup>), the cultural impact of this movement is dramatically demonstrated in this account of a Florida therapist, Phillip Sinaikin:<sup>3</sup>

'A 60-year-old divorced female was referred to me by a fellow psychiatrist who was leaving private practice. The frazzled looking woman informed me that she is diagnosed as a rapid-cycling bipolar and then presented me with a list of her current medications. She was being treated with Lamictal [an anticonvulsant] 100 mg three times a day, Alprazolam [a tranquilizer] 1 mg three times a day, Celexa [an antidepressant] 40 mg per day, Wellbutrin (an antidepressant) 150 mg twice a day, Seroquel [an antipsychotic] 300 mg at bedtime, Fiorinol [a barbiturate containing a pain pill] up to four a day and finally Ritalin [an amphetamine stimulant] 20 mg three times a day. That is 17 pills a day!... Asked about her current supply of medications, she didn't know what she had or needed. All she knew for certain was that she was out of Ritalin and needed a refill. By that time, the hour allotted for her intake was up. So, do I give her a refill and further legitimize what I view as

an irrational and dangerous diagnostic conceptualization and treatment plan by her previous psychiatrist? And if I choose not to, what do I do?’

There is more to the pharmacological turn than its impact on the suffering client. One must ultimately inquire into the message that the routinising of drug treatment sends to the culture at large. Essentially the culture is informed by professional authorities that drugs are the answer to common problems of human living. If one is deeply grieving, anxious about work, distressed by failure, frightened of social life, unable to stop working, worried about homo-erotic tendencies or growing too thin, drugs are the answer. In previous times we human beings acquired individual coping strategies or relied upon one another. These cultural resources for resiliency are increasingly under threat. In effect, the neurobiological shift increases dependence of the culture on artificial supports for normal life. Psychopharmacology takes its place alongside drugs for sleeping, sexual arousal, increasing athletic prowess and euphoric pleasure. We are approaching a condition in which we will turn to the medicine cabinet in order to ‘get through’ a normal day.

### **Cultural myopia**

There is substantial reason to believe that much of what we call mental illness is sociogenic in origin. This is so in two important ways. First, the origins of most human suffering are lodged within traditions of cultural meaning. Experiences of personal failure, loss of control, deficient self-confidence, shame, humiliation, loss of love, the death of an intimate and fear of evaluation, for example, are all common topics that are addressed to therapists by suffering patients. Yet all of these exist within traditions of meaning.

For example, there is nothing about personal failure that itself demands anguish. One could see a failure as an important and valued signal for means of improvement. Second, it is only in a culture that places a value on autonomy or the personal control of outcomes that losing control is a reason for depression. Even in many Western subcultures there is a strong value conferred on placing one’s destiny in the hands of a deity. To the extent that personal problems are embedded within processes of cultural meaning, the primary therapeutic emphasis should be placed on movement within these processes. Neurobiology is largely irrelevant.

This emphasis on culture is also important because it opens up consideration of the social conditions in which we live our lives. As Karen Horney once proposed,<sup>4</sup> many of our institutions are themselves sources of anxiety. Conditions of intense competition, high professional insecurity, information overload, poverty and oppression will all be reflected in degrees of human suffering. To treat such suffering as biological in nature is not only to blind oneself to the proper origins but to ensure that therapists are left only to treat the effects of our problems and never the cause.

There is a second way in which the attribution of anguish to neurobiological issues suppresses concern with sociocultural issues. As impressively documented by Whitaker<sup>5</sup> and others, there has been an exponential expansion in the diagnosis of undesirable behaviour as ‘mental illness’. If our definitional systems were otherwise, such behaviour would not count as illness and new questions could be asked about the source of its undesirability. For example, there is nothing inherently ‘ill’ about a highly active child, and the primary

reason for the diagnosis of attention deficit hyperactivity disorder (ADHD) resides in the inability of teachers to effectively carry out their task. In effect, the teacher’s suffering is redirected towards the child, and labelled as an illness for which pharmacology is the answer. Virtually no attention is thus directed to practices of teaching more optimally suited for highly varied student proclivities, or the cultural conditions that favour a need for stimulation (for example, videogames, Facebook, television).

Closely related to the cultural construction of illness is the impact of disease diagnosis on those who are treated. The individual who is labelled as mentally ill takes on a dimension of self-doubt for which there is no ultimate termination. Unlike physical illnesses, in which one can typically identify the onset and termination, the label of mental illness essentially remains forever.

### **The limits of neuroscience**

The mental health professions have a long tradition of instrumental reasoning. I argue that this most recent neurobiological turn serves only to intensify such an orientation. While a full review of all of the biological evidence is beyond the scope of this article, I do wish to take up the recent spate of neurologically-centred research. (I have written elsewhere a more extended account of the shortcomings of neurological explanations of human action.<sup>6</sup>) It is this work that has come to provide the most dramatic support for the biological orientation, spurred particularly by the development of various technologies (for example magnetic resonance imaging, positron emission tomography, electro-encephalography, magneto-encephalography) for scanning brain activity. Thus, as subjects are engaged

**‘In previous times we human beings acquired individual coping strategies or relied upon one another. These cultural resources for resiliency are increasingly under threat’**

in various activities – problem-solving, remembering, bargaining, watching films, meditating, and so on – measurements can be taken of heightened neurochemical activity in various areas of the brain. The typical approach is to locate those areas of the brain that are specific to a given psychological state or behaviour, or a given group (for example, people with schizophrenia or bipolar disorder) is singled out and compared with a ‘normal’ sample in terms of brain activity.

Such research is dramatic in implication because it seems to reveal the neural basis of the state or activity in question. In the field of mental health, the drama is particularly powerful. Rather than relying on the highly ambiguous diagnostic criteria outlined in *DSM-5*, brain scans can supposedly reveal the different locations in the brain implicated in various pathological states. The guesswork is finished.

My concern here is with major flaws in the logic underlying the attempt to locate neural bases of human problems.

### **1. Plasticity**

To say that a given brain state is the underlying basis of a given problem is to specify the brain as the causal source. Thus, if the source of the problem is located within the nervous system, therapeutic intervention must focus on the alteration of the nervous system. By analogy, if one’s automobile fails to function properly, engine repair may be required. However, this argument is reasonable only to the extent that it is the structure of the machinery in itself that is at fault. If the failure of the machinery can be traced to a prior cause – falling outside its confines – then correcting the machinery is only a temporary and possibly futile effort.

This latter possibility is most obviously relevant in those brain

studies that attempt to isolate a singular process from an ongoing stream. Here, for example, researchers focus on the neural processes that are ‘responsible for’ memory, problem-solving, trust, meditation, prayer, political preferences and the like. In all such cases, however, various experimental manipulations or instructions are required to bring the state of the brain into its condition. To create a brain state that is indicative of ‘distrust’, for example, requires that circumstances of distrust are established in the laboratory. Thus the circumstances, it may be said, bring the state into existence. It is not the brain condition that is the basis of distrust but the conditions of distrust that bring about the brain state.

A more compelling case for neural origins is found in research that compares brain scans of people who are chronically ill with those who are deemed normal. Here, as mentioned, researchers might compare those diagnosed with schizophrenia, depression, ADHD or obsessive compulsive disorder with ‘normals’. Yet, while such research often reveals differences, the question of cause still remains. To what extent is it the brain condition that gives rise to the symptoms, as opposed to a preceding condition that brings about the brain condition? If one lives for many years under oppressive, stressful, hopeless or anxiety-provoking conditions, it is possible that cortical connections are altered. However, we may ask, could we not be more effective by attending to the precipitating conditions as opposed to their results?

It is at this point that an enormous body of evidence for neural plasticity becomes relevant. As wide-ranging research has demonstrated, the brain continues to reorganise itself by forming new neural connections throughout life.

For one, neurons can be developed to compensate for injury. Existing neural pathways that are inactive or used for other purposes show the ability to take over and carry out functions that have been lost to degeneration. Further, neurogenesis (the development of new nerve cells) enables the individual to adjust to new situations or changes in the environment. Although accelerated in the pre-natal period, neurogenesis continues into old age. To the extent that plasticity prevails, we may abandon the view that the brain serves as the chief determinant of cultural action; rather, it is the cultural context that determines how the brain will function.

To the extent that the plasticity explanation is reasonable, then the reliance on pharmacological ‘cures to mental illness’ is also thrown into significant question. If states of what we call ‘depression’ (along with associated neural markers) are not inherent in biology but are created culturally, then pharmacological cure is akin to tinkering with the engine to cure the lack of oil. To be sure, medications may enable one to cope with oppressive or stressful conditions. If properly sedated, the conditions are less arousing. However, without intervention into the conditions or enhancement of the person’s resiliency skills, we succeed only in contributing to a culture of zombies.

### **2. Interpretation bias**

Brain-scan studies have been welcomed with enthusiasm by many mental health professionals because they seem to provide an answer to the plaguing problem of inference. This is the problem of inferring the existence of a psychological condition (for example, depression) from behaviour (for example, inability to sleep).

Do brain scan data solve this notorious problem of inference? Let us take a

**‘To treat such suffering as biological in nature is not only to blind oneself to the proper origins but to insure that therapists are left only to treat the effects of our problems and never the cause’**

closer look. Consider again the dilemma of psychological diagnosis. We are presented with a collection of expressions that we classify as symptoms of an underlying condition, but we have no access to the causal condition itself. In effect, we have been forced to speculate that loss of appetite, lack of sleep and feelings of hopelessness are symptoms of an underlying state of depression. We now observe the neural condition of the person whom we have shakily diagnosed as depressed. We succeed in locating a neural condition that is unique to this population. Yet, we may ask, how can we determine that the observed state of the brain is in fact 'depression'? Why is it not simply a neural correlate of sleeplessness, appetite loss or feelings of helplessness? Or, for that matter, how could we determine that the neural state is not one of 'spiritual malaise', 'anger', 'withdrawal from oppressive conditions' or 'cognitive integration and regrouping'?

In effect, brain scan data do not solve the problem of inference but simply remove it from one site of ignorance to another. Brain scans do not speak for themselves. To read them as evidence of depression, deceit, trust, empathy, political preferences and so on is little more than exercising a subcultural bias. It is precisely the reading of the mind in terms of 'mental illness' that contributes to the massive diseasing of the population.

### 3. Winks and blinks

Neurological description is optimally employed in giving accounts of specific observations of the brain. Brain-state terms may legitimately be employed to explain various behavioural movements of the body when neurological conditions are constituents of the movements themselves. Thus, if I have lesions in my motor cortex, I may not

be able to move my arms or fingers. The condition of the brain is neurologically linked to the bodily movements; I am physically constrained in what I can do.

It is thus that the study of the neural mechanisms involved in conditions such as aphasia, Down's syndrome or brain tumours may serve vitally useful purposes. We are speaking in each case of a contiguous neurological system.

Yet we encounter severe problems when we attempt to apply the neural model to what we might call 'meaningful actions' within the culture. In carrying out cultural life, it is useful to describe various people as 'aggressive', 'moral', 'helpful', 'dishonest', 'humorous' and the like. We may usefully describe our emotional expressions as 'anger', 'happiness', 'love' or 'anxious'. Yet, while such discourse is critical to living an effective life within the culture, none of these descriptors is linked to determinate movements of the body.

To illustrate, consider the following bodily movement: my hand takes the shape of a fist, and I move my index finger back and forth. To be sure, there is a neurological basis for the spatiotemporal movements of the finger. But our cultural descriptors are linked only partially and contestably to movements of the body. If the movement of the finger is pulling the trigger or a gun aimed at another person, our description is far different than if the finger is used to beckon us to the bedroom. And it is crucial for effective cultural life to make a distinction between 'murder' and 'seduction'. The scope of neurological expertise ends with the account of the bodily movement; it is mute with respect to cultural meaning. Neurology can tell us much about the blink of the eye but nothing about the wink.

On this account, neurological accounts are highly limited with respect to most activity that we describe as mentally ill.

Consider an eight-year-old boy walking about the classroom while the teacher is talking. We may account for the specific movements of his body neurologically. But these movements are not themselves significant in the diagnosis of ADHD. The boy could have walked slowly or rapidly, haltingly or smoothly, stamping his feet or not. The precise movements are not at all important. What is important in labelling the behaviour as a symptom of ADHD is that the movements are inappropriate in the classroom setting. In the same way, activities that are described as compulsive, phobic or masochistic have no determinate neural correlates. More broadly we may say that most of the behavioural descriptions employed in the DSM cannot be described in neural terms. The behaviours in question may be infinite in their variation; it is the cultural meaning that enables us to identify them, and it is by working within these systems of meaning that change may effectively be accomplished.

### A more promising future

I am not at all proposing a termination of neurobiological inquiry into problems of human suffering or the pharmacological treatments with which such inquiry is identified. However, if the current trajectory in our understanding of human problems and their treatment is continued, we are collectively bringing about a cultural disaster. In my view it is essential first to slow the pace of the neurobiological juggernaut and, as we do so, to nurture the kinds of careful assessment that can yield more reasonable and culturally protective policies and practices. Three initiatives seem especially demanding of attention:

First, restrict the pharmacological alternative. Policies might be developed that would place medication as a form of final resort treatment, essential only

**'Brain scans do not speak for themselves. To read them as evidence of depression, deceit, trust, empathy, political preferences and so on is little more than exercising a subcultural bias'**

in serious conditions. Policies should also require full disclosure before clients are placed on medication. Coupled with responsible warning practices, programmes of drug reduction are vitally needed.

Second, prioritise cultural meaning. Pharmaceuticals can sedate those who are suffering and thus provide a temporary 'time out'. Yet the ultimate cause of the suffering remains unexplored. In my view, strong investments should be made into forms of therapy and related practices that are 1) maximally sensitive to cultural meaning systems and/or 2) engender skills in navigating a world of conflict, oppression and threat.

In the first instance, the tradition of talking therapies, from Freud through cognitive behavioural, do engage the client in meaningful conversation and provide a supporting relationship. However these traditional therapies are also circumscribed in terms of their focus. The more recent therapies, often labelled as postmodern, are more directly concerned with transformations in meaning. Narrative and solution oriented therapies, for example, are more concerned with the process of creating viable meaning than with changing what is traditionally viewed as 'mental process'. I find especially promising a range of collaborative therapies (for example, see Anderson and Gerhart, 2006; Håkansson, 2009; Seikkula and Arnkil, 2006).<sup>7-9</sup> Here the emphasis is on developing meaning within ongoing relationships, with special sensitivity to multiply constructed worlds, and to the action patterns in which language functions.

With respect to engendering skills of resilience, most promising at present is the development of meditation skills, a form of action that can furnish relief from the intense stresses of daily life.

Much needed, however, are means of enhancing skills in conflict reduction, detoxing personal failure, avoiding overcommitment, acting collaboratively and moving improvisationally across complex contexts. The challenge is to develop resources for moving through cultural life effectively as opposed to sedating ourselves for the journey.

Third, virtually all mental health research, treatment practices and policy formation are in the hands of professionals. In effect, those who have the most extensive and intimate experience of suffering, therapy and pharmaceuticals have virtually no voice in the decisions that affect their lives. Those who are affected by the profession should be systematically included in developing research policies and practices, in evaluating therapeutic procedures, and in generating more promising pharmaceutical treatment.

And last, at present there is precious little dialogue about how we might move ahead towards more mutually acceptable practices and outcomes. In effect, we are witnessing the formation of two combatant camps – the majority of mental health professionals on the one side, and on the other those who reject the 'therapeutic state' for its problematic diagnoses, faulty research and injurious drugging. Productive dialogue is rare. In my view it is essential that such dialogue ensues. It should include not only mental health professionals and their critics but also pharmaceutical companies, health insurance companies and the Government. The dialogue should move beyond mutual recrimination to considering the future wellbeing of the societies of which we are all a part.

Ultimately, the most powerful lever of change may be legal. There is one significant point of vulnerability in the current rage towards pharmacological treatment. Psychiatrists are essentially

using a disease model of diagnosis, and prescribing medication with virtually no basis for either the diagnostic categories or evidence of neurobiological malfunction. The side effects of these prescriptions – both biological and psychological – along with the disinterest in terminating prescriptions, are injurious to clients. Perhaps it is in the 'return of the repressed' that class action litigation will take place. I would count this as a victory for human wellbeing. ■

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**‘We are witnessing the formation of two combatant camps – the majority of mental health professionals on the one side, and on the other those who reject the “therapeutic state”’**

# Community conversations

*Colin Berry* urges counsellors to look beyond boundaried relationships and personal growth and work with communities towards social health recovery *Illustration by Gary Sawyer*

Do therapists have a role to play in the recovery of social health in the streets and neighbourhoods where people lead their daily lives? How we respond to this question may depend on whether or not we think therapists have a part to play in addressing environmental factors that contribute to individual distress.

Therapeutic work tends to be defined by its boundaries – boundaried relationships that support personal growth, self-development, and the relief of distress. Over time patterns may emerge – common features may be found in the presentations of those asking for help and then we are faced with choices as to what we do with these findings.

I was faced with such choices in the charity I founded in East London. We were providing individual counselling, which itself had grown from some really effective community development work on a housing estate. Over time, a pattern emerged among the people who engaged in this local counselling. Each person was under exceptional stress and felt incredibly isolated and alone with their difficulties.

From 2007 onwards we began providing counselling skills courses on the estate. Against a background of community fragmentation and people feeling cut off from one another, there was a noticeable pleasure in participation. People really enjoyed taking part in a course on their doorstep and getting to know other residents. There were significant psychological benefits too. There was a tendency for participants to maintain strengths-based outlooks, affirming their own resources and also valuing qualities and strengths in others in the groups. In addition, the act of sharing difficulties and setbacks with other participants assisted people in recovering after relatively brief periods of time.

At the time I was working with individuals in one-to-one therapy where

the sense of struggle seemed relentless: people getting knocked down by setbacks, needing time to get on their feet, only to be knocked down again. Were we learning that, in settings of hardship characterised by survival difficulties, there is a place for psychologically-informed community-building activities as well?

## Everyday conversations

We quickly moved away from counselling skills when we found that participants saw counselling as a special activity that special people do in a special room. What we wanted to achieve was something that would be relevant and useful in people's everyday lives. At first we called this 'listening skills for parents and carers' but gradually the training became about 'conversational skills' – supporting participation in active conversation and the nourishment gained from mutual exchanges of talking and listening.

