For counselling and psychotherapy professionals

June 2015, Volume 26, Issue 5

Therapy Today

# Therapy Today

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## Why one in 20 clients feel harmed by therapy

## How diagnoses affect the counselling relationship

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# Editorial

## Power and harm

*Cover illustration by Sébastien Thibault*

Continuing last month's theme of counsellors going into places the rest of society would rather forget about, in this issue Andrew Smith describes his work with sex offenders. I don't recall having published any articles on this subject in the last 15 years, which would suggest that not many of our members practise in this area. I do remember interviewing the late Ray Wyre, in the early 1990s, about his pioneering work with sex offenders and about the obstacles he came up against because of perceptions of sex offenders within the criminal justice system. He once said, 'Even in the people who are hated by society, there is a good person lurking in there somewhere.'

As a member of society, Andrew Smith says he cannot avoid being affected by the demonised identity of sex offenders in the public mind. As a therapist working with sex offenders, he says that, in order to form an unconditionally non-judgmental alliance with the client, he has to bracket a range of negative feelings. Andrew also makes a convincing case for the need for more preventive counselling support in the community for this group – after all this is a growing problem: 50,000 people in the UK are viewing indecent images of children online and this figure is likely to increase. With the right help at the right time, Andrew believes many low-risk offenders may be able to reduce, manage or completely stop harmful sexual behaviour.

Another subject that we don't hear much about in the therapy press is the potential for therapy to harm clients. This is the focus of the AdEPT study at Sheffield University, led by Professor Glenys Parry. One in 20 clients of psychological therapies say they experienced 'lasting bad effects' from their treatment. AdEPT's findings tell us that the harm is rarely due to actual malpractice; issues around power came out time and time again in qualitative research with clients: the client's sense of lack of voice, lack of power, feeling belittled and judged. These issues are also raised by Premila Trivedi, writing from a client's perspective in the Your Views columns this month. Many of the professional systems and practices seemed to her to be 'rigidly prescribed, with in-built power relations that are more about upholding the credibility and status of the particular therapeutic model rather than empowering and addressing the needs of the individual client'.

*Sarah Browne*
*Editor*

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'Why are we so often pressurised into slotting into the therapy that is available rather than offered what we think might really help us?' *Your views (p5)*

'Let's move on from the criticisms of CBT and instead allow ourselves to be well informed, open, curious and challenged about what is not familiar to us' *Letters (p36)*

'The object of research ethics committees, ostensibly to protect the participants, seems in fact to derive from a fear that their institution might end up before the courts' *Letters (p38)*

# Fatherless worlds

## Father's Day is on 21 June. Jeanine Connor explores the meaning of the absent dad

We live in a patriarchal society. Yet it remains a sad irony that many young people will not be sending a Father's Day card this month, because they have no dad – not one they know about – to send one to.

They might have a father figure in the form of a step-parent or family friend, and a male teacher or counsellor can provide a male role model too. But there is a fundamental difference between a father figure and a dad proper that goes beyond the biological.

I run a Thinking and Feeling group for eight to nine year-olds. Jack is angry because his mum has a new boyfriend, and he is angry because he doesn't have a dad. Lenny tells the group he is sad because he doesn't see his real dad anymore. Skye says, matter-of-factly, 'Oh I know what that's like; my dad isn't my real dad either.' I encourage the group to consider what a real dad is. Millie knows her dad is her real dad because he's in photos she has of herself as a baby. Lenka has been DNA tested to prove whether her dad is her real dad and whether her mum is her real mum. The children's naivety, in an absence of accurate explanation, has left them feeling confused. So we struggle on, trying to make sense of their nonsensical, fatherless worlds.

One of the things about dads is that they anchor us and give us a sense of belonging. Even for younger children who are unacquainted with the biology of paternity, there is a recognisable yet nameless feeling associated with having a dad who is 'real' that makes us feel real too.

Nell, a woman in her 40s, reflected with me on a fatherless childhood and a lifetime of not-knowing. She was three when her parents separated and Nell's father was described by her mother as a wannabee, a dreamer and a weak man who remained living with his mother into adulthood rather than living in the real world. The real world involved being Nell's dad, and he'd opted out. Nell remembered her mother's words so precisely because they were all that she had of her father. She'd never seen a photograph of him and her memories were depleted.

Nell grew up believing she wasn't good enough – a certainty instilled in her by her mother's story. As a consequence, she worked hard and excelled in academia and in her career. But, despite her successes, she had never felt that she fitted in and had an enduring sense of not being good enough. She struggled to get along with female bosses, replicating early maternal rivalry, and felt let down by male ones, mirroring her relationship with the father who had disappointed her. She opted eventually to work freelance, taking care of herself as she had learned to do from a young age.

Unsurprisingly, Nell had a history of failed relationships. She chose good enough men and left them when they fell in love with her, so as to deny them the opportunity of repeating her father's abandonment. Nell told me on numerous occasions, 'I just wish I'd known my dad.'

I think about the adults who the children in my Thinking and Feeling group will become; perhaps adults like Nell with a fragmented sense of self, endlessly striving for perfection in an imperfect world. Fathers offer an alternative perspective to mothers, as well as support and equilibrium. Children without a dad have a sense of something missing and are likely to internalise that sense so that they feel inadequate too. They blame themselves (or are blamed) for their father's absence and go on searching for what isn't there, never really knowing what it is they are hoping to find. Knowing about our real dad helps us to recognise and consolidate our real self. We are a part of them and they are a part of us: biologically, emotionally and psychologically. That's why dads matter.

*Jeanine Connor MBACP works as a child and adolescent psychodynamic psychotherapist in private practice and in specialist Tier 3 CAMHS and is also a writer, supervisor and trainer. See www.seapsychotherapy.co.uk*

# Who holds the power?

## Premila Trivedi asks some searching questions about power in the therapy room

Talking therapies are highly prized by those of us who find ourselves caught up in mental health services. I wonder, then, why my experiences of such therapies have too often ended in disappointment and frustration.

I freely admit I am not an easy client. Asian, born in the UK and brought up within a traditional Indian family at a time when in-your-face racism was just a normal part of everyday life, this has, I believe, contributed to my constant feeling of alienation and desire to opt out of life. During my long journey in mental health services I have been privileged to have had access to various forms of therapy and each, no doubt, served a purpose for me at the time. But, reflecting back, I feel I never quite found the space I was looking for. I have been told more than once that this has ultimately been down to me and my inability to use therapy appropriately. I've no doubt some of this is true, but I do wonder if there was also something else going on that made therapeutic progress so elusive for me.

Was it something to do with the theoretical models of therapy that I encountered, and the professional systems and practices that have evolved from them? Many of these seem (to me at least) to be rigidly prescribed, with in-built power relations that are more about upholding the credibility and status of the particular therapeutic model rather than empowering and addressing the needs of the individual client. Maybe that was why I was so bad at therapy – because (as in so many areas of my life) I couldn't adapt myself to the shape that others expected me to be?

But this raises many questions, particularly about power – both how it is distributed and the ways in which it is used to mould and shape the progress of therapy. It's a process that begins long

before we ever enter the therapy room. I've summarised my concerns here in the form of questions about the professional and ethical practice of therapy, particularly in mental health services.

When accessing therapy:

1. How do we find out about therapy, and who determines what information we are given?

2. Who decides when we can be referred for therapy and what therapy might best suit us?

3. Who determines the assessment procedure we have to go through, and why does it so often end up feeling like an exam that we must pass in order to proceed to the next step?

4. Who chooses who 'passes' and how much is this determined by the beliefs and values of the individual assessor?

5. Why are we so often pressurised into slotting into the therapy that is available rather than being offered what we think might really help us?

In the therapy room:

1. Who sets the tone in terms of power, style and content of sessions?

2. Who establishes the rules of therapy and expects us to somehow know them, even when they are not made clear?

3. Why, if the therapeutic relationship is so crucial, can nothing be shared about the therapist as a person in sessions; is it possible to have a positive relationship with a blank slate?

4. Who determines which doors are opened (consciously or sub-consciously) in therapy and which issues and social contexts (eg experiences of racism) can be raised and explored?

5. Who decides when therapy ends, and the process by which this happens?

I ask these questions to make some sense of my personal experiences in therapy. But maybe they also raise questions about the professional and ethical practice of talking therapies, particularly in mental health services, where they are highly prized but may not always achieve their full potential as far as clients are concerned.

*Premila Trivedi is a mental health service user, trainer and adviser. She is speaking at a conference on 'Professional and Ethical Practice for Psychologists, Counsellors and Psychotherapists' on 17 July at the University of East London. For details, email Rachel Tribe at R.Tribe@uel.ac.uk*

# Between two worlds

## Interpreters carry a huge burden of others' emotional pain, writes Beverley Costa

*'Words by themselves are easy to interpret, but it is what's hidden behind them that is so very hard to convey.'*

The presence of an interpreter makes it possible for clients' voices to be heard. Their role is vital – sometimes life saving. Interpreters hear and relay often distressing and heart-rending stories, and how they do this can make a critical difference to clients' lives. Yet their own support needs are often overlooked and they have few outlets for the emotional impact of their work.

Their training can leave them feeling underprepared for the impact of this work: underprepared in terms of the support they may need and for the intensity of the emotions experienced by the clients. Interpreters frequently refer to their codes of conduct, which may prize neutrality and impartiality. In a mental health context neutrality may be aspired to but the reality is that the interpreter becomes invested with feelings, albeit at an unconscious level. Unconscious processes do not disappear if we ignore them or if we attempt to override them. If we do not attend to them we can 'act out' on them, without awareness. Supervision and training give space and opportunity to explore our unconscious processes safely so that we can act within awareness. This is not just an interesting and optional exercise; it is essential if the practitioner or interpreter is to provide the best possible environment for clients to access the help they need, to heal and to thrive.

Mothertongue, a multi-ethnic counselling service, has a firm commitment to training and regular clinical supervision for all our interpreters who work in a mental health context. But, from our supervision sessions, it has become very clear that this support is very rarely available for interpreters working elsewhere and, without adequate support, the burnout rate can be very high.

*In Other Words: the interpreter's story* is an anthology of accounts by the interpreters with whom we work, produced in a writing group we hosted last year and published this month (the quotes here come from the anthology). The interpreters write about their personal and professional experiences, what led them to becoming an interpreter, the impact the work has on them, the dilemmas they face, how they hold their professional boundaries while under great personal pressure that can come from both sides of the dialogue they are facilitating.

*'Although what was being said came from other mouths, it was from mine that she heard it. It made me feel like the executioner on pulling the trigger.'*

Interpreters, as the writings show, often become deeply personally involved in the cases into which they are invited. Their own experience of bridging cultures and their understanding of the nuances of cultural experience and of the non-verbal cues that often speak more than words contribute in many ways to their effectiveness.

These are real human stories from the interpreters' own experiences. The interpreters have been courageous in sharing and reflecting on their dilemmas, the risks they take and the mistakes they can make. We have done our best to anonymise and fictionalise the accounts so that no one is identifiable. Enabling vulnerable people to be understood and acknowledged is serious and important. These stories concern clients who would otherwise be doubly silenced – by having to speak through an interpreter's voice, and by having no one who will tell their story and listen to it fully and with compassion. Publishing this anthology will, we hope, help those in charge of interpreter services and those who employ interpreters understand their role better and how best they can be used and supported.

*Beverley Costa is Chief Executive and founder of Mothertongue. The book can be obtained from www.mothertongue.org.uk*

# Medics question medication

Doctors have joined forces in a campaign to cut back on use of prescriptions and medical interventions, including drugs for mental health problems. The Academy of Medical Royal Colleges (AcMRC)has signed up to the international Choosing Wisely campaign, which aims to curb use of unnecessary medical interventions and reverse what it says is a trend to 'over medicalise' illness.

Writing in the *British Medical Journal*, senior medics, including BACP Vice President Dame Professor Sue Bailey, argue that a culture of 'more is better' has resulted in patients 'sometimes being offered treatments that have only minor benefit and minimal evidence despite the potential for substantial harm and expense'.

The AcMRC is asking professional and healthcare organisations to create a 'top five' list of procedures to be avoided. For GPs, this is likely to include antidepressants for mild depression. Professor Maureen Baker, Chair of the Royal College of General Practitioners, said doctors can come under pressure from patients to offer medication when non-medical approaches might be equally effective: 'For example, mindfulness and talking therapies have been shown to have positive effects in some patients with recurring depression and anxiety, as opposed to taking antidepressants.'

The Choosing Wisely campaign encourages doctors to 'have conversations with their patients and explain honestly what the value of a treatment is,' said Professor Bailey, who chairs the AcMRC: 'It's just about taking a grown-up approach to healthcare and being good stewards of the resources we have.'
*http://tinyurl.com/k87wvxc*

# CBT wins NICE backing for menopause anxiety

CBT should be more widely available to women who experience low mood and anxiety related to the menopause, a new draft guideline from NICE says.

Around 80 per cent of women experience some symptoms during menopause and these commonly continue for around four years, although for one in 10 they can last for up to 12 years.

The guideline says that low mood related to the menopause can be helped by hormone replacement therapy and psychological therapies such as CBT, but that there is no evidence that other non-pharmacological treatments, such as herbal treatments, are effective. CBT is also effective for anxiety, and there is evidence for the effectiveness of genistein and red clover, but there are concerns about the safety of these two treatments.

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The guideline committee says that, while psychological symptoms are common in women in menopause and can affect their personal, social and professional lives, it could find only limited evidence of effective psychological treatments. But the one randomised controlled trial that has been published – comparing usual care with usual care and group CBT – does, it says, provide enough evidence of effectiveness to recommend its wider availability.

But SSRIs/SNRIs should not be prescribed as a first-line treatment for menopause-related low mood, unless the woman has clinical depression. This is because of their adverse side effects and because the low mood may be the result of hormonal changes.

The consultation on the draft guideline ends 13 July.
*http://tinyurl.com/qxyy8xq*

# Young people hide sadness

More than half of young people aged 18 to 24 (55 per cent) say they find it difficult to talk about their feelings when they are down, a new survey by Mind and the Lucy Rayner Foundation has found.

Nearly two thirds (64 per cent) say they put on a smile and pretend they are OK, 48 per cent keep it a secret and 49 per cent lie when they are feeling down. Less than a third (27 per cent) say they speak openly about their feelings, although nearly half say they feel better if they do.

The Lucy Rayner Foundation has funded a video, *#inourownwords*, where young people talk about their mental health. The video can be downloaded from www.mind.org.uk/inourownwords

# Bosses should do more for mental health

Half of all employees say they have never been asked about stress, depression or anxiety in a 1-2-1 with their manager, a study by Bupa has found. Yet 76 per cent of business leaders believe they actively encourage their managers to support employees' mental health, and 80 per cent claim to have measures in place to do this.

Bupa surveyed 50 business leaders and 500 employees. Less than a third of employees (32%) with a mental health condition agreed that their employers were doing enough to support them.
*http://tinyurl.com/nkljupk*

# Scotland cuts counsellors

The number of counsellors and therapists working in the NHS in Scotland has fallen by some 16 per cent, the latest workforce figures reveal. And an analysis by BACP shows that the brunt of the cuts have fallen on counsellors.

In March this year there were 37 counsellors, 51 CBT therapists and 18 other therapists, including psychotherapists and family and couple therapists, working for NHS Scotland. Of the 37 counsellors, 24 were part time and 13 were full time; three quarters of the CBT therapists were full time. BACP has calculated that counselling posts have fallen to 25.5 whole time equivalent (WTE) from 25.7 WTE in March 2014, while the equivalent WTE for CBT therapists is 46.2, up from 40.5 a year ago. No counsellors are employed by NHS Scotland in the North Region. Counsellors were the only therapists whose numbers and hours dropped over the year. Psychology assistants saw the biggest rise, at 20 per cent.

Over the past five years, counsellor numbers rose from 14.8 WTE in September 2010 to a high of 31.4 WTE in September 2012, and back to the current figure of 25.5 WTE in March 2015. CBT therapists have seen a gradual increase in numbers and hours from 31.8 WTE in 2010 to 46.2 WTE in March 2014.

There are no counsellors employed in NHS Scotland aged under 30 and 17.2 WTE of the total 25.5 WTE are over 50. Counsellors are also getting paid less: just 3.2 WTE are on band 7, 22 WTE are band 6 and 0.3 are band 5, while most CBT therapists are band 7.

'This is extremely worrying evidence of a trend that reduces choice for clients when we know that choice is an essential factor in therapeutic outcomes,' said Nancy Rowland, BACP Director of Research, Policy and Professional Practice. *http://tinyurl.com/nvzmmll*

# Black older people at higher risk of depression

Older South Asian and Black Caribbean people in the UK are at almost twice the risk of depression than their White European counterparts, new research shows.

The research, conducted by researchers at University College London, funded by Diabetes UK and published in *Psychological Medicine*, used data from a 20-year follow-up study of 632 European, 476 South Asian and 181 Black Caribbean men and women aged 58–88 years, living in West London.

Depressive symptoms were reported by 10 per cent of White Europeans, 16 per cent of South Asians, and 18 per cent of Black Caribbeans. Chronic physical health problems and disability were key risk factors explaining the higher rates of depression in the older South Asians; social disadvantage explained much of the higher risk among the Black Caribbean people.

Lead researcher Dr Emily Williams said the data are some of the first that compare depressive symptoms among older UK ethnic groups: 'This generation has been through considerable life stressors in their migration to Britain. We can't determine a causal link in this sample; there are likely to be other risk factors, such as racism, that contribute to their poorer mental health and the findings need to be confirmed with more research. However, it's important that GPs are aware of this increased risk and, if they observe these risk factors, they should be prepared to ask sensitively how the patient is feeling.' *http://tinyurl.com/olbezu8*



# Ask men about partner violence

Risk of depression among men who are violent and abusive towards their partner is up to five times higher than in the general population, new research shows.

The study, published in *BMJ Open*, questioned 1,368 men attending 16 GP practices in the South West about their experience of four 'negative behaviours' associated with domestic violence and abuse (DVA): fear, physical harm, forced sex and having to ask permission from a partner.

Nearly a quarter (22.7%) reported being victim of at least one of these behaviours and 16.9 per cent had inflicted them on a partner at least once. Victims were at least twice as likely to have symptoms of anxiety and depression, especially if the incident occurred in the past year; perpetrators were three times more likely to report anxiety and depression, rising to five times if they had inflicted these behaviours in the past year.

The researchers say health professionals should be alert to these links. Professor Marianne Hester, Chair in Gender, Violence & International Policy at the University of Bristol, said: 'Our data suggest very strongly that if men go to their GP and say they feel depressed their doctor should be asking them about their relationship, not simply about the mental health issue.' *http://tinyurl.com/njbhlx3*

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# When therapy does harm

## A major study at Sheffield University is challenging counsellors and therapists to accept that what they do can both help and harm. *Catherine Jackson* reports

'First, do no harm' is a fundamental principle in all health care. Yet to what extent do counsellors and psychotherapists acknowledge that what they do may cause harm, and how might therapy be harmful?

These are the questions that inspired the AdEPT Project, led by Professor Glenys Parry at the University of Sheffield's School of Health and Related Research (ScHARR), working with Gillian Hardy, Michael Barkham, Dave Saxon and colleagues in the university's Centre for Psychological Services Research. AdEPT stands for 'Understanding and preventing adverse effects of psychological therapies'. Some of the findings have been published and others are still to appear but Professor Parry reported the headlines at the BACP Research conference in May.

That these questions need answers can be seen from an analysis of clients' experiences reported in the second National Audit of Psychological Therapies, conducted by the Royal College of Psychiatry in 2013. Some 14,500 therapy clients responded, of whom 5.5 per cent said they had 'experienced lasting bad effects' from their treatment. 'Most therapists do a good job, and their intentions are honourable. But sincerity isn't enough,' says Parry. 'You may think that one in 20 isn't very many, but we are getting to a position here in the UK where talking therapy is becoming available on an industrial scale. That percentage could mean a lot of people potentially having lasting bad effects from therapy. We need to understand what this is about in a much more detailed way, so we as a profession can learn from it.'

AdEPT comprises five separate studies: a review of accounts of therapists and clients of their experiences of failed therapy and what they think would have helped avoid it; a qualitative survey of 193 clients and 322 therapists about their experiences of negative outcomes in therapy; a review of randomised controlled trials (RCTs) to compare deterioration rates among patients who received therapy and those who did not; an analysis of predictors of deterioration and drop-out rates drawn from existing large datasets, and, going forward, the development of information and resources to help clients and therapists prevent avoidable harm, take risks safely and foster safer practice.

