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For counselling and psychotherapy professionals

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www.therapytoday.net

Therapists and social action

Why young people can find it hard to be alone

Co-creating meaning across languages

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

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Contents

Sarah Browne
Editor

Jeffrey Kottler tells the story of how he became burnt out as a therapist. He describes how his clients – mainly affluent professionals – began to sound like they were whining. They had everything anyone could want but still it was not enough. Around this time he went on a trip to the Himalayas and visited a remote mountain village. Helping in the village school, he began to hear rumours about girls who 'disappeared'. He discovered that, because many families could not afford to send all their children to school, often the girls would be sold into sex slavery. He describes the moment of realising that, for 3,000 rupees ($50), he could save a 12-year-old girl from this fate. This was a life-changing moment for him and the beginning of a radically different direction in his career as a therapist.

Kottler is clear throughout his story that his journey is as much about himself as his clients or the people he is trying to help. One of his themes is that, as a therapist in private practice in the US, he felt replaceable, that many other therapists could do what he was doing as well or better. He talks about the frustration of how long it takes for therapy to work, even to make small changes, and by contrast the way he has been able to completely and immediately transform the lives of these Nepalese girls.

There is nothing like immersing yourself in a different culture to highlight what is wrong with your own. As Kottler says of the Nepalese people, 'It is both exhilarating and disturbing to encounter people who have so little and yet appear so content, especially for those of us who have so much and always hunger for more.' Although, of course, you don't need to go to a remote mountain village in Nepal to find difference – just spending time with people who live in your community but whose lives are very different from your own can have a similar effect.

Features

Cover illustration by Jamel Akib

Regulars

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Clare Pointon explores how victims of torture are finding healing through working in the Medical Foundation's Garden Project; Jamel Akib discusses illustrating our May issue; plus the latest news, reviews and noticeboard.

‘Sandwich’ carers stressed

So-called sandwich carers – people in their late middle age who are caring for elderly parents while they still have adolescent children living at home – are suffering from high levels of stress, a survey by insurer Aviva suggests.

An estimated one in five 45–60 year olds in the UK are caught in the sandwich carer squeeze, according to the charity Carers UK.

Aviva surveyed 2,000 UK adults for its annual *Aviva Health Check UK Report*. It found that 45 per cent of 45–54 year olds are unhappy with their lives, compared with 39 per cent of 55–64 year olds and only 27 per cent of people aged 65+. A third (33 per cent) of this age group said they didn’t feel their lives were worthwhile, compared with a UK average of 24 per cent. Stress levels were also highest among the 45–54 year olds: 40 per cent reported being stressed in the past year, compared with a UK average of 34 per cent. A quarter (23 per cent) had depression, 24 per cent had anxiety and 27 per cent said they suffered from insomnia (the UK average is 20 per cent). They were also less likely to feel positive about the future than those aged 55-64.

Work pressures were the main cause of stress for 46 per cent of 45-54 year olds, followed by money worries at 23 per cent. Of those with depression, 39 per cent were worried about money, 30 per cent had relationship difficulties and 23 per cent blamed family pressures. But, worryingly, few people in this age group would seek help. Some 71 per cent of 45–54 year olds said they would be unlikely to tell anyone about their problems, second only to 55–64 year olds at 75 per cent.
www.aviva

Antidepressant prescriptions continue to rise

GP prescriptions for antidepressants have risen yet again in England, to just over 53.3 million in 2012/13, according to the latest *Prescription Cost Analysis* report from the Health and Social Care Information Centre (HSCIC). The total cost of these prescriptions to the NHS was £282.1 million.

In 2012 the total number of prescriptions for antidepressants was just over 50.1 million. In 2008, it was 35.9 million. The most frequent prescription was for citalopram hydrobromide, prescribed for depression and panic disorder (13.7 million), followed by the tricylic antidepressant amitriptyline (11 million) and the SSRIs sertraline (6.3 million) and fluoxetine (six million).

Last year the Organisation for Economic Co-operation and Development (OECD) warned that prescriptions for antidepressants had outstripped the numbers of people being diagnosed. In its 2013 *Health at a Glance* report it warned: ‘These extensions have raised concerns about appropriateness.’

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Commenting in the *Daily Telegraph* on the latest figures, consultant psychiatrist Joanna Moncrieff said: ‘In my clinical experience, many people just carry on taking their antidepressant because they are too fearful to stop, and research in general practice confirms that people are taking these drugs for longer and longer periods... By encouraging people to view their difficulties as a disease, which is outside their control, antidepressants may make people less confident to manage their problems in the long-run.’
www.hscic.gov.uk

Bullying may have life-long effects

One in 10 young victims of bullying has attempted to take their own life, and 30 per cent have self-harmed or thought about suicide, the anti-bullying campaign Ditch the Label’s annual survey for 2013 has found. The survey also found that the experience of being bullied can cast a shadow over a child’s future hopes and prospects.

Ditch the Label surveyed 3,600 young people aged 13–22 from more than 30 schools and colleges in the UK. In total 69 per cent said they were bullied before their 18th birthday. Girls were more likely to be bullied (61.9 per cent) than boys (35.2 per cent), and 2.2 per cent of victims were transgender.

The survey revealed a clear impact on school work. Over half (56 per cent) of bullied students said that the bullying was having a negative impact on their studies. Bullied young people were less likely to achieve A* and A grades than those who had never been bullied (30 per cent, compared with 41 per cent). More than three quarters (83 per cent) said that being bullied had affected their self-esteem.

Ditch the Label says the effects of bullying ‘can extend beyond the school gates and impact throughout adult life’ and there is now ‘an urgent need for action’.

‘That 69 per cent of students experience bullying during their first 18 years of life is not acceptable,’ said Managing Director Liam Hackett.
www.ditchthelabel.org

Employee mental health fears

UK employers are increasingly worried about the risks of stress and mental ill health to their workers, a new survey shows.

In a survey of 500 UK businesses and 1,000 employees by Group Risk Development (GRiD), the trade body for the group risk industry, more than a third (36 per cent) said that stress and mental ill health were their main concern in relation to staff heath and wellbeing – five per cent more than in the same survey last year. One in four said that employees' work/life balance was their top priority.

The survey also showed the toll of mental ill health on businesses. Nearly half (45 per cent) the employers reported that stress and mental ill health were a major cause of long-term absence among employees and 25 per cent said they were a major cause of short-term sick leave.

Katharine Moxham, spokesperson for GRiD, said: 'Where once stress and mental ill health were commonly overlooked as a key health risk for businesses compared to acute medical conditions such as heart attack or cancer, employers appear to be taking note.'

According to the Chartered Institute of Personnel and Development, 42 per cent of UK organisations saw an increase in stress-related sick leave last year. The Centre for Mental Health has calculated that UK businesses lose some £26 billion a year due to employee mental ill health. Nearly half (47 per cent) of UK businesses offer their staff an Employment Assistance Programme. BACP says there is strong evidence from research that counselling can reduce sickness absence by up to 60 per cent.
www.grouprisk.org.uk

More men seek counselling

Men are more willing to seek help from a counsellor than they were five years ago, a snapshot survey of BACP's 40,000 members suggests.

BACP asked 250 counsellors and psychotherapists if they were seeing more men than previously, and 62 per cent said yes. Nearly three quarters (72 per cent) also agreed that men were 'more likely to see a counsellor or psychotherapist now than five years ago'.

According to IAPT data for 2013, of the 762,000 people referred to counselling with anxiety or depression, 38 per cent were men.

Young fathers and depression

Young fathers are at increased risk of depression in the early years of parenthood, a study published in *Pediatrics* journal has found.

The study used data on 10,623 young men aged 24–32, a third of whom were fathers. The depression scores of fathers who lived with their children increased by, on average, 68 per cent following the child's birth and through the first five years of fatherhood. Those who did not live with their children, had higher depression scores before fatherhood but these decreased during early fatherhood.

The researchers say the findings matter because depression in fathers affects children's development and behaviours. Depressed fathers should be encouraged to get help, they say.

Arts and sports make us happy

Dancing and swimming are worth over £1,500 a year in the happiness they give us, research funded by the Department for Culture, Media and Sport suggests.

It has calculated that an uplift in household income of £5,000 a year boosts social wellbeing by one index point. Using this formula they were able to value dancing at £1,671 a year, regular swimming at £1,630 a year, visiting libraries at £1,359, team sports at £1,127, arts and crafts at £1,020, going to the theatre at £999, individual sports at £828, and going to a concert at £742.

However, going to the gym and performing music equated to a loss of £1,318 and £1,248 per year respectively.
www.gov.uk/government/publications/quantifying-the-social-impacts-of-sport-and-culture

TT.net wins accolade

TherapyToday.net has won the 2014 Membership Magazine Website award from MemCom, the national association for membership marketing professionals.

The judging panel praised the 32 per cent increase in unique visitors over the year and the free Noticeboard listings for BACP members.

Last year TherapyToday.net won the 2013 Online Media Award for 'best health/education news site' and was nominated for the 'best specialist site for journalism'. *Therapy Today* Editor Sarah Browne said: 'The team works so hard to try to provide a useful resource for members and this inspires us to try even harder.'

Therapy Today.net

Visit www.therapytoday.net to read our weekly news bulletin.

The human need for connection

Jeanine Connor

We don't get a second chance to make a first impression. This paradigm runs through my mind as I write my first 'In practice' column.