Almost inevitably such enriching conversation fostered learning together about daily life. By its very nature conversation is an everyday activity and yet, when approached with sufficient openness, attentiveness and curiosity, it provides remarkably fertile material for growing imaginative interest and understanding. In a sense, everyday conversation can fire the imagination, for our brains seem hard-wired to catch fire through the sharing of vivid communications and stories. Traditions of storytelling recognise the part that social interaction plays in setting imaginations alight. Phillip Pullman, in his introduction to his collection of Grimm fairy tales,<sup>1</sup> celebrates the power of free, spoken language as altogether different from the written word. A fairy tale is not a text, he suggests, and to make it into a text is to put a robin redbreast in a cage. In a very natural way, the robin redbreast of our imaginations is set free through everyday conversation.



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## 'Her GP referred her for counselling for depression, but is the opportunity to speak with one person in particular the way to address a chronic breakdown of neighbourliness and community?'

Pictures get made in the mind as people talk and listen together. On the housing estate the vivid pictures that got made were of communities fragmented, of people feeling terribly cut off from those around them. One elder, for example, spoke of walking to the shops and not seeing anyone she recognised. The shopkeeper tended to be talking on his mobile phone and frequently made no eye contact; just held out his hand to take the money for her purchases. Despite having led a full and incredibly sociable life, this elder described her walk home in terms of depression and unhappiness. In my mind I can picture her as a sad and lonely figure – a picture that does no justice to the rich and remarkable life she has led.

Her GP referred her for counselling for depression but is the opportunity to speak with one person in particular the way to address a chronic breakdown of neighbourliness and community?

Those people who enjoy meeting new people may encounter many defensive walls. I vividly recall another elder, a retired professional, sharing her story of when she first moved into a quiet cul-de-sac. She made efforts to get to know her neighbours, visiting each in turn. She wanted to introduce herself and to find out if there were activities they might take part in together. One neighbour's response encapsulated that of each person she approached: 'I've got my books and my TV, what more do I want?' Rebuffed by each of her neighbours, this highly capable and dedicated professional was left with the equivalent of a closed door to conversation. Minds do go to difficult places when there are no opportunities for mutuality or feedback. In telling her story, she could share where her thinking went: 'Why have they closed the door on me? Is it because I'm black?'

Without opportunities to develop conversation, the details of the story

stay fixed, frozen or broken. Responses to the smoking ban illustrate what can take place. In public health terms, the smoking ban is seen as an enormous success as it has contributed to a reduction in the numbers of people who smoke. But has there been much attention to some of its unintended consequences? A traditional working-class man shared how every Friday night he and his wife would meet several other couples down the pub. His account conveyed to my mind customs of friendship built over time and of warm sociability. These were friends sharing a sociable drink and a sociable smoke. The smoking ban put the nail in the coffin to this tradition of friendship. 'We took the ban to mean, "We're not wanted here anymore"', he said.

Feeling excluded from a traditional meeting place is an outcome, I'm sure, no one would want. When social change takes place, opportunities to talk informally can greatly assist adaptation to those changes. On the housing estate where the charity was based, there used to be seven pubs; now there is only one. Of course, these closures can't all be put down to the smoking ban but how many of those who have stopped drinking in pubs also concluded, 'I'm not wanted here any more'? Where do those former pub drinkers socialise now? If we have in our minds a working model that, after significant social change, active and healthy parts of self shut down or die, we can picture how people can stop doing something they once valued, and quite possibly this much-enjoyed activity is never replaced. The situation is much less likely to stay fixed, frozen or damaged if there are relaxed settings where people feel safe to talk comfortably and freely with others. In such settings, the fixed 'I'm not wanted any more' can itself become a subject of curiosity and can be let go as unhelpful in a changing social world.

Social understanding is a term that psychologists use to describe how people think about themselves in social situations. It has clinical applications in mentalisation-based treatments;<sup>2</sup> however the Cambridge developmental psychologist Claire Hughes suggests that social understanding improves in everyday conversational settings, such as family meal times.<sup>3</sup>

The link between social understanding and an everyday activity like sharing a meal is significant. In many households meal times are not shared conversational times, either because a householder lives alone or because everyone eats in front of the TV. Do communication technologies reduce our opportunities to participate in satisfying conversation? In many neighbourhoods are we witnessing a steady reduction in the informal places where people can go for relaxed conversation?

### Social health

Good mental wellbeing and physical health are built on good social health. When social health declines there will be a corresponding decline in both mental and physical health. Robert Putnam, in his seminal work on social capital *Bowling Alone*,<sup>4</sup> highlighted the health effects of people leading insular, isolated and lonely lives. His findings are based on extensive data analysis and could not be clearer: 'The more integrated we are with our community, the less likely we are to experience colds, heart attacks, strokes, cancer, depression, and premature death of all sorts.'

A knock-on effect of poor social health can be that restricted outlooks get reinforced and maintained. Moment by moment, we move along a spectrum between:

- safety and fear
- open and closed
- enquiring and fixed or rigid
- curious and suspicious.

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## ‘If we stay within our fixed professional identities, the response we provide is already decided. There are very established ways of working with people and in a sense individuals just have to fit with what we offer’

A person who spends most of their time at the suspicious and fearful end of the spectrum will find it very hard to get to know anyone new. They will regard everyone as a stranger to be cautious around. A healthcare worker who lives on a local housing estate made the following observation: ‘Nowadays we don’t know our neighbours. We used to have a residents association but that stopped a few years back. A few of us would get to meet up in the local library – it used to be where word would spread about new people coming into the area. It helped as then you felt like you knew something about someone coming in. Since the council closed the library, we’ve got no way to find out about new people any more and I must admit it does affect you. I’m more guarded now. I don’t talk to anyone new in my block – you just don’t know where you are with them.’

His account captures how trust and safety can get eroded between people – if you don’t know people, you don’t know where you are with them. You are naturally more suspicious – in your own mind, everyone looks like a stranger.

### Social health reform

There are times when new paradigms are needed. We are probably going through one such time and the paradigm that is needed is for integrated social health reform. Social health is about the quality of people’s daily lives and crucial factors like how often they have the chance for nourishing conversation. If people do not feel nourished by enriching conversation on a regular basis, then something is lacking in their social health. Do therapists have a role to play in social health reform and, if so, does it require movement away from traditional ways of working into something more open, emergent and exploratory?

If we stay within our fixed professional identities, the response we provide is already decided. There are very

established ways of working with people and in a sense individuals just have to fit with what we offer. A more emergent position, on the other hand, allows for the possibility of not knowing in advance what people need. It allows for the possibility of learning with people about their daily lives and discovering together what will be useful and relevant. Such learning will be informal, conversational – a mutual and reciprocal exchange.

At the heart of conversational approaches are actions that support movement away from closed-in and rigid mindsets and that increase residents’ confidence as active contributors to the life, health and vibrancy of their communities. Esteem and meaning are gained from doing activities together that are seen as worthwhile and of value. In areas of high community fragmentation, where many people struggle with feeling isolated and alone, a worthwhile activity may be to join networks of emotional support – people choosing to make time to meet in an everyday setting in order to talk and listen together. By belonging to such networks, residents build esteem, dignity and worth. As one resident memorably said, ‘I’ve gone from me against the world to being part of a supportive community.’

A person who belongs to a supportive community is likely to feel they have a number of options that will help them manage in times of difficulty. By contrast, a person with a closed-in mindset may feel they have very few resources available to them and may rely heavily on problematic ways of coping. They may become isolated or housebound; they may try to avoid dealing with problems such as debt or ill health; they may turn to alcohol, over-eat, or become over-reliant on medication, whether street or prescribed. These observations surely suggest that, as therapists, we have a significant contribution to make

to rebuilding community life and improving social health.

### Learning networks

There is a growing movement for social learning in informal settings. A café or community centre may provide a setting where people feel willing and able to get to know others and to be curious about their readings of social situations. Intellectually, some of the contributors to this emerging field are Robert Putnam, Peter Fonagy, Claire Hughes and Sally Dunn.<sup>5</sup> But the ground is extremely fertile for direct learning – learning with people about their lives through informal, conversational approaches. In essence, these approaches have the potential to contribute to the re-building of communities and to improvements in community, social health.

This work cannot be done in isolation. Therapists who want to get more involved in community building will need to explore the partnerships and networks in which they can participate. By joining and creating networks it becomes possible to draw in resources – financial as well as human – and discover partners who may come from very different backgrounds to your own. ■

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# Self-care in hospice work

Counsellors exposed vicariously to the trauma of death, bereavement and dying need to pay particular attention to self-care, argues *Val Humphreys*

*Illustration by Gary Sawyer*

After 11 years of counselling in a children's hospice I have learnt the importance of caring for myself in order to be able to care for my clients. I have been a counsellor for a long time and I thought I was pretty good at looking after myself, but a recent incident shocked me into the realisation that my work was affecting me more than I had thought.

It started off innocently enough. I was at home, in the kitchen, discussing shopping with my husband. Our two-year-old grandson was coming to visit and we were stocking up with his favourite foods. My husband said something about grapes and I instinctively grabbed hold of him and shouted, 'No! Not grapes!' My heart was racing, I felt panicky and I could feel the adrenaline coursing around my body. My husband looked bemused and gently sat me down. I calmed down very quickly, although I was shocked and surprised by my reaction.

Immediately I understood what had happened. I hadn't suddenly developed a pathological fear of fruit; something had triggered traumatic material that I had absorbed in my work. Part of my role at the hospice is to support families in the community facing the death of a child. I had worked for over two years with a couple whose son had choked on a grape and died. He was 23 months old, their first child, and he was beautiful – bright, funny, full of life. I had come to know him well through his parents' loving memories and stories of him. I had also listened to heartbreaking, graphic details about how he died and

I had been exposed to the depths of the grief his parents were experiencing. They began seeing me three weeks after their son had died and their grief was visible, palpable and overwhelming.

I had been given a great deal of support with this case through supervision (both individual and group) and discussions with my colleagues. I am an experienced counsellor, well aware of the difficulties of working with traumatic material. I believed I had ensured that I had processed the material and I thought I was good at not taking my work home with me. I was wrong.

## Personal impact

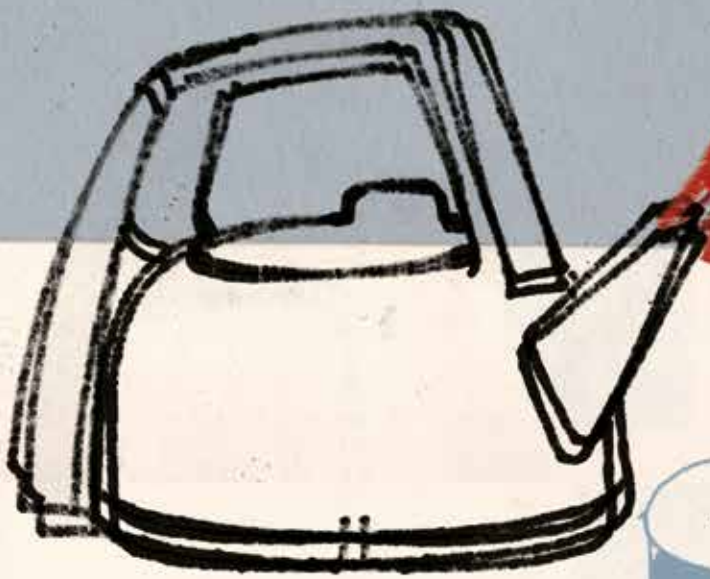
I decided to research the personal and professional impact on the counsellor of working with bereavement, death and dying for my dissertation for an MA in counselling studies at the University of Chester. I wanted to know if there were effects on the counsellor from accumulated experiences of clients' grief, what personal issues this kind of work brings up and if other counsellors sometimes found their defences had been unknowingly breached. I chose to do a heuristic study as I wanted to examine my own experiences and those of others working in this field. After discussions with colleagues and an initial pilot study, I conducted informal conversational interviews with five counsellors/psychotherapists working in children's hospices in the UK.

My study was small but the results clearly highlighted that counsellors who work within this field experience significant personal and professional

effects (both positive and negative) from exposure to traumatic material – to intense grief, death, dying and loss.

There's no doubt that these and other counsellors I have spoken to who work in this field feel they have been profoundly affected on a personal level. Indeed, many told me they feel they have changed as a person through constant exposure to intense, raw grief and dealing with death and dying. When asked about whether or not they had noticed a personal impact, one participant in my study said: 'The impact is immense, probably a lot worse than I like to admit,' and another talked about feeling 'wobbly' on occasions. For a third, 'The personal impact has been so profound and so significant that it's actually changed the way I practise.' Changes counsellors spoke about included the sense that their own defences were challenged by the accumulated effects of exposure to powerful grief and loss, resulting in worrying more, increased levels of stress and taking work home. One participant noted, 'The closer it is to home the harder it is to step back from it.'

The work is sometimes heartbreakingly bleak and, although there is much to be learnt about the resilience of human beings and their amazing ability to endure and survive, the bleakness is sometimes haunting and remains like a shadow in the mind and the heart. One of my study participants spoke of being able to be fully present with a newly bereaved family but, on leaving the hospice, she realised its impact: 'I got in the car and



I couldn't wait to get home and hug my children.' The danger of personal grief experiences being touched by those of our clients is also something to be aware of and participants agreed that it can be particularly hard if the client you are dealing with mirrors your own personal life in any way.

Counsellors spoke about their increased need for peace outside of work and many saw home life as an essential anchor. An interesting impact I noticed was that, although many counsellors talked about having a greater tolerance in general towards the behaviour of others (because you never know what has happened in someone's life), they also felt less tolerant of those complaining about trivial issues in everyday life.

Without exception there was an acknowledgement of the tremendous growth of self-awareness and personal development experienced through this work. The counsellors who had worked for many years in this field expressed a desire to contribute to research and pass on what they have learned.

### Professional impact

There is much to be learnt at a professional level in this field. Counsellors spoke about the limitations of some models of grief and the deeper understanding of grief and loss they had gained through working closely with death and dying. The participants in my study highlighted in particular what they had learnt from bereaved parents about the importance of continuing relationships with their child after the child's death. One participant noted: 'The parents' experiences didn't "fit" with some models of grief,' and that sometimes bereaved family members were said to be experiencing 'abnormal grief' or 'pathological grief' when in fact they were simply struggling to make sense of the enormity of the impact of the death of their child on them and their lives. Participants agreed that death in itself is difficult enough to understand but the death of a child is a truly terrible event, with powerful, ongoing ripples throughout the rest of the family. There is no comfortable 'resolution', 'moving on' and certainly no 'getting over it'.

The work is demanding and requires excellent professional foundations and extremely strong boundaries, but it also gives opportunities for working flexibly and creatively. The dangers of the seductive nature of the work (the need to be needed; being involved and effective in intense situations, crises etc) highlighted the importance of reflective

practice and reflexivity. Participants spoke about the sense of 'urgency' in crises and the intensity of some situations leading to a feeling of needing to stay late at work, not taking breaks or working longer hours. 'You have to take the chance sometimes when you can; miss it and you might never get it again;' 'Their time is precious and it isn't to be wasted,' they said.

A counsellor working in this field also needs to be emotionally robust and to develop professional resilience. The constant challenge can be overwhelming and the darkness of the work can create a sense of professional powerlessness as you can never give bereaved parents the resolution they desire. The pain of their loss is life-long.

There is a real danger of experiencing vicarious trauma, especially as the pressure of large caseloads leaves little time for thorough processing and self-care. All the counsellors I interviewed stressed the importance of supervision and those who had team support valued it enormously. Counsellors who felt valued and supported by the organisations they worked for fared better in terms of feeling less isolated and overwhelmed than those who had less support from their managers.

### Getting into deep water

For the counsellor working in this field there are myriad opportunities for personal and professional growth. Clients come from all walks of life, and many would never in a million years have expected to need to seek help from a counsellor under normal circumstances. Due to the intensity of the circumstances they face, clients come without their usual defences (or 'without their skin', as one counsellor put it) so working at depth can be instantaneous, without any gradual build-up. There is no place in the field of death and dying for pretence and every need for transparency and authenticity. When a child is dying the family need a therapist who is able to be professional but real, otherwise they are simply in the way. A therapist who can be there authentically can make a difference to clients facing loss, grief and death. The work is intense, gritty and demanding, but immensely rewarding.

The main dangers to the therapist as I see it centre around the challenges of the fundamental darkness of the work – the likelihood of sometimes unwittingly taking it home with you and your own issues being triggered, making you vulnerable to vicarious traumatisation. The constant pressures

of workload and accumulated stress can lead to compassion fatigue and burn-out.

Much has been written about vicarious traumatisation (for example, see Pearlman & Saakitne, 1995;<sup>1</sup> Papadatou, 2009;<sup>2</sup> Pearlman and colleagues, 2014<sup>3</sup>) and the importance of prevention, recognition and amelioration of its effects, which can be considerable and debilitating. For me the bottom line is to remember that if, as a counsellor, you are working empathically then, however much you protect yourself when listening to traumatic material, some of it will transfer over to you. Unrecognised, unprocessed and untreated vicarious traumatisation can lead to the dangerous deep waters of stress, depression, professional ineffectiveness and even compassion fatigue<sup>4,5</sup> and burn-out.<sup>2</sup>

### Coping strategies

Fortunately our bodies are pretty good at letting us know when something is wrong. It's easy when working with death and dying to get carried along with the urgency of the work – like being on a speeding train that you can't get off. We cannot, however, care for others effectively if we do not care for ourselves.

Counsellors experiencing symptoms such as disturbed sleep, unexplained irritability or extremes of emotion and changes to their normal behaviours, particularly if combined with panic attacks or a general sense of 'edginess' on a regular basis, would do well to pay heed to their health. Stress accumulates if left unattended and gets harder to let go of because we become accustomed to its effects. Our bodies try to tell us (for example, through painful, tight muscles and tension headaches) but we need to listen and take action.

Different people need different coping strategies but some are fundamental to all. Good supervision is of course essential, along with keen self-awareness and attention to boundaries. We are all different so some things will affect us more than others. We need to be alert to countertransference and to be clear about our responsibilities and limits.