The review of clients' and therapists' experiences of failed therapy produced some telling findings. Clients reported their experiences of failed therapy as extremely damaging; therapists with failed therapies (these were not client–therapist pairs) tended to think that, while the therapy was not good, some good would come out of it eventually. 'Perhaps that's not surprising – you find the same in midwifery,' Parry says. 'Women rate childbirth much more painful than their midwives do.' Clients with failed therapy talked about 'the sense of being silenced', and feeling pathologised: 'It was as if I was a damaged item and the therapist was trying to "fix" me;' 'Issues that were important to me just weren't addressed at all.' They described losing confidence, feeling 'dread' before going to sessions, and 'feeling more of a failure afterwards'. One talked about 'not having skills to deal with the emotions that it unravelled', and of being left 'in probably a dangerous place'.

The therapists reported stuckness. For some, the experience of the failed therapy stayed with them – like the clients, they felt a failure and lost confidence. Their comments included: '... it wasn't releasing anything you know, he was just feeling worse at the end of the session,' and, 'She appeared to take a passive approach to therapy, with an expectation that attending sessions in itself would lead to change.'

The meta-analysis of RCTs comparing deterioration in clients with anxiety or depression who received psychological therapy and others in control groups who did not revealed that overall the risk of deterioration was very similar in both groups. This shows, says Parry, that therapy itself is not systematically harmful, at least for people with depression or anxiety. 'So we needed to look at the therapist, the therapy, or the interaction between client and therapist, to understand which other factors may cause harm in the individual case.'

Their study to explore the 'therapist factor' found deterioration rates varied widely across individual practitioners: some therapists had no clients who deteriorated; others had several, and the range in drop out rates was even wider. These differences remained even when other factors predicting outcome were controlled for, suggesting that the therapist is an important factor in drop out and deterioration, Parry says. Yet, as a further review of trials revealed,[1] psychological therapy researchers rarely report adverse events or even monitor them properly. There was a lack of quantitative evidence but plentiful qualitative evidence, and this has informed the team's development work.

'What the qualitative sources showed was that context is important – that we need to attend also to things that happen before the therapy starts, as well as therapist behaviour and what can go wrong at the ending,' Parry says. 'Actual malpractice is only a small part and most of the behaviour would get completely under the radar of non-compliance or regulatory procedures. You can't rely on complaints procedures to deal with this because they aren't going to.'

Drawing on these findings, the AdEPT team has developed sets of markers that indicate when therapy is going awry, and 'fault lines' where things are more likely to go wrong. 'This is not about blaming,

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it's about understanding,' Parry says. The service context is vital: not being allowed to give a client more than a set number of sessions; too large caseloads; not enough supervision, and lack of fit – being required to work with this client, in this way. The type of client is also important: practitioners need to be able to say they don't feel competent to take on a client or need training to do so. Says Parry: 'We need also to be aware of our own behaviours – the power issue comes out again and again in qualitative interviews – the client's sense of lack of voice, lack of power, feeling belittled and worthless, feeling judged.' Another key issue is that of safety and containment: 'We heard of therapists taking phone calls in sessions, being late, not telling clients that they will be away on holiday, and over-stepping boundaries.'

Parry believes the answer is not tougher regulation and monitoring, which are likely only to result in defensive practice. 'There is a horrible culture of risk aversion in the NHS. You have to take risks to get results. Life is a risk. It's a question of balance.' Rather, practitioners need to change the way they practise, she argues. 'Be clear about what you're doing – have a plan, don't just hope for the best. Manage expectations – be honest about what you can and can't achieve. Explain the risks as well as the benefits. I explain how therapy can help but also tell clients that some people don't benefit and a few experience adverse effects. If we don't do this, we aren't getting informed consent.'

A simple but effective tool is to provide the client with the means to keep safe. Parry advises: 'Tell the client how to signal to you if they think they are getting worse. Ask if the therapy is helping, and conduct regular reviews. Be mindful of your own attitudes and behaviours: be open, warm, collaborative, enthusiastic, confident; don't be passive and withdrawn. And train yourself to notice and respond to alliance ruptures. The biggest mistake, we found from another study,[2] is that therapists don't even notice that there has been a rupture.' Perhaps the most important advice is: 'Don't be afraid to ask for help. And, if you're in a hole, stop digging!'

For counselling services and managers, her message is equally blunt. Don't give practitioners bigger caseloads than they can safely handle, and don't allocate the most challenging clients to the most inexperienced practitioners. She says services must track clients' progress and follow up those who are deteriorating more than would be expected. They should also follow up drop-outs. 'Some 40 per cent of IAPT clients drop out but we don't follow them up. If you don't, they can become just one more person through the door to keep your performance figures up.'

AdEPT has set up a website (www.supportingsafetherapy.org ) for clients and therapists with information and practical tools to help improve the safety and effectiveness of therapy for both. ■

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# Working with sex offenders

Psychotherapists in private practice could have a key preventive role working with clients at risk of sexual offending, argues *Andrew Smith*
*Illustration by Sébastien Thibault*

I have been working for the last 11 years with people (they are almost exclusively men) who have been convicted and accused of sexual offending, initially for Ray Wyre Associates and then for the past nine years with the Lucy Faithfull Foundation. My main role has been as risk assessor, primarily in the family court system, and then as therapist, to help lower and manage risk. In the last two years I have worked in private practice with people displaying compulsive or potentially harmful sexual impulses.

Up until recently, the main treatment for people who have committed sexual offences in England and Wales has been lengthy groupwork treatment programmes, run by the prison and probation services.[1] In this article I want to make the case for the potential preventive benefits of providing better access to counselling provision in the community as an effective way to reduce and manage risk of offending.

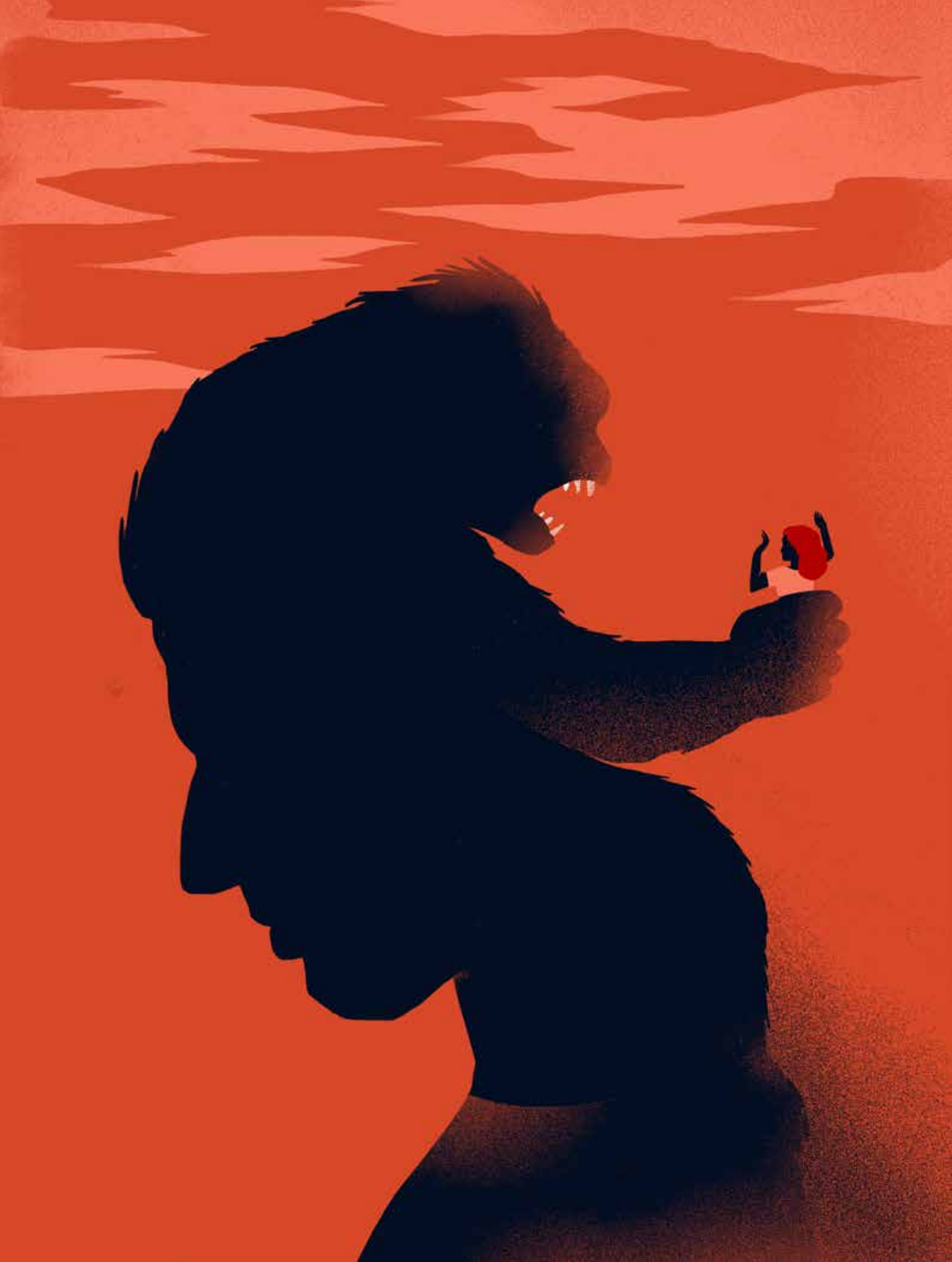
Working as a private therapist in this field presents challenges distinct from those of working for an agency, which will have clear organisational policies and procedures in place. In this role I am integrated within a multi-agency setting, working with social services, the probation service and the family courts, where it is generally understood by all that information will be shared and the main purpose of any intervention is increased public protection.

Working as a private therapist in this field places responsibility for complex ethical decisions squarely on the individual practitioner. Counsellors cannot be legally bound by a client to maintain absolute confidentiality; there are statutory duties to report certain criminal acts, and also if a practitioner has reasonable cause to believe that a client (or another person) is likely to place an adult or a child at risk of serious harm, and disclosure could avert that harm, then the practitioner must consider their ethical duty not only to the client but also to the child(ren) or potential victim concerned and to the public.[2] Those working in government, organisational or agency settings should be following their policies and procedures. For those who work independently, these are matters for supervision, and where necessary for expert professional advice on child protection law and practice, which should be available from the legal department of the local authority, social care services, specialist lawyers such as Children Panel solicitors, the Department of the Official Solicitor, CAFCASS duty officers, and from professional organisations such as BACP[3] and UKCP.

StopSO (Specialist Treatment Organisation for the Prevention of Sexual Offending) is a not-for-profit organisation that aims both to help people who have committed a sexual offence, or are at risk of doing so, to access therapy, and to support therapists working in this field. It publishes a list of private counsellors and therapists trained and willing to work with sexual offenders. It also offers training and support, including a list of supervisors, to counsellors and psychotherapists to help them make the transition to working with this client group. It offers similar support to therapists working with partners of men with sexual offending problems and with couples.

The core therapeutic tasks when working with sexual offenders can be summarised as:

- forming an unconditionally non-judgmental therapeutic alliance in which the client develops self-acceptance and self-compassion



‘Working with people who have sexually offended can be a prime site for unhelpful transference... and will be compounded if the therapist has unresolved abuse or victim issues in his or her own background’

## George: a case study

**The name and details in this composite case study are fictitious but the issues and interactions are typical of those I have experienced in my practice**

George is in his mid-50s. He was arrested after downloading thousands of abusive images of children, mainly teenage girls. He stressed he had been law-abiding all his life and loved his wife. They had raised two daughters, both now in stable relationships and with good careers. He vowed that he would never dream of harming a child in ‘real’ life, and could not explain his behaviour.

George had an indulgent but emotionally fragile mother, who periodically took to her bed with depression. He had one younger brother on the autistic spectrum. His father was in the army, emotionally disconnected and frequently physically absent too. He told George from an early age that he was relying on him to ‘take care of business’ while he was away. George had prided himself on being responsible and upstanding ever since.

George had chosen a wife completely unlike his mother. She provided the ‘fizz to our life’, as George put it. Even though she had felt shocked and betrayed by his secret internet activity, she had soon regained her sanguinity, believing that something would work out. But they were both conflict avoidant and George eventually came to see that there had always been a lack of emotional intimacy in their relationship.

George had risen to a moderately senior position at work but in his 40s had been passed over for promotion in favour of more junior colleagues. He had been made redundant and took premature retirement 12 months before the police called at his door to arrest him.

When he talked about work George’s anger was, for the first time, barely concealed. He had felt bullied by his line manager, that whatever he tried to do was not good enough. The strategies he had used – trying to be a generally ‘good guy’ – had been thrown in his face. He had still lost his job.

Depressed and angry and with much more time on his hands following his retirement, he began playing internet war games where he could act out the aggression he had always been too anxious to express in real life. He then began looking at pornography, deciding, resentfully, that he was going to explore the sexual experiences with teenage girls he felt had been denied him as a young man. The girls in the images became younger and younger as he began to access illegal sites. He talked of sometimes feeling a great sense of liberation as he looked at the prohibited images, and a sense of empowerment at breaking this powerful social taboo.

Gradually George began to gain more insight into how his life experiences and coping strategies had created an offending pathway. In understanding, though not excusing, his behaviour, he came to accept that he was not the monster he felt himself to be and that his offending had a sad logic to it. Once George had developed a degree of self-compassion, we could then go on to address more standard rehabilitative domains such as identifying effective fantasy management techniques and developing assertiveness and intimacy skills. At the beginning of the therapy his anxiety levels and sense of shame prevented him from focusing on the harm caused by his offending. By the end he was able to begin to de-objectify the children in the images and open himself up to understanding how his offending had helped sustain a market that exploits and abuses vulnerable children for financial profit and sexual gratification.

‘Therapeutic work with people who have worrying thoughts and fantasies about sexual offending but who have not yet offended can make an important contribution to the preventive agenda’

- helping the client to gain insight into how life experiences and unconscious coping methods can form a pathway to sexual offending
- assisting the client to overcome shame, in order to de-objectify victims and raise awareness of victim suffering
- helping the client to develop the self-management skills to establish a constructive lifestyle in which needs and desires can be met and realised prosocially rather than antisocially.

As a therapist, but also as a member of society, I cannot be unaffected by the demonised identity that sex offenders embody in the public mind. Some behaviour (sex offences, particularly against children) is considered taboo and polluting, provoking particular anxiety among practitioners. Other behaviour (ie violent armed robbery) may be equally harmful yet not provoke pollution beliefs.[4] Below are two quotes from my own research into the experiences of probation officers working with sex offenders, which illustrate their conflicted feelings.[5]

‘His sexual activity I just found so depraved and bizarre... I remember leaving the prison, and during the interview I wanted to get up and walk out... the main thing is based on respect... they are individuals who need respect even if they haven’t dished an awful lot out to others, and to work with them I’ve got to respect them as a human being’ (Probation officer 14).

‘Yeah, I said that at the beginning, didn’t I, that I couldn’t empathise with them and maybe on one hand I don’t want to, and maybe that is your safeguard for yourself, that you don’t empathise with them. It sounds awful, but do they deserve now to have a happy life?... I like to say “Yes they do,” but there’s, you know... With sex offenders, I do hope that they go on to have more productive lives, then a prejudice I suppose... I hope it’s not that pleasant’ (Probation officer 9).

Successful therapy with sex offenders is hugely dependent on the quality of the therapeutic relationship,[6] as it is of course with other client groups.[7] The treatment of sex offenders in the criminal justice system is increasingly focused on helping them to establish satisfying lifestyles in which their needs and desires are met prosocially rather than antisocially through offending.[8] The self-reflections of the probation officers show how emotionally complex this therapeutic task can be. Working with people who have sexually offended can be a prime site for unhelpful transference and projection – for therapists as well as probation officers – and such difficulties will be compounded if the therapist has unresolved abuse or victim issues in his or her own background.

Some sex offenders present themselves as great guys: guys who do the right thing, always helping others, considerate husbands and fathers, pillars of the community. More than anything else, they want to be ‘good’ and they want the world to know that they are ‘good’. Often these men have indeed been ‘good’ in many respects, apart from their offending, although apparent ‘good’ deeds are also frequently part of the grooming process. Whatever the reality, I usually have to bracket a range of negative feelings, ranging from mild irritation to anger, about the shift of focus from harm caused to victims to what appears to be self-congratulatory behaviour.

A typical example might be a client who starts a therapy session with the casual comment, ‘It’s hot out there. I was worried about being late so I had to run from the car park.’ The phrase ‘had to’ appears repeatedly in the client’s discourse, suggesting a compulsive moralistic and perfectionist agenda. For such a client, the repressed, non-conformist shadow side of the personality may have been acted out through sexual offending on the internet.

Some clients eventually come to see the lighter side of such a give-away verbal tic, and are amused when they or I bring attention to the habitual use of ‘oughts’, ‘musts’ and ‘have tos’. In a first session, however, clients tend to be far too anxious for such self-reflection, and some are apt to manage anxiety – as they have done for most of their lives – by masking it with displays of competence. Another typical opening gambit might be, ‘I was held up by roadworks on the motorway. I can’t stand people being late. I don’t like it in others, so I try to be on time myself.’ The client may have downloaded thousands of abusive images of children, many of the most serious kind, including adult men having penetrative sex with children. Nevertheless, he appears to want to impress me with his timekeeping.

The following is typical of the kind of statement an offender might make early on in an interview: ‘Look, I want to make one thing clear, I know I’ve messed up, but I want to do everything to make amends to my wife and grown-up children – who have both been super – and I also want to make amends to the Church. Only the leaders know, of course, but they have stood by me one hundred per cent.’

Internet offenders often express a desire to make amends to a partner, family members and friends for the betrayal and unhappiness caused by their offending. But they rarely mention making amends to the child victims in the images, or the impossibility of being able to do this now that the offence has been committed. It is important,

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however, not to challenge clients too early about this. At the start of therapy, many sexual offenders are likely to feel profound internal shame about their behaviour, which is too painful to explore at the beginning of the therapeutic process when anxiety is at its highest. For many, in my experience, empathising with the harm caused to victims tends to be the most painful step, and this is best done when the therapeutic relationship has been securely established and the client has developed sufficient trust in the therapist to allow her to accompany him to this dark place. If I were to challenge them immediately about their lack of empathy for their victims this would be, in the main, for the satisfaction of venting my own feelings of disapproval. The therapist has to be acutely aware of any judgmental and negative feelings towards the client in order to be able to bracket them appropriately. This is, I would argue, especially difficult with sex offenders.

Equally important is knowing when to raise difficult issues. To do this I also need to be aware of any feelings I may have about wanting to protect a client, and myself, from anxiety-provoking conversations. I find it is important in the first session to make it clear that I am willing to explore the reality of a client's sexual offending in an open, non-judgmental, matter-of-fact way. This fosters a therapeutic climate in which the client is more likely to speak openly about hitherto shameful matters. There is usually some sting for clients in bringing up the actual details of sexual offending for the first time, but it has to be done; otherwise therapist and client can mutually collude in order to avoid addressing the main issue at hand.

It is often assumed that 'once a sex offender, always a sex offender'. However the reconviction rate for sex offences is relatively low compared with that for many other crimes.[9] Sex offending can be seen in terms of a continuum. At one end are the 'critical few' – the high risk sex offenders who are not motivated to change their ways and/or do not possess the emotional regulation skills to do so. At the other end of the scale are relatively low risk individuals who are unlikely to reoffend. Risk assessment of sex offenders is a highly specialised area, and should be conducted by a specialist risk assessor before the client begins therapy, so that any rehabilitative gains can be independently assessed. That said, I believe there is great potential for many sex offenders to reduce, manage or cease entirely harmful sexual behaviour.

## Preventive role

It is always better to prevent harm happening than to attempt to deal with it after it has occurred. Sexual abuse is such a widespread problem, with much of it going undetected, that it is not possible for society to deal with the problem simply by arresting offenders after the event. Therapeutic work with people who have worrying thoughts and fantasies about sexual offending but who have not yet offended can make an important contribution to prevention.

Many potential offenders, especially those who are motivated to seek counselling, may never act out their sexual thoughts, just as the average person may never live out their sexual fantasies. And they are, like any of us, subject to human difficulties with relationships, grief, depression, anxiety and loneliness, with which they require help, in addition to their offence-focused issues. If they are not able to access therapy, they may be at risk of being marginalised from the general community, and they may well turn to pro-offending paedophilic sub-groups for support, which may consolidate and encourage that part of themselves tempted to offend.[10]

Cognitive behavioural approaches and, increasingly, strengths-based programmes used in the criminal justice system can be effective in reducing reoffending. However some people who pose a sexual risk have embedded attachment and trauma issues. These issues are often best dealt with in long-term psychodynamic psychosexual therapy, as an adjunct to more offence-focused cognitive behavioural work.