We learn a lot from first impressions of new clients. Take 15-year-old Henry, who had been described by his school and parents as unteachable, unreachable and uncommunicative. Henry's father 'forgot' to bring him to our first session and I sat in my therapy room thinking about him in his absence. When I did eventually meet Henry I was able to state honestly that I had held him in mind.

Unsurprisingly, Henry struggled to comprehend this or to communicate his feelings about it. Nevertheless, he attended 10 therapy sessions, where he was able to experience what it is like to be in the presence of an attentive other, and something shifted. He began spending time with his family instead of in his room. He invited a friend home for the first time in eight years. His academic performance improved dramatically. I was informed that therapy had done its magic! I think the 'magic' encompassed what Winnicott termed 'maternal preoccupation',[1] which *can* feel quite magical.

Therapy fulfils a human need for connectedness. It does other things too but the relationship is fundamental and evidence supports this. By connectedness I mean actual, in-the-moment connectedness. It feels nice to be with someone who wants to be with you. When we are, we often face each other, attuned to each other's facial expressions and micro-communications. We listen and we hear what is said and what is implied. We recall other shared conversations and experiences. We laugh, we cry. We experience things together, and we hope we will do it again.

> 'Therapy offers the possibility of a real, live person who is totally preoccupied with just you'

Well, sometimes it's like that. Sometimes I meet people and within moments their eyes glaze over as if they're not really present, not connected with me at all. I perceive a twitching in their hyperactive fingers. Within minutes they are checking their phone to see if anyone has texted or tweeted or updated their status. 'What about *my* status? What about what *I'm* doing? Right *here*, right *now*!' I want to yell as I metaphorically wave my arms in their vacant faces. I don't want to jump up and down to gain their attention; why should I? But I have a need to be attended to, to reassure myself that I am cared about. That's what Henry and all our other clients need too – to feel attended to and connected and cared about.

I witness a miserable lack of connectedness happening to all kinds of people in all kinds of places. Doctors review patients by staring at computer screens, avoiding eye contact with the person in the room. Highly skilled and highly paid professionals tap on smartphones secreted under their notebooks. Counselling sessions are interrupted by the all-too-familiar 'ping' that tells the client (or in some cases the counsellor) that someone, somewhere else, has just uploaded a picture of their dinner. People like Henry experience this too. It's the antithesis of maternal preoccupation, the epitome of un-connectedness, and it's depressing.

In my first column for *CCYP* journal two years ago I quoted from TS Eliot's 'Little Gidding': '... the end is where we start from.' Here I am again borrowing from literature – the opening of Ruth Ozeki's novel *A Tale for the Time Being*: 'A time being is someone who lives in time, and that means you, and me, and every one of us who is, or was, or ever will be.'

Therapy offers the possibility of a real, live person who is totally preoccupied with just you. Little wonder that some clients, adolescents in particular, find this baffling, especially if their earliest experience of being mothered was less than good enough. It is the norm for most of my young clients to have hundreds of online 'connections' but the idea of being connected with someone whose primary concern is them, for almost an hour, can feel alien. But it can also feel exquisite. That sense of feeling connected, once they are attuned to it, can indeed be magical. ■

Jeanine Connor MBACP works as a child and adolescent psychodynamic psychotherapist in private practice and in specialist tier 3 CAMHS and is a writer. Events, organisations and individuals cited here are anonymised and unidentifiable.Visit www.seapsychotherapy.co.uk

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The end of the rainbow

Rachel Kelly

Looking back, I'm astonished that it took me two major breakdowns, one in 1997 and the second in 2004, before I began having therapy. Even though, during the second episode, I was bed-ridden for nearly a year, I was prejudiced against seeing a therapist. I thought therapy was for losers. My family motto was 'Keep calm and carry on'; don't make a fuss and don't talk about your problems. Deep down, I was also frightened of what therapy might reveal. It was easier to trust my psychiatrist and his antidepressants and sleeping pills.

But something changed after my second major depressive episode. I knew I needed to keep working at recovery. A history of depression makes you more likely to relapse. Subsequent episodes tend to be worse and more difficult to recover from. I needed to try to pre-empt depression and minimise the risk of its recurrence.

In the end it was my psychiatrist who persuaded me. A person, unlike a pill, can listen to your story when you are well enough to tell it, and give you a fresh perspective, he said. There was a limit to what he and his prescriptions could do.

But, even after accepting the need for therapy, I still thought I could bypass a therapeutic relationship. I first tried to teach myself cognitive behavioural therapy from a book. Though I made tentative steps in being able to rethink difficult situations, I remained highly anxious and dipped in and out of depression.

I thought perhaps learning more about psychotherapy would help so I signed up to the Foundation Course at Regent's College. Studying therapy was safer than having it myself. Then I realised that undergoing therapy was one of the requirements of the course. I had no choice.

My tutors were persuasive about the importance of working with a therapist. We gain our sense of self from our interaction with others. Therapy is about a relationship between two people, in a room and, importantly for me, in the moment. This has become a key to my recovery: learning to stop regretting the past and worrying about the future; enjoy the present moment.

It took me three tries to find the right therapist. My first therapist was sympathetic and helpful, but she lived more than an hour away and, with five small children, I couldn't find the time to commit to seeing her. With my second, more local therapist, I was doing all the talking. This can be a good approach for some but I needed more interaction and for my therapist to actively try to help me with strategies and approaches to reverse my negative thinking.

Therapist number three was recommended by a friend with similar symptoms and behaviour to mine. Sarah worked by helping me identify my feelings, root them out, classify them and investigate how they had solidified into beliefs. By acknowledging my feelings, especially those of anger, I came to accept them, and became less judgmental of myself and others in the process. Under Sarah's supervision I would write letters to my different selves and plot maps of how I moved between them and the rules of behaviour I had created around them, many from long ago when I was an anxious child. I no longer needed to behave like that.

> 'Poems pinned me in time. They also worked outside of time, connecting me to another person who felt the same as me'

Sarah worked with my own love of words. One of my chief consolations during my depressive episodes, along with the love of my family, was poetry. When I was well enough to concentrate, short, accessible poems pinned me in time. They also worked outside of time, connecting me to another person, sometimes centuries old, who felt the same as me. Sarah encouraged me to use poems, and added breathing as another way to stay in the moment and reduce my anxiety.

She was both guide and instructor. Her aim was to encourage me to rely on myself, to trust my own feelings and ulitmately become my own guide.

Sarah and I ended our therapy last year, after two years. Since then, I feel I have my Black Dog on tight leash. Therapy taught me to be easier on myself, and to find a more compassionate voice. I only wish I hadn't had to endure two breakdowns and too many wasted years before realising what an immensely powerful tool it can be in the battle against depression. ■

Rachel Kelly's memoir, Black Rainbow: how words healed me – my journey through depression, *is published by Hodder & Stoughton. Its app, Black Rainbow, is available to download from the Apple app store. www.black-rainbow.co.uk*

In the supervisor's chair

Inner and outer worlds

Rosie Dansey

I wonder how many of my clients understand how important supervision is to my own personal and professional development. I inform them about it but cannot remember any client ever questioning it or asking for further information.

As a profession too, I don't think we question enough the use of supervision and what does and doesn't get taken to supervision.

I can control what I take to supervision but I cannot control what happens in supervision. Underlying feelings will emerge through exploration with my supervisor, some taking me by surprise and maybe her too, but I believe this is because our relationship has evolved into one of mutual trust. If a therapist does not have a healthy relationship with their supervisor or both of them are avoiding what is really happening in the relationship, if there are issues of transference or avoidance, this must surely have an effect on client work.

If supervision is too client-focused then the impact of the organisation on the work of a therapist will not reach the supervisor, or the supervisee may think it is not allowed in supervision. An agreement to focus on the wellbeing of the therapist will allow for discussion of any organisational issues affecting them, such as the wider ethos of the organisation or internal relationships with colleagues and managers.

In a previous full-time employment, my supervisor shared my concern about the number of clients I was expected to see each day. I was working 'back to back' with clients, with no opportunity for reflection or time even to write notes. The manager's response was that it was unlikely all the booked clients would turn up, but in reality most of them did. Despite my pointing to BACP's guidance on workloads,[1] I felt powerless to change matters and my experience may be quite common.

> 'An agreement to focus on the wellbeing of the therapist will allow for discussion of any organisational issues affecting them'

With a full syllabus, organisational issues are often not attended to in therapist and supervision training. Freeth refers to this in her recent column on bullying in the workplace:[2] 'How I wish someone had told me at the outset of my psychiatric training that one of the most useful things I could learn would be how to handle criticism and disagreement.' I hope that the 'safe spaces' she found to share her experience included supervision. An anonymous letter in response[3] to Freeth's article refers to 'the lack of camaraderie behind the scenes, back at the office', which was 'eye-opening in its negativity and bullying'.

Yes, bullying and harassment in counselling organisations featured in last month's *Therapy Today*[4] despite the BACP *Ethical Framework*'s focus on respect between professionals. This lack of respect can be from managers or colleagues in the team. I have observed that some newly qualified therapists naively expect a counselling work place to be different to other work environments but the same pressures of time and finance often make for little difference.