In my own experience I have felt the dangers of over-identifying with bereaved clients, particularly now that I am a grandmother, as my experience with the grapes illustrates. Family relationships are frequently challenged by bereavement and it is not uncommon for parents to experience breakdowns in relationships with the wider family and friends after the death of their child. With one particular client whose child had died in an accident I realised that I

**‘Their own defences were challenged by the accumulated effects of exposure to powerful grief and loss, resulting in increased levels of stress and taking work home’**

needed to be aware that I was responding more as a mother to her than as a therapist, as her own mother seemed unable to support her. With another client I was aware of feeling defensive when she spoke of not being able to cope with her mother’s grief as well as her own. When counselling a couple whose daughter and grandchild were killed in an accident, I found it incredibly hard not to get lost in their overwhelming grief. I found myself picturing my own pregnant daughter and feeling helpless, inadequate and not really wanting to listen. Good supervision, team support and reflexivity all helped me to be aware of the dangers in these situations and to manage transference and counter-transference effectively, to the benefit of the work rather than to its detriment.

### **Boundaries and inner resources**

Attention to boundaries is something I try to keep at the forefront of my practice as it is easy to feel drawn into clients’ lives and be tempted to ‘cross a line’, partly due to the intense intimacy of the work and the sense of professional powerlessness that can be experienced when supporting bereaved parents. Thus I have found myself wanting to share my own stories of sleepless nights with a mother struggling with her new son 18 months after the deaths of her twins; agreeing to attend the wake after a child’s funeral (even though I don’t normally do this, and I recognise now that it was my need, not theirs) and having to clarify boundaries with hospice clients whom I am likely to meet in the hospice dining room or when attending hospice events.

Paying attention to inner resources, reflective practice, keeping grounded and maintaining a healthy life/work balance are vital. It’s easy to become isolated so support, both professional and personal, is also essential. Top of my own list is to remember to breathe and to build plenty of fun into my life.

All of the counsellors/psychotherapists I spoke to had their own safety measures and ways of paying attention to self-care. These included exercise (swimming, going to the gym, walking in nature, yoga), meditation and mindfulness, and conscious ways of letting the day go on the way home. Common methods included singing in the car, playing loud music or, at the other extreme, sitting, walking or gardening in silence.

As with any demanding therapeutic work, there are many professional and personal benefits for counsellors working in this field. There are tremendous opportunities for

personal and professional growth and development, including the privilege of working at depth with clients at possibly the most vulnerable and difficult time of their lives. There is so much to be learned from those who suffer, endure and survive; it is humbling and inspirational. Pearlman and colleagues<sup>3</sup> discuss the process they call ‘vicarious transformation’ whereby the therapist learns to deepen their own understanding of human strength and endurance through exposure to the pain and suffering of their clients and appreciation of their resilience. This understanding and growth of inner resources in turn enhances what the therapist can offer others.

To be involved intimately in people’s lives at such difficult times and to sometimes feel that being there with them does make a difference are a gift. It is significant that, despite the pressures and difficulties, most of the counsellors I spoke to continue to work in this field simply because they love the job.

Last, but certainly not least, is the salutary lesson that all those I interviewed underlined. If we learn anything from working in the field of grief, death and dying it is the importance and joy of cherishing life. We need to cherish ourselves in order not only to enjoy our lives but to be effective in our work with others. When working in deep waters, if we skimp on self-care for any reason, we are in danger of drowning, however good we may be at swimming. ■

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*Charles Brown* draws on his own clinical experience to explain why racial difference needs to be brought into the supervision process

The elaboration and elucidation of how competences for multicultural supervision become an integral part of the supervision process is one of the greatest challenges posed to supervisors today. Often training has not sufficiently addressed the particular issues that arise in multicultural and inter-racial supervision. This article will focus on those challenges in supervision and show how issues are dealt with. Several brief examples are presented to illustrate the challenges and opportunities opened up by these issues.

In this article I use the term 'black' generically to include people who are of African or Asian heritage, and the term 'culture' to refer to the customs or traditions common to a community. Similarly I use the term ethnic to encompass both race and culture and to include personal identity. I draw on my own experiences as a black therapist working within a predominantly white British culture and providing supervision in a variety of settings.

My approach to group supervision understands that the human mind is interactive rather than monadic and that the group supervision process occurs between subjects rather than within the individual, enabling meaning and understanding to be co-constructed. The supervision of counsellors who do not share the same race, language or culture as the client and/or the supervisor has become increasingly relevant as British society becomes increasingly diverse.

To some degree the neglect of minority groups has been a particularly British phenomenon, with difference not being explored very much within the supervisory context.<sup>1</sup> The effects are to obscure the understanding of

the client and deny an important aspect of identity, resulting in poor quality treatment and uncovering a form of pathology in the therapist.<sup>2</sup> Although the counselling profession is beginning to engage more with issues of race and culture, it is still relatively rare to see real clinical engagement with these issues. Holmes argues that supervision is a necessary tool for therapists with respect to addressing racial problems, maintaining that race is always a factor in any therapeutic situation.<sup>3</sup> It is therefore crucial that issues are addressed with cultural sensitivity and an understanding of the different cultural models.

When the supervisor, supervisee and the client all have a different racial and cultural heritage, the supervisor must be attentive not only to the possible complexities of difference in the therapeutic process but also to those within the 'counselling culture' that dictate how the supervisor listens, what they listen for and how they hear.<sup>4</sup>

**Multiple transactions**

The process of group supervision inevitably involves multiple transactions at multiple levels, intrapsychically, interpersonally and intercultural, and must therefore encompass race. Any exploration of race in supervision involves the exploration of the responses of all participants (client, supervisee and supervisor) to uncover the powerful dynamics of racialised enactments co-created by the subjectivities of each participant.

One group I supervised had taken to referring to the Asian member of the group as 'Tim', which obviously was not his name. This came to light when the supervisor asked his name and thereafter

# Race and supervision

used it in the group. The supervisee's work greatly improved and he himself was visibly transformed, remarking, 'When I anglicise my name, I also, inadvertently, seek to deny my ethnicity – and without authenticity, without honesty, without accepting who I am and where I have come from, I cannot be an effective [therapist].' The supervisee was able to bring race into the supervision for the first time and to use the space to reflect on this, thereby allowing a more authentic approach to the work and for any blind spots to be addressed.

In a different setting, the supervisee's client was burdened by stress at work and in her personal relationships. Her mother, who was Portuguese, had sent her to live with her grandparents in Africa as a toddler. Later she returned to live with her mother, who regarded her as stupid and ugly. The client's depression and suicide attempts had meant that she had to take time off work. She had begun to experience hostility rather than sympathy and understanding from her colleagues and her commitment to her job was questioned. When I asked the supervisee about the possibility of a racial element in the work, it marked a turn of events: the supervisee reported how liberating the question was for the client – that one question transformed the therapeutic relationship. The exploration within the supervision group of these racial elements enabled the limiting attitudes in the work to emerge and be acknowledged and worked with.

Since the primary goal of supervision is to promote learning, we need to explore limiting attitudes in the supervision space. Supervisors must be able to provide supervisees with ways of thinking about and working with racism

**'When I anglicise my name, I also, inadvertently, seek to deny my ethnicity – without authenticity, without honesty, without accepting who I am... I cannot be an effective [therapist]'**

and its presence and possible meanings in the clinical setting. Addressing racial and multicultural issues is often avoided because it can often induce shame in the white counsellor.<sup>5</sup> Shame in the supervisory setting will also limit development and result in decreased empathy and an inability to work with clients.<sup>6</sup> A more thorough core clinical training can help to mitigate these issues, leaving the supervisors free to focus on the task of supervision. An understanding of race and culture is a basic clinical competency.

For example, in a group of four supervisees – two white, one Asian and one African – a white British female supervisee was working with a client of mixed heritage (Jamaican/British) when material about racial bullying and abuse arose. She asked the client if he would like a different counsellor to talk about these experiences with. In the supervision group the supervisee was surprised to discover that what she meant was someone of similar racial origin to the client. Not only does this reinforce racial stereotyping, it also allows racism into the consulting room. It was when thinking about the significance of this material that the supervisee came to realise that she was seeing who the client was not,

not who he was. The underlying block to her listening and thinking about the material appeared to have been shame, specifically towards me, her supervisor (and also black). The ensuing discussion enabled reflection on the supervisee's own racial and cultural subjectivity that had influenced her responses and also clearer understanding of how culture shapes our sense of self and other.

### **Responding to difference**

Bradshaw<sup>7</sup> states that: 'Due to real or imagined fears of the supervisor judging them to be ignorant or even racist, the white counsellors inhibit their own capacity to understand or to respond to the client.' He goes on to say that supervisees may feel caught between two hostilities – the black client and the black supervisor – and produce defensive distancing, pseudo kindness to the client or over-indulgence.

The task then is to find strategies for responding appropriately to difference – that is, in terms of dynamics of black and white – and to illuminate implicit assumptions in the supervisee's subjectivity that may impact negatively on the learning process. Supervisors and supervisees can often collude in same-race and cross-racial dynamics, which are then mirrored in the supervision space by focusing on the environmental dimension alone to explain the multi-faceted conflicts. In proposing strategies for engaging with racial issues and acquiring multicultural openness, it is worth noting that the supervisor who initiates discussion about race and culture enables open discussion while mitigating experiences of shame.

White supervisors who focus attention on black culture could be doing so in

order to avoid the reality of white racism. This preoccupation can result in the supervisor and the supervisee perpetuating limiting attitudes, falling in with prevailing stereotypes and myths and not being able to acknowledge the client's experiences.<sup>8</sup>

While it is undeniably true that ethnic minorities are most often seen as victims, white people may be victims too. The process by which jealously guarded ethnic and cultural superiority become meaningful in the group supervisory context are brought into play in the inter-subjective reconstruction of identity and relationship, as seen in the examples that follow.

A white German therapist was doing time-limited work with a client of white British origin. The therapist reported in the supervision that in an early session her client said that she had resented her older sister for taking all her friends from her when they were growing up, so that she was left to play with a 'half-caste' girl. Thinking about the meaning of that expression brought up the possible presence of racism, which the supervisee acknowledged. However she offered no further comment.

When the therapy was concluded, I carefully enquired how the issue had been worked with. The supervisee expressed an underlying feeling of anger throughout the work with this client and went on to say that she herself was a mother of mixed-race children and that she had been unsure about sharing this in a supervision group, where she felt she might have been judged by both the black supervisor and by her peers. Further discussion raised issues of safety and the supervisee's attempts

**'The supervisee was surprised to discover that she meant someone of similar racial origin to the client. Not only does this reinforce racial stereotyping, it also allows racism into the consulting room'**

to avoid exposure and being typecast by the supervision group members, who included a white British person, a Jewish person and the black British supervisor.

A very experienced supervisee who was of Indian heritage had been working with an older white female client who was training to become a counsellor. The supervisee soon began feeling interrogated and to experience subtle put-downs from the client. This was re-enacted in the supervision when I said something about competing and competitiveness, which evoked issues around competency for the supervisee. The supervisee began anxiously to explain her actions and why she had taken them. In her haste the supervisee began referring to the client as 'the teacher', thus illuminating the difficulties inherent in both the supervision and the work. The uncovering of the racial strands had left the supervisee feeling deskilled. Work was able to begin in the group on re-empowering the supervisee through use of affirmations, maintaining curiosity and reconstituting self-belief.

Supervisors need to be able to recognise culturally specific idioms of distress in and between the supervision group members and in and between the

work: ie. misunderstandings, lack of respect, and failures to acknowledge culture-specific behaviours and customs. These can be attributed to supervisees feeling less-than or the reigniting of old defences that manifest as rivalry and withholding between the group members and early drop-out rates and failures in the treatment of the clients.<sup>9</sup> Supervision offers exploration of limiting attitudes with respect to awareness of and ways of working with race in the supervision group and within the clinical work.

Recognising and dealing with issues pertaining to race and culture involve encountering and understanding the processes of othering and one's own difficult feelings. The supervisor with a more open approach can help their supervisees explore the identifications they have with members of ethnic minority groups and how their racial attitudes can influence behaviour towards different racial and cultural groups. Supervisors carry a great responsibility for helping their supervisees locate their cultural vulnerabilities. Effective supervisors promote an authentic understanding of the relationship between the supervisee and the client. To do so, supervisors must create an atmosphere in which supervisees are free to explore culturally or racially sensitive experiences, assumptions, and beliefs. Attention to the cultural and racial contexts of the treatment/supervision process requires all involved to examine personal beliefs. ■

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*Charles Brown is a psychotherapist and supervisor with a private practice in South London. He supervises in a variety of settings and also lectures on supervision.*

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# How I became a therapist

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## Roger Helyar

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**I realised person-centredness was a significant part of my life – a lifestyle, not something I'd learnt from a book**

I am severely dyslexic, although throughout my schooldays this remained undiagnosed, so I left not even sure how to spell my own name and address. School labelled me stupid, a non-achiever, a failure. I knew I had abilities, as I'd been school chess champion for three years. I began to research this inconsistency, and heard about dyslexia, but it wasn't until my 40s that I obtained an official diagnosis.

At home mum and dad were smart enough not to hand me answers on a plate. Rather, they made me think, gave me pointers, listened and dialogued with me. I learnt tenacity, empathy, integrity and, above all, common sense. After leaving school I got a job in Bournemouth demonstrating and selling musical instruments. I noticed families often wanted to return the instruments after a few months, saying they had lost interest in learning to play. I researched and realised the major stumbling block was the music teachers; so I developed my own teaching style, learning from pupils of all ages. Much later, this method was ratified by a Certificate in Teaching from the Associated Board of the Royal Schools of Music.

I married Liz and we moved to Exeter. There we quickly became good friends with John, who had a learning disability. Perhaps naively, when asked we took in his friend who had become homeless. We helped him develop life skills, enabling him to move on. For several years we continued to have a steady flow of men coming round for help, advice and friendship. However, some kept returning with the same problems. So in 1985 we opened Rockhaven, a residential family community with a Christian ethos, providing 24/7 support for those struggling with past or current life

events. Men from all walks of life came to live with us, including ex-prisoners, abusers, addicts, those experiencing loss of faith, marriage or mental breakdown.

I offered these men a simple form of counselling and, wanting to go deeper, took our therapy outdoors with activities like coastal walks, camping, music and repairing cars. These proved both popular and successful.

Realising the need to see an experienced counsellor, mentor and supervisor, I went fortnightly to Gordon Wright, the founder of Crossline Plymouth, who advised me that if I was expecting psychologists and psychiatrists to listen to what I was observing, I needed to get some qualifications. The thought of writing essays and reading reference books filled me with dread. But I joined a basic 50-hour course run by the Association for Christian Counsellors. Some years later I applied to join a certificate course but, because I had so much practical experience, was offered a place on the advanced diploma course. Once again I was on a very steep learning curve, but I successfully completed the course.



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**'I could identify with people who didn't fit the norm and I could also recognise the impact on people's lives of ill-conceived ideas and inflexible structures'**

Significantly, the only book on counselling I've ever managed to read was the first edition of *Person-Centred Counselling in Action*, by Dave Mearns and Brian Thorne. It really resonated with me; I realised person-centredness was a significant part of my life, starting with my parents' way of being, the music teaching style I developed, the work at Rockhaven – in fact, I now understood it to be a lifestyle, not something I'd learnt from a book. This grounded my counselling approach, which uses empathy, common sense, and when appropriate, my personal experiences.

Later I completed a PGC in supervision with Dr Kathy Raffles, who was able to work with my dyslexia and the practical experience I brought to the course. At school I was a square peg in a round hole. Now I see this as a benefit: I can identify with people who don't fit the norm and I can also recognise the impact on people's lives of ill-conceived ideas and inflexible structures, both in organisations, religion and society.

More recently I counselled David, a trauma client who had escaped from captivity after two years of torture, leaving behind his 47-foot boat in Africa. A year after much healing had taken place, David and I met again and talked about men who were struggling to express their feelings, and boats. Subsequently, we started Rockhaven Adventure Therapy, based around our motor cruiser, RockHaven Boat.

I enjoy working and living on the edge. Counselling goes a long way to ticking this box, but, I must emphasise, only with good supervision. For that I am grateful to Kathy Raffles, who holds me to account. I recognise she has her work cut out keeping me on the straight – but not necessarily – the narrow! ■

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*Roger Helyar is a Registered Member MBACP (Snr Accred), a Fellow of BACP and of the National Counselling Association and founder of Rockhaven Therapy, offering counselling and supervision in Exeter and the South West. [www.counsellingrock.co.uk](http://www.counsellingrock.co.uk); email [roger@counsellingrock.co.uk](mailto:roger@counsellingrock.co.uk)*

# Setting up a co-operative

*Justine Gore-Smith* describes how she and her four colleagues launched a counselling co-operative after being made redundant by their local county council

In the autumn of 2011, as a result of the austerity measures, five of us found ourselves no longer employed as youth counsellors with our local county council. We knew that there were few other trained counsellors with the same breadth of experience working with young people, and that the demand for good quality, specialist counselling in that particular area was still very high.

So we decided to set up on our own to fill the gap in provision created by our own redundancy. The name 'Phoenix' came easily to us, reflecting the fact that we were starting afresh. But why did we choose to become a co-operative?

## Why a co-operative?

We wanted an egalitarian business where everyone's input, experience and opinions would be heard and respected. We wanted to feel it was our own enterprise and that we could all shape and influence how it was run. And we wanted a model that would reflect one of our core principles: working together to provide an ethical, professional service. A co-operative fitted the bill best.

We contacted the Co-operative Enterprise Hub,<sup>1</sup> which advised us to apply for a grant from Co-operative Futures,<sup>2</sup> which we successfully did. A representative from Co-operative Futures met with us several times and advised us on many aspects of forming a co-operative, including how to register with Co-operatives UK<sup>3</sup> and the Financial Services Authority (FSA), how to decide and divide our roles, how to write and maintain a business plan, governance policies and procedures, the difference between customers and users, and also what type of co-operative would best suit us – as it turns out, there are several different types. We chose an industrial and provident model as this was the best fit for us as individuals working together with a common aim.

The help that we received was invaluable. Over the next few months we went through a very steep learning curve as we faced several challenges while at the same time fulfilling our first contract – providing counselling for staff at a secondary school. We had to learn how to write a service level agreement, keep and maintain our financial records, have a social media presence, set up a website, put out a press release and give a subsequent interview, choose our design and logo, decide what information to put in leaflets, and how to network and pitch our services to potential new customers.

Many of these skills were new to us and some did not come easily. Even in relation to counselling – our main strength – there were decisions to be discussed and made: which of us would take on our first few clients, which services exactly we wanted to provide and what we should charge.