Furthermore, trauma effects are often stored in body memories, impervious to exclusively talking therapies. Traditional talking methods can be augmented by a range of holistic methods such as body-mind approaches, EMDR, mindfulness, breathing techniques and promoting a positive lifestyle. These interventions are commonly used by therapists in private practice, and are transferable to people at risk of sexual offending.

As many as 50,000 people in the UK are viewing indecent images of children online.[11] The Director General of the National Crime Agency has declared publicly: 'There is going to have to be a range of interventions which might fall short, for some of the lower risk [internet] offenders, of taking them to court.'[11] This is where psychotherapy potentially has a role. ■

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# How I became a therapist

# Penny Leake

I find visual impairment is no barrier at all to building a relationship with clients – indeed, it sometimes seems an advantage

I began my working life in 1970 as a teacher, but soon realised that my real interest was in the backgrounds and difficulties that the children brought to the classroom. After three years I left work to start a family, and it was during my pregnancy that a GP picked up that I had retinitis pigmentosa, a serious and deteriorating eye condition.

At that time I was a church goer and of a fairly philosophical disposition, and I accepted the thought that from now on my focus would be on bringing up my own children. However I soon discovered that the less I saw the more I listened, and that this drew people to me to talk about their problems. When members of the church asked me to join them in starting a counselling service, I took my first step on the journey.

We had excellent tailor-made training from Marriage Guidance, and that was when I realised that some people turned their counselling skills into a career, often by going into social work. I realised that this had always been where my heart lay and, after some more years gaining voluntary experience, I was accepted onto the Certificate of Qualification in Social Work (CQSW).

Up until then I had stayed within my visual impairment comfort zone, but now I was about to become a student who couldn't read. The support of family and professionals (like my council's rehabilitation officer and the RNIB) allowed me to be as independent as possible. I learned Braille and touch-typing and, through the equivalent of today's Access to Work scheme, I was able to get a support worker and all the specialist equipment I needed, for free.

Even so, the beginning of the course proved unnerving as the hand-outs started to pile up and I hit the 'deskilled' feeling familiar to anyone starting something new. My identity had been a rehabilitated and capable one, which I feared losing. In fact that identity just kept evolving, as all identities do. I was fortunate that a principle of the CQSW was anti-oppressive practice, both with clients and with students. I remain grateful to social work for teaching me about diversity, power and the systemic context in which clients live, as this was not being thought about much in the counselling world at that time. Even there, however, stereotyping existed, as tutors at first assumed I wanted to work with blind people, when I actually wanted to work in child mental health.

When I started applying for jobs, before the Disability Discrimination Act 1995, I found big differences between the attitudes of HR departments. I had been somewhat sceptical when I first came across the idea that disability is socially constructed, but I now saw the truth of it. Thanks to an open-minded manager, I got a half-time post with a child protection team, alongside working as an addictions counsellor. I was then able to get a job as a social work therapist, working with sexually abused children and adults, and to take the three-year MA in counselling at Durham University.

'Worries about missing body language cues proved groundless – in my experience a greater subtlety of clients' feelings usually comes out in tone of voice'

I heard recently of visually impaired trainee counsellors being discouraged by fellow students on grounds that blind people will not be able to counsel proficiently. This saddened me. I have found in all my jobs that visual impairment is no barrier at all to building a relationship with clients – indeed, it sometimes seems an advantage. I discovered that my ear had become very finely tuned to tone of voice. Worries about missing body language cues proved groundless – in my experience a greater subtlety of clients' feelings usually comes out in tone of voice.

I have found it important to be congruent about my sight loss right from the start with clients, both adults and children, so that I am giving them my full attention and not worrying about any sight issue that might arise. Children in particular have been intrigued and never uncomfortable about it.

Visually impaired people often develop good recall skills, which are an advantage when summarising at the end of a session. I summarise on a microrecorder alongside the client or supervisee, which helps with trust and accountability. This is just one of the ways in which I have found that my disability has been a help in levelling a little the power imbalance that is inevitable in any therapeutic relationship. I have had to be alert for any signs of clients wanting to rescue me, but I have never felt like a victim; they seem to pick up, without any conscious modelling on my part, that disadvantage does not need to lead to disempowerment.

As I approach retirement I, like many others, find that the previously helpful digital revolution is becoming excessively vision-focused. We need to keep reminding all relevant bodies, including BACP, to ensure that visual impairment remains no barrier at all to study and to good practice. ■

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# What's in a label?

*Carol Swanson* explores how a client's mental health diagnosis can affect the counselling relationship

*Illustration by Sébastien Thibault*

Diagnosis has been described as 'the art of attaching labels to illnesses, of deducing the nature of an illness from the signs and symptoms presented by the patient'.[1] Two years ago the American Psychiatric Association published the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*).[2] As many readers will know, there has been widespread concern that its expanded list of diagnoses has extended the medicalisation of human distress by classifying as disorders emotions and behaviours that might be considered normal responses to the vicissitudes of life. Some 12,800 people signed an online petition against the draft revision and questions were raised about whether there was enough new research or biological evidence to justify this new edition with its new diagnoses.[3,4]

The psychiatric diagnostic system is frequently criticised for lacking clear biological evidence, which is seen to leave the door wide open to subjective interpretation of the same sets of symptoms.[5] The value of diagnosis has long been debated vigorously in the literature.[6-8] Unlike physical medicine, there are no blood tests, brain scans or X-rays that can confirm a disorder; for instance, it would be considered unsuitable for a patient to be diagnosed and prescribed medication for diabetes based solely on a questionnaire and an interpretation.

It could be argued that counselling/therapy is also based on subjective interpretation, although a different relationship exists between practitioner and client and medical professional and patient. The counsellor/therapist may diagnose and label a client's feelings or behaviour but maintains that the client is the best expert on their life. As Rogers wrote:[9] 'Therapy is diagnosis and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician.' For Rogers, therapy is a process of learning: if the therapist can provide the right learning environment, the client has the capacity to understand the causes of their problems and draw on inner resources to heal themselves. The prescription of medication to alleviate or contain difficult feelings or behaviour brings with it the risk that these feelings and behaviours may return, thereby creating dependency on the treatment. Therapy and counselling, by contrast, aim to provide a safe space in which the client is able to explore and make sense of these feelings and behaviours, thereby encouraging autonomy and empowering the client to make changes.

Another important departure from the medical model is that counselling/therapy considers the whole person rather than a set of symptoms divorced from the rest of the physical, emotional and social self. Read and Sanders make the point that a diagnosis does not offer any better understanding about the cause or prognosis; it simply provides a label.[10]

This article briefly outlines my findings from a recent qualitative study that I completed for my master's degree. I was prompted to conduct the research by my own experience of working in a clinical counselling practice. I became aware of an increase in clients presenting with a diagnostic label and observed from our discussions in group supervision that the presence of this label, and the medication prescribed to treat it, evoked unease in colleagues. I wanted to discover more about what appears to be an under-researched phenomenon in counselling/therapy, and one that is likely to become more important if current trends continue.

A recent UKCP survey[11] has given statistical support to anecdotal reports that counsellors and psychotherapists are dealing with increasing numbers of referrals of clients with more severe mental health problems, many of whom have a mental health diagnosis. How well prepared are we for this? What are the experiences of counsellors working with a 'labelled' client? How are counsellors responding to the referrals and what are the effects on the counsellor of working with this client group? What is happening in the counselling room when a client presents with a mental health diagnosis?

I interviewed seven experienced counsellors (one man and six women), from a range of theoretical orientations. They worked in a variety of settings, including further education, private practice, the NHS and the voluntary sector. One worked in an addiction service. Three worked in more than one sector. All the counsellors had experience of working with clients with a mental health diagnosis: most commonly depression and bipolar disorder (six therapists), obsessive compulsive disorder (four), and schizophrenia, general anxiety disorder and borderline personality disorder (three). Other diagnoses mentioned by one or two of the counsellors included agoraphobia, PTSD, psychosis and eating disorder.

I explored with my interviewees their concerns about working with a mental illness diagnosis; their reasons for referring these clients elsewhere, and their personal thoughts about a mental health diagnosis. The following themes emerged from their responses.

### The element of risk

A key concern for these therapists when working with clients with a mental health diagnosis was the client's best interests – that they should be getting the right support: 'What concerned me more than anything was, was he getting the proper care? Because, in my experience, they don't get enough support and they don't get enough care.'

They were concerned that they might not be equipped to help the client, and that they might make their condition worse. One questioned: 'I shouldn't have been working with her, so that was the main fear. It was probably more about she would be made worse and the work we were doing.' If they felt unable to support the client, this would be a reason for onward referral. 'Sometimes we will work out between us and the client that this is not the right place for them and we will help find a place for them.'

For six of the therapists, the workplace setting appeared to be a major influence on how they practised. Four said they would want to have the support of other work colleagues or an organisation to undertake this work. 'We work in a quiet though public space, so there are plenty of people around if we need support. I might feel very differently if I was working in private practice.' One felt there was an increased 'element of professional risk' in working with people with a mental health diagnosis now that they had moved into private practice.

But four also regarded the workplace setting as potentially restrictive, both in terms of what could be offered to the client and the workplace culture. They talked of a cultural attitude towards labelled clients as 'difficult patients'. 'I think I became more anxious just because of the increased concerns in the NHS about working within your set parameter and not stepping outside of it,' one told me.

There was even some suggestion that the diagnosis may influence the treatments offered to clients in NHS settings: 'In a service where the work is time limited, I might be giving you a different answer, in terms that you might feel that somebody would benefit from a more long-term support.'

In all the interviews there was a real sense of the importance of looking at the client, not the label. Interviewees talked about a label disempowering the client, preventing the counsellor getting to know the client, pre-empting progress and 'getting rid of feelings', as one put it: 'It's almost like it's there between us before we've even got to know each other.' Another observed that having a diagnosis may also stop clients exploring why they are experiencing these difficulties: 'They have accepted this label of not being normal or extreme, without a concept of why they have come to this place, what has caused this kind

'A key concern for these therapists when working with clients with a mental health diagnosis was the client's best interests... they were concerned that they might not be equipped to help the client'

of situation and in the end what has led to this label they seem to accept.' Another observed of young people with a mental health diagnosis: '... being given a diagnosis, they can take on a sick role; they take on that persona – it is fixed for them'.

All the therapists emphasised the autonomy and uniqueness of the client and said they would not refer someone elsewhere simply because they had a mental health diagnosis. However many said they would keep the label 'in mind' and three said they felt more comfortable if the diagnosis was one with which they felt familiar.

What they did express was a curiosity and a wish to explore and find meaning in their clients' presentations: 'I would be curious with a patient what their label meant to them and whether I felt it was really an accurate one or helpful one in the first place.'

### Outside their comfort zone

I also explored with the therapists their experiences of working with clients with a mental health diagnosis. All but one of the therapists said that if a client presented with a mental illness label it suggested to them a greater degree of vulnerability and risk, that they would need to work with them differently and that they would not necessarily feel comfortable in doing so. 'This guy was quite chaotic so my supervisee did a care plan, which counsellors don't normally do, but she constructed something to try to give him some structure,' one said. Another felt: '[There is the] risk that this person may become more ill and therefore that may present me with the need to perhaps do something outside of what I would normally hope to do in a counselling room... alert their GP or something like that or speak to people outside of the room, other professionals, which is not something that I would normally do or want to do'.

Alongside the expectation of risk and vulnerability was an associated anxiety about their own competence to work with this client: 'Am I good enough to be able to contain that? Am I approaching this kind of work in the right way, being containing? Am I getting out of my depth? Basically am I doing the right thing seeing this client?'

Four of the therapists described a specific countertransference experience. One talked about how other people's vulnerability can stir up one's own. Another described how a mental health label can dent therapeutic optimism, wiping out a client's own sense of hope, and so disempower the therapist: '... and that's a powerful projection because it very quickly becomes concretised in the room. One starts to think, I'm not going to be able to do anything with this person; they are beyond it.'

Two of the therapists experienced a very strong countertransference experience that threatened their own equilibrium: '... I got to the point where I thought, I don't know what is real and what isn't. I think that was very much their experience,' one told me. The other commented: 'I found myself confused, not knowing where I could anchor myself and ground myself.'

Interestingly, despite the acknowledged discomfort with involving others outside the counselling room, these therapists appeared to work more collaboratively with colleagues across a broad spectrum of professions when working with this client group. There appeared to be a strong need to feel grounded when faced with difference. All the therapists recognised the importance of having support, whether from other health professionals or from supervision. It was also important to them that the client was also getting other support outside the therapy room: 'A sense of needing to know what kind of other support is around when I feel so unsettled in the work. Who else is involved in the client's wellbeing or treatment, finding out about medication, how often this client is seen by other health professionals.'

The therapist who worked in an addiction service was the least concerned about risk and vulnerability, largely because they knew what support was available through the NHS. It may be that they had the benefit of training to equip them for the role: 'I thought, well there is a CPN there. He also has a key worker within the organisation, so I thought, there are avenues in which he could go.'

Supervision was regarded with mixed views, certainly by two of the therapists. One felt taking the issue to supervision might suggest they lacked the skills to work with this client; another was worried that they might be seen to be working outside their remit.

Medication, and whether a client was taking it or not, also emerged as an important point of tension. Five of the therapists felt that combining therapy with medication could be helpful to a client in difficult times. However some also spoke of the medication interfering with the therapeutic process: '... so to me being on medication has helped her stay quite stuck;' 'Some medication makes them so flat that it is quite difficult for them to function.' Both the NHS counsellors described feelings of 'failure' if a client started taking medication during therapy.

### Training needs

I asked the therapists how well their core training had prepared them to work with people with a diagnosis, and what training might be helpful.

'There was a real sense of the importance of looking at the client, not the label. They talked about a label disempowering the client, preventing the counsellor getting to know the client'

All said their core training had given them very little or no knowledge about mental health diagnoses, and all felt that having more knowledge would be helpful. Indeed, one felt that current training actively warns students off working with people with a diagnosis: 'Training I think always gives a warning and maybe too much of a warning not to engage with clients who are labelled, diagnosed with a certain condition.'

However not all agreed that mental health diagnoses should be part of the core training. Four said that they had learned by experience and that this was the best way to gain this kind of knowledge. Others felt it should be given through post-qualification CPD. One felt there would not be enough time in the core curriculum to get a 'real understanding of mental health issues', and another worried that not being able to devote enough time to the topic would 'maybe confuse and muddy the waters'.

Five felt that having some contact with clients with a mental health diagnosis was useful, whether through a placement or by volunteering with a charity working with this client group: 'I got a lot from my two-year placement in the outpatient clinic, also the work in the NHS.' But others thought it might have a deterrent effect: '... other people might end up so terrified they would hate it.'

Three of the therapists suggested that more knowledge and direct experience would dispel some of the myths about people with severe mental illness that they felt were propagated by the media: '... they are all axe-wielding maniacs, which is of course what all the papers would like us to believe.'

Although based on a small sample, this research suggests that counsellors are likely to be working with a wide range of mental health diagnoses, many of which are complex and serious conditions. These therapists vividly describe the fears, challenges and conflicts faced by counsellors today and, given the lack of preparation in the core curricula, how ill-equipped most are likely to feel to engage with this client group.

These findings support those in the literature that discuss how the referral of a client with a mental health diagnosis can raise anxieties in the therapist. They suggest the anxieties are related to perceptions of client vulnerability, risk and the implications of working differently, all of which took these therapists out of their comfort zone. I would argue that there are considerable emotional demands in the work and that practitioners require a good level of support and training, since uncontained fear and anxiety can impact negatively on their practice and on the individual therapist him or herself.

### A powerful presence

The literature and my own findings suggest that a diagnostic label can be a powerful presence in the counselling room. A label can implicitly shape the practitioner's understanding, attitude and approach. This study illustrates the paradox: even when they were making every effort to look beyond the label, it still exerted a significant influence on how these practitioners worked. Since a label relates to the medical model, it could be argued that the medical model is thus an influential and dominant force in the counselling room.

The study also reveals the many ways a mental health diagnosis can impact on the therapeutic relationship: the underlying fears and the challenges and conflict faced by the therapists when working with a labelled client. Therapists must manage both the implicit and explicit presence of the label and also create a neutral space for reflection.

A key finding from this study is the participants' perception that there is inadequate preparation for this work in counselling core trainings. Do we need a training module or series of workshops on working with clients perceived to be more vulnerable that could be included in core training courses or available as continuing professional development? Training tailored to the needs of therapists would increase confidence, expand understanding and help normalise some of the anxieties.

The proposed training might cover risk awareness, working collaboratively, self-care in supervision, the process and complexities of a diagnosis and, most importantly, recognising professional limitations. This could be delivered through a range of learning experiences and could usefully include client contact through placements in mental health charity or NHS outpatient clinic.

That said, counsellors are probably better equipped than many health and social care practitioners to work with this client group. The core techniques of building trust and rapport, establishing relationships, non-judgmental acceptance and looking beyond the superficial presentation to the complexity of the individual and of their context are common to all counsellors.

If counselling is to take its rightful place in the field of mental health, we need to be confident in our knowledge and skills and not allow medical terminology to alienate, influence or scare us. ■

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# Circle Diagram: a visual aid to therapy

*David Waite* applies some of the skills learned in his original profession of engineering to his new role as a counsellor

Question: What does an engineer do when he becomes a counsellor?

Answer: He draws diagrams.

My first profession was in engineering. I loved designing devices and processes to overcome difficult problems. I also loved working with project teams to translate those designs into reality. I still enjoy that now. In parallel to this, I was navigating 'Project Me' through its own life journey. When I decided to stop the engineering, I felt drawn towards making use of what I had learnt in my life to help others. Counselling became an obvious route, if I could achieve it. I saw that I could use a lot of what I had learnt, but that I needed to find effective methods to apply it.

My whole career and modus operandi had been about persistent action, but now I had to learn that, as an integrated person-centred counsellor, doing nothing was often going to be the best strategy. It was unlikely that I would discover very quickly what a client's potential was going to look like or how they might get there, so I was not there to tell them the way; I was there to help them find their own way. I am still amazed by the effectiveness of this method and am still delighted when I see clients rising from the ashes of their existences, often with minimal input from me.

So I approached the issue of intervention with some caution. Sand tray work, stones and drawings seemed to me to stray from the person-centred ethos. But then I felt that, provided I adhered to Rogerian principles, I should be offering clients whatever tools I had to help them find their true selves. In the particular instance of children or clients with special needs whose vocabulary may be limited – indeed, with any clients with a limited emotional vocabulary – the use of an external reference could help them process and convey their feelings and could therefore be really useful.

Sunderland suggests, in her beautifully clear book *Draw on your Emotions*, that 'many people could... recover from the pain they have suffered if they could just somehow describe it... Sometimes with the help of pictures people are able to describe feelings where they may not have been able to talk them out'.[1] Pictorial expression was never my forte, but I have spent much of my life transmitting information in diagrammatic form. In this way I could explain extremely sophisticated engineering concepts and details to fellow engineers whom I might never meet and whose first language I didn't share. Such is the efficacy of the diagram.

## A simple circle

I take courage from Colin Feltham's article in *Therapy Today*, 'Whatever happened to critical thinking?', in which he seems frustrated with a general reluctance to challenge old thinking with new ideas.[2] My engineering penchant is mainly in design, so new ideas are my stock in trade. I had picked up some concepts from supervisors, so as I began my own practice and felt freer to give more to my clients, I began to offer them a simple circle as a means to help them express themselves more comfortably to me. I wanted to establish a relationship in which I was working alongside them to find out how the person inside was managing, or not managing the lot that life had dealt them at this stage. I wanted to team up with my client on their project of finding a better way for them to conduct their life.

By drawing a simple circle on a piece of paper and saying that represented me, them or anyone else – but can we make this 'you'? – I helped clients to be objective about their issues, thereby reducing the difficulties of 'confessing themselves' to someone else. It was factually objective rather than embarrassingly subjective. Many clients seem to find it useful, so I continue to offer it as and when needed. It is there for them if they want it. I see helping the client to look objectively at him or herself as a really useful function in itself. However, what is more interesting is how discussions with clients have developed this simple shape. Many of us would agree that we learn most of what we know from our clients. This has proved no exception.

As the use of the diagram expanded, I wondered whether I should give it a therapy-related title. However I decided to stick with my original 'Circle Diagram' because I wanted it to be what the client made of it rather than injecting any of my own concepts into it from the start. Better to be unimaginative than risk biasing the tool I was offering.