Hawkins and Shohet's[5] seven-eyed supervision model incorporates the outer, organisational and professional environments and is so relevant to these issues. Our work is much wider than the therapist/client focus. A therapist may be trained to work in a certain way but the employing organisation or EAP (Employee Assistance Programme) contracting the work may specify a different approach, and this potential conflict is relevant to supervision. An organisation may be focusing on efficiency to the detriment of client wellbeing and a therapist's values are being challenged by having to work to seemingly impossible targets. A therapist could be the scapegoat in a team, and it is possibly a sick team. The organisation may be struggling financially and this will impact on the therapists working for it. I believe all these incidents are relevant to supervision. An external supervisor can support and help empower a therapist through challenging times.

It is more difficult if the organisation has employed an internal supervisor, who may find that their integrity is being challenged. There is also the dilemma of management supervision. Supervising in organisations can be a very lonely position and fortunately supervisors have the opportunity for consultative support with their own supervisor.

If you have any thoughts on these matters, your responses are welcome to rosiedansey@hotmail.com. ■

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Drop-outs aren't just a statistic

Barry McInnes

A recent post on client 'no-shows' on the BACP Workplace LinkedIn forum had some suggestions for reducing the numbers of clients not attending appointments. These included using SMS and email confirmations and reminders, requiring prepayment for sessions, and identifying 'repeat offenders'. While these may have some effect, I couldn't help feeling that there was a missing element – namely, making the effort to try to understand the client's point of view.

Having spent the best part of two decades looking at service performance data as service manager and consultant, I've ceased to be surprised by the high levels of drop-out that many services experience. But I remain disappointed at the matter of fact way in which drop-out is often treated, as if it were an unfortunate and unavoidable fact of service life. I know because I've done it myself. The client who disengages gets turned into a number, and drop-out is discussed in terms of statistics: 'Our service rate of unplanned endings is 31 per cent.' All of a sudden we've lost the client.

Drop-out wastes precious counselling resources, creates administrative burden, deprives clients of a service, and may well contribute to a decline in therapist morale, especially if not addressed.

The proportion of clients who terminate prematurely varies significantly across services. Wierzbicki[1] reported a mean rate of premature termination of 46.8 per cent across a range of treatment modalities. Analysis of CORE data collected routinely by 35 primary care counselling services[2] reveals an estimated unplanned endings rate of 52 per cent, with an astonishing range of between 26 and 90 per cent. A literature review by Barrett et al[3] from 2008 finds rather depressingly that: 'Remarkably, clients continue to disengage from mental health services at a rate comparable to that found more than 50 years ago...'

I suggest that there are four things that we can do. The first is to stop seeing client attrition as in any way inevitable. This is an attitude thing – the only acceptable rate of client drop-out is zero per cent. Second, we need to start seeing each and every premature termination as an opportunity to reflect on the experience of that client, and to ask some honest questions of ourselves about what we could have done that would have engaged that client and kept them engaged.

Third, rather than closing the stable door after the horse has bolted, we can be much more systematic about gathering feedback from our clients during therapy – about how they, and we, are doing. In a searingly honest blog post, Tony Rousmaniere provides an account of how he went about this and what he learned from the process.[4] He recalls one client who told him: 'You understand me 30 per cent of the time.' This type of feedback is difficult to hear, but can we afford to assume that it applies only to other therapists and not to ourselves?

> 'Stop seeing client attrition as in any way inevitable. This is an attitude thing – the only acceptable rate of client drop-out is zero per cent'

There are also many other system and process level responses we might make. Many are summarised in a meta-analysis from 2012[5] of randomised controlled trial interventions designed to increase therapy attendance. The effect size of each of the interventions tested is helpfully listed.

One that caught my eye was the study by Swift,[6] which highlights that clients routinely under-estimate the number of sessions that they are likely to require in order to benefit from therapy, and that they often do not attend more sessions than they originally expected. In this study, 63 adult clients were randomised into a control group (n=32) and an education group (n=31). The education group received information about the effectiveness of therapy based on the dose-effect model – that the chances of recovery are greater the more sessions one attends, and that it generally takes between 13 and 18 sessions for 50 per cent of people to recover.

On average, the education group estimated that they were likely to require 15.16 sessions, against the control group's estimate of 6.43, and they were more than three and a half times as likely to complete therapy.

We can influence drop-out, and it's time to start seeing every client who drops out as a missed opportunity for them, and a learning opportunity for us. Let's put ourselves in the client's seat and, where we can, prevent drop-out before it happens and, where it's too late, ask ourselves what might have made the difference. ■

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Learning to be together alone

Learning to be alone is part of growing up. *Nick Luxmoore* reflects on his role as counsellor in guiding young people through this important stage on the journey to adulthood

The theory is relatively straightforward. A baby with an attuned, attentive parent gradually internalises the presence of that parent, no longer needing them to be physically present to know that she's never forgotten and, in that sense, never alone.[1] With enough of this experience, the baby is likely to grow up comfortable in her own company.

But without enough of the experience, without ever being able to take the attention of other people for granted, a baby/child/young person will grow up feeling non-existent, terrified of being alone, clinging to other people, shouting for attention and, where necessary, seeking out confrontation as a desperate way to have any kind of relationship.

The fear of aloneness is a constant sub-text in the behaviour of young people. It's a fear that affects the quality of their relationships because it can make being apart from other people – even temporarily – feel impossible. Whether the aloneness is physical or psychological, young people's anxieties about it seep into everything: unconscious reminders of what they've experienced and don't want to experience again, of an original baby experience when they felt helpless, disconnected from the world, unable to attract anyone's attention, ignored by those around them. Young people dread the prospect of living through anything like that again. They come to counselling expecting to learn how to have happier, loving, more fulfilling relationships. They don't come to learn how to get better at being alone. And yet the quality of their relationships will always be informed by this ability to be alone.

Jake's dropped his sandwich in the school corridor, where it lies messily. I ask him to pick it up. He looks at me fiercely: 'Why should I?' 'Because it's going to get trodden on.' 'So? I don't care,' he says, 'I don't want it!'

No doubt he worries that being seen by his friends to scoop up a soggy sandwich from the floor will be vaguely humiliating but there's a part of him that simply won't take responsibility for this most mundane of incidents. To pick up the sandwich would be a brief but solitary experience. He'd rather get into trouble, which will give him a prolonged social experience involving arguments with me and possibly with other members of staff.

It's a tiny incident and, of course, there's a lot more to know about Jake's relationship with authority figures. But young people feel alone in all sorts of daily situations and often struggle to deal with the experience. They range from the mundane – getting up in the morning ('Do I have to?'), to doing your homework ('Do I have to?') – to the more dramatic – going to a party can provoke huge anxieties of aloneness: 'When I get there, will anyone talk to me? Can I rely on my friends to be there?' These are situations where, however supportive the people around you may be, no one can do it for you: you're on your own, obliged to take responsibility for your own life.

Sensing how much this disturbs young people, parents sometimes use aloneness as a threat and punishment – isolating or sending young people to their rooms, taking away their phones. (Schools and prisons have always used aloneness as a threat.) As a result, there are some young people who grow up to be compliant, desperate to please, doing anything to avoid aloneness being imposed on them. At the other end of the spectrum, there are young people who are never left alone by anxious parents and, as a result, never get the chance to practise being alone. And there are other young people who grow up with aloneness as their *modus vivendi*, avoiding eye contact, staying on the margins, keeping quiet. No one has ever taken any notice of them; they become so accustomed to being alone that the thought of company is terrifying. For them, relationships involving trust and intimacy are threatening rather than comforting or reassuring.

Merger and separation

From the moment we're born, we're negotiating a pathway between merger and separation. Initially, that negotiation is with a mother or parent figure: we want to be close to her, to be intimate and trusting, but at the same time we want to be independent, in need of no one, autonomous, solitary, proud. Gradually, we start learning where she ends and we begin and, in so doing, we start making sense of the world, making meaning. Ogden writes that '... meaning requires difference, a dynamic relationship between an idea and that which it is not'.[2] We learn that our mother has her own identity, that she's no longer an extension of us, that she's a person with a will of her own and not just an experience. We can affect her but can't control her. Phillips writes about the developmental importance of frustration: a child who is never frustrated never learns the limits of what can and can't be controlled.[3]

Caught up in all this, young people scorn the extremes of merger and separation: the shy boy still wholly dependent on his mummy and the loner incapable of relationships. Most young

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‘So how do counsellors and psychotherapists help young people get better at being alone? How do they help them learn where one person ends and another begins?’

people give their parents mixed messages: ‘I want you with me!’ and ‘I don’t want you with me!’ They’re practising, discovering how much separation, how much aloneness they can tolerate.

So how do counsellors and psychotherapists help young people get better at being alone? How do they help them learn where one person ends and another begins? How do they help them learn to be intimate and trusting while remaining independent and able to take personal responsibility?

Seventeen-year-old Annie sits with me and howls, tears all over her face. ‘*Why*?’ she wails. ‘*Why*?’ Normally articulate, her 17-year-old words have been replaced by noises of bewilderment, fear, frustration: ‘*Why*?’

She’s asking why people behave towards her as they do. I could say, ‘Because that’s what they’re like, Annie. Sometimes they don’t understand. Sometimes they don’t think. They don’t realise that what they’re saying affects other people.’ I could say all this but, right now, it would be pointless. She wouldn’t hear. So I say nothing. I sit with her and wait. In effect, she’s reminding herself of what she always knew: that there’s nothing to be done, that this is how the world is, that we might have other people with us – in this case, a counsellor – which might feel fine but never takes away the brute fact that we’re on our own, in relationships with lots of people while also being alone.