All of this took place around our own private practices and existing work commitments. We met (and still do) at each other's homes. We use a shared mobile for incoming calls and we deliberately keep our overhead costs low so that we can provide as much counselling as possible free at the point of delivery.

## Challenges and benefits

We spent a lot of time chasing potential leads and went to several meetings that led nowhere. Again and again we heard that budgets were being cut, that there wasn't money available. GP surgeries that knew us from before and wanted to use us were unable to, due to lack of funding. Where we did win contracts, we weren't always able to offer everyone open-ended counselling (ideally this would be our aim) because it wasn't always financially or logistically possible (due to waiting lists or finite funding, for example). Customers often expect

us to be available full time and to get replies to emails and phone calls sooner rather than later. A one-day-a-week counselling post at a school can take up a lot of extra, unpaid time.

We also faced different interpretations of confidentiality and room suitability. Customers would sometimes try to discuss clients in more detail or less privacy than was ethically appropriate. When we worked with the county council we had our own private, suitably equipped counselling rooms, but now we were at the mercy of others' choices and what equipment we were able to bring with us, often on public transport. In some cases we can be given a different room and time slot from week to week.

In addition, if our contracts don't pay on time, we are unable to pay ourselves, which obviously has implications for our personal finances and budgeting. This has been a major difference to adjust to after working in the public sector, and it's been hard to get across to our customers that we are just a small set-up with few reserves, so we need to be paid on time. In fact we've had to change our policy to insist on payment up front when we don't have a rolling contract with a customer. Financial issues are barely touched upon (if at all) in counselling training, and it's been particularly challenging to develop our fiscal policies and deal with late payers. When you're in a helping profession it seems almost inappropriate and often awkward to bring up the emotive subject of money.

Dealing with HMRC, swapping roles, updating our guidelines – the challenges are ongoing and shifting. At the time of writing, it's looking like we will hit the VAT threshold later this year, which we didn't expect to happen so quickly. This is going to provide us with yet more new issues to tackle.

Alongside the challenges, there have of course been many benefits. We have been

able to take the best aspects of our work – essentially summarised as our passion for delivering high-quality counselling tailored to the individual client in an ethical and professional manner – and apply our principles in a method of our choosing, without red tape, unnecessary meetings and restrictions. We are answerable to each other, and we all understand the realities and practicalities of the job. This is all good.

Every week, we meet to discuss and update each other on our existing contracts, any new referrals, our finances and any other relevant issues. This has always been a meeting of equals. On alternate weeks we make time for peer supervision, which has been both clinically helpful and of enormous benefit in helping each other to feel supported and connected in a profession that can feel very isolating at times. Once a year we have an AGM, which includes associate members too, and a Christmas event. As well as being colleagues for a number of years, we are friends, and it's important to us that we recognise this important aspect of our co-operative.

Recently we have been able to contract a former colleague to help us with some of the admin. Working again with someone who knows our history and understands what we are trying to do has been a positive experience that has also relieved us of some of the more time-consuming and onerous tasks, thus easing the workload.

Being a team of five means that there are enough of us to see siblings or other family members of a client and we can liaise easily where needed. This wouldn't be as simple to organise if we were working independently from each other. When we are in schools and seeing both staff and pupils, confidentiality and boundaries are maintained – and if there are two or more of us in a school we can try to ensure that best friends/worst

## **'We have been able to take the best aspects of our work... and apply our principles in a method of our choosing, without red tape, unnecessary meetings and restrictions'**

enemies (often the same people!) are seen by different counsellors.

I think the biggest benefit has been to see our original, fledgling idea take shape, evolve and grow. Phoenix has become an organisation that we are all proud to have founded and continue to shape. I don't think any of us expected that in just over three years we would be at full capacity and have worked or be working in more than 10 different schools, colleges and early intervention hubs in the county.

### **The future**

Looking forward, it's hard to predict how things will stand this time next year. All of our contracts are for 12 months, and any one of our customers could decide not to renew for the next academic year. And the busier we get, the harder it is to schedule irregular services like restorative supervision, which may only take place on a monthly, or even termly, basis. We want to be able to offer a wide range of services and we want also to continue to be able to provide the services our customers are used to getting from us.

Interestingly, and more recently, we have found ourselves creating bespoke products and services in response both to requests from customers and trends that we've seen in our client base. We produced a self-harm leaflet<sup>†</sup> for parents and carers in direct response to the high levels of self-harm that we

were all witnessing and working with in teenage clients. It has been very well received, and this may lead to us creating more leaflets for other areas of concern. Having it available as a download means that direct costs have been minimal.

We've also been developing exam stress workshop materials in response to a request, and we may well see further demand in the future for training and tailored materials on specific issues. All of this means the future is uncertain but exciting. Not only do we want to continue to provide free-at-the-point-of-delivery counselling and supervision but we want to be a voice for child and adolescent mental health issues. Keeping these core principles in mind has led us to where we are today and we hope it will continue to guide us in the future.

Starting up on our own has by no means been easy, but it has been immensely rewarding. We've found that being determined yet flexible, focused on our goals yet open to new opportunities and, most importantly, being fair and honest with each other have created a warm, fulfilling and above all supportive working environment that we all enjoy belonging to, and of which we also have a real sense of ownership. ■

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*Justine Gore-Smith is one of the members and founders of Phoenix Counselling Cooperative. Visit [www.phoenixcoop.co.uk](http://www.phoenixcoop.co.uk)*

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*This article was first published in the June 2015 issue of Children & Young People. See [www.bacpcyp.org.uk/journal.php#q1](http://www.bacpcyp.org.uk/journal.php#q1)*

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## Confidentiality after a client dies

### This month's dilemma

Fabienne works as a counsellor in a hospice that prides itself on offering support for both patients and their relatives. Fabienne's client of six months, Louisa, has just died, having recently been reunited with her son and daughter, now in their 40s, who were adopted at an early age. Louisa had only met them twice but the meetings had gone well and she had so much she wanted to tell them about her life. She had shared her joy at seeing her daughter and son with Fabienne, and was looking forward to telling them her life story, but died earlier than anticipated.

Louisa's children knew she was having counselling and have written

to Fabienne at the hospice asking to meet her. The nurse manager, who is not a counsellor, thinks this would be the right thing to do, and Fabienne is very tempted to meet them as a final service to Louisa. However she suspects that she will be tempted to tell them things that Louisa told her in counselling, as she knows Louisa would want them to know these things.

What should Fabienne do? Please note that opinions expressed in these responses are those of the writers alone and not necessarily those of the column editor or of BACP. You can read additional responses to this month's dilemma at [TherapyToday.net](http://TherapyToday.net).

### Don't risk opening a can of worms

**Zoe McPherson**  
Family Support Co-ordinator,  
Pendleside Hospice, Burnley

As a compassionate person, I would say Fabienne should tell Louisa's children the story of her life on her behalf. Tell them about her joy at meeting up with the two children she gave away for adoption. Tell them the reasons for the adoption, if she knows, and ultimately give them an insight into the mother they never knew and now never will. But, as a professional counsellor working in hospice care, I would say don't do any of these things: Louisa had a right and still has a right to confidentiality.

Fabienne says that she knows that Louisa would have wanted them to know about her life but how does she know this? How does she know that she will not 'open a can of worms' by speaking to the children? If she gives them even a glimpse into what kind of a woman their mother was, it is human nature to want to know more, and at what point does she stop?

More controversially, we live in a culture of blame and how does Fabienne know that the children will not make a complaint against her or the hospice for causing 'emotional distress'? Therapy is based on privacy and confidentiality but a counsellor's duty of confidentiality does not end when a client dies.

The fact is Fabienne doesn't know Louisa's children's agenda. Yes, they could simply want to hear more about their biological mother, but they could just as easily harbour feelings of anger and hurt at being adopted – to say nothing of the fact that they are also grieving for their mother and possibly for what could have been. If I were in Fabienne's position, I would explain to the nurse manager why I was making the decision not to meet Louisa's children.

**'If she gives them even a glimpse into what kind of a woman their mother was, it is human nature to want to know more, and at what point does she stop?'**

I would explain that if the children had asked for Louisa's medical records they would not be given to them, so why is this different? Finally, I would write to the children and explain kindly, empathically and with much understanding why I am unable to meet them, in the hope that they will respect their mother's right to confidentiality.

### It's not her story to tell

**Doreen Fleet**  
MBACP (Accred) independent  
counsellor and award leader for the  
MSc/diploma in psychotherapeutic  
counselling, Staffordshire University

This dilemma, although challenging for the counsellor, appears fairly straightforward in terms of making a decision. The ethical principle of being trustworthy and honouring the trust placed in the practitioner is most relevant here. In my opinion Fabienne has a duty to hold confidentiality, despite the client now being deceased.



Offering a confidential space in the counselling relationship enables the client to freely explore their issue, with the boundaries being explicitly communicated by the counsellor in the contracting stage prior to obtaining informed consent from the client. Obviously Louisa's consent to breach that confidentiality and disclose details of her life story that she explored in therapy cannot be obtained. If Fabienne were to agree to meet with Louisa's son and daughter and disclose information from the counselling sessions, she would be in breach of that contract.

Fabienne knows that Louisa was looking forward to telling her son and daughter her life story. It is presumptuous of Fabienne to think she could place herself in Louisa's position. She has listened to part of Louisa's story but not lived that experience herself. More importantly, it is not her story to tell. What is not evident in the scenario is whether Louisa has any other living relatives who could possibly be affected should Fabienne disclose Louisa's life story to her reunited adult children, and it appears that this possibility has not been considered, either by Fabienne or the nurse manager. Furthermore, Fabienne was told by Louisa that her first two meetings with her son and daughter went well but there is no way of knowing how the next meeting, had there been one, might have been, or how a potential meeting with Fabienne

in which Fabienne tells Louisa's story would be for the son and daughter.

With regard to the nurse manager of the hospice who is not a counsellor but who believes it would be right for the meeting to go ahead, it is likely that they may not fully appreciate the boundaries to confidentiality according to the counselling context and the BACP *Ethical Framework*. In my view, it is important for Fabienne not to be swept along with this emotive issue and to carefully consider the commitment to confidentiality and inform the nurse manager about the ethical requirements that need to be maintained, even for a deceased client.

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## It may be a kindness to meet them

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**Penny Toller**  
**Registered MBACP (Accred)**  
**counsellor and psychotherapist in a**  
**community mental health centre and**  
**private practice**

Maintaining client confidentiality is so fundamental that any temptation to break this boundary serves as a clear warning to the counsellor to tread carefully. Presumably, as a hospice counsellor, Fabienne is used to keeping what she hears confidential and holding her own feelings in check in distressing

circumstances. She is sufficiently self-aware to fear she may not be entirely in control of herself were she to meet with Louisa's adult children.

So I wonder what it is about this particular client and her story that has triggered this response. Perhaps Fabienne's own personal issues have been disturbed in some way? I hope she would arrange supervision time before she makes any decision about whether to meet with Louisa's children as she needs to be as consciously aware as possible of her own needs and impulses in this situation and understand some of the vulnerabilities she is feeling.

What was said in her sessions with Louisa is confidential and remains a matter of trust between them, even after Louisa's death. How Fabienne has formed the impression that Louisa would want her to reveal more about her life to her children, or why it feels so important to speak on Louisa's behalf, is not entirely clear. I assume Louisa did not give explicit permission for Fabienne to do this or maybe it was implied at some stage, but it is a crucial issue to discuss with her supervisor. Without a clear understanding of how her own feelings and needs have got into the mix, Fabienne will find it difficult to keep appropriate boundaries in any meeting.

Her colleague, the nurse manager, may not fully understand that the professional boundaries for a counsellor are different from their own, and good counselling boundaries can sometimes be experienced as withholding by other colleagues. They may feel that it would be helpful for Louisa's children to hear more about their mother's life, although the risk for Fabienne too is that it may raise painful and tantalising questions that can never now be answered. It is important for Fabienne to seek the support of her supervisor, who can affirm good ethical practice and help her hold her ground if under pressure at work to act against her better judgment.

It is understandable that Louisa's children want to meet a person who was close to their mother in her final illness. If Fabienne is able to tease out in supervision where the boundaries lie between what can be shared and what kept confidential and prepare carefully what she is actually going to say, then it might be a simple human kindness to meet with them. But if she still doubts her own capacity to hold the boundaries, I hope she would opt for safety and write a letter in response to theirs in which she can at least convey something of the care and respect she felt for Louisa.

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# Confidentiality must take priority

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**Sara Mathew**  
Registered MBACP (Accred) hospice counsellor

Louisa's confidentiality must take priority even though she has died. Louisa shared things she thought she would like to talk to her children about. This is different from actually talking to them and engaging with their questions and responses. Were Fabienne to give way to temptation she would immediately be acting beyond her knowledge. She cannot know how Louisa might respond to the reality of her children, as opposed to an imagined, possibly idealised conversation.

I wonder if there are other members of staff at the hospice who had contact with Louisa who might be able to meet her children and share things with them about their mother's care? Perhaps the nurse manager might be involved in such a meeting to offer a compassionate and appropriately bounded conversation?

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## Potential to cause distress

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**Claire Thomas**  
Registered MBACP person-centred psychotherapeutic counsellor, Oxfordshire

It is not too presumptuous, given the nature of the counselling environment, to assume that the event of Louisa's death would have been discussed

between Louisa and Fabienne, even though it occurred much sooner than anticipated. Fabienne is said to 'know' that Louisa would have wanted her children to learn certain things about her life. It could perhaps be argued that Louisa's desire to share certain aspects of her life story with her children may suggest implied consent for Fabienne to pass this information on to them. But how could Fabienne know whether this information would be of benefit to them or a cause of potential distress?

Fabienne has had quite limited access to Louisa's life story and probably has little knowledge of how those pieces of history may affect her children. It is not stated how long after Louisa's death her children wrote to Fabienne; this may also have an impact on the extent to which the disclosure of information regarding Louisa has the potential to cause distress to her surviving relatives.

Fabienne works in a hospice and I wonder how this impacts on her wellbeing. How did Louisa's death affect her personally? Is this something she has discussed in supervision? To what extent is Fabienne's temptation to meet with Louisa's children part of her own response to Louisa's death – perhaps a need for a continuing bond with her?

Confidentiality, as far as I am aware, does not cease when a client dies. Although Fabienne feels she knows what Louisa would have wanted, this is not something she can assume. Louisa had not chosen to share her life story with her children, and there may be good reasons for this. It doesn't seem appropriate to assume that Louisa's expressed desire to share

**'To what extent is Fabienne's temptation to meet with Louisa's children part of her own response to Louisa's death – perhaps a need for a continuing bond with her?'**

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her story with her children is equivalent to consent for Fabienne to disclose this information.

I would suggest that Fabienne takes this to supervision as a matter of importance. She would, I think, find it helpful to discuss with her supervisor her feelings about Louisa's death and what is tempting her to want to meet her children and discuss Louisa's life with them.

I would also suggest that Fabienne meet with the nurse manager to discuss the issues around this situation as it seems likely to recur and it would be supportive for Fabienne to know the team around her understands her role and respects the importance of confidentiality within a counselling relationship.

I would advise Fabienne to write a letter in response to Louisa's children, expressing her condolences for their mother's death and explaining about the boundaries of confidentiality within a counselling relationship. I would want to empathise with their feelings of loss and their desire to find out as much about Louisa as possible. However I do not feel it would be appropriate to go any further than this.

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## September's dilemma

**Malcolm, a counsellor, attends a Bible study group at the house of his friend Tariq, who is also a counsellor. A stable core of members has formed over the years and, as well as studying the Bible, the group provides a space for mutual self-help and members frequently discuss personal and existential issues at a profound and moving level. For Malcolm, as for the other members, the group feels sacred and nurturing. Like Malcolm, Tariq always shares his own issues and engages with the self-revelations of the others.**

**Caitlin, who has been attending the group for several months, recently disclosed within the group that she is one of Tariq's private counselling clients. Malcolm is appalled, and concerned about Caitlin's presence**

**and the way in which Tariq interacts with her in front of the group. However he finds the group extremely valuable and emotionally supportive, as do all the others, and is anxious that raising the issue will disrupt the group dynamics and be detrimental to all the members. He is also personally very grateful to Tariq for his generosity in providing space in his home for the group to meet.**

**What should Malcolm do? Please email your responses (500 words maximum) to John Daniel at [dilemmas@bacp.co.uk](mailto:dilemmas@bacp.co.uk) by 3 August 2015. The editor reserves the right to cut and edit contributions. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but they will not be answered personally.**

## Circles of support for sex offenders

On reading Andrew Smith's article 'Working with sex offenders' (*Therapy Today*, June 2015), I felt glad that this difficult and taboo subject has been spoken about. I currently work as a counsellor in an NHS IAPT service but have almost 10 years' experience of working in custodial settings, and undoubtedly with sex offenders.

Although I am no longer working in a custodial setting, I am writing to highlight the important volunteering work that I do with Circles of Support and Accountability (Circles UK). As mentioned in Andrew's article, treatments for sex offenders are 'increasingly focused on helping them to establish satisfying lifestyles in which their needs and desires are met prosocially rather than antisocially through offending', and this is what Circles UK aims to do.

Circles UK responds to the evidence and research that highlight that a community-based response to sexual offending leads to a reduction in harm to others. A Circle of Support and Accountability is community based and works with those assessed as suitable who are motivated to commit no further offences. A Circle consists of four or five carefully selected, professionally trained and supervised local volunteers from all backgrounds and careers who give up their time to meet weekly with a 'core member' (the offender in the Circle). A Circle also works closely and alongside the police, probation services and the prison service so that any risk can be managed and so that the volunteers feel supported. A Circle can last from 12 to 18 months and aims to meet Circles UK's main objective of 'no more victims'. The Circle's aims are to support 'safe' social outlets, hobbies and volunteering opportunities, model appropriate ways of behaving and relating to people, help the core member manage the day-to-day challenges of adjusting after prison, and motivate them in avoiding dangerous behaviour and situations.

One of the reasons that as a therapist I have become a Circles UK volunteer is to help those who have sexually offended to monitor their own safety, increase their awareness of their offending behaviour and to reduce the overall harm to the public and community. One of the main contributing factors to re-offending sexually is social isolation; as Andrew commented, there is a 'risk of being marginalised from the general community, and they may well turn to pro-offending paedophilic sub-groups for support'. Providing a ready-made support group within society via a Circle reduces a core member's social isolation and hopefully has a knock-on effect on their offending behaviour.