As part of my contracting, I describe the therapeutic model I use so they will know what is on offer and what is not. I tell them that Rogers believed that within everyone is the tendency to find the healing we need and we just have to find it.[3] I propose that this capacity resides at the core of their being, and can be depicted as the centre of the circle. Our job is to find out together how to access it. In this way they can see that:

1. this task may be possible, so they have new hope
2. they are not on their own
3. this is not 'me treating you' – it is 'me helping you'
4. we have a visual focus to work on.

The development of the diagram then becomes a participation in the process of problem resolution – one that is within them, not external to them, as they may have thought before. So we have a simple circle with a little circle in the middle

‘I see my job as walking with my client into those unpleasant places where they would otherwise be too scared to venture and allowing them to experience a peace there’

representing the core of the self, the source of the perfect being they were meant to be before things went awry.

At some time we inevitably talk about what they are able to manage in their conscious processes on the one hand and, on the other, what seems to be out of their control. I see much of my job as helping clients understand the emotional world within them – a world that seems to drive them to keep doing things they regret or that just makes them feel horrible one way or another. I want to help them develop their emotional intelligence. So it’s good to differentiate between the conscious mind and the rest of the human functioning. I call that other part ‘subconscious’, and clients seem to relate readily to that. I wanted to avoid the word ‘unconscious’, which is used in the field of psychoanalysis.

### The circles explained

A thin annulus round the existing circle represents the conscious mind (see figure 1). Clients generally agree that what we can consciously understand is very small in comparison with all the information the human system processes. This annulus functions as the interface between our inner subconscious self and the external world we perceive. It receives incoming information, which it then passes to the ‘subconscious’ self, where it is processed in either a fruitful or a destructive way. The response comes back to the conscious annulus and we react from that area accordingly. So we might then have another drink to dilute the anxiety a bit more or we might do something more altruistic – like help an old lady with her shopping.

So why do we have different responses? Most of my clients who took another drink would have preferred to have been able to help the old lady. I am not sure any of them would have truly wanted the reverse. Why are we not the perfectly happy people we might have been? The answers are normally that we were not treated perfectly when we were growing up, or even later, as adults. Rogers refers to this in his Proposition 14 as ‘psychological maladjustment’.[4] Bad things happened to us. So then we add black blobs in the circle to show the damage we have sustained (figure 2).

Some blobs are bigger then others. Some are blacker. Some took place early in life, so those go near the centre. Some are more recent and are toward the outside. I don’t find the need to persuade the client to identify their blobs at the time, but I do suggest they can take the diagram away with them to consider before we meet for our next session.

So what can we do with these blobs that are stopping us enjoying life properly? They are our memories, but it’s not the memory per se that hinders us; it’s the emotions attached to the memory. We recognise that memories themselves cannot be expunged, but they can be normalised so that they no longer poison how we feel or how we act. I see my job as walking with my client into those unpleasant places where they would otherwise be too scared to venture and allowing them to experience a peace there, rather than the fear they previously felt. The black blobs then start to grey off a bit. We have started a process of healing. ‘Project Client’ is now under way.

Clients also find the blobs useful in helping to explain moods and actions. They experience their external world through their senses. Our outer ‘conscious’ annulus is where we sense events. We have some control there. These experiences then enter into the subconscious area where there seems to be much less control. So, if an incoming experience relates to a previous experience identified by one of their blobs, they see that their reaction would probably replicate their original response, however inappropriate it might be now. This can be depicted by a line of thought, A, coming through the conscious annulus, into the subconscious area and hitting a blob, thereby stimulating an old and negative response (figure 3).

If, however, an experience did not correspond to a black blob, then their response might be a wholesome one. This could be represented by the line entering as before, but accessing the

**Figure 1**

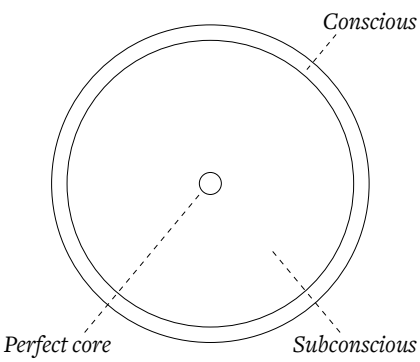
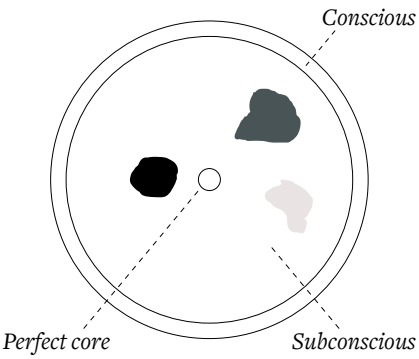
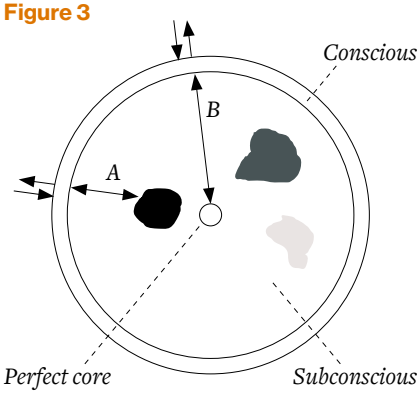



**Figure 2**



‘By drawing a simple circle on a piece of paper and saying that represented me, them or anyone else – but can we make this “you”? – I helped clients to be objective about their issues’

**Figure 3**




perfect core at the centre, B. That way the response is positive and desirable. Clients seem to work well with this depiction, especially if they have sought resolution to their issues externally but that has failed. They now have a new route to try, and this time the route is inside them.

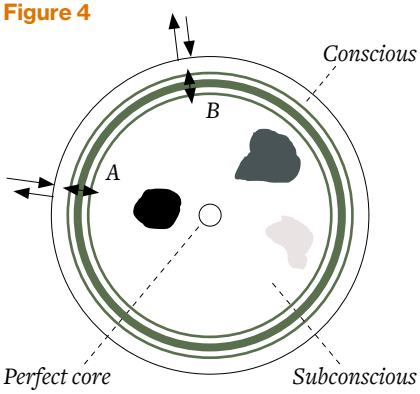
### The perfect core

It seems natural that this central core would be the source of the perfect being they were meant to be before all those black blobs emerged in their life. It is a grounding point, a place of peace. That is a powerful concept for those with low self-esteem, for a number of reasons. They see that they are not all bad; that all of their ills are not of their own making; that they might be truly beautiful and desirable inside, and that change is available and possible.

Almost by that set of premises alone, this perfect core could be seen as a powerful source that could change their lives for the better. And it will need to be powerful if it is to overcome the issues they have faced and failed to defeat by themselves, often despite enormous effort. And the promise is good because I see clients identify with this model and improve in themselves. It seems to provide a template upon which they can construct a working model of themselves that they can readily comprehend. It helps them untangle the mess of their emotional lives and discern the important from the superfluous.

The use of the diagram seems almost endless. With one client a mushy line was drawn round the inside of the conscious annulus, purporting to describe how medication was insulating the subconscious from the impacts of the experiences of the world (figure 4). The medication reduced the negative reactions to events like A, but also numbed the joy of touching the central core of their being via B. They saw it as an inhibition both to developing those healthy responses and also to healing the damaged memories.

**Figure 4**




Another observation was that a blob near the middle, representing damage in early life, had more impact than one near the edge, being more recent. It cast a greater shadow. For its size, it prevented more experiences from reaching the core and returning a wholesome response.

For me, the beauty of this diagram is its simplicity, which prevents me putting my own personality into it. It can be a blank canvas on which a client can build a model of their emotional self. That depiction outside of themselves enables them to discuss their inner world with a neutral figure, the counsellor. I feel it is more acceptable and less prescriptive than some of the more conventional pictorial tools that have been developed, albeit mainly for the younger client.

I have avoided technical language in this article and that reflects my counselling style. This is about what the client is saying and how they understand and talk about themselves. While much of what has developed has been client driven, I recognise clients will not generate all these ideas from the beginning. Accordingly, I offer some basic ideas for them to build on, always with the objective of helping them express themselves. At the same time I continue to remain wary of introducing my own values into their thought processes.

I hope that readers feel able to let the Circle Diagram help their clients find a way through the confusion of their inner lives a little better. ■

*David Waite retired from his profession of engineering and felt called to work with people rather than projects. He has a master’s degree in counselling and has worked with a broad spectrum of clients. He teaches meditation. Feedback is welcomed to waite@davidmalcolm.co.uk*



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# Living with a deafened partner

*Dick Hill* explores the experience of people living with a partner with acquired profound hearing loss and their overlooked need for psychological support

*Illustration by Sébastien Thibault*

This article is about change and how people respond. In this case, the change is acquired profound hearing loss. The article is the product of a research project that I carried out as a result of working as a counsellor with the charity Hearing Link.

Becoming deafened or having 'acquired profound hearing loss' are terms used to describe people who have, through accident, illness, age or other causes, experienced severe to total loss of hearing. There is a distinction between becoming a deafened person and being deaf. Being deaf, often referred to as 'big D deaf', describes having no hearing from birth, or from a very early age, sometimes pre-lingual. These individuals will have a life experience that is entirely different to that of people who have had hearing for much of their life before losing it.

Becoming a deafened person positions the individual in neither the deaf world nor the hearing world, and potentially at odds with both. The effect on the individual can be considerable and the implications for their relationships with others equally so. The distinct states of deaf and deafened have been characterised as 'the warrior' and 'the wounded'.[1]

My contact with Hearing Link came about through a casual conversation with a friend. I had recently completed training in person-centred counselling and had launched myself into private practice. My friend was managing Hearing Link's residential programme for deafened people and their partners/family members/friends. She invited me to attend one of their programmes and suggested I might consider working with them as an in-house counsellor.

The week-long residential programme had a powerful emotional impact on me. Previously I had no idea what loss of hearing actually meant for the individuals concerned – the strategies they used to disguise the loss of hearing, the practical and emotional changes and the sense of isolation that can be experienced.

Part of the programme included separating the participants into two groups: deafened partners in one group and their hearing partners in another. The purpose of this was to allow the focus to be shifted to the partner's experience, separate from that of the deafened. For the majority of partners this was their first opportunity to express what it was like for them. There was a degree of stoicism – many saw themselves as having little choice but to fulfil what they saw as their role, to support their partners.

As the session moved on, the hearing partners began to describe their frustration – with the deafened person and with others, and particularly professionals. There was a strong feeling that what they had to deal with was not acknowledged or appreciated. They described being placed in the position of intermediary or communicator, expected to convey sometimes distressing information to their deafened partner with no acknowledgement of what this information meant for them. Attending that programme and my experience of subsequent programmes brought home to me that there is a clear unmet need for counselling support for partners of deafened people.

The National Association of Deafened People estimates that there are some 80,000 deafened people aged 16 to 60 in the UK, and possibly around 560,000 aged over 60.[2] The literature on acquired profound hearing loss[3-5] refers to the effect on relationships but, while they often cover ways to improve communication, studies tend to make only passing reference to the impact on partners. Research into the psychological and social impact of becoming deafened in adult life, conducted by Greenwich University and Link Centre,[6] noted that partners had 'a strong need for their voice to be heard'.

I liken the impact of one partner losing their hearing to an earthquake. The person who loses their hearing is at the epicentre, where there is total destruction of the building blocks and routes forward in their life. Their partner stands next to the epicentre, witness to this destruction but also experiencing their own losses, and may attempt to become a rescuer, which for some may prove too great a task.

This article is based on interviews I conducted with five partners of deafened people, who volunteered to meet me twice over a 12-month period in 2013. The interviews sought to identify their feelings about their partner's hearing loss and its impact on their (the hearing partner's) life and the

'You're angry because your life changes, you're angry because your partner who you care about can't enjoy the things they did'

couple's relationship. A number of themes emerged from my analysis of the transcripts.

**Feelings of the partners**

Partners expressed feelings of sadness, guilt, anger, loss and grief. One participant stated with tears in her eyes:

'I feel really sad that it happened to him and it changed him – his life changed totally.' Another stated: '... if I could do more to help him of course I would [but] there's nothing more I can do, it's down to him really. It is very sad...'

The comments that had guilt as a central theme demonstrated a mix of feelings for their partner and for themselves. Partners described 'the feeling of, sort of, guilt really, of being able to hear things and X not being able to hear', and 'feel[ing] guilty because I can't mend her'. The sense of powerlessness in the face of their partner's loss is evident.

Participants expressed anger about the loss of hearing and the response from others to that loss: 'You're angry because your partner who you care about can't enjoy the things they did.' One participant described a less than constructive response from his partner's employer: 'You want to do the John Wayne: you want to walk up there, you want to hit someone in the face – [I am] aware I am probably displacing by feeling angry at somebody else because I can't do something [about it].'

A female interviewee was equally fiercely protective of her partner: 'I do get quite annoyed with people or upset with people when I see their attitude when he's in their way – it does annoy me because he doesn't do it deliberately.'

This range of feelings described by interviewees is reminiscent of those associated with the death of a loved one but they are mourning not just the loss of the individual; they may have lost a relationship and a whole way of life. As one interviewee said, quite simply: 'You stop becoming a partnership, you almost become one.'

Such comments reflect also a great sense of loneliness: 'You lose the ability to share... Being the partner of somebody who is deafened in those situations, you are tending to become alone.'

The responses resonate with some elements of Stroebe and Schut's 'dual process' model of grief.[7] This describes how the bereaved person oscillates between 'loss-orientation' and 'restoration-orientation'. It is not so clear-cut as Kubler-Ross's five stages or phases of grief.[8] Loss orientation is to do with feelings of grief and loss and moving to a point of being able to let go emotionally of the person who has died; restoration is to do with dealing with the practicalities of coping with the here and now and going forward.

'... once you've become the partner of a deafened person you will have mourning, you will miss what you used to do. You have to learn rapidly.'

'I'd always been looked after and I always liked to be looked after and then suddenly when X wasn't very well, especially at the beginning, and then it was down to me.'

**Changes in intimate relationships**

The next theme captures a range of experiences that evidence the significant effect of the acquired hearing loss on the partner relationship. The changes included practical changes to accommodate the hearing loss – 'I always have to be on the right hand side' – but also a more radical upheaval in lifestyle and habits: 'Overnight my life just changed completely and whereas we would go out all the time – and suddenly we weren't going out.'

'We've always done everything together – if X can't do it we won't do it and that doesn't seem right to me.'

One of the profound losses identified is that of spontaneity in conversation – for some, an essential element in their communication: 'Being spontaneous you know, spontaneity has just gone out, you have to think more.'

Interviewees were strongly aware that their interaction with the wider world had changed: 'You suddenly find your world shrinks.'

Even though none of the research participants' relationships had broken down as a result of the hearing loss, all partners acknowledged that their relationship had come under strain: 'I don't mean we've drifted apart... but the gap gets bigger because you can't hear.'

'If you want your relationship to continue then adaption, that constant adaption is absolutely essential. If you can't do it then the relationship will fail.'

One interviewee felt: 'The relationship needs to be strong in the first instance – it can be a very corrosive experience.'

That relationships can fail and that the failure can be directly attributed to hearing loss would seem to add weight to the argument for counselling support for couples, both together and individually.

**Relationships with others**

These partners had experienced a wide range of reactions from others in respect to their spouses' hearing loss, from positive and supportive to dismissive and insulting.

Positive experiences came from friends and others who have direct experience of deafness. 'Friends became even more important – the friends are really good because they always encourage X. Every other month they make sure they go out for lunch.'

Sadly, however, there were also reports of negative experiences: 'They would ignore her and that's what hurt me more because that was deliberate.'

**Educating others**

Some partners countered their experience of powerlessness by informing themselves about the condition and its consequences by,

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for example, accessing the internet, contacting support organisations (often voluntary organisations or charities) or attending self-help groups.

Hearing therapists were identified as being particularly helpful in giving advice about communication strategies. Lip reading classes were also useful, as were programmes organised by voluntary sector organisations such as Hearing Link and the East Sussex Hearing Resource Centre, which were experienced as a very valuable source of support and information and a means of countering the isolation often felt by partners. Three of the five partners had become active in promoting awareness of hearing loss through various charities and through informally educating others in day-to-day conversations.

It was also interesting to note how much knowledge most of my interviewees had accumulated about the medical conditions commonly associated with hearing loss – in particular Meniere's Disease, which affects balance. Some felt able to challenge the medical specialists treating their partner and reported that frequently their knowledge was more up to date than that of the specialist.

Most of the interviewees said that the wider community needed to be better educated about the condition and its consequences: 'There's a lack of understanding out there.'

Professionals involved with the care of people with acquired hearing loss could also benefit from further education, particularly with regard to the effects on the partner, interviewees said: 'When the specialist spoke to me and told me that he felt X wouldn't get his hearing back and then I had to actually tell X that's what they thought would happen – just dreadful.'

To confront the hearing partner with this information and expect them then to convey it to their partner implies at best a lack of sensitivity but at worse a complete lack of understanding of the likely emotional impact.

### Impact on the partner

The final theme was the experience of partners of people with acquired hearing loss – the impact on their lives as individuals, distinct from their couple status. Interviewees talked about feeling overlooked by healthcare professionals and not appreciated by families and friends: 'The focus was on him all the time, everybody was coming round and it was all about X and... I was doing all the caring and all the running around and everything else and I was worn out.'

Another said: 'It isn't all about the deaf person, it is about the other person as well.' This suggests a need for more acknowledgment of the demands on the hearing partner to meet the practical and emotional needs of their deafened partner, as well as support with their own emotional needs. Partners of those who have lost their hearing are asking for some understanding of what they are dealing with, hour by hour, day by day, on a routine basis.

There is also the direct impact on their own lives and the changes that creep in, almost unnoticed. This was illustrated most vividly by one interviewee in relation to listening to music: 'I never listen to music any more which is awful, terrible, what a state to get in, and I have to rectify that.' This is, I suggest, a telling example of how a 'small story' can illustrate a much bigger story.

It was significant too to discover that the interviews themselves had some beneficial therapeutic effect. One interviewee told me: 'I drove back and I had the radio on all the time and I actually noticed the fact that I was singing along to the music and I thought "interesting".'

Another said simply: 'Until you talk like this, you don't realise it, you know.'

A number of the interviewees compared hearing loss with losing one's sight and suggested that people generally respond less positively towards hearing loss. Relationships may be more fundamentally affected by hearing loss than loss of sight, perhaps because of the impact on communication. Comparisons are invidious but Zazove argues:[9] 'Being deaf is worse than being blind because deafness cuts them off from people whereas blindness cuts them off from things.'

My research set out to address a lack of knowledge about the experiences of partners of people who have acquired hearing loss – experiences that I have likened to an earthquake, such is the depth and breadth of the destruction to the lives they lived previously. It is, I would argue, a unique life experience. There are strong similarities with bereavement following the death of a loved one but with one very major difference: the loved one is still alive, physically present, yet profoundly changed, and so too are both partners' lives, individually and together.

My interviewees' comments suggest a large, unmet need for counselling/psychological support for these couples. This counselling needs to be available from the point of diagnosis. That the rate of separation/divorce increases with the severity of the hearing loss[6] underlines this need and the stress that hearing loss can place on relationships. All credit to the couples who manage to negotiate these difficulties. Echoing the observation of one of my interviewees, it seems to me that the relationship would need to be strong prior to the hearing loss for this negotiation to succeed without some form of external help. ■

*Dick Hill holds a postgraduate diploma in person-centred counselling and an MA in Counselling Studies. He has been in private practice since qualifying at the University of Brighton in 2000, working for agencies including the local authority, Sussex Police, local education establishments and charities.*

PHOTOGRAPH BY KIND PERMISSION OF ORGANISATION B

# Counselling across cultures

British Indian counsellor *Mané Kumria* describes a trip to India and how counselling offered one small group of women a powerful catalyst for change

Sometimes the best experiences of life come from unplanned events. I had given myself four months in India to help me decide about building a house there but had no idea what this entailed. I found myself with quite a lot of time on my hands and so started to explore the possibilities of helping out somewhere. This is how I found myself counselling with two NGOs, who offered me a unique opportunity to rise to the challenge of working in a completely different environment to the one I was used to. It has been a profound experience that has helped me find answers to my eternal quest – my search for an identity as a British Indian.

Before becoming a counsellor I had for years gone back to India to help in women's empowerment and education programmes for girls, and had felt both rewarded and frustrated doing this. But it was experience that was to stand me in good stead this time. I decided to explore what was happening in my home town in North India – a chaotic city that is a rich amalgam of urban and rural, traditional and modern.