At the moment, it seems as if this normally articulate 17-year-old person has become a 17-day-old, 17-month-old infant, unable to speak, terrified of the world and wanting to be scooped up in a parent’s arms and comforted. Other 17 year olds might regress into complete silence or might, as a grandiose defence against aloneness, start hurling things around. Annie simply howls. I could scoop her up with comforting words but I judge that, for now, she can bear this panic with me alongside, implicitly supportive but in the background: part of her life but never able to change it.

Being with young people in counselling is like being a parent with a baby, constantly judging when to intervene and when to let the baby discover things for himself. Newborn babies need a parent to intervene most of the time, taking charge, making all the practical decisions. But there are also times when the parent simply sits with the newborn, reflecting back his sounds and facial expressions, extending them and adding new ones. There are times when the parent judges that the baby can be left for a minute to gaze at the ceiling, while they go to make a cup of coffee. Leave the baby for too long and she’ll panic; never leave the baby and she’ll only ever recognise the face and voice of the parent. The aim is to hold the baby securely in a relationship while also giving her opportunities to explore for herself. Parents never stop making judgments about when and how much is enough: how much relationship and how much aloneness a baby can tolerate.

Aloneness-togetherness

Hobson writes about ‘aloneness-togetherness’ where, in a therapeutic relationship, ‘there is an apprehension of distinction and of mutuality, of autonomy and of reciprocity, of identity and of sharing’.[4]

Young people bring to counselling an experience of ‘aloneness-togetherness’ in their lives so far. At the extremes, some will come expecting to get nothing whatsoever back from a counsellor and others will expect the counsellor to do all the work. Annie brings to counselling a perfectly adequate experience of aloneness-togetherness, which will have been developing from the beginning of her life. She can listen and she can talk; she can initiate and she can allow me to initiate. It’s just that, from time to time, when life gets tough, she panics, and when she panics she regresses, temporarily like a baby.

‘*Why*?’ she asks, glaring. ‘*Why* can’t they understand? Surely they know what it’s like when people say things about you that aren’t true? Surely they’ve been through that themselves? So *why*?’

As a 17 year old, she knows perfectly well that people can be cruel as well as kind. But as a 17-day-old baby or 17-month-old child, she can’t answer her question. Appealing to a 17-day-old baby’s rational mind (‘Well, it’s because people can be cruel as well as kind, Annie…’) would indeed be pointless. However, she’s starting to re-discover her words. It’s as if she’s growing up again, leaving behind her howling, panic-stricken baby-state. ‘I suppose there’s no answer,’ she volunteers. ‘People are just bastards!’

‘It’s tough,’ I say. ‘Tough when people behave badly.’

The context is important. In a few weeks’ time, Annie will be taking exams, and after that our sessions will finish because she’ll be leaving school. For her, the prospect of aloneness is everywhere, from going into the exam hall on her own, her academic life in her hands, to leaving school and (as she says) the ‘whole weirdness’ of that. For most young people, leaving school throws up old anxieties about leaving mother figures.[5] In the weeks and months before leaving, they regress: they feel like giving up; they fall out with their friends; they panic. So it’s not surprising that Annie is re-visiting anxieties about aloneness at this time in her life. It is as if she’s a baby, wondering all over again, ‘Does anyone notice me, hear me? Does anyone understand me, think about me? Am I worth anything to anyone?’

She wipes her face. ‘I know there’s nothing you can do. I know I have to deal with it…’ I ask, ‘What’s it like when you’re alone, Annie?’ ‘Fine, most of the time,’ she says, ‘except when no one’s replying to my texts. Or when they’ve all gone out somewhere and they haven’t invited me.’ ‘What does it feel like?’ ‘Like no one wants to be with me. Like I’m worthless. Like I don’t exist…’ Again she looks panic-stricken. ‘Can we not talk about this?’ I explain that I’m asking because being alone *can* feel horrible

‘For a sophisticated 17 year old, the world has become a whole set of variables: some good, some bad; some understandable and some that make no sense whatsoever, like people dying’

and we tend to think that we’re the only people feeling it. ‘But it’s important to be alone sometimes,’ I say, ‘not because it’s good to have horrible experiences, but because in lots of ways we *are* alone and have to get used to it. In our relationship here, in this room, we’re together but also alone. Sometimes we might feel very together and very connected and at other times we might feel very alone and disconnected. That’s normal. It’s a bit like being connected to another person *and* alone.’

Playing together

Winnicott would describe us as playing together.[6] Like a parent and child, we take turns, sometimes anticipating each other, sometimes frustrating each other. It’s what he calls the ‘potential’ or ‘intermediate’ space wherein the counsellor and client try things out, practising being together and being apart, understanding each other and not understanding each other. If a young person begins a counselling relationship in a baby-state, the counsellor will – like a parent – need to keep control, initiating the conversations and steering them in certain directions in anticipation of the young person’s need. But as the young person grows up within the relationship, the power will increasingly need to be negotiated and shared as the young person learns to bear the ups and downs of the relationship, with all its satisfactions and limitations. In this sense, the young person is learning what it feels like to be alone sometimes (frustrated, relaxed, angry, calm, lost, happy) while still connected. At the end of each session, he or she goes away, physically alone but remembered, as if the counsellor were saying, ‘See you next week! I’ll be thinking of you.’

Sometimes young people regress and grow up again within the space of a single counselling session. In response to my comment about being connected and alone, Annie says that she understands. ‘I worry that I’m not normal, though. I mean, you don’t see other people worrying all the time about stupid things, do you?’ I suggest to her that they might worry in private. ‘I doubt it!’ she says. ‘Other people are just better at dealing with stuff.’ She’s tussling, challenging me as an independent 17 year old. In Winnicott’s terms, we’re playing together as adults: Annie’s no longer my baby and I’m no longer her parent.

I say that I admire her ability to be honest about how scared she feels. ‘You mean, when I come in here and lose the plot?’ ‘No, I mean when you’re being honest about how you feel and about how scary things are.’ ‘They are scary,’ she says. ‘Especially when bad things happen and there’s nothing you can do.’ Her grandmother died of cancer nine months ago. I ask if that’s what she’s referring to. ‘Not just that,’ she says, ‘but everything. All the crap...’

For babies, the world is a mother who does or doesn’t make things safe. But for a sophisticated 17 year old, the world has become a whole set of variables: some good, some bad; some within the young person’s control, some not; some understandable and some that make no sense whatsoever, like people dying. Annie’s also aware of an existential aloneness. ‘...All the crap in the world that doesn’t make sense, that’s pointless...’

I say nothing. She’s quiet, thinking.

Silence can be disturbing at the start of counselling relationships. For those young people with little or no internalised sense of being connected to other people, the threat of non-existence is ever present and the need for another person’s verbal presence is desperate. An ability to tolerate silence in counselling is an ability to tolerate aloneness. When they feel connected, young people can bear silence. When they don’t feel connected, they can’t. My silence with Annie feels comfortable at the moment but all that may change. I break the silence myself sometimes, as evidence that our relationship is fluid, mutual, not bound by rigid rules, that we share responsibility for initiating conversation.

I remind her that we have three more meetings before she leaves school. Still she says nothing, still thinking. Then she starts telling me about an old film she’s seen. A teenage girl and her much younger brother are lost in the Australian desert after their father tries to kill them. They get more and more lost until they meet an Aboriginal boy who’s on ‘walkabout’, forced to survive by himself as part of his initiation into adulthood. He teaches them to survive before eventually leading them back to the city. I ask what made her think of this film.

‘It’s quite scary at first,’ she says, ‘because they’re lost and you think they’re going to die. And the girl’s trying her best but she hasn’t got a clue. And then, at the end of the film, she’s grown up and living in the city with a really boring husband and you can see her thinking about the past and what happened when they were alone in the desert and how she misses it. How it was just her and her brother and the Aboriginal boy and they didn’t really need anyone else. They were fine on their own.’

I ask her if she feels like the girl in the film. She laughs at me. ‘God,’ she says, ‘you’re such a *counsellor* sometimes!’ ■

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Burned out with client work, US therapist *Jeffrey Kottler* describes how a chance trip to Nepal inspired him to apply his skills in a very different way to transform people's lives

Illustration by Jamel Akib

The life you change may be your own

I had been working as a therapist on and off for almost 30 years when the trajectory of my life and work abruptly shifted. I've worked in a variety of mental health settings through the years and spent a fair bit of time training and supervising therapists in various countries, but most of my clinical work has been in private practice, mostly with affluent professionals.

It isn't that I haven't found my work as a therapist satisfying and fulfilling; rather, that I feel replaceable. Many others could do my job with equal (or superior) effectiveness. Sometimes, listening to my privileged clients complain about their troubles, I've found it hard to remain compassionate. During other periods, those complaints began to sound like incessant whining and the critical voice inside my head would scream: 'You've got everything anyone would want in life, and still it is not enough for you!' It took me a while to figure out I was speaking to myself, as much as to my clients.

I stopped practising therapy altogether for a time, concentrating instead on my teaching, research and supervision. I had become burned out and found it difficult to listen to my clients any more. They all began to sound the same. I found it more and more challenging to remain present with them. I became bored not only with them, but also with myself – I was tired of listening to my own stories.