Circles UK, particularly in the south west, is relatively new but it has been in Canada since 1994. Although Circles have only been in the UK since 2002, the evidence and statistics speak for themselves. Research (see [www.circles-uk.org.uk/resources](http://www.circles-uk.org.uk/resources)) demonstrates a 70 per cent reduction in re-offending among offenders who have experienced a Circle. Unfortunately the statistics for any prison or probation-based treatment programme, such as the sex offenders treatment programme (SOTP), are not as successful and are yet another indication that a lot of the rehabilitation work needs to be done within the community and with the support of the community.

As Andrew indicated, it is hard to work with sex offenders in a therapeutic way without being affected by their crimes and the harm caused to others. However, I think that Circles UK is an inspirational charity that accepts that hardship and attempts, with excellent result and success, to make the community a safer place and to help sex offenders reintegrate back into society in a healthy way.

**'I feel that there is still a long way to go before society is open to helping reduce the risk to the public by helping offenders reduce their own risk'**

I am glad that this work with sex offenders isn't unnoticed but I feel that there is still a long way to go before society is open to helping reduce the risk to the public by helping offenders reduce their own risk. But for now being part of a Circle is a start and I hope that, through continued work, we can move forward and change the way in which we view the treatment of sex offenders.

**Elie Myers**

*MBACP counsellor and IAPT practitioner. For more information about Circles UK, email [info.circlesw@gmail.com](mailto:info.circlesw@gmail.com) or go to [www.circles-uk.org.uk](http://www.circles-uk.org.uk)*

## IAPT CBT is very different

Reading the responses to Helen Hadfield's robust article in the May issue about CBT as practised in the NHS, it struck me that all but one miss the fact that IAPT CBT is completely different from what I think of as 'pure' CBT.

The current emphasis in the NHS on targets and 'results' is skewing any therapeutic process those working in other fields would recognise. Statistics are king. 'Recovery' rates are currently being recorded as if someone 'recovers' after a few brief sessions. A first contact counts as a person being seen within a specified time frame, so phone assessments are done simply to hit that target.

Groups are touted as the best way to get more people off the waiting lists, regardless of how a group might feel to a depressed or anxious person. And anxiety and depression are all that seem to count because they are 'symptoms' to be 'treated'. This is a medical model.

Bereavement and natural grief reactions are 'normalised' by agency staff doing telephone assessments. People are sent leaflets to read when what they and their GP hoped for, I think, was someone to listen to and hear their stories.

I don't doubt that CBT trainers try to inculcate warmth and empathy. The NHS offers little personal support to practitioners themselves and sickness levels due to stress are phenomenal. Young, inadequately trained staff

are struggling to cope with all the demands made of them. This is the reality within the NHS and I can only see it getting worse.

**Name withheld**

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## Proud to work in an IAPT service

I write in response to the article 'My year working in the NHS' (Your Views, *Therapy Today*, May 2015) where the author has 'survived' working in the NHS for a year. While I recognise and empathise with many of the challenges raised by the anonymous author, I feel the need to respond and defend NHS counselling services.

I have worked as a counsellor in NHS IAPT services for eight years and recognise the pressures on staff and services. All the counsellors I have met in these services are highly skilled and resilient, and offer an excellent service to a broad range of clients along a spectrum of complexities of presenting issues. The service I currently work in is supportive, client driven, effective, caring, appreciated and professional. I am proud to work in such an environment provided by the NHS that enables greater access to counselling for a wider public than otherwise.

I am disappointed that BACP is continuing to promote the unhealthy, negative assumption that counselling in the NHS cannot 'heal people in an environment that has such little respect for clients'. I know that the counselling clients in my own and my colleagues' care would disagree.

**Sue Balmer**

*Trafford IAPT*

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## Services as good as they can be

I am writing having read the article 'My year working in the NHS' in the May issue of *Therapy Today*.

Unfortunately the author chose to remain anonymous as I would have

**'I do not support all that IAPT does and aims to do but I make sure both that clients come first and that staff are supported. I also know that these priorities are not just mine'**

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liked to address her personally. I work as a counsellor lead for a London IAPT. My experiences are so different from yours and I want to describe how different IAPTs can be.

Thank you for writing the article; it raised important issues and I am sorry that your experiences were as they were. I do not support all that IAPT does and aims to do but I make sure both that clients come first and that staff are supported. I also know that these priorities are not just mine and that colleagues in other IAPT services share the same priorities.

Clinicians no longer have offices for their sole use as this is no longer feasible in many NHS services. In our service all clinicians book rooms to see clients and do all their admin in shared spaces. Space comes at a premium and rooms to see clients are often not easy to book. As clinicians we have had to get out of a room with the client and move to a desk to allow someone else in.

You raise a valid question about short-term work. This is not only a response to waiting lists and demands; for many clients it is what works. In my recent experience of interviewing prospective candidates for a counsellor job, we asked about belief in the efficacy of brief focused counselling. Those candidates who believed in the efficacy of brief focused therapy were more likely to be offered a post in IAPT. My belief is where the counsellor believes that brief focused counselling works (for many and not all), then clients begin to see this happening. I would describe the work as facilitating the client to leave the sessions confident enough that they are on track to live the life they want to be leading. It is our aim to support those who would benefit from services other than ours.

We aim to provide a five-star service within the limitations of the NHS. To offer our clients the best service we can, we support our staff in the best way possible and the outcome we get is staff contentment and retention while working extremely hard. Counsellors are provided with fortnightly group supervision and ongoing line management, mainly by phone and email. My compromise is that I am both line manager and clinical supervisor for the counsellors. It was not possible to have separate people in these jobs and enough counsellors for the clinical work.

Our counsellors struggle to fit in admin tasks and increased bureaucracy. Working for an IAPT service is becoming more and more different to the job many of them did formerly in GP surgeries. The counsellors in our service work extremely hard to fulfil all they are required to do. Whatever we think about these changes, IAPT has increased access to psychological therapies, and more people are being seen for more types of therapies. Unfortunately services will never all be as perfect as we wish. However our aim is to make sure that they are as good as they can be in the modern world in which we live.

**Carolyn Emanuel**

*Lead counsellor, Brent IAPT*

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## Stereotyping fatherlessness

I am writing in response to the article 'Fatherless worlds' (Your Views, *Therapy Today*, May 2015) as I feel it provides a myopic, gender-based, stereotypical view that perpetuates the myth that the only fully functioning family is one where a father is present. This appears to overlook situations where fathers are present but where there are issues of alcohol or substance misuse or domestic abuse. Are these the dads who anchor us and give us a sense of belonging?

The author's view does a disservice to lesbian couples and the multitude of family set-ups where children are brought up in loving relationships and who exhibit positive attachment styles. Anyone with a rudimentary

understanding of child development can see that the children the author talks about in her Talking and Feeling group are likely to display poor attachments, irrespective of their family set-up.

On a personal note, my father left before I was born; when I was two years old my mother married a man who drank excessively and was physically and emotionally abusive. This lasted four years and the rest of my childhood was spent moving around, interspersed with periods of living with my grandparents. In junior school I had a sense of being different but in the early 1970s single parent families were rare. I certainly did not have 'a sense of something missing' and I did not internalise that sense so that I felt inadequate. Nor did I spend years in therapy as an adult wishing I had had a father around during childhood.

I have lived in a monogamous relationship with the same woman for 23 years and we have two teenage children who appear to be emotionally resilient. So either I have bucked the trend or there are plenty of people like me, who grew up without a father present and who do not conform to the author's narrow perspective.

**Ian Plágaro**

*MBACP (Accred)*

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## BACP needs to protect its members

As a new counsellor I feel proud to be a registered member of BACP and hope to be able to enjoy a future career in the profession. However, month after month I read in *Therapy Today* that the situation is bleak: no jobs, no money and no hope. This is extremely disheartening! I'm sure that I speak for many in saying that it has been hard work achieving this qualification around a full-time job – the classes, the hours in placement, the supervision and the homework. It takes a huge amount of dedication and passion to pursue such a demanding course for so long and it is obviously deeply frustrating to find that one cannot get a job at the end; unless one is accredited with at least x years experience or x hours, basically one is not worthy.

There is clearly a need for counselling that is not being met by the current healthcare system yet it seems that the agency jobs available offer either only a few hours or very little salary. In trying to keep up with practice hours, counsellors are being forced to work for free, which seems completely unfair. Trainee teachers receive a bursary, as do many apprenticeships (eg hairdresser, electrician etc) and, despite now being fully qualified, I and many others remain volunteers, trying to fit in a few hours a week after a full-time paid day job. This devalues our service and gives the impression that counselling is not to be taken seriously. After all, in which other profession are workers paid not even the minimum wage?

Besides the cost of initial training, there is the insurance, CPD and annual BACP membership. It is no exaggeration to say that I have spent thousands to date, but I still do not have a paid counselling position. The counselling directory website shows me hundreds of independent workers in my local area yet no central body for recruitment. Given that it seems impossible to find an agency job, I am left to ponder setting up a private practice but this comes with further expense of room hire, website, business cards etc. I enjoy the work with clients, but I had hoped that this would be a career decision, not an expensive hobby.

BACP Chair Andrew Reeves asks: 'What do you want next for BACP?' I would suggest that BACP needs to adopt two critical roles. First, to act as a union to protect its members from being exploited. As we abide by the *Ethical Framework*, so should counselling agencies abide by a framework that sets out reasonable

**'It takes a huge amount of dedication and passion to pursue such a demanding course for so long and is obviously deeply frustrating to find that one cannot get a job from it at the end'**

working conditions, including a basic financial obligation to remunerate the skills and time of the counsellor.

Second, BACP could work in partnership with the NHS and other stakeholders to try to link people in need of help for mental health issues with counsellors looking for work. I recognise that there are a few jobs advertised on the members' website but, as a counselling authority, BACP could be highly instrumental in improving access to mental healthcare nationwide. In considering a strategic view for the future, much more could be done to benefit both counsellors and clients.

**Jessica Woods**

*MBACP unemployed counsellor*

### Response from BACP Healthcare

BACP Healthcare has produced a range of free downloadable resources on NHS commissioning pathways, written from the counsellor perspective. With each successive government making changes to the NHS in order to save money and improve patient experience, we consider the best way to negotiate the sector is by understanding how it works and how our members can put themselves in the best position possible to engage with it. Resources on commissioning can be found at [www.bacp.co.uk/commissioning](http://www.bacp.co.uk/commissioning). 'It's Good to Talk' leaflets and A3 posters are also available free (email [healthcare@bacp.co.uk](mailto:healthcare@bacp.co.uk)) for display in GP surgeries, giving patients access to counsellors either via their GP or independently.

**Judy Stafford**

*BACP Healthcare Department*

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## A label is just a label

Following on from Carol Swanson's excellent article ('What's in a label?', *Therapy Today*, June 2015) exploring how a client's mental health diagnosis can affect the counselling relationship, I wanted to offer a few comments from my own experience.

First, clients can sometimes be relieved to get the 'label', as it allows them to conceptualise their symptoms as 'X' and that they are not 'mad' or dreaming it up. The flipside of this can be the perception that they have been

told they have an incurable disease, especially when a diagnosis involves a 'personality disorder'.

I felt that the tone of the article somehow gave almost reverence to the diagnosis. It talked about the need for extra training, careful management of risk etc, which are all important. However, my experience of using CORE, for example, with clients with and without a formal diagnosis, is that they can both score equally high and both should be treated with the same seriousness.

I am also at pains to point out to my clients that a mental health diagnosis is very different to a medical one. A broken arm, say, is clear, visible, and easily allocated into a specific category based on the type of fracture etc. Mental health diagnoses involve subjective questionnaires, rating of symptoms and assessment by psychiatrists who normally have specific interests in certain conditions, and they are an inexact science.

The taxonomy of the *DSM* (or *ICD* in Europe) is also based around medication, and the point Carol made about increased medicalisation of mental distress is also very true. I have heard second-hand stories of patients being given different diagnoses by different psychiatrists, which really, to my mind, makes the whole process somewhat flimsy, even if it does have a very great veneer of respectability. There is almost always an element of comorbidity in diagnosis, which seems to be a consequence of trying to 'label' mental health conditions.

As a therapist who is interested in psychological trauma, I always look at the underlying life experience of the client sitting in front of me, and have been surprised, for example, to find clients with a diagnosis of bipolar having significant childhood adverse life events that the psychiatrist never enquired about. Not surprisingly, helping the client to resolve the traumatic impact leads to an improvement in emotional regulation and a reduction in the 'bipolar' symptoms. It is also no surprise that a high proportion of clients with emotionally unstable personality disorder (what used to

### **'It is obviously important to work within the boundaries of our competence, but also not to be too "fazed" by the diagnosis... it is just a label given to the client'**

be borderline personality disorder) have been abused or neglected as children.

So, as therapists, it is obviously important to work within the boundaries of our competence, but also not to be too 'fazed' by the diagnosis, and realise that it is just a label that has been given to the client and that we need to pay attention to the person while being cognisant of the label, rather than it being the other way around.

**Justin Havens**

*MBACP (Accred); psychological therapist.  
Email mail@justinhavens.com*

### **Medication is the answer sometimes**

At Refugee Resource, a therapeutic charity in Oxford, a few people referred to our counselling and psychotherapy service come with a diagnosis of a mental illness such as bipolar disorder, personality disorder, eating disorder, severe depression etc. Some of these have been misdiagnosed, and their symptoms, which mimic actual mental illness, are caused by complex post-traumatic stress disorder and traumatic multiple griefs. A few others do suffer actual mental health issues.

Our approach is to ask that a psychiatric referral is made, if it has not been made already, so that the client is supported both medically and therapeutically. If medication helps relieve distressing symptoms, we aim for the lowest possible dose to facilitate integration into everyday life activities, but we accept that medication is the answer to mental anguish at times when a psychotherapeutic approach alone could be unhelpful and even dangerous.

**Sushila Dhall**

*Therapeutic Services Manager*

## **Understanding hearing loss**

Well done to Dick Hill for his article 'Living with a deafened partner' (*Therapy Today*, June 2015). I was delighted to see that he had completed his independent research undertaken in 2013 and written up findings to be shared in this journal.

I agree completely with Dick that sudden deafness is a unique and traumatic event and impacts on the whole family, whether the family unit is just two adults or a full, busy household. One of the lasting memories I have of work with Hearing Link on rehabilitation courses is how frequently the hearing person attending in support was surprised to be given the time and space to talk about their reaction and how much their life had changed through the family member/friend becoming deaf.

I am investigating the idea of running workshops for qualified therapists covering deaf awareness and communication strategies that would help them when working with a deaf/deafened client and increase their understanding when working with someone who has a deaf person in their family. Please do contact me if you are interested in the idea.

**Caroline Bickerton**

*MBACP (Accred); email caroline@deafviewcounselling.co.uk; visit www.deafviewcounselling.co.uk*

## **A new paradigm for mental health**

I write in reply to the writer of the article 'What If It's Your Child?' (*Therapy Today*, May 2015), which describes the anguish of a psychotherapist whose teenage son was compulsorily admitted to hospital under the Mental Health Act.

It is so sad to think that the writer has suffered from the fall-out from out-of-date dogma suggesting that it is must be something a family has done that causes such serious suffering and ill health. This is by no means always the case and, while

I acknowledge that issues of neglect, abuse and trauma lead to stress and often mental health problems, there is another important area of knowledge that needs to be incorporated into mainstream general health and psychiatry.

I hope that my letter will be passed on to the person who wrote this thought-provoking piece, and that my thoughts may be helpful. I make reference to books currently being published on the subject of the relationship between our gut micro biome, the food we eat, the toxins we are exposed to, our genetic make-up, our allergies, and our brains. It is all very positive and has given me encouragement as I see family members and clients alike benefitting from this new paradigm. I make no claim to be a microbiologist, a neurologist or a practitioner of functional nutrition, but I hope this letter at least opens up a new way of thinking: symptoms of chronic health problems are frequently a consequence of many different influences combined. Mental illness is indeed surely a symptom of imbalance in just the same way as a symptom that manifests elsewhere in the body.

When I was training as a social worker in the 1970s we were introduced to RD Laing's concept of 'schizophrenogenic' families, as referred to in the article.

I also remember Thomas Szasz and his book *The Myth of Mental Illness*.<sup>1</sup> These ideas – so powerful in their day – led me as a naive trainee to think that it is the fault of families, and social constructs or games, that lead to mental illness. Thomas Szasz argued that 'psychiatric diagnoses are stigmatising labels, phrased to resemble medical diagnoses and applied to persons whose behaviour annoys or offends others'. He also said: 'Strictly speaking, disease or illness can only affect the body: hence there can be no mental illness.'<sup>2</sup>

As a psychotherapist practising in the 21st century, I am now firmly wedded to the notion that there is indeed no such thing as mental illness, but not in the way that Laing and Szasz were expounding, but rather because we now know far more about the complex relationship of how things that are wrong in the human body can affect every aspect of our body's functioning, including the brain – behaviours, affects, cognitions and all.

I would refer interested readers to the work of the American neurologist David Perlmutter whose most recent book, *Brain Maker*,<sup>2</sup> outlines how gut microbes can heal and protect the brain. His book includes chapters on autism, obesity, anxiety, depression and a host of chronic conditions relating to brain functioning. Another useful reference is Natasha Campbell-McBride's *Gut and Psychology Syndrome*.<sup>3</sup>

This way of looking at mental illness is a lot to tackle single-handed and without the right training. I am now working very closely with a functional nutritionist and together we are seeing really exciting results in clients – and my own family members too – who have been struggling with serious mental health related issues as well as other chronic medical problems.

**Mary Turner**

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2. Perlmutter D. Brain maker: the power of gut microbes to heal and protect your brain – for life. London: Yellow Kite, 2015
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## Problems with peer supervision

I read with interest Emma Wilkinson's article on peer supervision ('Peer supervision and collaborative power', *Therapy Today*, May 2015). I am currently a member of three such groups and, while there have been occasional difficulties, overall it has been a very positive experience.

The article did prompt me to reflect on the difference between mine and Emma's

more problematic experiences. I'm not sure if it is possible to make a hard and fast definition of peer supervision, but the features that characterise mine are that it is a freely entered into voluntary arrangement in which the members ultimately are responsible for themselves. We are all experienced enough to be confident in both making sure we get the supervision we need and addressing the supervisory needs of each other.