The staff of both organisations with which I worked are highly motivated and dedicated; they feel that they make a difference and bring about significant change. From my discussions with both organisations before joining, I felt we could work together as, besides being a counsellor, I believe strongly in social justice and have always worked towards this through counselling. I felt I had a unique opportunity to explore new ideas with them and take counselling outside my usual comfort zone.

I was literally snapped up by the very first NGO I went to meet (I'll call it organisation A). I heard about them several years ago and was curious to find out more. The job was short term, working with parents of children who were mentally and physically challenged. I say 'parents' but it was in fact only the mothers who came for counselling; the fathers played their more conventional role as breadwinners as well as occasional providers of transport.

This organisation works from several different sites and offers care and education as well as training for parents in how to help their children. I was replacing their regular counsellor for three weeks, doing one-to-one counselling, weekly groupwork with the mothers, and also working once a week from a hospital site where new parents

could bring their anxieties and concerns. The organisation does outreach work in much of the rural area around the city. I shadowed their counsellor for three days and then was on my own.

The second organisation (B) was recommended by a friend. It works with women from poor socio-economic areas, helping them to access better paid work through additional skills training. It provides gender-sensitisation training, including the concept of equality, and has excellent programmes to bring these concepts to young people and encourage dialogue among them. It also does advocacy work and provides crèche facilities for domestic workers. The children are provided with meals and proper under-five pre-school education.

Organisation B asked me to run workshops for some of its staff to help them cope with anxieties affecting their work. These were staff who felt they were reaching burnout stage and were unable to regulate themselves. I devised two four-hour workshops: the first to introduce them to basic counselling skills and the second to deal with anxiety around their expectations of themselves and build confidence. Increasing empathy and being non-judgmental took up a lot of the time but I felt it was time well spent. India is a competitive society where, by and large, you are expected to help yourself, and empathy for the self is lacking in Indian culture. All the work I did with this organisation connected to the experience of the staff and to my own firsthand experience of growing up in India. The punitive parent and the anxious self, the internal persecutor, being unkind to the self – all of this was discussed and acknowledged as part of our own upbringing and related to the group's high expectations of the self and a lack of response from clients for whom they were advocating.

The language I worked in was always Hindi. This was not a problem for me as I am fluent in it. Most British Asians from India are multilingual and many of us would like to use these skills to benefit our clients in Britain. In counselling, using a language that you share with your client is a way of reaching out to their culture too and encourages a different communication, as we well know. I have only ever had two clients in London with whom I have worked in Hindi and I could tell from the relieved look on their faces how anxious they had been about their own inability to speak fluent English.

Having lived in Britain for 40 years, I had to familiarise myself again with Indian cultural ways. I had to learn to relax when it came to familiarity and issues of boundaries. The women in both organisations – staff and clients – were curious about me: who was I, where did I come from, was I married, did I have children? Initially I perceived this as intrusive but it was actually not that at all; it was a way of getting to know me and establishing contact. Some clients, seeing me outside the therapy room, viewed this as an opportunity to continue with the explorations they had already started, and it was difficult to establish my private space without causing offence. I remained aware that even the language I used to address the client had to be appropriately chosen.

### Pain and sorrow

This was the very first time a counsellor had worked at organisation B. At organisation A they were more familiar with psychologists. In fact, very few people in India are familiar with counselling and what it offers. There is a tendency to medicate mental ill health.

At organisation A the number of women coming for group therapy fluctuated between nine and 15. There was a well-bonded core group who had been meeting for over a year, and others had joined in the last six months. They met while their children got on with their education and physiotherapy on the same site. Although there was a lack of structure or themed work, the group exuded the warmth and excitement of a much-needed social gathering that reconnected the women each week. It ran for an hour and three quarters and by the end of the first session (while I was shadowing) I sensed a real lack of confidence in the group, covered up by a lot of loud talk. There was a genuine need for praise and many had adopted bravado as a means of survival. All of this touched me deeply. I wondered how they felt about me – a complete stranger imposed on them.

In the first of the three sessions I facilitated with this group of women I encouraged them to move from the narrative to the self-reflective, staying with the theme of the self. This move opened doors; it allowed some to face their own pain and sorrow about the discrimination they experienced as mothers of disabled children. Many who had fought back against such discrimination had, in the process, shut the door on their own pain in order to survive. Women felt safe enough now to explore their own defences and share their feelings in the group. They expressed strong feelings about the injustice in Indian society where there is intolerance of mentally and physically challenged people. I wondered if this lack of compassion was linked to our general cultural belief in India that we reap what we sow. There is also a tremendous lack of education about disability in India.

In the following two sessions the women chose to stay with the self as they were clearly enjoying this exploration of their own needs and rights as women. I learnt that most of them came from extended families. I had imagined that the extended family would become a nuclear one in an urban setting, but this was not the case at all. The extended family was a source of comfort and support, particularly where childcare was concerned. Yet it was also an oppressive institution that allowed domestic violence and generational oppression of men and women. Most of the women felt silenced and unheard.

A young woman in her early 30s agonised over the dilemma of whether she should ask her in-laws' permission to visit her mother (just a couple of miles down the road) or whether to just tell them. Did she have such a right? I encouraged the women to state their feelings about this. Every woman had a take on it – all agreed they must inform in-laws when leaving, but the group was split between those who felt it was their right to go and others who felt it was safer to ask. Another woman said she would ask permission as she did not want to be the 'black sheep and put down' in the family or have her reputation ruined in the neighbourhood. This scared her. I wondered if this was a new fear or whether it had been there previously, and this brought an instant response from her. She was able to recount many instances of being put down as a girl child. Other women too traced their lives back to their own childhoods when they were deprived and humiliated in many slight and petty ways as girl children, until they were left with no confidence in or expectations for themselves.

At the other end of the spectrum, a couple of days later, to my surprise, a woman told me quietly that she had adopted a girl child because she wanted to be a mother and she wasn't going to allow anyone to tell her what she could or couldn't do. She had become a single mother – no mean feat in India.

I came across ageism too. That older women in the group were addressed as 'granny', while all the others were addressed by their first names, appeared discriminatory to me. I wondered aloud

'The punitive parent and the anxious self, the internal persecutor, being unkind to the self – all of this was discussed and acknowledged as part of our own upbringing'

how the older women would feel if I were to call them by their names. They looked pleased, and agreed. (I wondered later if this had more to do with my being both an older woman and in a position of authority.) I noticed that, as soon as the others too addressed them by their names, they integrated themselves into the circle (they had been sitting slightly separately from it) and were much more open to joining in the discussion. I was delighted. Sometimes misplaced respect can lead to exclusion and hierarchies need to be dismantled.

I noticed that a recurring presenting theme was about the longing for space – a room of one's own– and invasion of privacy and boundaries being broken, and the impact this had on the individual and the family. Some of the younger women felt guilty about wanting this space and talked with anger towards themselves and resentment towards their family.

Several women who were victims of domestic violence had abusive, alcoholic husbands. Women expressed both rage and feeling caged by their circumstances. I shared information about addiction and the telephone number of a rehabilitation centre. The women felt empowered both by the knowledge they had gained and the fact they could ring this number for further information and help. All the husbands denied their addiction as they were binge drinkers and felt they were therefore not alcoholics, which they associated with daily drinking. One husband stopped his violence as he was ashamed that I knew of it. His wife told me she didn't blame him for his actions, as this was what his father did too. It was exciting to see her recognise the patterns of relating within the family and her determination that this would not happen to her son.

### Trusting and open

The work was short term – between three and six weeks – but I was moved by the response. The women were trusting, open and willing to talk and tell me of their lives. I could see how much it mattered for them to be heard. They felt good about themselves.

Some felt grateful for the change in their relationship with their partner, because we explored sexuality and sex – both taboo subjects. I worked intuitively on this aspect. The women started to become reflective, giving me encouraging feedback on their previous week. I had one case where a woman literally jumped out of her chair and said, 'Thank God someone has asked me,' when I asked if she was fulfilled in her sexual needs. She responded by saying her marriage had never been consummated. In India, marriage and family are two powerful institutions that are difficult to challenge, and it would have brought shame to both institutions had she voiced her dilemma. So she remained silent. There is also confusion about sexuality, sexual health and emotional intimacy, and there is a lack of sex education in schools.

I listened. I used imagination and imagery to take the women outside themselves and help them visualise their dreams. I used body scanning, relaxation and mindfulness techniques to help them get in touch with themselves and the here and now. They truly loved the relaxation. Many presented looking very tense and drawn, and left looking amazed at what they had achieved for themselves.

I feel strongly that the society these women and I come from has to change and that social justice must prevail. Our patriarchal society has silenced women (and some men) for too long and has created many of the problems the women face today. The punitive society this has brought about imposes distorted views of how people should be at different stages in their development, and gender bias towards men has brought about horrendous behaviour towards women and their liberty and rights.

For me, this was an amazing journey. I connected with these strong women and felt this was work needing to be done. I felt accepted. The stories they told were my stories too, going back to my life in India. As a British Indian, I feel far more comfortable in my own duality now and believe that, with my experience of Britain, I have something different to offer to help bring about change. I was exhausted from the intensity of the work I had done and traumatised by the stories I heard. I am also aware that the process of writing has brought up a lot of trauma for me once again that needs to be processed and understood through supervision and self-reflection. ■

*Mané Kumria MBACP is an integrative counsellor working at CCIWBS – Camden City and Islington, Westminster Bereavement Service and at the ISIS Project, working with drugs and alcohol addiction. Mané also has a small private practice and is particularly interested in working with culture, race and class and the use of first language in counselling. Email mane.kumria1@gmail.com*

# To hug or not to hug?

## This month's dilemma

**Anthony is a counsellor in a specialist unit in a primary school that supports children who have identified mental health needs. The school draws its pupils from a particularly deprived area. Recently a member of staff was dismissed, amid widespread publicity, for sexual contact with a pupil.**

**Anthony has a client, Joshua, who is seven but has a developmental age of three to four years. Joshua has only one parent, who has very little time for him and does not show him affection. In his sessions Joshua often tries to hug Anthony and finds it unbearable if he refuses his approach. Anthony believes, with the support of his supervisor, that Joshua's need to be hugged is developmentally appropriate. The school does not have a policy that forbids physical contact with the children. Naturally, however, Anthony is anxious.**

**How should he proceed?**

***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.***

## Whose need is being met?

**Jeff Surma**
**Person-centred counsellor in a hospice, primary school and GP setting**

As a male non-directive play counsellor in a primary school, I can understand Anthony's anxiety and concern over how to proceed. To hug or not to hug? This is possibly the most difficult question relating to counselling boundaries. And why limit this to actual sessions? Do I respond to the 'high fives' of children as they file past my playroom from the yard first thing in the morning, watched by parents, carers and the like? Or how do I act with a child who runs up to hug me and asks if it is their class's turn to come for free play during mid-morning break?

Most children experience difficulty adjusting at some time – the school setting is not immune. They can feel vulnerable or afraid and be unable to express this in words but their actions are always telling us something. Initiated by the child, a seeking for a hug, properly responded to, can enhance their sense of wellbeing and be forgotten in a second.

Neuroscientific research suggests that touch not only enhances emotional and psychological wellbeing; it also aids brain development and thinking ability. The counselling relationship is a professional one, not a friendship as that term is generally understood, and its aim is to establish trust and provide conditions for the child's positive growth. Of course caution is needed here, but what is a proper response?

In client work I try to ask myself if my response is the right one to help the child's process. There is no one answer to this as every situation and child is unique. I am used to receiving spontaneous hugs. Sometimes I feel it is appropriate to set limits, and if I initiated such contact then I should rightly be challenged as to whose needs are being met.

I also wonder about Anthony's relationship with the school and its staff. How does he feel he is viewed by the school? That the school 'does not have a policy that forbids physical contact with the children' is not specific, but I hope true. What damage might be caused if a teacher (or therapist) stands rigid with arms held high? What message might the child be receiving?

However, might Anthony, perhaps with support from his supervisor, feel confident enough to offer to work with the school to provide suitable written information, guidance and training? How visible does he feel he is to the parents/caregivers of the children attending the school? Does he take time to be known? Is his playroom suitable? These are further questions for Anthony to explore with his supervisor, if he has not done so.

'How does he feel he is viewed by the school? What damage might be caused if a teacher (or therapist) stands rigid with arms held high? What message might the child be receiving?'

## Hugging is never helpful

**Gina Crowley**
**Teacher, lecturer in special educational needs (SEN), coach and trainee couple counsellor**

The dismissed employee, Joshua's supposed developmental age and the lack of a school policy that clearly forbids

ILLUSTRATION BY LARA HARWOOD

staff having physical contact with pupils, are all irrelevant – red herrings even. Anthony should not hug Joshua, even if Joshua wants to be hugged, because it is not part of a counsellor's role. And it is never helpful. However, for a clear lead on this Anthony should ask the advice of the person who is responsible for child protection and safeguarding in the school. This will be a senior teacher, possibly even the head teacher. He has no option but to follow this advice.

Adults set boundaries in school, not pupils. I have worked with children with additional needs in a number of different school settings. These children are able to understand that, just as adults are not allowed to smack pupils, they are not allowed to hug them. It is against the rules.

I wonder what form the counselling takes? I'm guessing that Joshua has some language difficulties. Maybe play therapy or group therapy might be more accessible to him. If he has a clearly unfulfilled need for affection and physical comforting, is there not someone in his wider family who could offer this? Maybe a grandparent would be willing to be involved in supporting Joshua? Maybe the one parent should not be written off so lightly? Maybe they too could be become part of this therapy? The long-term need for affection can never be assuaged by hugs from a counsellor. Even if the counsellor is keen to hug.

## Support the parent

**Jo North**
**MBACP (Snr Accred) psychotherapist and chartered psychologist specialising in adoption support**

Any developmentally delayed child who is not being shown affection and whose parent does not have time for them has a problem with which they need help. Frankly, giving them a hug is only a temporary solution. In my view this looks like a safeguarding issue, with potential problems ranging from a despondent parent who does not know the importance of emotional parenting to possible neglect and emotional abuse. Children need both time and hugs from parents and this parent may need help and support with meeting Joshua's needs. Anthony could have a conversation with Joshua's parent about this but should reflect on his course of action with his supervisor first, and if necessary the head teacher. If his concerns remain, this information needs passing on to the school's child protection officer, as it is for them to follow through and help Joshua's parent to help him.

In sessions Anthony should give Joshua some hope and a reparative experience. Making a clear policy on hugs in his therapeutic plan and placing it on record with his supervisor, the head teacher and Joshua's parent if appropriate, can achieve this. Anthony could explain to Joshua: 'I would love to give you the biggest hug in the world every time we meet but we will do this when someone else is with us so that you feel doubly safe and so everybody is caring for you. Who would you like to be there for the hug? We do this because we want to make sure that children get lovely safe hugs.'

He should then always record who is present for 'the hug' and ask them to initial his notes to say they witnessed it. In this kind of situation I would leave the counselling door ajar for the session and ask teachers or the head teacher to put their head round the door mid-way through a session to ensure that all is well. This will protect Anthony from any possible misunderstandings about his intentions, and make him feel safe too. Hugging then becomes an accepted ritual that Joshua can expect. So having given a major 'hello' hug, Anthony can concentrate on the creative therapeutic work, which includes emotional nurturing techniques other than hugs, so that Joshua can be helped to self soothe. At the end of the session there could be a 'goodbye' hug in front of the teacher/head teacher. Maybe they could join in and do some emotional work too?

Anthony should make a clear therapeutic plan and ensure teaching staff, his supervisor and Joshua's parent approve it. He should also make notes of his actions and keep them on record to ensure that any hugs are transparent.

## What is the meaning of the hug?

**Susan Utting-Simon**
**MBACP (Snr Accred) counsellor, psychotherapist and supervisor in private practice**

Anthony and his supervisor believe that Joshua's need to be hugged is developmentally appropriate. But that does not necessarily mean that it is appropriate for the therapy room. That the school doesn't have a policy that forbids physical contact allows more freedom to respond to individual clients appropriately. However, with this freedom comes the weighty responsibility to make the best decision possible in the given circumstances about whether to accept a hug or not.

Whether it would be beneficial for Joshua to hug Anthony is a complex question. His developmental age is very

young, at a stage where hugging is very natural. Sometimes it may be appropriate to accept a hug within a therapeutic environment – for example if a child is especially emotional in a particular session or if the work is ending or there has been some significant event. In these circumstances it may be more damaging to refuse the approach, but even then it is important to be careful and explicit about the meaning of that hug.

However Joshua is unlikely to fully understand the boundaries of therapy. Anthony would need to ensure that Joshua understands the nature of their relationship, and I'm not certain that it is possible to be so clear with a child of his developmental age. Also Joshua's home life appears to be exacerbating his need for affection. Therefore Anthony accepting a hug from Joshua may not be helpful, as it may be that Joshua really wants a hug from his parent. It may be more appropriate for Anthony to meet Joshua's parent to explore possible ways to improve their relationship.

The recent dismissal of the staff member and the surrounding publicity may make other members of staff and parents hypervigilant to perceived potentially inappropriate behaviour from other adults towards pupils. Anthony could find a well-intentioned act becomes a major issue, potentially damaging the therapeutic relationship as well as his professional reputation and that of the school. Joshua is unlikely to understand the implications of telling someone else that he hugs Anthony in their sessions. Therefore, if Anthony does decide that it is appropriate to accept a hug from Joshua, he would need to educate other professionals about his thinking around that decision, while maintaining confidentiality for his client. Whatever decision Anthony reaches, he needs to feel confident that he can stand by his decision and explain his actions if they are questioned.

## Explore other means of support

**Katharine Cossham**
**Counsellor in schools and in private practice**

I had mixed reactions to this dilemma. My first thought was, 'No! Don't hug him!' I explored this and realised it comes from my training as a Place2Be volunteer counsellor. They have a clear policy of limited touch and no proactive touching. There are caveats, which refer to the developmental and circumstantial needs of the child and the importance of taking this issue to supervision.

In this case Joshua is initiating the touch, which still leaves the question of how to react. One response to a child seeking comfort is that touching an arm or shoulder may be appropriate, rather than hugging. A child could also be encouraged to hug or touch a proxy, such as a soft toy. As the school doesn't have a policy forbidding physical contact with children, it pushes the dilemma back to Anthony.

Contrary to my original response it could also be argued that it's unethical to withdraw physical contact from a child in need. While it is developmentally appropriate for Joshua to want a hug, is it therapeutically appropriate? How does Anthony see his role and aims as Joshua's therapist? There are others in the school in *loco parentis* roles, such as the teachers and teaching assistants, who will have regular contact with Joshua and not in a one-to-one setting. I wonder if it might be more appropriate for them to offer safe touch to Joshua?

'I'm struck by the fact that Joshua finds it unbearable if Anthony refuses his approach. Might it be better for Anthony to explore other avenues than therapy to emotionally and physically support him?'

I'm struck by the fact that Joshua finds it unbearable if Anthony refuses his approach. Might it be better for Anthony to explore other avenues than therapy to emotionally and physically support him? Could he or another member of staff explore the possibilities of other trusted family members offering time and comfort to Joshua? Or could social services offer support to the family?

If Anthony did choose to accept Joshua's hug, how would Joshua feel when Anthony finishes working with him? He may not understand the withdrawal of affection then, any more than he understands it in the moment. In the background is the dismissal of the member of staff and I wonder which pupils may have been affected by this individual's behaviour and whether Joshua could be one of them. Given the seriousness of what has happened in this school, perhaps a school-wide discussion about safe and caring conduct would be appropriate.

# July'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 of 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 had told her in counselling, as she knows Louisa would want them to know these things.**

**What should Fabienne do?**
***Please email your responses (500 words maximum) to John Daniel at dilemmas@bacp.co.uk by 1 July 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.***

# In defence of EAPs

We would agree wholeheartedly with your contributor ('Are EAPs short-changing clients?', Letters, *Therapy Today*, May 2015) that the EAP market has become more competitive in recent years, with a number of new entrants to the market and a noticeable shift in the way EAPs are being sold, bought and promoted within organisations. In particular the last few years have seen the rise of the 'free' or embedded EAP that, on paper certainly, seems to offer a full EAP service at little or no cost. Yet these programmes often have more limited services when compared with traditional 'full service' EAPs, which can mean a lower uptake.