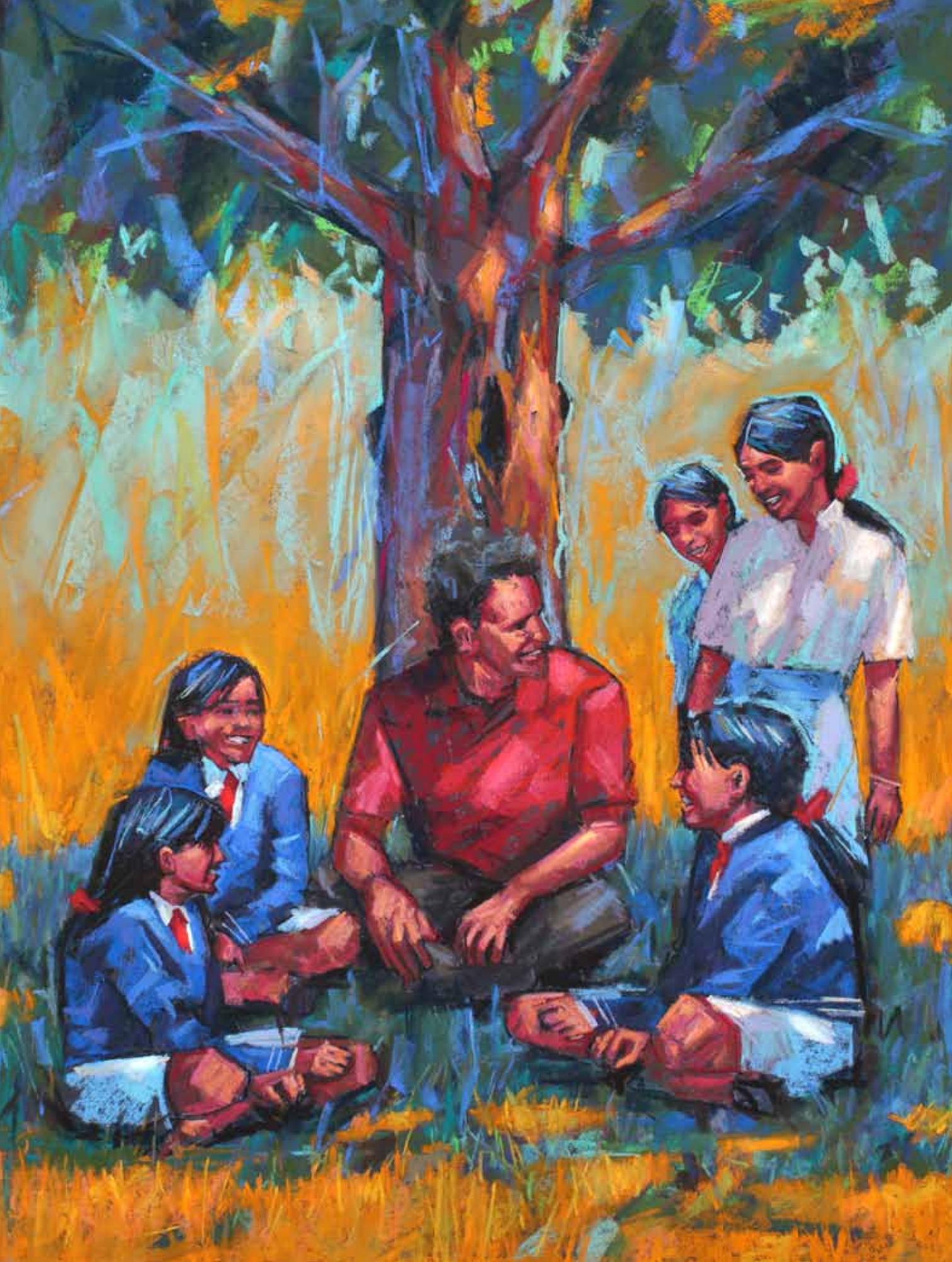
Feeling like a hypocrite, teaching and writing about a profession that I was no longer actively practising, I gradually began selecting new clients very carefully, choosing only to work with those who presented novel or interesting challenges. With a very small practice, I once again found myself energised and intrigued with my work, yet something was still missing.

It had always been one of my life's dreams to travel to Nepal and trek in the Himalayas. I am an avid hiker, climber, cyclist and adventurer who has used travel as stimulation when my work felt stale and repetitive. None of my experiences of therapy as a client, supervision, workshops or books have ever been able to affect me nearly so dramatically as some of my adventures abroad.[1,2] I've spent months working in Australia, New Zealand, Iceland, Peru and on Semester at Sea [a shipboard global study programme], and have always returned a profoundly different person from the one who departed. Yet even these experiences did not prepare me for my first visit to South Asia.

One of my doctoral students, Kiran, was an obstetrician in Nepal who was researching childbirth experiences in remote regions. She wanted to learn qualitative research methodology to investigate why her country's maternal mortality rate is among the highest in the world. Kiran invited me to follow her on her rounds to isolated villages to teach her qualitative interviewing and grounded theory analysis. What a perfect excuse to do some trekking!

The disappeared girls

It was during our visit to a remote village along the Indian border that I first learned about the 'disappeared' girls. While Kiran was examining her patients, as the only doctor who ever visited that district a few times each year, I spent time in the school working with the children and teachers. I kept hearing rumours about certain girls who were 'disappeared', but couldn't quite



get a handle on what that meant. I asked the school principal, who pointed to a girl of about 12 years old talking with some friends: 'Do you see that girl? She will be disappeared next.'

I learned that 'disappeared' meant that this girl was likely not be around much longer because her family was too poor to keep her in school. All families have to pay for their children to attend public school, and when they have many children and limited resources, they often allow the boys to attend school and keep the girls at home. Since they can't afford to feed them all, the girls end up being married off as early as age 12; the unfortunate ones are sold and smuggled across the border, where they end up as sex slaves in brothels.

On further investigation, I learned that each year 12,000 Nepali girls end up stolen, kidnapped, or sold into slavery – some as young as eight years old. This was just about the most horrifying thing I'd ever heard.

Imagine standing on the school grounds, staring at a vibrant young girl with tremendous academic potential who lives in such poverty that she has no future other than as a child sex slave. In addition, some Indian men who frequent the brothels of Mumbai are HIV positive and believe that having sex with a virgin will cure their disease. That is why young virgins are in such demand, especially innocent Nepali girls who have no rights or recourse.

I asked the principal how much it would cost to keep this girl in school for a year. He did the mental calculations in his head. 'Oh, sir, it is very, very expensive. I'd say about 3,000 rupees.' Three thousand rupees? That's 50 dollars! The thought that for $50 I could save a girl's life was irresistible. Without considering the consequences of my action, I reached in my pocket and pulled out some money and put it in the principal's hand. 'This is for her. She stays in school. And I'm coming back next year to make sure that she's OK.'

Walking away from that encounter, it felt like the single most meaningful and important thing I'd ever done in my life. I'd spent the previous decades doing all kinds of things to be helpful to others: volunteering my time to causes, working *pro bono* for clients who couldn't afford my services, and working for universities in which the vast majority of my students were minority and first generation immigrants. Yet it always seemed to me that, if I weren't there, somebody else would be, and could do the job just as well. But in this case, if I didn't intervene, then nobody else would. Forget the books I'd written and the other lives I'd touched – this was what mattered most. I couldn't believe that for $50, for the cost of a good meal, I'd just saved a girl's life.

Educating women

I had no idea when I reached in my pocket and pulled out a bit of money how this would change my life, my commitments, my priorities, my very life path. I went home soon after and resumed my usual duties – teaching students, seeing a few clients, writing more books about therapy – but I frequently found myself thinking about the girl and wondering how she was doing. Since she lived in a place without electricity, without even an address that could receive mail, the only way I could check on her was to return to her village. I immediately made plans to do so, and discussed with Kiran ways we might identify other academically gifted girls who were at greatest risk of being sold.

Kiran's research study was groundbreaking; it revolutionised obstetric care in Southern Nepal.[3] She discovered from her interviews that so many women were dying in childbirth not only because 90 per cent of the country had no access to healthcare whatsoever, but also because, even when it was available, women refused to avail themselves of the services. One reason was that lower-caste women were treated like animals by the male doctors, who humiliated them, touched their private parts and put 'snakes in their arms'. The latter refers to inserting intravenous tubes without explaining what they were for – or, for that matter, without talking to the patients at all. The few women who did go to the hospital for complicated pregnancies returned to their villages and warned their neighbours never to go to that place where they were treated so poorly.

Kiran and I decided to pool our own funds to support more girls in school. For a few hundred dollars each year, we could provide scholarships for a handful of other girls. I began thinking about all the superfluous indulgences on which I fritter away money: $50 for a good meal – that's the cost of a girl's life; $150 for a pair of shoes I don't really need – that's three girls who could be saved; $500 for a new chair – that's 10 girls! It wasn't so much guilt that was motivating me as a new-found understanding of ways I could spend my own money and time.

The next year, I returned to Nepal to check on the girl and distribute scholarships to three other girls in her village. The year after that we expanded to another village, then another, then

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another, each in a different district. Before we knew it, we were supporting dozens of lower-caste girls, all of whom had great potential but few resources. Kiran and I had this audacious vision that we might grow the next generation of women doctors who could save other women at risk.