Perhaps the problem Emma is encountering with her 'peer group' is that essentially it is not a group of peers. She is the coordinator of this organisation and thus has a dual relationship and authority over her less experienced fellow supervisees – hard to see how it is possible for the power relationships to feel truly equal.

She characterises some of the sessions as 'excruciating'. I'm not sure how long I would be prepared to stay in such a group if the situation were left unresolved – but are members in her organisation able to make such a choice? And do they all want to be in a peer supervision group?

I wonder also whether supervisory needs are being met, with some members being unable or unwilling take on the supervisor role while others may be feeling resentful at having to take on the burden and not getting the quality of supervision they require.

There are many ways to organise group supervision – it is probably more important that it is functional and members are getting good supervision than it adheres to a particular format. If Emma wants an experience of peer supervision (and I would highly recommend it), she may need to look elsewhere.

**Jonathan Rosen**

*Counsellor and supervisor*

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## Contact us

We welcome your letters. Letters may be cut and edited at the Editor's discretion. Those that are not published in the journal may be published on the *Therapy Today* website at [TherapyToday.net](http://TherapyToday.net). Please email the Editor, Sarah Browne, at [therapytoday@bacp.co.uk](mailto:therapytoday@bacp.co.uk)

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**'We are all experienced enough to be confident in both making sure we get the supervision we need and addressing the supervisory needs of each other'**

## Freud, faith and fundamentalism

### God, Freud and religion: the origins of faith, fear and fundamentalism

Dianna T Kenny

Routledge, 2015, 223pp, £29.99

isbn 978-1138791336

Reviewed by John Eatock



This is an arresting title, given the current political circumstances of our world, and whatever your major discipline there will be something here to intrigue and fascinate.

Dianna Kenny has an astonishing breadth of thought, ranging through psychoanalytic theory, cognitive and behavioural science, neuropsychology, psychiatry, sociology, comparative religion and theology, spirituality, history and philosophy.

She begins by placing Freud at the centre of the science/religion debate and argues that psychoanalytic theory provides a fertile and creative approach to the study of religion. Early on, in chapter two, she revisits the arguments for and against the existence of God, discussing morality and its possible derivations and the importance of subjective experience in religious belief. There is a very useful update and consideration of the evidence of neuroscience *vis-à-vis* out-of-body, near-death and numinous experiences.

The whole book is shot through with references and pithy, but not extensive, quotes from Freud's work. The generally received discourse that Freud expounds is that religion is so compelling because it solves the problems of our existence and offers comfort in an age of anxiety, fear and uncertainty. The big question, of course, is whether God created man or did man create God? Chapter four uses Freud's argument to look at the crossroads where religion, culture and philosophy intersect from a psychoanalytic perspective. This moves on to a consideration of religious belief and madness, with numerous examples from medieval times up to the present

day, including a look at Richard Dawkins, the militant atheist. For therapists this chapter is full of insight and may well provide echoes of clients seen in our everyday practice.

Kenny then goes on to look at societies and movements. Nationalistic and religious violence comes under the microscope of psychology, psychoanalysis and social psychology, illuminating much about the roots of fundamentalism and terror theology that impinge so forcibly on today's world.

As BACP's first Lead Advisor on Spirituality and Counselling, I often pleaded for more research and an in-depth consideration of the motivation and meaning in people's lives and for this to receive more attention in our professional community. Kenny certainly delivers the former, and deserves the latter, whatever our discipline or personal beliefs.

*John Eatock is a retired counsellor, trainer and supervisor and a Fellow of BACP*

## Where political and therapeutic thought meet

### Passions, persons, psychotherapy, politics: the selected works of Andrew Samuels

Andrew Samuels

Routledge, 2015, 228pp, £90 (hb)

isbn 978-0415707923

Reviewed by Steve Page



This is a retrospective compilation from previously published works, selected and introduced by the author, who has written extensively on a range of social and political issues from a therapeutic, post-Jungian perspective. As such it can be read as both a summary of and an introduction to a number of Andrew Samuels' key ideas, which sit where political and therapeutic thought meet.

The book explores such diverse topics as the father, the environment,

political transformation, relationships between women and men, the market economy, the feminine principle, the therapy relationship (and countertransference) and the parental relationship. There are also chapters addressing Jung, anti-semitism and the Nazis, Jung and leadership, and a concluding consideration of the current stage of development of analytical psychology.

The author demonstrates both clarity of thought and courage of heart as he seeks to address complex and often controversial subjects. I sometimes really struggled with the challenging intellectual terrain in my efforts to reach the sometimes inaccessible viewing points from which he chooses to address his subjects. To give just one example, in chapter three ('Against Nature'), Samuels challenges some of the strongly held views within environmental thinking and he does so through his critique of two very different works of literature. At first I found this an obscure and frustrating approach, yet it rewarded my persistence with a deeper understanding of potentially creative tensions in a field that can be beset with polarised and unhelpfully simplistic positions.

Rather like a 'Best of' collection of songs, this book introduces the reader to many different topics about which the author has written much more extensively in the original publications from which the chapters are drawn. I currently have two of these source texts on my bookshelves and will add to them, based on reading this collection. However I will exercise caution in doing so. I appreciate the breadth and depth of source material the author uses to draw out his ideas, but it is a style of writing that I will never find easy to digest. Nevertheless, as a therapist, I do find satisfaction and challenge in considering current significant and complex social and political issues from a psychotherapeutic perspective and in that endeavour Samuels has shown himself to be writer of credibility, rigour and insight.

*Steve Page is a counsellor, coach, supervisor and author*

## Reparation and healing the past

### **Woman in Gold prompts David Polak to reflect on the lasting impact of the trauma of war**

Sixty years after fleeing Vienna, Maria Altmann (Helen Mirren), an elderly Jewish woman, attempts to reclaim family possessions that were stolen by the Nazis. Among them is a famous portrait of Maria's beloved Aunt Adele – Gustav Klimt's *Portrait of Adele Bloch-Bauer*. With the help of her friend's son, Randy Schoenberg (Ryan Reynolds), a young lawyer, Maria embarks on a lengthy legal and emotional battle to recover this painting from the Austrian government.

The death of her sister triggers memories of her family and their personal connections to the Holocaust begin to resurface. The painting of her aunt, the 'Woman in Gold', becomes a symbol of a survivor's attempts to heal something of their past, to achieve justice and to find peace.

Schoenberg is the grandson of Holocaust survivors, but is unaware of his own family history. While visiting the Holocaust memorial in Vienna, he is overcome by the legacy of his own past and becomes committed to the emotional task of reclaiming the painting.

The story is told partly in flashback as Maria relives the traumatic events that led to her fleeing her homeland, leaving her mother and father to their fate. As someone who runs groups for second and third generation descendants of Holocaust survivors, I recognised the impact of inter-generational trauma and the character's attempts to heal their past. The phenomenon of flashbacks is common among trauma survivors and also in their descendants, as the unconscious memories and experiences are transmitted through the generations.

Also common is the need to make reparation, to make sense of and find a way to honour the past. 'Not belonging', a longing to 'go home' and achieve their own personal 'restitution' are familiar



themes, and not just for Holocaust survivors and their descendants. Living in multi-cultural London, which is host to many refugees, therapists are increasingly seeing these presentations of trauma.

*Woman in Gold* highlights the aftermath of war and the subsequent trauma that presses for resolution in the psyches of survivors and the generations that follow. Survival is just the beginning. Often it is only possible to repair the psychological damage in the second and third generations, as the trauma reaches a place where it can be talked about from a certain 'safe distance'.

Survivors themselves are often too fragile to open up about experiences that feel too terrible to articulate, or for which there are no words. The task of therapy is to help people to find a language to speak the unspeakable and break the silence that surrounds the trauma of war and the loss it entails.

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*David Polak is a psychotherapist who identifies as and works with second and third generation Holocaust survivors*

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*Woman in Gold (2015, 109 minutes) is directed by Simon Curtis and stars Helen Mirren, Ryan Reynolds and Daniel Brühl*

## Ethical practice

### **Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists (2nd edition)**

Rachel Tribe, Jean Morrissey (eds)

Routledge, 2015, 341pp, £29.99

isbn 978-0415705295

Reviewed by Angela Cooper



Greater regulation of counselling means therapists are working in a changing and more challenging environment. This updated edition explores the increasing need for practitioners to be aware of professional,

ethical and legal implications. It focuses throughout on current codes, and the ethical principles informing good practice. A number of dilemmas are explored, using a mix of academic and clinical experiences. Personal reflection is encouraged, using case studies, questions at the end of each chapter and clinical vignettes. These help the therapist to understand that no code provides clear-cut answers, and that each ethical dilemma is unique and can require a different interpretation and response.

The book is in five sections – 'Professional practice and ethical considerations', 'Legal considerations and responsibilities', 'Clinical considerations and responsibilities', 'Working with diversity: professional practice and ethical considerations', and 'Research supervision and training'. One of the strongest chapters is by Tim Bond, who looks at new challenges facing practitioners in the light of the series of scandals in the NHS. Other chapters that stand out include one on self-harm and suicide, another on professional and ethical issues working with people with learning disabilities, and one on the wounded healer, which discusses the importance of introducing ethical practice awareness during training.

The closing clinical vignettes encourage the practitioner to reflect and gain confidence using a wide range of ethical problems and contexts, bearing in mind readers may work in a variety of

models and subscribe to different codes of ethics. It is tempting to want a bit more guidance here, highlighting the frustrations of knowing that it is ultimately the therapist (albeit usually with supervision support) who interprets and decides.

It would be hard to read this book and not feel more confident and professional as a result. The important changes in the field and the increasing need for demonstrating professionalism and responsibility make it an essential read for therapists at all levels.

*Angela Cooper is a counsellor and supervisor in private practice*

## Power and the learning process

### **Cradling the chrysalis: teaching and learning psychotherapy**

Mary MacCallum Sullivan, Harriet Goldenburg  
Karnac, 2015, 138pp, £18.99  
isbn 978-1782201496  
*Reviewed by Michele Head*



This book argues that there are significant parallel processes that link working therapeutically with clients, the teacher-pupil relationship and the process of learning.

It provides some useful thinking around power and reflexivity about one's own position as teacher or supervisor, explores the role of emotions in learning (p13), and discusses how to help students 'grow into their

chosen way of being with clients' (p107), rather than being 'indoctrinated' or taught a 'truth'.

There are many ideas here that resonated with me – particularly the ways in which the therapeutic stance of 'kindness, consideration and recognition of the Other often get lost in the busyness of the day, or overshadowed by the conflicting concern for a maintenance of professional boundaries' (p35) and how teachers need to model this ethical position consistently. Elsewhere the authors discuss the tendency to 'reduce others (the client) to what is already known to us', rather than meeting the other 'in all her strangeness' (p39); the need to be 'touched' and 'surprised' by what we hear, rather than to understand; and the importance of acknowledging the multiple layers of what is being said (p97).

In thinking about institutions and how these contribute to a 'safe base' for the learner, the authors highlight Menzies Lyth's ideas (1988) connecting the ways in which institutions deal with anxiety, and their success and viability. Many organisations appear to facilitate the evasion or denial of anxiety rather than actually reducing it.

While I did enjoy many of the ideas scattered throughout the book, there were passages where I found the style very theoretical and repetitive. At times the authors represent their differing views through a written dialogue, which aims to reflect the ongoing dialogue with students and clients. However, for me, these ideas were less well formed and the approach made the reading a little disjointed. I also felt that the theory could have been broken up with more engaging, practical examples of clinical or teaching dilemmas and reflections.

This book is likely to interest those who enjoy thinking about the process of learning, as well as more generally the process of therapy itself. I feel it could have been more succinct and engaging but it does prompt some interesting thinking about one's own stance, as both a teacher and a clinician.

*Michele Head is a clinical psychologist*

## Extraordinary sex therapy

### **Extraordinary sex therapy: creative approaches for clinicians**

Gina Ogden (ed)  
Routledge, 2015, 140pp, £85 (hb)  
isbn 978-1138842960  
*Reviewed by Julie Sale*



The chapters in this book were originally published in the journal *Sexual and Relationship Therapy*, (volume 29, issue 1), in February 2014 and this publication offers them a deserved wider

distribution. Although I would hesitate to describe any therapy as ordinary, least of all that which attempts to address human sexual intimacy, this publication certainly offers something 'extra' to the UK sex therapy community. This is achieved partly by describing non-UK perspectives and addressing contentious areas such as sex coaching and sex addiction, but largely by taking an integrative, inclusive and holistic approach to working with sexual issues, bridging analytic and behavioural models with the addition of spirit and soul.



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Most chapters contain something either philosophical or practical (and often both) that could add value to the practice of psychosexual psychotherapy. I was reminded of the paradox between the needs for safety and excitement in couple relationships, the importance of human touch and the impact of culture and context on sexual identity. There is a slight bias in the book towards the female sexual experience, which as a female reader and psychotherapist I enjoyed. The only part of the book that caused me concern is the attempt to distinguish sex coaches and sex therapists in chapter 10; for me, the differences cited simply don't correlate with my experience as a sex therapist.

The overall message of this publication is to look beyond pathology and biology towards the essentially individual and complex sexual identities of each client, captured in the neat existential concepts of 'bracketing' and 'horizontalizing' (chapter 3) – that is, holding our client's map of the world distinct from and no less valuable than our own.

Unfortunately, the book's wider distribution will certainly be affected by its prohibitive price tag.

*Julie Sale is a psychosexual psychotherapist*

## Psychoanalysis on screen

### Screen relations: the limits of computer-mediated psychoanalysis and psychotherapy

Gillian Isaacs Russell  
Karnac, 2015, 206pp, £25.99  
isbn 978-1782201441  
*Reviewed by Jane Cooper*



If you are a psychodynamic therapist considering the use of Skype in your practice, this well-written book is a must. Isaacs Russell draws on patient and therapist experience, psychoanalytic theory and neuroscience and information communication theory to thoroughly examine the benefits and drawbacks.

Her background is in British object relations theory, with an emphasis on the importance of the facilitating environment, the 'use' of the therapist (Winnicott) and the therapist's capacity for reverie (Bion). It is in this particular combination of intimacy and limitation that transformation occurs – a process that Russell argues can be disrupted by the requirements of computer-mediated sessions such as a client needing to find their own 'holding' environment in which to have the session, or, as the therapy progresses, to re-enact a childhood drama and try to test their therapist's survival on screen. As she puts it, safety in the presence of risk is different from the absence of risk that 'screen protection' brings. As to reverie, most of the therapists she interviewed agreed with the view that being glued to a screen is not conducive to evenly suspended attention and clinical intuition based on non-verbal cues.

Russell is not against the use of technology, but is refreshingly in favour of an embodied, relational psychoanalysis supported by evidence from neuroscience. She argues a strong case for the development of an internal and external sense of the self being connected to a sense of 'presence'. In an impressive chapter towards the end of the book she brings findings from virtual reality research together with those from neuroscience, infant observation, psychoanalytic theory and Fonagy's work on mentalisation.

Russell concludes that undoubtedly some practitioners and patients do experience technologically mediated psychoanalysis as effective. We humans are wired to relate and, where there is a will (and perhaps no choice), there is a way. Many of those interviewed made a distinction between working with patients they had never met and using it as an adjunct to a co-present therapy where residual trust is already in place. Russell emphasises that they are different processes and recommends that the gains and losses should be discussed before treatment starts. As the title of her book suggests, computer-mediated psychoanalytic psychotherapy has its limits and this book clarified for me why I value co-present work.

*Jane Cooper is a counsellor and supervisor*

## Reviewed on TherapyToday.net

### Eavesdropping: the psychotherapist in film and television

Lucy Huskinson, Terrie Waddell (eds)  
Routledge, 2015, 190pp, £29.99  
isbn 978-0415814102  
*Reviewed by Colin Feltham*



'An interesting investigation of the connections between film and therapy that focuses on the portrayed character and performance of the therapist, rather than on plotlines or therapeutic themes.'

### Clouds of Sils Maria

2014, 123 minutes  
Starring Juliette Binoche, Kristen Stewart and Chloë Grace Moretz  
*Reviewed by Julian Edge*



'... invites us to reflect on the processes of ageing... and of the interpenetration of fact and fiction as we construct stories that enable us to give our lives a sufficient sense of meaning and coherence.'

*If you would like to review a book that has influenced your development as a counsellor or psychotherapist, or a new film, concert, exhibition or event that you think has special resonance for counsellors and psychotherapists, please email Chris Rose, Therapy Today Reviews Editor, at reviews@bacp.co.uk*



## From the Chair

Social change or social control – the ‘safeguarding’ route leads to both, writes

*Andrew Reeves*

There is no doubt that, for all the advances in the availability and accessibility of counselling over the recent years and the fact that, for many, it is now seen as a mainstream and viable option for help at times of difficulty and distress, there are many challenges too. Some are more apparent in their threat, such as the impact of austerity measures leading to the scaling back or closure of key community-based services and the sheer number of counsellors who are compelled to work voluntarily simply because they cannot find paid employment.

There are challenges, however, that are less apparent, more insidious in their impact and that put at risk the very nature and philosophy of counselling itself and what we hold central to our work. One that concerns me greatly is what appears to be the cultural shift in what we call ‘safeguarding’. This is all our responsibility and yet it is increasingly, and inaccurately, being used to mean ‘child protection’ specifically.

In setting an important context for the point I wish to raise here, I would argue that the post-Savile culture has, quite rightly, forced us to question behaviours and actions that previously have been overlooked or conveniently put out of our minds. Also, as a former child protection social

worker, I am very aware of the most dreadful actions that human beings are capable of inflicting on another. There is no doubt that we must always act to safeguard the wellbeing of those experiencing harm, abuse, violence and damage either from other(s) or from the situation in which they find themselves. This is a given and I do not question that at all.

However, as a counsellor working with young people and vulnerable adults, as a safeguarding lead governor in a large secondary school, as a supervisor of school counsellors and as a practitioner-researcher specialising in work with suicide risk and self-injury, I am faced daily with the shifting nature of what ‘safeguarding’ means and how the person we are meant to be safeguarding actually can be left vulnerable and without support – victim of the procedures that are meant to protect them. Increasingly counsellors are being required – through policy, practice and working expectations – to make early disclosure to others of any information that may raise concerns about the client’s wellbeing, whether or not the client consents to that disclosure or believes it would be helpful to them. This is often a risk to the therapeutic alliance and can also lead to a rupture in that alliance that leaves the client distrustful of their counsellor – and potentially counselling

per se – and without a real opportunity to find ways to support themselves. Practice, it seems, is becoming more directed from a position of practitioner anxiety rather than one of trusting the client’s capacity for change, where it is possible to do so.