The UK Employee Assistance Professionals Association (EAPA) was established by the EAP industry to represent the interests of those working in the employee assistance field and to promote the highest standards of practice in EAP delivery. Since the industry is not formally regulated, it is important that buyers of these services carefully choose the right EAP that meets their needs. EAPA has taken an active role to help educate buyers and has published a variety of documents to assist purchasers in making an informed choice, all of which are available to download, free of charge, from www.eapa.org.uk. For instance, we have published a *Buyer's Guide* (2011) and the *EAP Guidelines* (2012). We have also found that counsellors can benefit from understanding how EAPs work and have recently produced the *Counsellors Guide to Working with EAPs* (2014).

There is also a document called *EAP Standards* that EAPs who are UK EAPA-registered members have to follow, and they make a formal declaration that they meet these standards. The aim here is to ensure a high quality service that is delivered by highly-qualified and dedicated professionals who have a real and positive impact on the wellbeing of those who use the EAP service.

Your contributor seems to be taking a more negative view of the industry and also makes assumptions about face-to-face counselling being superior compared with telephone and e-counselling. From EAPA's perspective, decisions on referral to face-to-face, telephone and e-counselling should always be based on clinical need and client choice within the contract being provided – the *EAP Standards* state: 'a professional referral is essential to provide the client with the most suitable intervention and support. The referral carefully matches the client and his/her needs with the resources available internally to either the EAP, or the purchasing organisation or externally. A professional referral maximises problem resolution, improves job performance and increases employee wellbeing... referral options are discussed with the client and explanations given of the advantages and disadvantages of the options.'

UK EAPA-registered providers also need to show they have robust due diligence, contracting and clinical quality assurance processes in place to ensure the affiliates they contract with achieve high standards in terms of educational qualifications, professional accreditations and experience. Services also cover non-counselling aspects such as legal, debt management, mediation, workshops and practical information such as access to government benefits or accommodation issues.

It is true that the awareness of the EAP in some organisations can be low and it is a constant challenge for HR and occupational health teams, as well as for EAP providers, to maintain the profile of all the support services within organisations. Account management support is available from EAP providers, but it is also important to note that the responsibility of promotion is a partnership, with the purchasing organisation taking their share of responsibility to use every available channel to reach their employees.

> 'Purchasers need to be mindful that higher take-up rates show that employees are making good use of the service, which supports a higher return on investment, and that this may mean they need to pay slightly more'

We would support the view that employers need to monitor EAP usage and practice, just as any service that an organisation contracts with should be assessed and reviewed. Purchasers need to be mindful that higher take-up rates show that employees are making good use of the service, which supports a higher return on investment, and that this may mean they need to pay slightly more for their EAP.

EAPs have become a vital part of an employer's toolkit to support and nurture the psychological health of employees and this privileged position is underlined by the *Health at Work – an independent review of sickness absence* report (Dame Carol Black and David Frost CBE, November 2011), which emphasised the positive impact that EAPs can have when it comes to supporting the mental health of organisations and their employees. A clinical evaluation also showed that EAPs are highly effective, there are fewer drop-outs from counselling and the waiting list is much reduced when compared with NHS provision (Mellor-Clark et al, 2012).

Yet, rightly so, this position can only be maintained if the unique relationship between EAP provider, employer, counsellor and client is nurtured and maintained and that the needs of the individual employees remain central in the planning, promotion and delivery of services.

Your contributor's letter refers to EAPs but there are also some excellent examples of internal workplace counselling services or hybrid partnerships between EAPs and internal services within this sector which provide much needed support to employees and these should not be overlooked.

**Andrew Kinder, Chair UK EAPA**
*On behalf of the Board of UK Employee Assistance Professionals Association.*
*www.eapa.org.uk*

## Not the CBT I know

I read 'When CBT doesn't help' (*Therapy Today*, May 2015) with dismay for a number of reasons, especially the closing sentence, which framed up CBT as *barbaric*. That's quite extreme. I guess the meaning of the communication is the response you get (by the way, I'm an NLP Master Practitioner and trained to trainer level).

'*Je pense donc je suis*' (Descartes) alerts us to the fact that we are not just sentient beings, we are also conscious, mentalising beings and you cannot dispute the relationship between thoughts, the meaning of events and even feelings and behaviour. Even if you are emotion-focused, you will admit that *beliefs* about feelings like anger and shame (*anger is bad and if I am angry I am bad*) have a profound effect on how we manage these feelings when they arise as a result of the slings and arrows of outrageous fortune.

The experiences of the people in this article *are at complete odds* with the kind of CBT I know, which is gently wound into other holistic approaches that manage behavioural problems like OCD and eating disorders. We all know that there are good and bad CBT therapists, as there are good and bad Rogerian counsellors (I have met some). I am thus as comfortable asking people how they are *thinking* as I am with asking them how they are *feeling*. Especially when people cannot access *how* they are feeling, they are totally shackled to their thoughts, which play like a hiss in the background of their experience. In fact the fastest and most elegant way I can enter into the world of my 'service users' is to access their mind-set rather than 'just listen' and empathise with their stuff.

A good CBT therapist is a wonder to behold, and can change toxic behaviour, emotional deficits and beliefs very quickly. Add-ons like mindfulness-based CBT and cognitive emotional behaviour therapy are powerful and useful.

There are many conditions for which CBT is not helpful, including perhaps severe attachment problems, PTSD and dissociative disorders and the difficulties of people who cannot easily access their thinking despite patient guidance from

'CBT done properly is something I couldn't work without and, while I am a holistic therapist, it is the very *centre* of my work and deeply collaborative'

the therapist. This represents a proportion of people with mental health issues. I have *never* met a CBT therapist who suggests that a patient shouldn't be thinking as they are thinking; nor have I *ever* met a patient who has been told to just *stop* OCD behaviour without a great deal of supportive background work. I am quite horrified about the cases the article describes, which are about poor therapists not poor CBT.

Go and look at Christine Padesky's work, for example. It is pure CBT and straddles NLP with such elegance that you will be amazed. CBT done properly is something I couldn't work without and, while I am a holistic therapist, it is the very *centre* of my work and deeply collaborative, striving to deconstruct unhelpful thoughts at an unconscious level, rather than force people to change their minds. I believe that CBT skills should be a robust part of the training of every person who works with mental health.

**Deanne Jade**
*Founder, National Centre for Eating Disorders*

## Let's move on from the criticisms

What is on trial here – the CBT approach, the delivery of approach, the individual therapist, or the organisations that train ('When CBT doesn't help', *Therapy Today*, May 2015)?

I can't help feeling sad when I read such titles. It's been a tiring period of hearing unbalanced views and perceptions with reference to CBT. CBT is just another therapeutic approach. There is a vast depth of knowledge and understanding to be gained from CBT that goes far deeper than just negative thoughts. I feel that the writer of this article has been somewhat short-changed in her conception and assimilation of CBT.

Is the writer frustrated that she had to retrain? As a CBT-schooled therapist, I too would have had to do the same if I wanted to work within the IAPT services. I have previously been turned down for positions for this very reason, despite my qualification. Is the issue here about IAPT training or perhaps bad practice compared with the writer's own? If the latter is the case then, as Rod Holland mentions ('Empathy key to CBT', in the same issue), I'm sure we can all share instances of this, whatever the approach. I like Rod's response where he states that 'the therapeutic relationship is key'.

CBT teaches that the client is an expert on self not just at the beginning of therapy but throughout the whole process – length and depth. It is a collaborative therapy that moves with the mover in a deeply conceptualised and contemplative way.

Let's move on from the criticisms of CBT and instead allow ourselves to be well informed, open, curious and challenged about what is not familiar to us.

**Di Hall**
*CBT/mindfulness private practitioner*

## Therapeutic alliance is central to CBT

I was disheartened by Helen Hadfield's experience of CBT described in the article 'When CBT doesn't help' (*Therapy Today*, May 2015).

Hadfield, an integrative practitioner, places a strong emphasis on the therapeutic alliance being maintained through empathy and mutual respect and therefore concludes that CBT is 'not a suitable technique for her style of therapy'. CBT techniques essentially emerge from a strong therapeutic alliance and therefore are wholly conducive to an integrative approach.

Judith Beck in her book *Cognitive Behaviour Therapy: basics and beyond*[1] clearly states that CBT requires 'a sound therapeutic alliance, warmth, empathy,

caring, genuine regard and competence' as well as 'collaboration and active participation', and Hadfield rightly acknowledges this.

The course Helen attended appeared to reduce CBT to a standard sequence to be taught irrespective of client needs. This denies an inherent strength of CBT – namely, responding flexibly to clients.[2] Perhaps those promoting an incorrect 'straitjacket' approach have missed the point of experimenting with the approach. Padesky, who is frequently seen as a role model for good CBT, makes the memorable point that we should guard against rote delivery: 'If you are too confident of where you are going, you only look ahead and miss detours that can lead you to a better place'.[3]

Another common misunderstanding is that CBT ignores the emotions, to its detriment. Judith Beck defines CBT as '*emotions* and behaviours, influenced by perception of events with particular interest in the level of thinking that operates simultaneously with the more obvious, surface level of thinking'.[1] This is reiterated by Frank Wills, who elaborates thoughts and beliefs needing to be identified *with the troubling emotions* while 'therapist and client engage in a collaborative, empirical process to test out these thoughts and beliefs and *their accompanying emotions* to promote enduring therapeutic change'.[4] The tutor who described CBT as 'a cruel bastard therapy' did a grave injustice to CBT, to the students on the course and to their future clients by denying them access to good CBT.

Interestingly there is no requirement for CBT therapists to have personal counselling and herein lies room for improvement. The value of personal growth and awareness should not be underestimated and there is I feel added value in the practitioner experiencing their approach first-hand from the client's perspective.

Like Hadfield, I am also an integrative practitioner and, as one develops a personal philosophy for counselling, the question arises whether a 'constructive dialogue'[5] can be formulated between CBT and the philosophical assumptions adhered to by the practitioner.

The collaborative, relational aspects of CBT would seem to complement a relational-based integrative approach to counselling. A practitioner who upholds the view that the core conditions are necessary for change may evaluate CBT as an optional extra. However if a practitioner concludes that both core conditions and structure are required for a positive therapeutic outcome then CBT becomes a vital asset to the toolbox of the integrative therapist.

One can only conclude, based on the examples given in Hadfield's article, that it is not necessarily the case that CBT doesn't help; rather, it was never CBT in the first place.

**Tracy Nolan**

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## All win and all should have prizes

I read Helen Hadfield's article today ('When CBT doesn't help', *Therapy Today*, May 2015) with relief that you have named something that's worried me for many years. I too (having worked as a Gestalt psychotherapist for 25 years) hear frequent accounts from clients about the impersonal and task-oriented approach of some CBT therapists. In many cases the experience has put off clients from seeking other therapy for a long time.

'What concerns me is the often-quoted notion that CBT is the most effective therapy for most conditions and that the NHS has swallowed this wholesale'

Recently I published a case study in the *British Gestalt Journal*, describing a client with severe childhood issues. Before he came to see me, he'd briefly seen a CBT therapist but been given such impossible tasks, that he'd felt sick with fear. My own view is that he was subjected to a re-enactment of childhood trauma within that therapy.

Other clients have told me similarly: 'She took a list of homework tasks for me from a shelf' when these were either irrelevant or too difficult. The CBT therapy I've known that was successful was used by therapists trained in relational, humanistic therapies who used CBT as an add-on.

I understand that meta-research into the efficacy of therapy shows a 75 per cent success rate across all modalities and that the success does not depend on the method used but on the quality of the relationship between client and therapist. Therefore what concerns me is the often-quoted notion that CBT is the most effective therapy for most conditions and that the NHS has swallowed this wholesale. Indeed, in the same issue of *Therapy Today* there is a report of a study confirming that all therapies are equal: 'Study confirms "Dodo bird verdict" was right'. I know of several experienced therapists who have been made redundant from their jobs in GP practices and been replaced by IAPT practitioners with little or no training in listening skills, never mind in any form of therapy. They are described as using CBT, aka the magic wand of the NHS.

**Margaret Rosemary**

## Thank you for your honesty

I would like to thank the anonymous author of 'What if it's your child?' (*Therapy Today*, May 2015) for her honesty and willingness to share her experience. I have had a very similar experience as a parent. I wish to protect the privacy of my now adult child so I don't want to share the details. One of the things that struck me about this

article was the universality of experience independent of our own personal histories. 'He has had a difficult life, despite our love and our best efforts to give him what he needs.' I was interested in the reference to Lyn Hoffman's work that it is the symptom that causes the system.

**Name withheld**

## Ethics committees 'stifling research'

I would endorse Stacey Goldman ('Why make research so hard to do?', *Therapy Today*, March 2015) and Werner Kierski (Letters, *Therapy Today*, May 2015) in their call for a change in the research climate – a loosening of the stifling constraints imposed by university ethics committees. The object of such committees, ostensibly to protect the participants, seems in fact to derive from a fear that their institution might end up before the courts.

My own research project, the culmination of an MSc counselling programme, was into the use of counselling for those who have suffered traumatic disability. The proposal had been trailed since my first year, and seemingly viewed with approval. In the third year we were to confront the Departmental Research Ethics Committee – a task, we were warned, equivalent to the labours of Hercules.

My proposal was rejected: 'The committee did not regard this as an appropriate subject for a student project. It has considerable potential to cause distress.' A concern was that the participants constituted 'a vulnerable group'. Are not most counselling clients 'vulnerable'?

I would say that I am in my 60s, have had a career as a lawyer, and that the research was supported by four national charities working with people who have lost a limb and those with spinal cord injury. One charity commented that the research would be, 'very, very useful'; another that it was, 'really exciting'.

I was told that I needed 'to get a new topic and start again'. Ideally the 'new topic' would have me as its subject; presumably on the basis that this would pose no legal threat to the university. Such an exercise is, to borrow Kierski's word, banal, and to my mind does not justify being classified as research.

Rather, I modified some aspects of the methodology, including removing a question using images to stimulate reflection, which had proved particularly contentious, and resubmitted.

This time the Departmental Committee declared itself not competent to decide whether my proposal was compliant with the ethical requirements and said I should apply instead to the University Research Ethics Committee, the first such referral of a master's project.

A fresh application process, and a different procedure. But this committee's membership was wider than departmental functionaries and included lay people. The application was, finally, approved. But the delays had cost me a year.

Was all this necessary? Of course the safety of participants is paramount, but surely this can be ensured in an environment that is not designed to deter research? Ironically, participants were keen to be involved and described the experience as positive. It put them in charge of their story: 'It makes me appreciate what I've been through and how I've sort of succeeded;' 'At the moment I'm the teacher, and that's fantastic.'

It's sad that, at a time when counselling is increasingly being subjected to the 'is-it-value-for-money?' test, research that might demonstrate this is being discouraged by unimaginative, bureaucratic hurdles.

**David Gladwell**
*MSc, MBACP (Accred)*
*counsellor@unseen.is*

> 'The NICE demand seems to be solely for target-driven, manualised approaches, unfairly placing a burden on people already well trained to undertake another expensive training'

## Release the NICE stranglehold

The latest batch of letters and articles about evidence reminded me of a key phrase omitted from the published version of one of my *Therapy Today* letters ('Don't rush into private practice', Your Views, *Therapy Today*, February 2015) – to the effect that we should work to release the NICE stranglehold over the NHS. Conversations with people responsible for NHS policy strongly suggest that if anything is to be taken seriously it must be supported by RCT evidence or something similar, and there was the implication that complaints about this insistence would be fruitless. This has resulted in a polarisation of views: those who believe it's the RCT or nothing and others who are pressing for consideration of different kinds of evidence. Power seems very much to reside with the first group.

It is encouraging that institutions like the Tavistock Clinic and the Anna Freud Centre are pursuing research to demonstrate the efficacy of psychodynamic psychotherapy and one researcher thought the tide was starting to turn at NICE, opening the door to consideration of other forms of evidence.

Meanwhile, the controversial NICE guideline on Depression in Adults will be revised over the next two years so I hope this will be an opportunity to make the case for a range of evidence. However the NICE demand seems to be solely for target-driven, manualised approaches (eg IPT, DIT etc), unfairly placing a burden on already well-trained people to undertake another expensive training, let alone not meeting the needs of many patients. I applied to join the Guideline Development Group, only finding out about it via Twitter. If such opportunities are not openly advertised (an advert on the NICE website would not suffice in my view), it does beg questions about this recruitment process. I was not successful so I look forward to finding out who was and what we can look forward to in the revised guideline.

**Roslyn Byfield**
*MBACP (Accred) counsellor in private practice*

# Outdated views about domestic violence

I was very interested to read last month's article 'The strength to change' by Mark Farrall and Nick Young, exploring the successes of a programme that works therapeutically with perpetrators of domestic abuse, as I had just come from a day's course on counselling clients who have experienced domestic abuse. During the morning session, someone presented who had worked in the police force and had gone on to develop training for them, as well as contributing to training with a counselling service to which the police referred victims of abuse. I couldn't help feeling uncomfortable during their presentation about the theoretical profile of a perpetrator that was being put forward, which felt rather reductionist – as if all perpetrators carry the same pathological/psychopathic need to repeatedly groom, coerce and have power over women in relationships. In fact, it seemed to tie in with the Duluth programme model, as described in the article, as an outdated method that more recent research has continued to find ineffective.

As someone with experience in this area, I was at pains to put forward a different scenario that is actually much more complex and, I felt, can now be better understood through my psychodynamic training around early family attachment dynamics and how these provide blueprints for the unconscious repetition of behaviours in adult intimate relationships – as this article states, paying attention to the 'emotional drivers for behaviour'.

It feels worrying that a police force and this counselling training are putting forward a stereotyped, one-dimensional and outdated view of a complex situation that often involves ambivalence and perpetrators who have also been victims. How do we spread the word among organisations like the police on the more helpful attitudes and approaches towards working around violence in relationships, so that more understanding and less vilifying is encouraged?

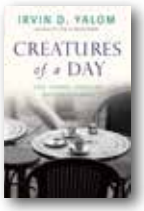
**Jo Bisseker Barr**
*MBACP (Accred)*

# 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 www.TherapyToday.net. Please email the Editor, Sarah Browne, at therapytoday@bacp.co.uk

# The inevitability of death

**Creatures of a day: and other tales of psychotherapy**
Irvin D Yalom
Piatkus, 2015, 211pp, £14.99
isbn 978-0349407425
*Reviewed by Gill Ingram*




Yalom, 83, still practising and writing in California, has just published this, his 15th book. Warm, humane, occasionally tipping into cosiness, he still packs an existential punch. His book of 10 case studies is unashamedly about confronting the inevitability of his clients' and his own death.

One of the most moving chapters, on Ellie (her real name), takes us through to her death from ovarian cancer. Experienced as he is in dealing with such trauma, Yalom is characteristically open about his guilt about not getting too 'dangerously close', but close enough to trust her own account that she felt she was really relating to him (p170). The most valuable thing he has to offer is his 'own sheer presence' (p158).

Yalom strives to be fully in the moment and as authentic as he is able. This leads to unorthodox practice that more traditional and certainly more psychodynamic models eschew. He is constitutionally averse to diagnosis. He makes home visits, shakes hands at the beginning of sessions and hugs clients at the end, asks all clients to 'call me Irv', makes practical recommendations, answers personal questions straight, and suggests reading matter to be explored in the next session. He sometimes supervises and sees the same colleagues for their own therapy. He takes it as given that he will go to their funeral.

Core psychoanalytic concepts are still at the heart of his work, but with a twist. This leads to a dynamic use of transference that is more existential than psychoanalytic – part of the reality and meaning of the moment. So, in chapter two he tells a patient who lost his father at eight and at that point stopped psychologically being alive: 'On the one hand I want to be like a father to you, but at the same time I want to help you get past the need for a father' (p25).

Yalom has worked on his own terror of death and has helped himself as much as he has helped his clients. A major theme is that 'anticipating endings may encourage us to grasp the present with greater vitality' (p29) As Ellie wrote to him, 'What I want is to be intimate with the knowledge that life is temporary. And then in the light (or the shadow) of that knowledge, to know how to live' (p164). That is the toughest demand of all.
*Gillian Ingram is a psychodynamic counsellor and supervisor*

# Working at the margins

**Psychoanalysis in an age of accelerating cultural change: spiritual globalization**
Neil Altman
Routledge, 2015, 140pp, £27.99
isbn 978-0415812566
*Reviewed by Chris Rose*

Some might think that psychoanalysis has become an elitist activity – only available to the financially privileged, cut off from the pressing concerns of the majority of those needing help. Neil Altman is a psychoanalyst who would agree.

Altman's book challenges psychoanalysis to come out from its privileged consulting room and engage with community work and cultural diversity. He has himself worked with NGOs in India and elsewhere, and uses his experience to insist that psychoanalysis can and should be used in working with the poorest and most deprived peoples.