So far we had funded our project solely from our own pockets; we had no paperwork to keep track of and no bureaucracy. We knew each of our girls personally and could monitor their progress carefully, and make sure that all funds were spent solely to support them. In a region where corruption was so rampant, we wanted to be as careful as possible with how our money was spent.

Friends, colleagues, family members and students learned about what I was doing and asked if they could help. I began to collect donations that made it possible to double, then triple the number of girls we were helping – 20 the next year, then 60, and now well over 300 children in nine villages around the country. It became necessary to register as a charitable organisation in the US, as well as in Nepal. But I was still determined that we would remain solely volunteers. We would have minimal overheads, no office, no paid staff, so that almost all of the donations would go directly to support the girls.

Around this time, someone who had been thinking about making a donation said, 'How do I know what happens to this money? I've never heard of you. How do I know that the money goes where you said it will?' I suppose there is a theme of impulsivity that runs throughout my story, because my immediate response was: 'Why don't you come with us on the next trip and see for yourself? Why don't you meet the girls and their families yourself and see what is happening? That way, you can act as a witness for anyone else who wonders about what is really going on.' That's how the next stage of this project evolved into a kind of reciprocal exchange process, in which our volunteers have been affected almost as much as our girls.

Helping and being helped

As a psychologist, I've long been frustrated by how long it sometimes takes therapy to work, and how the effects are often short-lived. I've long had fantasies of being a travel agent, planning trips for people that would transform them dramatically in a relatively short period of time – with enduring effects. As I mentioned earlier, such travel experiences have been the most powerful change experiences in my own life. I wanted to design experiences for our volunteers that not only maximised their commitment to our cause but also exposed them to the kinds of things that have been so influential in my life.

It is just amazing to spend time with people who, even though they have so little (most don't even have shoes and eat one meal a day), are so spectacularly happy. I don't mean to over-idealise their plight, but so many Nepalese people we meet along the way greet us with '*Namaste*' and the most glorious smiles you can imagine. They have nothing except the clothes on their backs, but their Buddhist/Hindu beliefs guide them to appreciate whatever small gifts life might offer them. It is both exhilarating and disturbing to encounter people who have so little and yet appear so content, especially for those of us who have so much and always hunger for more.

Team members often return from our visits completely disoriented about what they have discovered and determined to put into practice what they have learned from our children. I have long been a fan of the idea that our clients are our best teachers, and so it has been with our scholarship children and their families: they help us as much as we help them.

It has now been 13 years since we began our project. Our very first girl is the first in her village to pursue higher education. She received a full scholarship to attend an elite university, and has been followed by dozens of others. It just amazes me what is possible with such (relatively) little money and effort. Yet if I've made this enterprise sound like an easy, fun adventure, I've left a lot out. What began as a lark, an impulsive gesture, has now taken over my life.

It's easy to launch a service project: it really is as simple as finding somewhere to make a difference. But, alas, the follow-through is the killer. All these lives now hang in the balance of my being able to continue raising money and recruiting volunteers. There are so many other girls who need help, and I sometimes feel so frustrated that I can't do nearly as much as I want.

I face many other problems that are so overwhelming and dispiriting. I've taken more than 100 team members with me over the years, but less than a handful have stuck with the project after they return. Most carry on with their lives, perhaps haunted by what they've seen but not enough to keep them involved. Meanwhile, all those girls who once cost $50 per year to support in school now cost $125; those entering university or medical school cost several

'Most of the girls never dreamed that they could ever do anything other than be a wife and mother... Our volunteers and team members never dreamed it was possible to be so happy and content with life while having so little'

thousand dollars each per year. Where will I find the money to support so many children? How can I recruit more help as we continue to expand?

Then there are the logistical and physical problems with which I must frequently contend. It takes three planes, a bus trip and several days' walk in the Himalayas to get to some of our villages. Last year it took me seven weeks just to visit all our girls, who are spread across the country. In some cases, it took me a week to get to a village and return.

The cultural misunderstandings and political shenanigans I experience are exhausting. After all, we are attempting to change the culture of the country so that girls become more valued and are afforded opportunities that are ordinarily closed to them. I have to rely on my Nepalese partners to implement our strategies, but often a lot is lost in translation. We are constantly battling an entrenched system in which the village elders, all men, resent the fact that we are assisting lower-caste 'untouchable' girls. Why aren't we helping the Brahman boys, the highest caste? Many of them need help too.

Exhilarating and exhausting

The money our organisation provides to support the education of at-risk girls in Nepal is crucial to their survival and welfare, but the relationships we develop with each of the girls and their families are just as important. Most of the girls never dreamed that they could ever do anything other than be a wife and mother until they met professional women from around the world, who showed them what was possible. Most of our volunteers and team members never dreamed it was possible to be so happy and content with life while having so little. We come home from our visits to Nepal determined to devote ourselves to things that matter so much more than mere ambition and achievement – friendships, family, creative pursuits and, yes, service to others.

Although I still do therapy on a small scale, and continue my work as a professor, supervisor and researcher, I now think of my main job as advocating for girls in Nepal. I still find the visits there to be exhilarating, but also exhausting and overwhelming. I make time to go trekking each trip – I'm still in love with the mountains. And one of my favourite things in life is to bring friends and colleagues with me to meet the wonderful children and experience the Himalayas up close.

It has been fascinating to use my skills as a therapist to make a difference on a larger (or at least a different) scale, and I am aware that throwing money at causes is not nearly enough without adequate and ongoing support, outcome evaluation and personal contact. Based on what we know and understand about systemic change, our teams visit the homes of every one of our girls to honour them in front of their families and neighbours. We've been concerned that, once we leave, our financial support alone won't be enough to sustain the children in an environment that is less than encouraging. Our public ceremonies mean that the families would lose too much face if they married off or sold their daughters: even though they are at the bottom of the caste system, being selected as scholars with great potential gives the girls a certain status. Many of the places we visit have never had visitors from abroad before, and our donors and volunteers come from all over the world.

All of this began with just one girl who needed help. It is truly amazing what you can do once you get out into your own community – or to other parts of the world. There is an ancient Jewish saying: by saving one life, you save the world. I truly believe that's also how we save ourselves. ■

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Jeffrey Kottler will be the keynote speaker at the BACP Summit on social justice on 21 November in Manchester. To register your interest, email enquiries@bacp.co.uk

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'We come home from our visits to Nepal determined to devote ourselves to things that matter so much more than mere ambition and achievement – friendships, family, creative pursuits and, yes, service to others'

Talking point
All need not always have prizes

Andy Rogers argues that pay is not the only measure of counsellors' value

There is growing concern about voluntary work in the world of counselling and psychotherapy. The issue has recently provoked debate in the BACP Universities & Colleges division in relation to the use of unpaid 'associate counsellors'[1] and similar concerns have been expressed in *Therapy Today* in the context of working in the NHS.[2]

After my own training and before my first payslip as a counsellor, I volunteered for a few hours a week in the charity sector while holding down a low paid job in retail and living in my mate's spare bedroom. I didn't do the hours 'for nothing'. In fact, I gained a great deal. There was no money, yet it never felt like the counselling was devalued by virtue of it being unpaid. Indeed, it would be a terrible thing if money was the only designator of value.

Other therapists will have had very different experiences. Voluntary work is neither unquestionably good nor intrinsically exploitative or devaluing. It depends, of course, on the specifics of each situation, and these require close scrutiny. What does the experience mean to the participants? What is motivating them? How is the arrangement functioning within the organisation?

We also need to consider the wider context, not least that there is an economic reality to confront. The resources to pay every trained counsellor simply do not exist. Services are being cut, not on a whim but in response to public sector underfunding and the effects of a global recession. This can leave us feeling threatened, undervalued and undermined, even (or perhaps especially) when we're on the payroll. So it can be tempting to look for ways to shore up our professional status. Understandably, we want to feel valued and to protect our positions, and in that context voluntary work might seem an affront. After all, we are 'qualified professionals'!

But the notion of 'qualification' as a fixed line that, once crossed, entitles us to some level of financial reward is problematic because therapy practice is at heart subjective, relational and idiosyncratic. When we refer loved ones to other therapists, it is rarely, if ever, accreditation and training ('qualifications') that we prioritise in our choices – more often our advice is based on personal relationships and trusted recommendations. And, in any case, it might be best to think of therapists as 'in training' beyond graduation and into the first few years of practice, when we learn to be practitioners without the support of a course community. Don't these features of our work call into question the idea of entitlement to a salary at a specific, standardised point of 'qualification'?

Given the uncertain nature of therapeutic work, the increasing number of trained therapists competing for relatively few paid positions and the devastating impact of tough economic conditions, it is hardly surprising that feelings of insecurity and being undervalued are widespread, particularly in the public sector. The debate about voluntary work offers an outlet for such feelings, which can manifest in calls for 'parity with other professions', as if parity will bring salvation. But other professions are also riddled with insecurity, the sense of being undervalued, overwork, status anxiety and dehumanising organisational dynamics. And, as healthcare and teaching warn us, parity with other professions has another potential dark side: a culture of oppressive monitoring and targets, with practice rigidly controlled and a deep incongruence between the values of the system and the therapeutic principles that, for many of us, are crucial to our work.