I am aware that this issue is brought into sharper relief in Scotland, where counsellors in the statutory sector are expected to comply with GIRFEC (Getting it Right for Every Child) and as such have additional challenges to consider when working with, and holding, risk.

Risk is increasingly being viewed from a binary perspective – someone is at risk or is not – without acknowledging that while risk ‘A’ does indeed exist, the risk of action ‘B’ might be greater to the client’s wellbeing. As society becomes more risk averse – perhaps in the genuine belief that it might help avoid a repetition of previous awful events – we actually run the real risk of undermining a client’s capacity to find their journey to their own safety. While I acknowledge there are times when we clearly do need to act to safeguard the client’s wellbeing, blanket expectations of premature disclosure are a threat to counselling in that we become agents of social control rather than facilitators of social change. Perhaps this is a strategic imperative we must keep in mind. ■



## BACP members who coach

*Veronica Lysaght* reports on the recent survey of BACP members who are practising as coaches

Earlier this year BACP surveyed some 600 members who had expressed an interest in coaching. We wanted to find out if BACP members practise coaching skills and techniques or identify as coaches. The results are fascinating.

First, BACP members who coach tend to be experienced: of those who told us that they are currently offering coaching, two-thirds have been practising for more than three years, and half for more than five years. Typically BACP members who coach have acquired their skills and knowledge from a wide range of sources. This is where BACP's continuing professional development, network groups and professional development days can be particularly useful to our members. One in 10 holds a postgraduate qualification in coaching.

They also tend to have portfolio careers: mostly they work with individuals, followed by in-house coaching and working in the business/corporate sector.

Our survey asked how many BACP members who coach are drawing on their knowledge of counselling and/or psychotherapy when they're working with a client. Only 20 per cent told us that they keep coaching and counselling strictly separate in their practice.

Becky Wright, a founding member of BACP Coaching, a member of its Executive, and Director of New Leaf Life Design ([www.newleaf.uk.com](http://www.newleaf.uk.com)), started coaching in 2009 when she was asked to help a number of people, who were about to be made redundant, find other opportunities. At that stage, Becky wasn't sure what life coaching entailed, so decided

to experience some herself. She found it a future-focused way of working. 'I enjoyed the experience of being on the receiving end of the process but I was a bit irritated that the coach didn't want to look at the past in any way,' she now says.

Overall, though, she found it a positive and engaging experience and decided to give it a go. To maintain her standards, Becky hired an evaluator to assess her work: 'I needed to see the value and benefit people were getting from it.' The evaluations were excellent and Becky's coaching career was born.

Becky doesn't think all counsellors necessarily have the skills to work as coaches, especially in the business world. 'What we don't have is the experience of working within corporate systems and companies. It's that experience we need to learn about.' Becky's guiding principle is always to stay 'strictly within one's limits of competence and providing services on the basis of adequate training or experience', as the BACP *Ethical Framework* says.

Becky joined the Association for Coaching and has taken their courses 'to learn and interact with other coaches'. She updates her coaching skills through CPD. 'I do more coaching CPD than counselling, because I find the courses inspiring.'

She is unusual in belonging to another professional body: 73 per cent of the BACP members who coach who answered the survey said they didn't belong to any other professional body.

A high percentage of BACP members who coach are in private practice (80 per cent, compared with a third of BACP members overall).

Becky is one of them. She says counselling was the best training she could have for her work. 'I am so far ahead in some ways of other coaches who don't have this background. The things they are struggling with, I feel I'm already there. For example, we're used to working with uncertainty and the unknown, we have many skills in how to build relationships quickly, in somatic experience and the emotional territory.'

Well over half of BACP therapists who coach who replied to our survey said that they have supervision with a therapist who has no coaching expertise. It was important to Becky to find a supervisor able to work with both counselling and coaching modalities. Her original supervisor was a very good counselling supervisor but inexperienced with coaching: 'It was making me feel unheld. I want to be able to lean into them and have them hold me in their role as my supervisor,' Becky says. She has since found a supervisor who knows coaching, counselling and business – which is what she needs for her practice.

Some 200 members who aren't currently coaching also answered our survey. Of these, two-thirds said they were either likely or extremely likely to introduce coaching or coaching skills into their practice in the future. It appears that the number of BACP members who coach is on the rise.

*Veronica Lysaght is BACP Lead Adviser Coaching. Email [veronica.lysaght@bacp.co.uk](mailto:veronica.lysaght@bacp.co.uk)*

*You can find out more about BACP Coaching by going to [www.bacpcoaching.co.uk](http://www.bacpcoaching.co.uk)*

# Keeping your client records secure

**bacpac, the digital client management system for counsellors/psychotherapists, is entering its third year and still growing**



Intended for the independent practitioner, bacpac was launched by Maiden, the healthcare IT systems developer, in partnership with BACP in 2013. Its leading feature is that it provides the same high level of security for client records as iaptus, the system that Maiden developed for the NHS.

But it also offers numerous other practice management features for the private practitioner, and is constantly being further developed in response to user feedback. Says Dawn Bould, bacpac Product Owner at Maiden: 'We like to talk to the people who are using it. We want people to be critical because then we can be sure we are building things in that our users want rather than just what we think they want.'

It was the security that first attracted Martyn Blair, former NHS counsellor, now in private practice for two years, with a thriving part-time caseload. He dislikes paper records and needed an electronic storage system he felt he could trust. 'With their iaptus credentials, Maiden is probably at the forefront

in security. They're not some new company coming from nowhere,' he says.

Susanne Hart, who qualified in 2013 and has already established a healthy full-time private practice, wanted a system she could access from different work locations. 'I've got a laptop at home, but I use my tablet when I work from my therapy rooms. bacpac is secure, portable and very convenient as I can access my notes from anywhere on my tablet.'

But it's not just the newly qualified who are drawn to an electronic client management system. Becky Midwinter has been practising for some 15 years and has a part-time client caseload alongside her academic career. 'I had already come to the conclusion that writing paper notes was not the way forward. I do a lot of online work now, a lot of Skype supervision, and paper notes just feel old fashioned.' And, she says, electronic records keep her focused. 'I give myself 15 minutes to put my notes in after every client. The online structure keeps me much more succinct.' She

also finds it helpful when she is having supervision herself by Skype: 'I just click through my notes – no more sifting through papers and files.'

Martyn commends the financial management tools. As a self-employed builder by background, he is used to running his own business, but he says the bacpac system is easy to use and very handy for those new to private practice. 'I have a graph on my homepage that shows how I am progressing towards my target income. It means I can keep a constant check on my cash flow.' Shane Sneyd recently progressed into full-time private practice after 12 years' working part time: 'Private practice is a business and it's good to keep a tab on your expenses. I like knowing what I need to aim for.'

Susanne finds the diary/calendar feature invaluable – 'being able to track not just my client appointments but my supervision and CPD and having that all in one place, with my billing,' bacpac is very useful for keeping a record of CPD activities for accreditation and registration, Shane agrees. He also highly commends the 'professional will' feature that allows him to nominate a colleague who can be permissioned to access his client records should he be taken seriously ill or die. 'It's a headache for the lone practitioner but this makes it so easy. I was recommending it to my support group only last weekend.' Martyn raised this feature with Maiden

when he first starting using bacpac and is delighted that they responded so swiftly.

Mayden's support and responsiveness is something that Susanne appreciates too: 'The support from Maiden is excellent. There is usually someone available who will sort things out for you.'

There are features that they don't use – like the patient scoring systems such as GAD, PHQ and CORE that allow practitioners to track their clients' progress. 'I had enough of that in the NHS,' says Martyn. Susanne doesn't use the client self-referral feature: she prefers to have a phone or email conversation with clients before they arrive on her doorstep.

bacpac has been criticised as too expensive for the part-time practitioner who sees only a few clients a week. It costs £15 a month or £150 a year, plus VAT. But Becky, who sees fewer than 10 clients a week, says it's a price well worth paying. Susanne also says it's a good investment: 'The cost is equivalent to that of some of my advertising and it's just as necessary for the success of my business. If it makes it possible for me to do my work ethically and professionally, it's worth every penny.'

Says Dawn: 'We do regularly review our pricing structures but are confident that, as a complete client management system, bacpac offers great value for money.'

*Visit [www.bac-pac.co.uk](http://www.bac-pac.co.uk) for more details and a free trial.*

# Ethical Framework goes online

BACP has published the new *Ethical Framework* online.

The new framework will be formally adopted on 1 July 2016, when it will replace the existing one. It is being published online one year ahead of its formal adoption so that BACP members, organisations, stakeholders and clients can familiarise themselves with the changes and begin to develop their practice in accordance with its principles.

The revised and retitled *Ethical Framework for the Counselling Professions* has been written by Professor Tim Bond, with contributions from many others and following an extensive consultation with the BACP membership (see article in February's *Therapy Today*) and other stakeholders.

It contains a number of significant changes from the current BACP *Ethical Framework*, including:

- an explicit recognition of the roles represented in the BACP divisions, particularly counselling, psychotherapy, coaching and pastoral care
- inclusion of these roles within the new title, the *Ethical Framework for the Counselling Professions*

- a new short opening section on 'Commitments' to clients
- changes to the ethics of 'Autonomy' and 'Identity' to take account of social diversity in the section on 'Ethics'
- updates to 'Good practice' to endorse the positive contribution of the counselling professions to safeguarding vulnerable people by empowering clients or taking preventative actions, honouring the social diversity of our clients in contemporary society, and considering the ethical challenges of working online and the use of social media.

'Our aim has been to find a voice that fosters the ethical resourcefulness of practitioners appropriate to listening professions that need to be responsive to diverse client needs and contexts,' said Tim Bond.

In the foreword to the *Ethical Framework*, BACP Chair Andrew Reeves said: 'Ethical practice not only sits at the heart of what we do as counsellors and psychotherapists, it has also informed the work of BACP for many years. From the *Code of Ethics and Practice* through to the current *Ethical*

*Framework for Good Practice in Counselling and Psychotherapy*, our members have been encouraged not only to think about the good practice parameters of their work, but additionally to embark on an ethical engagement to ensure what is offered to clients meets the highest professional standards of practice and accountability.'

BACP will be producing a range of online resources and training events to help members explore the implications of the revised *Ethical Framework* for their work. The first will be *Commonly Asked Questions* relating to the new *Ethical Framework* (Good Practice in Action 038), which will be published online on the BACP website by the end of July.

Supplementary guidance arising from the framework is also being prepared for publication over the coming months, on a wide range of topics such as legal issues, ethical problem-solving, informed consent, record keeping, working online and many more.

*The new Ethical Framework is on the BACP website at [www.bacp.co.uk/ethics](http://www.bacp.co.uk/ethics)*

## Cheque scam warning

BACP has been informed by a member that a scam targeting counsellors is currently in operation.

The potential 'client' contacts the counsellor via email and asks about having a course of counselling and says they would like to pay for the sessions up front. They say the cheque will be paid by a third party. When the cheque arrives it is for a much larger sum than the counselling fees.

The client tells the counsellor to bank the cheque and send them a cheque for the excess, minus an admin fee. The cheque received by the counsellor then turns out to be fake.

The member reported the scam to Action Fraud, which is investigating. BACP is advising members who experience anything similar also to report it to Action Fraud, via their website at [www.actionfraud.police.uk](http://www.actionfraud.police.uk) or by calling 0300 123 2040 (textphone 0300 123 2050).

## Making Connections

BACP Making Connections will be coming to Norwich on 10 September.

Making Connections is an opportunity for members to network locally, meet BACP officers and staff, and have your say about issues affecting the profession.

Making Connections events are free to BACP members. To register, go to [www.bacp.co.uk/events/conference.php?eventID=117661](http://www.bacp.co.uk/events/conference.php?eventID=117661)

## Booking open for BACP CYP conference

Booking is now open for the BACP Children & Young People (BACP CYP) conference on 7 November in York. The theme of the conference is 'Working with childhood abuse'.

The keynote presenters are Will Linden, from the Violence Reduction Unit,

and Dr Renee Marks, consultant therapist and clinical lead at Integrate Families, the national centre for children with complex trauma and dissociation.

Workshops include use of EMDR with children and young people, secondary trauma and how it can affect

the practitioner, working therapeutically with grooming, compassionate presence, and working with embodiment trauma.

To book and for more details go to [www.bacp.co.uk/events/conferences.php](http://www.bacp.co.uk/events/conferences.php) or ring Customer Services on 01455 883300.

# BACP Registration update

In 2012 we developed and launched the BACP Register as a standard for all our practising members. Our register is now home to over 25,000 members and we promote it to employers and client groups as the entry level to practice, alongside accreditation as the hallmark of the experienced practitioner.

We are committed to raising and promoting standards of training, ethical practice and competency in counselling and psychotherapy. Our register and our accreditation scheme are the main ways we demonstrate these commitments to the public.

If you are a current MBACP member or accredited member, please remember you have until 31 March 2016

to register. If you are a MBACP member and have not yet registered, then please contact us now so we can help you register before the deadline (see contact details below). Accredited members who are not yet registered can do so very easily by going to [www.bacpregister.org.uk](http://www.bacpregister.org.uk) and clicking on 'Join the register'.

Some members may not consider themselves eligible as they are not currently in practice. We define 'practice' to include not just working with clients but also practice management, training, supervising and researching. We would consider you to be 'in practice' if you have done any of these within the last three years. If you are unsure, please contact us.

Current Individual Members have 24 months

to become registered from the date of joining this membership category.

If you are having problems completing registration or have any questions about the process, please contact us. We'd be very pleased to help. You can call 01455 883300 Monday to Friday, 9am–5pm, or email [info@bacpregister.org.uk](mailto:info@bacpregister.org.uk). If you would like to give us feedback on registration, please complete the short survey at [www.surveymonkey.com/r/non-register](http://www.surveymonkey.com/r/non-register) – it should only take a few minutes of your time and we do appreciate it.

For information on becoming registered or to book your free CoP assessment, please go to [www.bacpregister.org.uk](http://www.bacpregister.org.uk) for details of available dates up to March 2016.

## BACP Private Practice event to be webcast

BACP will be live webcasting the BACP Private Practice conference 'Trauma: the challenge of our age?' on 19 September. This is the first time BACP has webcast live one of its own conferences.

For those unable to attend the live conference in central London, the webcast will feature the two keynote presentations and two workshops on the day, plus access to a chatroom and studio panel discussions with guests and speakers, and 30 days' access post-event. A CPD certificate will also be provided.

The opening keynote speaker is PTSD specialist Mark Brayne, on 'Trauma, Healing and Modern Media'. Canon David Wilbraham, leader of the National Association of Chaplains to the Police, will close the day with 'The Power of Spiritual Support Following Trauma'.

Workshops include intergenerational trauma with Haya Oakley; EMDR with Derek Farrell; borderline personality disorder with Dr Gillian Proctor; dissociative identity disorder with Katy Woodger; working with military veterans with Margaret Chapman; trauma following a major incident with Noreen Tehrani, and somatic trauma for the client and self-care for the therapist with Michael Gavin.

To book your place for either the live conference or the webcast, please visit [www.bacp.co.uk/events](http://www.bacp.co.uk/events) or ring BACP Customer Services on 01455 883300 or email [events@bacp.co.uk](mailto:events@bacp.co.uk)

## TT.net wins online award

TherapyToday.net, the journal's flagship website, has won the Online Media Award for best health/education news site for the third year running. The judges said that the site was 'a strong entry and it continuously provides relevant and useful information in convenient format for therapy professionals and those interested'.

Visit [www.therapytoday.net](http://www.therapytoday.net) to access our free rolling news coverage, regularly updated noticeboard, the current issue and our searchable archive of articles (some free, some paid for) from every issue going back to September 2005.

## Commissioning.gp update

Since the beginning of the year, BACP has been working closely with the BBC Radio 4 consumer affairs programme *You and Yours*. The programme has been investigating the activities of [commissioning.gp](http://commissioning.gp), a company that contacts counsellor/psychotherapists and offers to list them on a directory for GPs.

A number of concerned members have been in touch with BACP after being approached by a company offering this type of service, some of whom took part in a second *You and Yours* broadcast on 5 June (you can listen again at [www.bbc.co.uk/programmes/b05wzokp](http://www.bbc.co.uk/programmes/b05wzokp)).

The NHS has formal commissioning processes to enable GPs to refer patients for NHS-funded counselling. It is our understanding that being on a directory is highly unlikely to be enough to secure NHS-funded referrals. GPs are also highly unlikely to use directories to make direct referrals to independent counsellors as this would be considered a recommendation and there is no guarantee of quality of care.

We recommend members to read the accurate, up-to-date information about the commissioning process and how it works on the BACP website at [www.bacp.co.uk/commissioning](http://www.bacp.co.uk/commissioning)

# New BACP accreditation resource

BACP has launched a new e-learning resource to help members apply for accreditation. The resource is for individuals considering applying for accreditation. It has been developed in partnership with BACP's team of accreditation assessors, and is built around the workshops that BACP used to run for potential accreditation applicants.

The e-learning covers the application and assessment

processes, the accreditation standard, eligibility and routes to entry, reflective practice, the supervisor's report, the proposer's statement, and the deferral process. Each topic is accompanied by a video of a BACP assessor delivering a live workshop session, with click-through answers to frequently asked questions.

Some 15,000 BACP members are on the BACP Register but not yet accredited. BACP is currently

piloting the resource with a sample of 1,000 members. It will go fully live and be available to all members towards the end of July.

Comments from members who have helped pilot the resource include: 'Very well put together and easy to follow;' 'Self-explanatory and very informative,' and 'Legible and user-friendly.'

Says Liz Aston, BACP Accreditation Standards Manager: 'We think members

will find it both accessible and helpful. Accreditation is the benchmark for the competent, experienced practitioner. We want to support as many members as possible to become accredited. An online resource is cheaper and more accessible for members.'

The accreditation application resource will be available at [www.bacp.co.uk/accreditation/resources/index.php](http://www.bacp.co.uk/accreditation/resources/index.php) from the end of July.