'People in extreme poverty and pain are dehumanised and demonized by mainstream society precisely to avoid identification with them in a way that could produce unbearable pain. Those who would wish to defy such dehumanization and marginalization must first come to terms with the extreme anxiety and pain that their work will entail' (p21).

Altman writes clearly and modestly about offering support in this endeavour. Psychoanalytic understanding in his relational model focuses on the conscious and unconscious interactions between patient and client, drawing out the ways in which each makes sense of the world and how they mutually influence each other. An understanding of transference and countertransference, the necessity of self-reflection, the capacity to acknowledge and tolerate helplessness, and a systemic view that links the intrapsychic, individual, group and society can all be taken out of the consulting room and used to support those working at the margins.

He is passionate about inequality, enraged by the way in which banking disasters have been paid for by savage cuts to public funding; by therapy and care being reduced to commodities; by the assumption that short-term manualised treatments are for the poor and psychoanalysis for the rich. Although throughout his writing he refuses the temptation to split good from bad, there is no doubt where his heart lies.

The book is deliberately not linear; it loops around, examining the relationships between psychoanalysis, culture and community-based clinical work. He presents examples of the ways in which psychoanalytic thinking can be used in a variety of challenging community environments, questioning the privileging of the 'scientific' perspective over the supernatural and religious, the individual over the group.

If any counsellor or psychotherapist is tempted to think that, because 'psychoanalysis' is not their field, they can dissociate themselves from Altman's critique, they are mistaken. Any profession that has taken on the commitment to look at itself as well as others must acknowledge the ways in which 'we avoid suffering, shame, guilt and pain at the expense of our humanity' (pxi). This is a book for all of us.
*Chris Rose is a psychotherapist, author and Reviews Editor of* Therapy Today

# After the avalanche, the meltdown

**Suzie Chick reviews *Force Majeure*, a dark Swedish comedy about gender roles and family dynamics**

*Force Majeure* is an uncomfortable yet darkly funny film about a picture-perfect Swedish family on a five-day skiing trip.

The family is caught up in an avalanche as they dine at a mountaintop restaurant. Gasps of delight at the scenery soon turn to shrieks of fear as the rumbling snow gathers pace and heads for the restaurant. Our Swedish family scrambles for safety: Ebba grabs the two children and calls out for her husband, Tomas, to help. But Tomas has already run for cover, taking his gloves and mobile phone with him and leaving his family to face the onslaught alone.

As the snow hits, it soon becomes apparent that the avalanche has been controlled and that there is little danger. Somewhat dazed, Ebba and the children settle back to their seats, quickly joined by Tomas, to finish their food in the most awkward of silences.

The rest of the film depicts the emotional fallout from Tomas' abandonment of his family in their time of need. We see Tomas try unsuccessfully to reassert his masculine status through various macho activities, including raucous, heavy drinking and mild flirtation. Traditional family roles are reversed as Ebba, cold and withholding, watches her husband sink into an emotional and hysterical crisis. The children rush to comfort a tearful Tomas, taking the parental role to their infantilised father.

The end of the film sees the family suffer another ordeal when Ebba gets lost in a snowstorm. Tomas finds her, and (rather unnecessarily) carries her back in his arms to their children, thereby restoring his identity as the family's protector. It seems the family collude in restoring Tomas' role as they find it preferable to the current confusion.

*Force Majeure* raised a number of issues for me relating to my practice. Our sense of identity is enmeshed with gendered roles; cultural stereotypes, as the film demonstrates, are immensely powerful and tenacious. We psychotherapists need to be aware of the gendered roles that we and our clients embrace. The process of therapy may well challenge assumptions about gender roles but our ability to alter these fundamental beliefs is often limited. It is important that we do not underestimate their power and influence, as change can cause an imbalance in the family dynamics, which may be unconsciously reversed in order to preserve the status quo. And, of course, we have to apply the same searching questions to ourselves as therapists, and watch out for those moments when we too have been pushed out of our comfort zone and are struggling as hard as we can to get back there.

*Suzie Chick is a trainee psychotherapist and blogger*

Force Majeure *(2014; 119 minutes) is written and directed by Ruben Ostlund and stars Johannes Bah Kuhnke, Lisa Loven Kongsli, Clara Wettergre and Vincent Wettergre*

# The personal and the public

**The psyche in the modern world**
Tom Warnecke (ed)
Karnac, 2015, 174pp, £23.99
isbn 978-1782200468
*Reviewed by Yvonne Farley*

In this book the concept of the *psyche*, 'the human inner dimension' (p1), is juxtaposed with that of the *agora*, the Greek communal 'gathering-place'. The essays it contains seek to investigate how psychotherapy can begin to bridge the historical gap between the personal and the public. Here is a book about politics and society and about how psychotherapy can site itself in a bewildering, ever-changing public environment in a way that is respectful of personal choice, diversity awareness and resource availability.

Essentially the essays address questions of inequality: whether in the power balance in the therapy room, in the availability of therapy to disadvantaged groups in society, in the funding allocation to research projects, in the financing of government-funded psychotherapy programmes or in the relative importance society attributes to the *psyche* and the *agora*. They do this both by interrogating clinical issues, such as how to deliver therapy – and choice – to the 'intellectually disabled' (p23) or to 'children with complex disturbances' (p43), and also by holding several meta-conversations – about the nature and role of research in the psychotherapeutic world (p149), for instance, or about the construction of psyche-related disciplines in a world where 'the contradictions and multiplicities of our modernity present unprecedented challenges' (p67).

I was particularly fascinated by a survey of the cost of psychotherapy training and the almost complete lack of financial forward thinking undertaken by those who launch themselves into this training (p131). In any other modern

business world context this would be seen as madness and it serves to illustrate the peculiar position of psychotherapy within our society. The essays ask – and then offer answers to – how, then, may psychotherapy find a valid, pertinent and meaningful voice in our science-oriented, modern culture?

The book would have benefitted from sharper copy editing. It is also a rather eclectic collection of essays that have been skilfully drawn together in the foreword and introduction. Together, though, these create a book that is vibrant and exciting that challenges and inspires all practitioners to rethink the psycho-socio-political assumptions we make about the agency of our work and its context. Overall it made me feel pretty fortunate to be in a profession that is willing to address issues ranging from prickly to potentially damaging with such curiosity, inventiveness, humility and reflexivity.

*Yvonne Farley is a psychotherapist and psychosexual therapist*

# Connection and reconnection

**Solution-oriented spirituality**
Bill O'Hanlon
WW Norton & Co, 2015, 136pp, £11.99
isbn 978-0393710625
*Reviewed by Omar Sattaur*

'People have spiritual resources, even when they are not religious or when they profess no spiritual sensibilities or beliefs,' O'Hanlon writes (p8). This book aims to draw on what he believes is a well-spring of unconscious spirituality in clients – a resource waiting to be tapped by solution-oriented practitioners.

O'Hanlon quotes Alan Watts on the difference between belief and faith. Belief starts with wishing that things are the way I think they are; faith, says Watts, 'is an unreserved opening of the mind to the truth, whatever it may turn out to be... Belief clings, but faith lets go' (p33).

Spirituality for O'Hanlon comprises the 'Three Cs': Connection, Compassion and Contribution (or Service). He then devotes three chapters to exploring 'Pathways' to each of the three Cs. In chapter six, O'Hanlon summarises his model in his three simple steps. Step one is to help clients identify a problem or stuck place in their lives. As they are connecting with this, they are asked to notice how it feels in the body and the emotions they have. How do they relate to themselves and others when they feel this way? Step two is to visit spiritual moments and reconnect with them, assuming that the client has had such experience to draw on. Step three is to bring 'that sense of spirituality to any situation in which they are having current difficulty or anticipate having difficulty in the future' (p104). This is followed by questions typical of solution-focused practice, such as 'What do you notice that is different as you are examining it from this new place?'

One of the things I most admire about solution-focused therapy is the care with which therapists word their questions and interventions, since this subtly helps to achieve the all-important shift from a fixed view of the status quo to a preferred future of possibility. O'Hanlon warns against glibness (p67), yet many of the questions he suggests do appear glib. For example, 'Do you think people are reborn? If so, what do you make of this experience you are going through right now?' (p33); 'Is there anything you could do to make the world a better place or to reduce the likelihood that others will suffer as you have?' (p28); 'How do you typically connect to something bigger within or beyond you?' (p21).

However the book offers a refreshing pragmatism in its view of spirituality, although I suspect that for some clients this perspective may seem minimising of a profound part of their lives. As long as our questions are thoughtful enough to guard against this danger, this book offers a neat model for harnessing an important and valuable aspect of people's experience for therapeutic good that can otherwise easily be overlooked by therapists.

*Omar Sattaur is a counsellor and Editor of* EMDR Now, *the newsletter of EMDR Association UK & Ireland*

# The group and the anti-group

**Beyond the anti-group: survival and transformation**
Morris Nitsun
Routledge, 2015, 250pp, £26.99
isbn 978-0415687386
*Reviewed by Christopher Davies*

Morris Nitsun introduced the concept of the 'anti-group' – a term describing anxiety and hostility towards the group that can undermine its constructive and creative potential – and explored its clinical manifestations and ramifications in his first book, published almost 20 years ago. Now he has written a sequel that has a much wider purview.

The first part of the book looks at the social, cultural and organisational context of contemporary group processes, examining in particular the NHS as a sort of case study in anti-group processes and their impact; the second part is more rooted in clinical work, exploring 'group psychotherapy on the edge', painting a picture of group therapy in the inner city and – with hope – looking at what group analysis can offer to CBT groups. The third part, entitled 'developmental perspectives', focuses on the person of the group practitioner and how both positive and problematic aspects of our personal development can impact on our groups and how they are led. A second chapter in this part, 'Falling in love: a group analytic perspective', drawn from his more recent work in conducting and supervising private groups, documents the substantial gains group members can make in the area of close interpersonal relationships. The final part of the book comprises two chapters on group analysis and the arts.

Vignettes, some clinical and others organisational, are interspersed throughout. Nitsun cites group analysts Foulkes and Anthony to remind us that the group is 'solely for the benefit of its individual members and its efficacy can only be gauged by the extent to which

it becomes an efficient instrument for the treatment process' (p76). In an environment where evidence of individual treatment outcome determines funding, this is a salutary counterweight to the rather abstracted idea of the group as an instrument of social change. I found the chapter describing his work in convening a new diploma in CBT and innovative group approaches at the Anna Freud Centre an encouraging read. It describes how helpful group analytic thinking can be to other clinicians, affirming the value of the approach, but also challenges widely held myths about CBT and explores what the two therapies can offer each other.

Morris Nitsun has created a rich tapestry in which group psychotherapy, organisational process and the arts come together in unexpected ways, rather like the interweaving process of a creative and well-functioning analytic group. It is likely to be of greatest appeal to readers who practise in some way as group therapists or facilitators.

*Christopher Davies is a group analyst and NHS adult psychotherapist*

# Correction

Gill Ingram has pointed out a mistake in our edit of her review of *The Search for a Relational Home*, by Chris Jaenicke, published in last month's issue. The review should have been headed 'A reworking of countertransference'. Similarly, the first sentence should have read: 'At the heart of the intersubjective model lies a radical and challenging reworking of the concept of countertransference.' We apologise for the error, which is entirely ours.

# Shelf life


**Nothing special: living Zen**
Charlotte Joko Beck
HarperSanFrancisco, 1993, 177pp
isbn 978-0062511171
*Reviewed by Frances Basset*

'Enlightenment is not something you achieve. It is the absence of something. All your life you have been going forward after something, pursuing some goal. Enlightenment is dropping all that. But to talk about it is of little use. The practice has to be done by each individual. There is no substitute. We can read about it until we are a thousand years old and it won't do a thing for us. We have to practise...' So writes Charlotte Joko Beck in a book that continues to inspire and guide me, personally and professionally.

Beck, who died in 2011 at the age of 94, was a Zen teacher in San Diego. The book's strength lies in the fact that it is not weighed down with unwieldy theory. It includes actual question and answer sessions from Beck's talks with her students. In her simple presence, Beck embodies the Zen quality of 'nothing special'. She brings the insights of Zen to ordinary life in a way that makes their application to Western living a reality.

I first read this book a few years after qualifying as a psychosynthesis psychotherapist and have found it invaluable in helping to 'just be' with my clients. I particularly appreciate being able to pick the book up and dip into it. I find it renews my ability to be in the moment with my inner experience; to notice thoughts, feelings and physical sensations without judgment. To me, it is the easiest way to apply mindfulness to my everyday life.

The book comprises eight chapters, each tackling an area of human concern. Chapter headings cover issues such as Struggle, Sacrifice, Separation and Connection, Change, Awareness, Freedom, Wonder and, finally, Nothing Special. In addition to the book I also find her audiotapes extremely useful.

This book has helped me so much personally and professionally and continues to do so. While I am not a Zen Buddhist, I do find meditation to be highly important in keeping me fit and well as I carry out my work as a therapist. Of course mindfulness is also something that can help clients.

So I recommend this book to others, both as a great read but also as, in its title's words, 'nothing special'.

*Frances Basset is a psychosynthesis psychotherapist*

*Which books influenced your development as a counsellor or psychotherapist? What makes them still significant for you? 'Shelf life' is a new, occasional space for readers' reviews of old books that still have pride of place on your shelves. Books may be non-fiction or fiction – whatever has made an impact – and your review may cover more than one. Contributions should be between 350 and 400 words and should be sent to Chris Rose at reviews@bacp.co.uk*

# From the Chair

*Andrew Reeves* reflects on the challenge of change as BACP embarks on a new strategic plan

The nature of how we see the world around us, and how we then position ourselves accordingly in terms of our identity and world-view, so often sits at the very heart of our work as therapists.

During our training and thereafter we are rightly encouraged to explore these aspects and, in doing so, sometimes need to confront our ways of being that have worked previously but need to change to help us to continue to progress.

Likewise, our clients also often bring their intrapersonal and interpersonal struggles into the room: the ways in which they relate to their worlds and how their relationship with themselves facilitates and hinders that process. Both are equally important: the bigger picture of the world around us and the sense we make of it, as well as the intricate, deeply personal but often seismic shifts of our sense of self and our moment-by-moment experience of being.

The same is true for the systems in which we live: culture, community and society and the institutions and organisations that contribute to that entity. It can often seem that everything is always in a process of change and evolution, even if that change is sometimes so imperceptibly small – or large – that it is hard to notice at the time.

I remember thinking this when my father died many years ago: something so significant, so enormous, had happened to me as I said my goodbyes to the man who had been so pivotal in my own development that it was almost too large to determine. For sure I knew of my grief and pain at his death, but the enormity of what had really changed for me was so profound it was difficult to experience or describe. It is a bit like the spinning world – we know it happens theoretically but were it not for the rising and setting of the sun we would be hard pushed to appreciate the vastness of that movement around us.

Professor John Norcross spoke at the BACP Research Conference in Nottingham about the process of change in therapy: the importance of knowing the stage of change our clients find themselves at. If we are 'precontemplative' then we are yet to realise the need for change; at 'contemplative' stage we understand that change is needed but are not yet ready to take those steps; at 'preparation' we are getting ready for the change process before then moving into 'action' – the act of change itself. Later stages contribute to that process. It was a compelling talk by Norcross that made so much sense of my client work. It is harder to make sense of those stages during the potency of grief, however.

BACP is in the process of change too. The Association has already changed so much over many years in response to the shifting nature of therapy itself and the world in which it is now positioned. This has been under the steerage of CEOs, the staff at BACP and the many thousands of volunteers – from the Chair and Board through to the many committees and divisions – who have contributed to its growth.

Change is upon us again however, and over the coming weeks we will be asking you to think about the questions I raise at the beginning of the piece in relation to our Association. That is, what do you want next for BACP; what do you want for its identity; what should be our underpinning philosophy and ideology; what should be its main functions, and what contributes to you being proud to be a member – or what would help you feel proud to be a member?

I hope you feel able to contribute to our new strategic direction. For how we see the world around us, and how we then position ourselves accordingly in terms of our identity and world-view, will sit at the very heart of the future of BACP. ■

*See BACP News on page 45 for details of the consultation on the new BACP strategy.*

# BACP consults on strategy

With a new Chair and CEO in post, BACP is currently consulting on our new strategic plan, which will take us through to 2020. More than a list of objectives and targets, the plan will outline our vision and values and set out where we want to take BACP and how we'll get there.

Before we start thinking through our options and priorities, it is important that we understand our members' views. We are therefore consulting with the whole membership through a survey. This is a chance for you to let us know what's important to you, how well we are doing and where we can be challenged to do better.

We cannot achieve this without you. We need and value your input, so that BACP can be an association that supports and values you and all our members.

The survey is open from 16–30 June. It can be found on the members' section of the BACP website and at www.surveymonkey.com/r/strategic_member

It can be completed anonymously but if you wish to have a chance of winning a year's free BACP membership, you will need to give your contact details at the end.

We aim to be transparent with our new plan. We are also consulting with other important stakeholders – the Board, BACP staff and some key external organisations – and drawing on a wide range of evidence we've collected recently. When the consultation has finished and the strategy is written, we will make it available on our website and report back frequently in *Therapy Today* on how, and where, we are making progress.

Let us know your views!

# BACP features in the national media

Members may have spotted the recent *Guardian* article (11 May) on university counselling services to which Lead Advisor Patti Wallace and BACP member Ruth Caleb contributed.

Also in the broadsheets, two letters signed by Andrew Reeves on behalf of BACP have been published in the last month or so. A letter to the Times (1 April), co-ordinated by StudentMinds, called for a radical overhaul of youth mental health services in the UK. A second letter, co-signed with fellow members of the Early Intervention Coalition and published with a news report in the Independent (5 May), called on the Government to invest in effective early intervention services for children and young people.

In the lifestyle sector, BACP member Julia Greer offered relationship advice in *The Debrief* in April and in March Sherylin Thompson talked to *Candis* about ways to 'spring clean your life'. And BACP's campaign to influence the nation's agony aunts continues to reap success.

# Certificate of Proficiency assessment dates

BACP has now confirmed the calendar of Certificate of Proficiency (CoP) assessments up to the 31 March 2016 deadline for MBACP members to join the BACP Register in order to stay in membership.

CoP assessments for 2015 can be booked now in Bristol on 9/10/11 July and 15/16/17 October; London on 16/17/18 July, 20/21/22 August, 22/23/24 October and 3/4/5 December; Belfast on 6/7/8 August; Birmingham 3/4/5 September and 26/27/28 November; Glasgow 10/11/12 September; Manchester 1/2/3 October; Newcastle 30/31 July and 1 August; Southampton 13/14 November, and Plymouth 18/19 December.

In 2016 CoP events will be held in Belfast on 28/29/30 January; Birmingham 25/26/27 February; London 4/5/6 February and 17/18/19 March; Manchester 14/15/16 January and 10/11/12 March, and Newcastle 19/20 February.

The CoP assessment is free. To check dates and book, visit www.bacpregister.org.uk and click on Certificate of Proficiency, or please call BACP Customer Services on 01455 883300, Monday to Friday, 9am–5pm.

# Setting up in practice

In response to growing demand from members, BACP is introducing a new one-day conference for practitioners who want to set up in private practice.

'Setting up in Private Practice – Are You Ready?' is on Monday 13 July in London. Presentations in the morning will focus on key issues such as lone working, isolation, managing risk, working within the limitations of your experience and self care. Afternoon presenters will discuss the range of services that can be offered and give practical advice on how to deliver them.

To register an interest in this BACP event, email jade.ingham-mulliner@bacp.co.uk

# BACP Private Practice

Rabina Akhtar has joined the BACP Private Practice Executive Committee as Finance Officer.

A former chartered management accountant, Rabina has been in private practice since 2011 and currently also works in NHS primary care and for an agency specialising in counselling Muslims across the globe. She also teaches counselling at City College Peterborough and is a partner in a small training company that runs CPD workshops for counsellors. 'I look forward to supporting budding private practitioners and want to encourage practitioners from ethnic minorities to venture into this arena,' she says.

# Retired members welcome

BACP has launched a new Retired Member category.

The category has been introduced to recognise the skills and knowledge of members who are no longer practising and so are unable to join the BACP Register but want to continue to keep up to date with developments in the counselling and psychotherapy profession.

The fee for Retired Membership is £74 a year.

Members who choose to transfer to Retired Member will continue to receive many of their existing membership benefits, including their subscription to *Therapy Today*, access to the BACP members' area and discounts on BACP publications and events.

However the Retired Member category is only for members who are no longer in practice, so they will no longer hold Registered and/or Accredited status.