The issue is not whether we volunteer – although we should think carefully when we do – but how we challenge the real injustices. So yes, let's kick up a stink about a society that does not look after its citizens well enough; let's criticise government spending priorities; let's oppose cuts and promote the value of therapy at the personal, organisational and political levels, but without being blind to its shadows.

I don't think we should be ashamed or compliantly grateful when we're rewarded financially; nor should we idealise volunteering, which can be mutually beneficial but also subject to exploitation. But, as each of us decides whether, and how much, we need to be paid, let's not imagine that demonising voluntary work in the pursuit of standardised pay scales is the therapy our profession needs. ■

Andy Rogers is a counsellor and service co-ordinator in a large college of further and higher education. A version of this article appears with other contributions to this debate in the May issue of University & College Counselling, *the journal of BACP Universities & Colleges. For more details, visit www.bacpuc.org.uk*

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Counselling in many tongues

Beverley Costa explores the creativity of working multilingually, whether or not the client and therapist share the same first language *Illustration by Jamel Akib*

'Every language contains its own naïve picture of the world, including its own ethnopsychology.'[1]

A young man is facing a major dilemma. He wants to pursue his life's dreams and ambitions but to do so he must be away from home for extended periods of time and so neglect his family. Alexia Panayiotou,[2] in a fascinating piece of research, presented bilingual (Greek/English) people with this dilemma, written in both languages, and invited them to write down their responses. When she analysed their answers, she found that their moral beliefs about and the solutions they suggested to the dilemma varied, depending on the language in which they were thinking. After reading the text in one language, the majority of the participants endorsed the young man's desire to follow his dreams. In the other language, the majority were much more concerned about who was going to look after his widowed mother. I will leave the reader to speculate about which languages produced which reactions.

This exercise vividly draws attention to the cultural and moral values carried by language. It has implications for the psychotherapeutic language used by therapists and the cultural and moral values it carries, and also for the spoken language in which therapy is conducted.

This article is concerned with the experiences of multilingual psychotherapy patients/clients. It is based on a longer research paper on multilingual clients' experiences of psychotherapy,[3] which is itself a companion study to an earlier piece of research into the experiences of monolingual and multilingual therapists.[4] Together they indicate the very great significance of multilingualism in the counselling/psychotherapy room.

For this second study, almost 200 multilingual patients/clients completed an anonymous online questionnaire. The questionnaire sought to find out how much importance multilingual clients attach to their therapist's ability to speak more than one language and the role of language switching (using more than one language interchangeably) in therapy. Below are the themes that emerged.

Multiple personas

Eva Hoffman, whose memoir *Lost in Translation* describes a life lived between two languages, refers to the way in which she, a bilingual person, makes sense of her world:[5] 'Because I have learned the relativity of cultural meanings on my skin, I can never take any one set of meanings as final...' Charlotte Burck writes:[6] '... if an individual's other languages are ignored in the relationship altogether, significant aspects of their experience and of themselves might never be brought forth in their relationship.' She is speaking here about people's personal relationships but the same is arguably true of therapeutic relationships: how much of a multilingual person's personality is ignored if they only use one language?

Marian and Kaushanskaya[7] propose that the language we speak influences our perception of ourselves and others, our identities and how we construct the narratives of our lives. Ozanska-Ponikwia[8] has explored the differences in the felt sense of self and ways of expressing emotion experienced by Polish immigrants in English-speaking countries. She concludes that most people feel different when using a second language but some are more aware of it.

Other tongues

What might change when we speak in one language or another, in addition to our moral values? I pride myself on being quite a positive person and yet when I speak Spanish I find myself complaining endlessly about things to which I would pay hardly any attention when speaking in English.

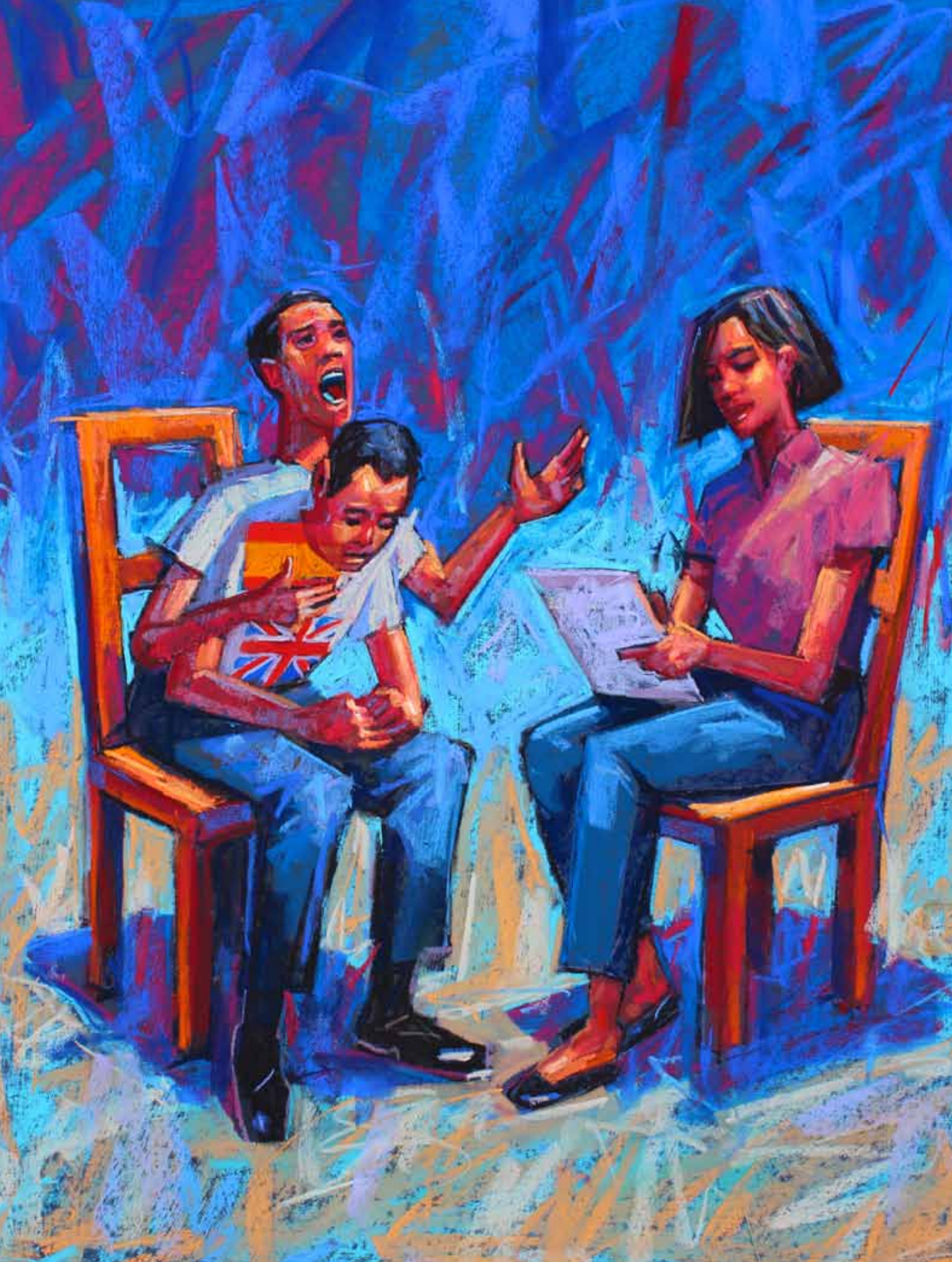
Languages resonate with political history. Rajagopalan[9] describes a Portuguese-speaking, Guarani-heritage Brazilian national who considers himself to be a very honest person – in Guarani. When he uses Portuguese, however, he considers it to be perfectly legitimate to make promises he has no intention of keeping, as he is speaking the language of the oppressive coloniser.

Aneta Pavlenko[10] explains that for her, a Russian-Jewish immigrant to the US, the Russian language is heavily freighted with oppressive memories, whereas English is a language of political and emotional freedom. 'To abandon Russian means to embrace freedom. I can talk and write without hearing echoes of things I should not be saying. I can be me. English is a language that offered me that freedom,' she writes.

What may be resistant to change? Sujata Bhatt, in her poem 'Search for My Tongue',[11] refers to the competing identities of her different languages and the way her mother tongue 'ties the other tongue in knots'. For Bhatt, her mother tongue – which for her represents both language and identity – is irrepressible, despite her attempts to suppress or 'lose' it: 'Every time I think I've forgotten,/I think I've lost the mother tongue,/It blossoms out of my mouth.'

In our own research with multilingual clients,[3] one participant described how they experienced themselves differently in different languages: 'I feel like a huge part of me just doesn't go to therapy with me. I have different personas with each language I speak so only speaking in English in therapy isn't helpful... If I have to translate into English... it just isn't the same for me.'

Clients also talked about having to use a particular phrase or term in their own



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language in order to explain a cultural concept that might have no equivalence in the therapist's language and culture: '... when I worked with a humanistic counsellor I spent time explaining what "*Xiao-Shuen*" [filial piety, or being a good daughter] means and how that affects my decisions,' one explained. The choice of language might also be necessary to capture the nuance of a particular phrase, as this client explained: 'I once used a French phrase, *à voile et à vapeur*, to express someone's sexuality, because there is nothing like it in English.'