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## Newly accredited counsellors/psychotherapists

Olubumi Akinmutande  
Joanne Anderson  
Deborah Auer  
Eileen Barnard  
Fiona Begg  
Susan Bennington  
Lorraine Birkett  
Amanda Bouvier  
Michelle Bradley  
Adrienne Brady  
Mitch Bresland  
Jayne Briggs  
Wendy Burrill  
Deborah Burton  
John Callaway  
Julie Calvert  
Paul Chamberlain  
Jason Chambers  
Paula Collins  
Robert Cravagan  
Rosheen De Sousa  
Sonia Derby  
Bronach Donnelly  
Marcus Elliott  
Susan Evans  
Sarah Ferguson  
Myra Fricker  
Danielle Fugler  
Janet Funnell  
Sandra Gallacher  
Anne Galloway  
Tracy Harrison  
Julie Hood  
Ulrike Kennedy  
Samuel Kindred

David Kippax  
Simon Lewis  
Melanie Lovegrove  
Inez Lovering  
Karen Macwhinnie  
Sally Madley  
Alicia Marr  
Joanna McCulloch  
Geraldine McGhie  
Stephen McLaughlin  
Soraya McMurray  
Rachel Murphy  
Sandra Nyakupinda  
Kwame Opoku  
Kathrine Owen  
Karin Peeters  
Rebecca Pollard  
Susan Price  
Gill Roberts  
Jane Skelton  
Sally Smallwood  
Deborah Smith  
Sue Spong  
Karen Staniforth  
Margaret Thermes  
Debbie Tinkler  
Mark Tonkinson  
Alison Trott  
Louise Tyler  
Pablo Van Schravendyk  
Fiona Watts  
Caroline Weiland  
Naureen Yawar

**Newly senior accredited supervisor of groups**  
Eileen McAleer

## Newly senior accredited supervisors of individuals

Susan Braddock  
Kieran McCrystal

## Newly senior accredited counsellors/psychotherapists

Karen Collins  
Lisa Mayall  
Victoria McLaughlin  
Nicola Strudley

## Organisations with new/renewed service accreditations

For a list of current accredited services, visit the service accreditation webpages

## Members not renewing accreditation

Dhuana Affleck  
Jane Aird  
Jane Alvarez  
John Baker  
Rosemary Beal  
Sue Bedigan  
Bernadette Broderick  
Linda Buchanan  
Ruth Campsall  
Sandra Chitty  
Anne Clarke  
Esther Cox  
Michael Da Costa  
Louise de Board  
Susan Dennis

Pamela Devlin  
Susan Douglas  
Hava Drummond  
Penelope Edwards  
Mine Feridun  
Patricia Flannigan  
Valerie Ford  
Antony Froggett  
Alison Harrison  
Imogen Holt  
Jaki Hose  
Margaret Hutton  
Sheila Hymas-Parry  
Martin Jelfs  
Susan Jones  
Sevilay Kazim  
Martha Knox-Forrester  
Colleen Long  
Janett Melloy  
Yvonne Murray  
Julie Pattison  
John Seex  
Elke Stratford  
Rachel Vaterlaus  
Aileen Walker  
Norma Wallace  
Lena Weston  
Lynne Whitlock

## Members whose accreditation has been reinstated

Suzanne Gray  
Nicola Sworder

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

# Counselling for Depression update

Counselling for Depression (CfD) provides a definition of counselling as specified in the 2009 NICE guideline for depression. It is distinguished from other interventions recommended by NICE for depression, such as cognitive behaviour therapy (CBT) and interpersonal therapy (IPT).

The NICE depression guidelines currently recommend that counselling should be considered for people with persistent sub-threshold depressive symptoms or mild to moderate depression who decline antidepressants, CBT, interpersonal psychotherapy (IPT), behavioural activation, or behavioural couples therapy, and say they should be offered 6–10 sessions over 8–12 weeks.

IAPT recommends CfD as ‘... a manualised form of psychological therapy as recommended by NICE... for the treatment of depression. It is based on a person-centred, experiential model and is particularly appropriate for people with

persistent sub-threshold depressive symptoms or mild to moderate depression. Clinical trials have shown this type of counselling to be effective when 6–10 sessions are offered. However, it is recognised that in more complex cases which show benefit in the initial sessions, further improvement may be observed with additional sessions up to the maximum number suggested for other NICE recommended therapies such as CBT, that is, 20 sessions.’

BACP has been conducting a programme of work to provide resources supporting CfD. These now include a competence framework, a training curriculum and a textbook. CfD training is provided by Metanoia, Keele University, UCLAN, York St John, University of Nottingham and Colchester Institute, and BACP is developing a programme of research for CfD in collaboration with the University of Sheffield.

In addition to the work going on within BACP, other

research was presented at the BACP Research Conference in May. This included ‘A client-focused perspective of the helpful/unhelpful aspects of Counselling for Depression’ by Stacey Goldman, and ‘What factors predict successful completion of the Counselling for Depression training programme?’ by Catherine Hayes.

The BACP Research Foundation has funded the University of Sheffield to undertake a pragmatic randomised controlled trial assessing non-inferiority of counselling and its effectiveness for depression (PRaCTICED). The trial, which is taking place within the Sheffield IAPT service and is led by Professor Michael Barkham, is ongoing and is expected to be completed in 2017.

Additionally, we have set up a practice research network (PRN) for CfD practitioners. A survey of its current membership indicates a spread of CfD practitioners across England. Half the respondents work as a Step 3

high intensity therapist, 94 per cent are currently working as CfD practitioners, and just over half are employed in IAPT services (others are employed mainly in other NHS services). The majority (85%) of respondents have completed the CfD training, and a further five per cent are currently undergoing training. Ninety per cent routinely collect client outcome data. Respondents indicated the reasons they joined the PRN were to build the evidence base (90%), opportunities to get involved in research (85%), networking (85%), and sharing best practice (75%).

BACP is currently looking to develop a programme of work for the CfD PRN that may include exploring the experiences of training in CfD and how to collate and share outcome data. This could help to build the evidence of the effectiveness of CfD in routine settings.

*To join the CfD PRN or for further information, please contact the BACP Research team at [research@bacp.co.uk](mailto:research@bacp.co.uk)*

## CYP and long-term conditions

We have recently published a literature review on counselling and psychotherapy for children and young people with long-term conditions. The review seeks to answer some general questions about children with long-term medical conditions, the most common forms of psychological therapy available to them, and the evidence for the effectiveness of those therapies.

Following filtering of results from a literature search of key databases, 71 papers were identified reporting on the following conditions: multiple long-term conditions, asthma, diabetes and myalgic encephalomyelitis (ME)/chronic fatigue syndrome (CFS). The review can be downloaded free from [www.bacp.co.uk/research/publications/bibliographies.php](http://www.bacp.co.uk/research/publications/bibliographies.php)

## Funding for researchers

In addition to our own Small Research Grants (currently open for applications), the BACP Research team maintains an updated web page of current research funding opportunities from external funders that might be applicable to counselling and psychotherapy research.

The research funding database is continually updated. If you have a funding opportunity you want to

include, please forward your details to [charlie.jackson@bacp.co.uk](mailto:charlie.jackson@bacp.co.uk). Inclusion in the database does not imply endorsement by BACP.

The research funding page is at [www.bacp.co.uk/research/Finding\\_Research\\_Funding/currentfundingopportunities.php](http://www.bacp.co.uk/research/Finding_Research_Funding/currentfundingopportunities.php). Details on how to apply for a BACP Small Research Grant are at [www.bacp.co.uk/research/resources/small\\_research\\_grant.php](http://www.bacp.co.uk/research/resources/small_research_grant.php)

# Counselling LGBTQ clients

This month's research enquiry asked: 'Is there any recent research that has looked at counselling and psychotherapy for lesbian, gay, bisexual, transgender, questioning and/or queer clients?'

We searched our internal abstract database and Google Scholar (<http://scholar.google.co.uk/>) using the terms 'counselling' OR 'psychological therapy' and 'LGBTQ'.

In 2007 BACP commissioned and published a systematic review of research on counselling and psychotherapy for lesbian, gay & transgender people.<sup>1</sup> The authors concluded that, despite relatively few papers meeting the inclusion criteria, affirmative talking therapies

appeared to help LGBTQ clients to normalise their day-to-day experiences and face and counteract the homophobia they experienced when growing up. Affirmative therapies were also perceived to offer clients a therapy that focused on the issues they brought to therapy, rather than on their sexual identity.

A more recent study<sup>2</sup> has explored the experiences of novice counsellors when working with LGBTQ clients. Sixteen novice counsellors were interviewed about their experiences of critical incidents when working with LGBTQ clients. Three superordinate themes emerged: engaging with learning; finding strategies that work, and entering the

client's world. Confronting homophobia and heterosexism was also identified as a core category. Generally, novice counsellors felt unprepared by their training to deal with sexuality issues. However they gained valuable learning from the challenges they had faced. The authors concluded that initial counsellor training should include an emphasis on inclusive theory, with facilitated opportunities for exploring sexuality issues.

Both of these studies contribute towards a growing field of research. However, as noted by King et al,<sup>1</sup> there is a lack of randomised trial research with this client group. In addition, it has been

suggested that there is a lack of research investigating transgender clients' experiences of counselling outside gender identity clinics, although some initial research has recently been published in this area.<sup>3</sup>

## REFERENCES:

1. King M, Semlyen J, Killaspy H, Nazareth I, Osborn D. A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people. Lutterworth: British Association for Counselling & Psychotherapy; 2007.
2. Owen-Pugh V, Baines L. Exploring the clinical experiences of novice counsellors working with LGBT clients: Implications for training. *Counselling and Psychotherapy Research* 2014; 14(1): 19–28.
3. Hunt J. An initial study of transgender people's experiences of seeking and receiving counselling or psychotherapy in the UK. *Counselling and Psychotherapy Research* 2014; 14(4): 288–296.

## Research surgery

The BACP Research department runs a regular research telephone surgery to support members who do not have access to research supervision and have a research dilemma, question or problem.

For example, you may want advice on how to get started on a research project, how to determine a research question, how to design part of a study, or how to apply research evidence.

The next research surgery is on Wednesday 5 August 2–4pm. If you would like to book a session (up to 30 minutes), please email Stella Nichols at [stellanichols@bacp.co.uk](mailto:stellanichols@bacp.co.uk)

## CPR to go online from 2016

From March 2016, BACP's research journal *CPR* will be going online only.

Printing and dispatching over 40,000 copies of *CPR* four times a year creates a substantial carbon footprint and moving to an online-only circulation for members will significantly reduce this.

Members will have fast and secure access to *CPR* online and will be emailed content alerts. Members who still wish to receive a print copy will be able to notify BACP of this when renewing their membership.

The latest issue of *CPR* contains a special section about working with client diversity. Four papers are included that explore long-term counselling for women

on a low income, provision of counselling in women's centres, childhood abuse and gender dysphoria and therapeutic practice with refugee clients.

This issue also contains a paper on the use of therapeutic skills in research. Authored by Lynn McVey and colleagues from the University of Leeds, the paper explores the role of the 'research-practitioner' and uses psychotherapeutic intersubjectivity theory to discuss the relational processes in which researcher and participant interact.

BACP members can access these and all past issues of *CPR* for free through the members' area of the BACP website at [www.bacp.co.uk](http://www.bacp.co.uk)

## 2016 Research Conference

The 22nd BACP Annual Research Conference is to be held in Brighton in May 2016. Details of the venue are still to be finalised.

The theme is 'Research matters: evidence for an evolving profession', and our co-hosts are the Society for Psychotherapy Research (SPR) UK Chapter.

The call for papers is already open. Submissions are invited from students and practitioners as well as experienced researchers, and from all methodological perspectives and theoretical orientations. Information on how to submit a paper can be found at [www.bacp.co.uk/research/events/](http://www.bacp.co.uk/research/events/)

## BACP faces youth committee

BACP Lead Advisor for Children and Young People, Karen Cromarty appeared before the Youth Select Committee in the UK Parliament on Friday 26 June to contribute oral evidence for its inquiry into young people's mental health.

Facing the Committee, which is made up of 11 young people aged 13–18, Karen responded to questions about children's mental health, including the funding of children's mental health services, the benefits of school-based counselling, the barriers to commissioners and service providers working together and whether mental health training for teachers should be mandatory.

On the issue of funding, Karen said that more funds should be invested in mental health services for children at an earlier point, when they first start to feel emotionally distressed, to prevent more severe mental health problems developing.

Asked about the key benefits of school-based counselling, Karen told the Committee that counselling in schools is both 'effective and accessible' but said that national standards are needed in England, as exist in Wales and Northern Ireland, to ensure all children and young people have access to the same high levels of counselling in their school. She said that BACP wants

to see a counsellor in every school in England, that all counsellors in schools should be professionally qualified and they should have strong links with other local services.

BACP was invited to speak to the Youth Committee's inquiry hearing alongside representatives from Youth Access and the Royal College of Psychiatrists.

The Committee functions in the same way as a standard Select Committee, taking both written and oral evidence and producing a report that is sent to the Government for a response. The inquiry into mental health was launched with a call for written evidence in March.

## School-based counselling

Counselling in schools has also featured in Parliament in the past few weeks.

Currently schools in England are not required by law to provide a counselling service. Labour MPs Jim Cunningham MP, Rachel Maskell MP and DUP David Simpson MP have all raised this issue in recent weeks.

Sam Gyimah, Parliamentary Under Secretary of State for Childcare and Education, responded: 'It is a priority for us to support schools and other settings in how best to help pupils succeed through the development of character, resilience and good mental health.'

## Assisted Dying Bill to be debated by MPs

The debate around assisted dying is set to continue in the new Parliament following the reintroduction of a Bill by a backbench MP.

Rob Marris, Labour MP for Wolverhampton South West, has come first in the Private Members' Bill ballot, which means his bill will be debated in the House of Commons.

Previously, BACP lobbied for assisted dying legislation to include safeguards so that those considering ending their life could access counselling/psychotherapy. Family members should also be able to access emotional support even if they support the decision throughout the process, BACP said.

A previous Bill, led by Lord Falconer, was overwhelmingly supported in the House of Lords but was brought down due to lack of parliamentary time. When Rob Marris' bill gets its second reading in September, it will be the first time assisted dying has been debated in the House of Commons since 1997.

## Scottish mental health

MSPs in the Scottish Parliament have been discussing the state of mental health services in Scotland.

Scottish Liberal Democrat Spokesman for Health and Housing Jim Hume has been campaigning for increased funding to mental health services. Cara Hilton, Scottish Labour Shadow Minister for Children and Young People, has also raised concerns over the lack of mental health support for young people in schools and the effect of delayed treatments on educational attainment.

Jamie Hepburn, SNP Minister for Sport, Health Improvement and Mental Health, has restated that mental health services 'are an absolute priority of this Government.'

## Consultation on infant mental health

BACP has responded to a consultation from Northern Ireland's Public Health Agency about infant mental health. BACP argues that the mental health of caregivers (such as parents) has an effect on the mental health of the infant; improving the mental health of the mother

will promote the emotional development of the infant. It is therefore important to support postnatal and perinatal mental health, and policies should be put in place to ensure access to a range of psychological therapies.

We also point out that psychological therapy

interventions, such as parent-child interaction therapy (PCIT), pre-school parent psychotherapy (PPP) and multi-systemic therapy have all been shown to reduce symptoms of mental ill health in children, promote good parenting and prevent abuse of children.

# Professional conduct

## Sanction compliance

**Robert Black**

**Reference No: 700524**

**Norfolk, NR2**

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

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

## Sanction compliance

**Francis Jacob**

**Reference No: 590709**

**Lichfield, WS14**

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the July 2013 edition of the journal has been lifted. The case is now closed.

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

## Sanction compliance

**North East Counselling Services CIC (NECS)**

**Reference No: 132619**

**Tyne and Wear, NE8 1BG**

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

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

## Sanction compliance

**Connie Johnson**

**Reference No: 524513**

**Edinburgh, EH10**

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the May

2015 edition of the journal has been lifted. The case is now closed.

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

## Sanction compliance

**Debbie Walker**

**Reference No: 571328**

**Herts, EN6**

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

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

## Sanction compliance

**Laurel Morgan**

**Reference No: 708437**

**Denbighshire, LL18**

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

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

## BACP Professional Conduct Hearing

**Findings, decision**

**and sanction**

**Robert Morrissey**

**Reference No: 705648**

**Rochdale, OL16**

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

The Panel was unanimous in its decision that these findings amounted to professional malpractice in that the service for which Mr Morrissey was responsible fell below the standards that would reasonably be expected of a practitioner exercising reasonable skill. The Panel found that Mr Morrissey was reckless, incompetent and provided an inadequate professional service.

The Panel found evidence of mitigation and imposed a sanction.

Full details of the decision can be found at [http://www.bacp.co.uk/prof\\_conduct/notices/hearings.php](http://www.bacp.co.uk/prof_conduct/notices/hearings.php)

## BACP Professional Conduct Hearing

**Findings, decision**

**and sanction**

**Roddy Macdonald**

**Reference No: 598547**

**Edinburgh, EH12**

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

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

The Panel found evidence of mitigation and imposed a sanction.

Full details of the decision can be found at [http://www.bacp.co.uk/prof\\_conduct/notices/hearings.php](http://www.bacp.co.uk/prof_conduct/notices/hearings.php)

[bacp.co.uk/prof\\_conduct/notices/hearings.php](http://www.bacp.co.uk/prof_conduct/notices/hearings.php)

## BACP Professional Conduct Hearing

**Findings, decision**

**and sanction**

**Monika Jephcott**

**Reference No: 514976**

**East Sussex, TN22**

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

The Panel was unanimous in its decision that these findings amounted to Professional Misconduct in that Ms Jephcott had contravened the ethical and behavioural standards that should reasonably be expected of a member/registrant of this profession.

The Panel found evidence of mitigation and imposed a sanction.

Full details of the decision can be found at [http://www.bacp.co.uk/prof\\_conduct/notices/hearings.php](http://www.bacp.co.uk/prof_conduct/notices/hearings.php)

## Withdrawal of membership

**Susannah Lee**

**Reference No: 719337**

**Surrey, KT12 5BJ**

A sanction was imposed on Ms Lee following a Professional Conduct Hearing.

Ms Lee failed to comply with the sanction and subsequently her membership of BACP was withdrawn. Any future application for membership of BACP will be considered under Article 12.3 of the Memorandum and Articles of the Association.