For more information and to request an application to transfer form, please email retiredmember@bacp.co.uk or contact our Customer Service team on 01455 883300.

# Making Connections comes to Glasgow

BACP visits Glasgow on Thursday 2 July for another Making Connections event.

Making Connections is an opportunity for members to meet senior executive and non-executive officers, network with fellow BACP members locally, and have their say about issues affecting the profession.

Speakers on 2 July include founder of the Muslim Counsellor and Psychotherapist Network Myira Khan and Joshua Hepple, a law graduate who has cerebral palsy and who has launched TalkTime Edinburgh, a counselling service for 16-25 year olds with physical disabilities.

Making Connections will also be visiting Norwich on 10 September and Belfast on 22 October.

Making Connections events are free. For more information and to book, visit www.bacp.co.uk/events/conferences or ring Customer Services on 01455 883300 on Monday to Friday, 9am–5pm.

# BACP UC conference

More than 70 delegates attended the first of the two BACP University & College Counselling one-day conferences, on 8 May in London, and a similar number is expected to attend the second, in Leeds on 22 June. This exceeds attendance at the two-day residential conferences of previous years.

The conference theme is 'Innovation and Care' in the higher and further education sector. There's still time to register at www.bacp.co.uk/events/conferences or ring Customer Services on 01455 883300.

# BACP Spirituality resources

BACP Spirituality has put together a *Research and Resources* pack that lists texts and other resources for practitioners who have an interest in spirituality. It is available free to BACP Spirituality members from the members' page at www.bacpspirituality.org.uk

# Professional Standards team

Victoria Hatchett has recently joined BACP's Professional Standards team as Education and Development Officer to support its work in developing counselling training standards built on evidence-based competences.

Victoria's role involves researching the counselling training field to inform the review of future standards of training and practice.

Dr Julie Waumsley has also joined the team as Professional Standards Development Manager. She will develop competences for counselling specialisms and curricula. To find out more about the team's work, email julie.waumsley@bacp.co.uk

# New BACP Fellows

Congratulations to two new BACP Fellows announced at the BACP Research Conference last month.

Tessa Roxburgh is a solicitor and counsellor and a longstanding member of the BACP Professional Conduct Panel, on which she has served since the late 1990s. She was also part of the BACP team running workshops around the country from 2004 to 2008 to introduce members to the first *Ethical Framework*. She was until 2013 a tutor on the Introduction to Counselling course at Warwick University and continues to co-tutor the Counselling Concepts and Skills module of its social studies degree course.

Roger Helyar is founder of Rockhaven, a therapeutic community providing residential support, counselling and adventure therapy for men in Exeter and the South West, which he established with his wife in 1985. Roger originally trained as a demonstrator and teacher with Hammond Organs of America. Severely dyslexic, he took a special interest in teaching music to people who found conventional learning methods difficult and developed his own 'person centred' approach that subsequently became a model for his counselling practice.

Fellowships are a lifetime honour given by BACP to members who have made a significant contribution to counselling/psychotherapy or to BACP as an organisation. For information on how to apply or sponsor someone for a Fellowship, go to www.bacp.co.uk/fellows/

# All change in Government

The 2015 General Election has brought a big change at Westminster and altered the balance of political power in the UK.

Many of the mental health policies of the Coalition Government came from the Liberal Democrats. However the Conservatives have pledged to keep up the momentum. Their manifesto promised:

- to ensure access to therapy throughout the country
- new access and waiting time standards for mental health treatment
- that women have access to mental health support during and after pregnancy.

As we go to press, the Government was due to set out its intentions for the year in the first Queen's Speech on 27 May.

Meantime the Liberal Democrats will be finding out who their new leader is on 16 July. The choice is between former Care and Support Minister Norman Lamb and the Liberal Democrat President Tim Farron.

Shadow Health Secretary Andy Burnham, Shadow Minister for Care and Older People Liz Kendall and Shadow Home Secretary Yvette Cooper are currently in the line-up for the Labour Party leadership contest, which is looking like a traditional battle between the left and centre ground.

Aside from David Cameron, the big winner of the election was Nicola Sturgeon and the Scottish Nationalist Party. The SNP has 56 MPs taking their seats at Westminster, keen to make their mark.

BACP will be working with all the political parties to improve the awareness and understanding of counselling and psychotherapy and the profession and will be writing to the new ministers and opposition spokespeople over the coming weeks.

# Alistair Burt appointed Mental Health Minister

Alistair Burt MP has been appointed Minister of State for Community and Social Care with responsibility for mental health, replacing Norman Lamb. Veteran MP for North Bedfordshire, Alistair Burt has been in Parliament since 1983, with a four-year break 1997–2001, and has held a variety of positions in government and in opposition.

Speaking about his appointment, Burt outlined some of the key areas on which he plans to focus, including 'the delivery of aspects of the Care Act, the better integration of health and care services, and the enhanced attention to be paid to the provision of mental health support'. He said: 'The work done within the areas for which I am responsible touch on the lives of many people, and I believe it is an extraordinary sector full of remarkable individuals. I am looking forward to listening to those involved and doing all I can to ensure the Government plays its full part in the further development of vital services.'

Alistair Burt was educated at Bury Grammar School and St John's College, Oxford. He and his wife, Eve, have two children, now adult. He enjoys football, modern art and outdoor leisure.

# New funds for child mental health

The Scottish Government is to invest an extra £85 million in improving mental health services over the next five years. The funding will partly be used to further improve child and adolescent mental health services (CAMHS) and bring down waiting times. It will also help improve access to services, and in particular to psychological therapies.

The Welsh Government has announced extra funding of £7.6 million a year to help improve mental health services for children and young people, including out of hours and crisis care, access to psychological therapies, local primary mental health support services and early intervention for psychosis.

# Self-help books scheme

Titles in the national Books on Prescription scheme for children and young people must address wider issues affecting mental and emotional health and wellbeing, and should not only focus on diagnosed disorders, BACP has said.

The national scheme recommends self-help books to treat low-level depression and anxiety, which can be accessed via local libraries.

Responding to a consultation on titles that should be recommended, BACP highlighted to the Reading Well Agency the effectiveness of self-help books and the importance of good mental and emotional wellbeing in children and young people's holistic development. However, BACP also raised some concerns about future access, given the cuts in local authority funding for local libraries.

BACP also said the titles chosen will need to span the range of literacy skills and stressed the importance of including books covering issues that can lead to mental health problems, such as bereavement, anger, family breakdown and stress.

BACP has also responded to NHS England's Mental Health Five Year Forward View Survey that will help to shape the work of the national Mental Health Taskforce.

*For the full responses and information about current consultations, please visit the BACP Policy and Public Affairs webpages on the BACP website at www.bacp.co.uk/policy/consultations/index.php*

# Accreditation/Professional standards

## How to succeed

Increasing numbers of BACP members are applying for accreditation. *Liz Aston* offers some advice

As the newly appointed manager of BACP's Accreditation team, one of my first actions has been to conduct a review of statistics across all the BACP accreditation schemes.

The good news is that increasing numbers of BACP members are seeking accreditation. Clearly our members are keen to develop their learning and skills post-qualification, and welcome the endorsement that accreditation brings, on top of registration. We now have just over 10,800 accredited individual members, and are receiving higher numbers of applications for accreditation than ever before: some 250 individual counsellors/psychotherapists have applied in the past six months alone. But I was surprised and dismayed by the number of deferred or unsuccessful applications.

Part of my job is to investigate the possible reasons behind this and to ensure that all applications are assessed to the same standard. I asked the members of the assessment team for their views on why applications fail. The general consensus was that, in the case of the more straightforward criteria, some members quite simply misunderstand the requirements and do not provide us with the necessary information. In the case of the more complex reflective practice criteria, it is usually that applicants have not been able to articulate the qualities expected of an experienced practitioner and, again, this may be simply due to misreading the guidance we provide.

But another reason may be that counsellors are simply not ready to apply. Accreditation has long been held as the benchmark for a mature practitioner, and accepted as such by many employers. This is almost certainly and understandably the reason for premature submissions by counsellors eager to start to earn a living after costly and often lengthy training.

So, what are these qualities that demonstrate this standard? Again, I consulted with the team, and I briefly summarise their responses here.

1. Is the applicant able to demonstrate that they are familiar with and experienced in using the BACP *Ethical Framework* and that working ethically is continuous throughout their application?

2. Does the applicant demonstrate a clear understanding of their working model and are they able to articulate why they work in this way? If they are integrating more than one approach, how do they do this and why? How has their experience and knowledge acquired since qualifying reinforced/enhanced their initial training and how have they integrated this in their practice?

3. Does the applicant clearly articulate self-awareness and show how they use this in their practice?

4. Does the applicant demonstrate reflexivity – the ability to reflect on and critically evaluate their own practice independently and within supervision? Does their application show a high degree of self-awareness and awareness of the impact of self on others?

5. Do they have a well-developed internal supervisor? Is there evidence of their ability to make clinical/ethical decisions independent of their supervisor and that they seek appropriate guidance when required? Do they know the limits of their competence?

6. Do they make effective use of the supervisory relationship and supervision itself in the service of the therapeutic relationship and their professional/personal development as therapists? Are they able to demonstrate this? (Simply adding a couple of sentences about supervision to a case study will not be enough!)

7. Does the applicant demonstrate a commitment to their ongoing personal/professional development through CPD that is relevant to their practice and do they evidence their ability to apply new learning to their practice?

It is difficult to find a balance between providing enough guidance to enable members to complete their application and ensuring we don't compromise the standards of accreditation by giving applicants too much help! We already have a very experienced administrative team who can (and do) offer advice on the more practical questions. In early summer this year we will be launching, with the help of the BACP Events team, a set of online learning resources, free to members. These will be available to download from the BACP website – we'll keep you informed via *Therapy Today* and the BACP monthly e-bulletin.

It is also important to ensure that accreditation remains current: that it continues to reflect the evolving requirements of stakeholders/employers and pertinent developments in the mental health field, while

continuing to demonstrate excellence in an increasingly competitive field.

Accreditation needs scrutiny and review in order to maintain validity. We need to consider how we can ensure it remains an effective indicator of a counsellor/psychotherapist's fitness to practise in multiple arenas. We also need to review what other qualities, skills and experience we may need to capture to reassure employers that BACP accreditation continues to set the standard for mature, competent practice, and whether there are other ways than those we currently use to measure mature competence.

We will shortly be embarking on this review and would greatly value your views. The first stage will be a survey, which we are asking all our qualified members to complete on SurveyMonkey later this month. We also hope many of you will volunteer to join the forum we are setting up to help to shape the future of accreditation.

*The accreditation review survey is at www.surveymonkey.com/r/SF5YSJG. The closing date is 30 June 2015.*

**Newly accredited counsellors/psychotherapists**
Joanne Adejumo-Platt
Emma Alexander
Lou Allen
Marco Aloisio
Jane Armstrong
Joanna L Ashburner
Pam Basra
Susan Birch
Gabrielle Bohme-Goad
Kate Emma Bowler
Geoff Brooker
Jane Burgoyne
Susan Claire Carr
Amanda Chapman
Sue Christy
Helen Clifford
Lorraine Connolly
Alison Cooney
Roseleen Cowie
Beverley Cummins
Jo Derry
Nazneen Dholoo
Kenneth Easdon
Mike Ellis
Sharon Fairclough
Declan Farrell
Patricia Fotheringham
Alison Fox
Lesley Freeman
Aisling Goodison
Julie Greenwood
Janine Gumm
Janet Gurung
Gillian Haddon
Pamela Hamill
Jacqueline Hart
Julie Hay
Lisa Jayne Haydon
Dawn Hayward
Jacqueline Hewitt
Elaine Hoey
Paula Hoppins
Richard G Jackson
Mervyn Wynne Jones
Lynn Keys
Teresa Kowalska
Joanne Lindsey Loach
Bernadette MacBean
Malgorzata Matthews
Sandra Mckie
Gail McKillop
Julie Meehan
Sharon Michell
Sally Mitchell
Jo-Anne Moore
Sarah O'Donnell
Benjamin Opaleye
Susan Osborne
Sarah Parker
Samantha Pepin
Jill Porcher
Judith Roberts
Tracey Rowlands
Camilla Saunders
Juliette Saville
Jo Sharkey
Michaela Sinclair
Caroline Smith
Rachael Smith
Miriam Somerville
Damian Sweeney
Dewi Thompson
Maria Tierney
Selina Turkington
Phill Turner
Margretta Vauls
Diane Vian-Coe
Corina Voelklein
Joanne Wainer
Sherron Walker
Wayne Walker
Diana Webb
Nikki Wilkins
Jacqueline Williams
Alis Yurddas

**Newly senior accredited supervisors of groups**
Annie Collinge – Kissane
Agnes Rees

**Newly senior accredited supervisors of individuals**
Joseph Conlon
Anne Ferris
Ewan Innes
Agnes Rees

**Newly senior accredited counsellors/psychotherapists**
Anne Gisby
Mari Green
Deborah Sharp

**Organisations with new/renewed service accreditations**
- City Pregnancy Counselling & Psychotherapy
- Faversham Counselling Service
- Relate Greater Manchester South
- Sutton Counselling

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

**Members not renewing accreditation**
Gail Ashton
Victoria Berringer
Josephine Bradshaw
Mary Chisholm
Dawn Cockram de Chamuel
Valerie Collins
Elizabeth Conner
Maria Cornwell
Sarah Darby
Julie Devlin
Anthea Elias Meakins
Annette Elliot
Laura Fargher
Glynis Gadd
Valerie Golightly
Maureen Graham
Barbara Hollingworth
Priscilla Hunt
Rachael Hunter
Carmel Kelly
Silvana Lawton
Susan Lewis
Helen Lloyd
Eileen MacDonald
Marsali MacDonald
Coral Martin
Sara Mauleverer
Patricia Millar
Jane Muscroft
Gwen Newstead
Maureen O'Connell
Valerie Parker
Rita Pennington
Anne Pluckrose
Dawn Radford
Barbara Read
Ian Reeman
James Rees
Jane Robins
Jane Roe
Beryl Simpson
Lea Srabonian
Sharon Swaden
Sheila Symons
Hilly Todd
Carole Trowbridge
Denzil Underwood
Patricia Urquhart
Vito Ward
Rita Warden
Diana Wetz
Frances Wharmby
Colin Williams
Susan Williamson
Sally Wood

**Member whose accreditation has been reinstated**
Avril Jones

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

# Research conference awards

The 2015 BACP Research Conference was once again a huge success. The two-day event, co-hosted in May by the University of Nottingham, attracted over 200 delegates.

Jeanette Hennigan was awarded the *CPR* New Researcher Award for her research into 'UK secondary school therapists' online communication with their clients and future intentions'. Graham Westwell was awarded the BACP Outstanding Research Award for research into 'The person-centred and experiential psychotherapy scale: a convergent validity study'. Liz Harrison was awarded the PCCS Books prize for her research into 'Can I be me? The experience of the person-centred counsellor working with suicidal clients online'.

Next year's BACP Research Conference will take place in May 2016, co-hosted with the Society for Psychotherapy Research (SPR) UK Chapter. The venue is to be confirmed. The theme is 'Research matters: evidence for an evolving profession'. The call for papers is now open and submission details can be found at www.bacp.co.uk/research/events/index.php

# Apply for a Small Research Grant

BACP is inviting applications for the 2015 Small Research Grant. Three awards are available for research in three categories: children and young people, outcomes in routine practice, and a general category for any research into counselling/ psychotherapy. Any BACP member is eligible to apply. You can find more details at www.bacp.co.uk/research/resources/awards.php. The closing date is 14 September 2015.

# BACP Research enquiry of the month

This month's enquiry asked: 'Is there any research that has looked at counselling/psychotherapy for individuals with attention deficit hyperactivity disorder (ADHD)?' We searched our internal abstract database and Google Scholar (http://scholar.google.co.uk) using the terms 'psychological therapy' and 'ADHD'.

A multicentre study conducted by Philipsen and colleagues[1] evaluated the effectiveness of a structured skills training group programme for adults with ADHD. They found that the programme led to significant improvements of ADHD, depressive symptoms and health status. Participants regarded 'behavioural analyses', 'mindfulness' and 'emotion regulation' as the most helpful aspects of the programme.

An earlier randomised controlled trial by Safren et al[2] aimed to examine the efficacy of cognitive behavioural therapy (CBT) for adults with ADHD who had been stabilised on medication but still presented with clinically significant symptoms. Participants randomised to receive CBT plus psychopharmacology had significantly reduced ADHD symptoms (both self-reported and independently evaluated) and global severity than those who had psychopharmacology alone, as well as significantly reduced levels of anxiety.

A more recent systematic review[3] of the published literature on psychological treatments for adults with ADHD tentatively concluded that CBT appeared to be the most effective psychological treatment. However they also concluded that there was very little research comparing the two active psychological treatments with each other under controlled conditions and that this warrants further research.

REFERENCES:
1. Philipsen A, Richter H, Peters J et al. Structured group psychotherapy in adults with attention deficit hyperactivity disorder: results of an open multicentre study. The Journal of Nervous and Mental Disease 2007; 195(12):1013–1019.
2. Safren SA, Otto MW, Sprich S et al. Cognitive-behavioral therapy for ADHD in medication-treated adults with continued symptoms. Behaviour Research and Therapy 2005; 43(7): 831–842.
3. Ramos-Quiroga JA. Psychological treatment of attention deficit hyperactivity disorder in adults: a systematic review. Actas Españolas de Psiquiatría 2012; 40(3): 147–54.

# Developments at *CPR* journal

*Counselling & Psychotherapy Research* (*CPR*) journal changed publisher earlier this year and the editorial team are now beginning to work with its new publisher, Wiley, to enhance the experience of reading research.

You'll find content to support your reading of the journal on our website at www.cprjournal.com. Digests are accessible summaries of the papers published in the journal. The Digest content is now searchable. Practitioner Notes – also searchable – are written by the researcher and highlight how you can use their research in your day-to-day practice. We are looking at developing video abstracts where our authors introduce an accessible account of their paper, and an online book club. We're also beginning to develop a *CPR* App.

Our Twitter feed @cprjournal is a good way to keep in touch with us. In February we ran an #asktheeditor Twitter event and explored issues like getting a paper published, our peer review process, and how to select the right journal for your paper. The content is now available, via Storify, on our Twitter feed and will be soon on www.cprjournal.com.

We are currently developing a survey of members to find out how you access research, how you use research in your practice, how you read *CPR*, and what new innovations you would like to see us develop. But you don't have to wait for the survey to get in touch. We can be contacted about anything to do with the journal at cpreditorialoffice@bacp.co.uk

# Professional conduct

## BACP Professional Conduct Hearing

**Findings, decision and sanction**
**Carol Gordon**
**Reference No: 519410**
**Surrey, CR0**

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 on the grounds of the provision of inadequate professional services and incompetence.

The Panel found no 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

## BACP Professional Conduct Hearing

**Findings, decision and sanction**
**Valerie Collins**
**Reference No: 574652**
**Derbyshire, DE56**

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 on the grounds of incompetence and the provision of inadequate professional services in that the service for which Ms Collins provided fell below the standard 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

## BACP Professional Conduct Hearing

**Findings, decision and sanction**
**Joseph Cullen**
**Reference No: 525916**
**Newcastle Upon Tyne, NE15**

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 that the service for which Mr Cullen was responsible fell below the standards that would reasonably be expected of a practitioner exercising reasonable skill. The Panel found that Mr Cullen was incompetent, reckless and provided inadequate professional services.

The Panel found no 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

## BACP Professional Conduct Hearing

**Findings, decision and sanction**
**Jan Bardua**
**Reference No: 678116**
**Essex, SS0**

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 that the service for which Mr Bardua was responsible fell below the standards that would reasonably be expected of a practitioner exercising reasonable skill. The Panel found that Mr Bardua was incompetent, reckless and provided inadequate professional services.

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

## BACP Professional Conduct Appeal Hearing

**Findings, decision and sanction**
**Susan Campbell**
**Reference No: 541500**
**Sheffield, S8**

The complaint against the above individual member/registrant was taken to Adjudication in line with the Professional Conduct Procedure. The decision of the professional conduct panel was appealed and subsequently considered at an Appeal Hearing. The alleged breaches of the BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy* were considered and a number of findings were made.

The Appeal Panel was unanimous in its decision that these findings amounted to Professional Malpractice in that the services that Ms Campbell provided fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill. In particular, the Panel found that Ms Campbell was incompetent and had provided inadequate professional services.

The Appeal Panel upheld the appeal in so far as it considered that the findings were not of sufficient severity that Ms Campbell was reckless, as defined by the *Oxford English Dictionary*.

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