Another client commented: 'I suspect that undergoing therapy in a language not your own is like *pisser dans un violon* [talking to the wall]!!' One way of dealing with the '*pisser dans un violon*' effect is to work with an interpreter. (Accounts of working in this way are outside the focus of this article and can be found elsewhere.[12, 13]) This client of an IAPT service, interviewed about her experiences of having therapy with an interpreter, commented (translated from Urdu):[14] 'During therapy, many times you are not in a normal state of mind... if you are speaking in your own language to someone sitting in front of you, then it is much easier in Urdu. Even when you can communicate in English, because it's not your first language, it is a good option to have an interpreter with you.'

It can be beneficial for clients to express themselves in the language that comes most naturally to them, even if the therapist does not understand, as this client in our research reported: '... describing a situation or a sentiment idiomatically in one language provides better approximation to the "real" thing and expresses more subtle nuances... If in one of the languages I speak there is an expression like that, it does come to my lips whether I want it, or not. Then it's up to me to let the lips share it, which I usually do.'

Another client, who was also a therapist, described how speaking in a language even in the presence of someone who did not understand it could of itself be therapeutic: 'It felt liberating and allowing. I have applied this sometimes with clients myself. It doesn't matter whether the therapist understands the actual language spoken: there comes a point where I as a client am invited to hear and listen to myself. This is very helpful, in the presence of another benevolent being.'

Language switching

Some clients expressly felt that language switching was beneficial: 'I think that there are experiences imprinted in the mother tongue (such as songs, poems, sayings, idioms etc or words carrying symbolic meaning) that could be beneficial to be expressed through language switching.'

If one of our aims as therapists is to help people reconcile polarities and to find a point of balance and integration in their lives, then encouraging people who are multilingual to bring all their languages into a session may help accommodate the tensions between differences. As one therapist has commented: 'In some cases, when clients can't find any similar words in English, they may use phrases or words from their language which I may not be able to understand but which allow them to express the emotion."[15]

Participants in our study[3] offered numerous examples of particular expressions for which they felt there was no adequate English equivalent, or described the particular cultural nuances of a phrase they had used in therapy. These included (with translations by the participants):

- (in German) *Gratwanderung* – 'the narrow zone that humans inhabit/ the precariousness of existence'
- (in Portuguese) *Quem me dera?* – 'How I would wish!'
- (in Spanish) *Me siento como un perro mordido* – direct translation 'I feel like a bitten dog'; nearest equivalent in English 'I am not at my best'
- (in Spanish, recalling a word used about her in childhood) *aburridora* – [literally, boring, tedious, wearisome] – 'I still can't find the English equivalent.'

Several commented on the importance of being able to switch languages in couples therapy if the couple did not share a mother tongue: 'It helped to be able to switch languages when talking about things that transpired between me and my ex-boyfriend who was Mexican. It helped to be able to describe some of our transactions using the language (Spanglish) that we interacted in.'

A second or subsequent language can provide a vocabulary to talk about taboo subjects.[16] Dewaele[17] describes how several Arab and Asian participants in his study said they would switch to English when discussing sensitive issues, to escape the social taboo on talking about such matters in their culture. In our research too,[3] participants frequently talked about switching languages to capture a particular essence of meaning or to avoid cultural constraints associated with using their own language: 'I was not carrying as much cultural baggage when I spoke French in therapy. I felt more at ease talking about "taboo subjects" [sex] in therapy in French than in English. I felt I was more distanced from the "controversial subjective" and probably culture- based aspects of sex.'

Alternatively, using a second language may temper the expression of an emotion. As another participant said: 'Swear words in a second language do not have as much strength.' Some clients said they found the ability to switch languages helped them feel safer when talking about very sensitive topics: 'For me

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using English when describing something very delicate or important is like having a safety net or a parachute. If I cannot say it properly in German, I know I shall be able to say it properly in English.'

However others, most notably those who had had psychoanalytic therapy, found language switching only further complicated their struggles to make themself understood: 'There would have been more "misunderstandings" and word (power) games. Actually I felt misunderstood enough in a monolingual setting as it was.'

Emotional proximity and distance

We are likely to experience heightened emotionality in our mother tongue because we generally learn this language very young and within our family context and it co-evolves with our emotional regulation systems. This means it has greater connections with the subcortical brain structures that mediate arousal, including amygdala-mediated learning.[18] Attention is increasingly being paid to the way in which multilingual people use different languages to express or repress emotions.[17, 18, 10] In the words of one of our survey participants:[3] 'When speaking in English my therapist assumed that I suppress emotions and advised me to let myself go... then she changed into Spanish and noticed that I do not suppress emotions at all.'

In our research, clients described how using their first language allowed them to get in touch with early memories, emotions and relationships: '... when I mixed in some words from my [first language], it started to make more sense talking about my childhood. As if English language did not let my memories come back efficiently enough, and I just needed some key words in [my first language] to bring memories back.'

Another commented: 'It [speaking in her mother tongue] was very beneficial for my getting in touch with how I feel and felt in the past about my mother, with whom I only spoke my mother tongue, and so I needed to "speak" with her (in my mind) in that language. I could not begin to really feel what I would "say" to her unless I imagined the words in my native tongue.'

People may experience greater healing from psychic distress if they are able to express themselves in a language that has no associations with their abuse or trauma. A language learned after the early childhood years can provide a protective filter, a psychic defence.[19, 20] If, for example, the trauma happened in a setting where one language was used, the client may be able to talk about their experience more easily and with less emotional intensity in another language, making it more bearable to describe what happened to them.[21] One of our survey participants said: 'I felt more comfortable speaking about traumatic events in my non-native tongue. I feel that in my particular case I was able to let go of pain easier thus.' Another described using a second language for '... speaking about topics which I was ashamed of. It is a way to put facts in the distance'. That said, another client found that she was better able to process the trauma by describing it in the language in which it occurred: 'I remember being given permission/being asked to express a traumatic incident in the language in which it happened. This I found very liberating.'

Conclusions and continuations

With an increasingly multilingual population and increasing global mobility, working across languages is likely to become more and more common for therapists and counsellors, in the UK and elsewhere. As with all therapeutic work, there is a danger in making assumptions. There are, of course, no manuals for working with human beings; we can have guidelines but we must always check that those guidelines work for the person who is seeking our help.

Freud referred to psychotherapy as one of the impossible professions. The subtlety of difference in meaning conveyed by different languages arguably adds to the impossibility. But it can also act as a spur to therapists to find creative ways to understand the untranslatable. This article contains many quotes from clients, which are so often the best source of learning for therapists.

Clients teach us that we can work effectively with interpreters and, whether monolingual or multilingual, we can also work creatively with language. We can allow different languages into the room, whether we understand them or not, while of course attending to safety and the risk that we may miss a vital clue to, for example, suicidal feelings. Careful preparation and ensuring that you have checked the meaning of the client's words by reverse-translating what they have said can help to ensure safety and containment for the client.

We can avoid making assumptions. We can maintain interest and concern. We can co-create meaning across languages. We can continue to reflect and discuss this fascinating topic. And we can continue to trust in the power of not knowing and share the joy of unfolding meaning with our clients as we attempt to understand the untranslatable. ■

Dr Beverley Costa is a therapist. She founded Mothertongue multi-ethnic counselling service in 2000 and has been its CEO and Clinical Director to the present day. Mothertongue hosts a bilingual forum for therapists and mental health interpreters twice a year in London. To join, please email beverley@mothertongue.org.uk or visit www.mothertongue.org.uk

What makes military bereavement different?

Bereavement presents unique challenges for military families, who face not just the loss of a parent or spouse but their home, friendship networks and their way of life *By Liz Rolls and Gillian Chowns. Illustration by Jamel Akib*

Since the beginning of the conflicts in 2002, there have been 626 military fatalities in Iraq and Afghanistan.[1] However, 'hostile action' is not the only cause of death among service men and women; between 2001 and 2012 a further 1,355 members of the UK regular Armed Forces have died as a result of injury and poisoning (accidents, violence, suicide and open verdicts), from disease (cancer, diseases of the circulatory system and other diseases) or from causes that are 'not currently available' (that is, awaiting an inquest verdict).[2] As a result, a considerable number of spouses, partners, parents, siblings, children, other family members and friends will have been left bereaved of relatively young people – and many will have sought support from civilian support services, including counsellors.

Is the experience of people who have been bereaved through a military death different and, if so, in what ways? And what are the implications for those who provide bereavement support?

This article draws on a scoping study that explored the work of organisations who provide support to people bereaved through military death.[3] It considers some of the specific features that make this form of bereavement different and how counsellors can address this group's particular needs.

What are the differences?

The experience of bereavement following a military death is shaped by the 'cultural script of military life':[4] the impact of deployment prior to the death; the nature and timing of the death; those who have died and those who have been left behind; media coverage; the military culture and personal identity and additional losses and changes.

The impact of deployment prior to the death

Although no two experiences of deployment are alike – in terms of length, frequency, exposure to combat and levels of risk – military families are used to the service person being absent for periods of time, including deployment in theatres of conflict. Deployment may have been a prompt for marriage, even when the strength of the relationship was unclear. For partners, deployment constitutes varying degrees of loss in companionship and intimacy, as well as emotional and instrumental support, especially in relation to childcare. A number of studies note the association of deployment with spousal depression, anger, sleep disturbance and physical symptoms, significant increases in parenting distress, disruption in parenting rules and expectations for children, and increased rates of child abuse and intimate partner violence.[5]

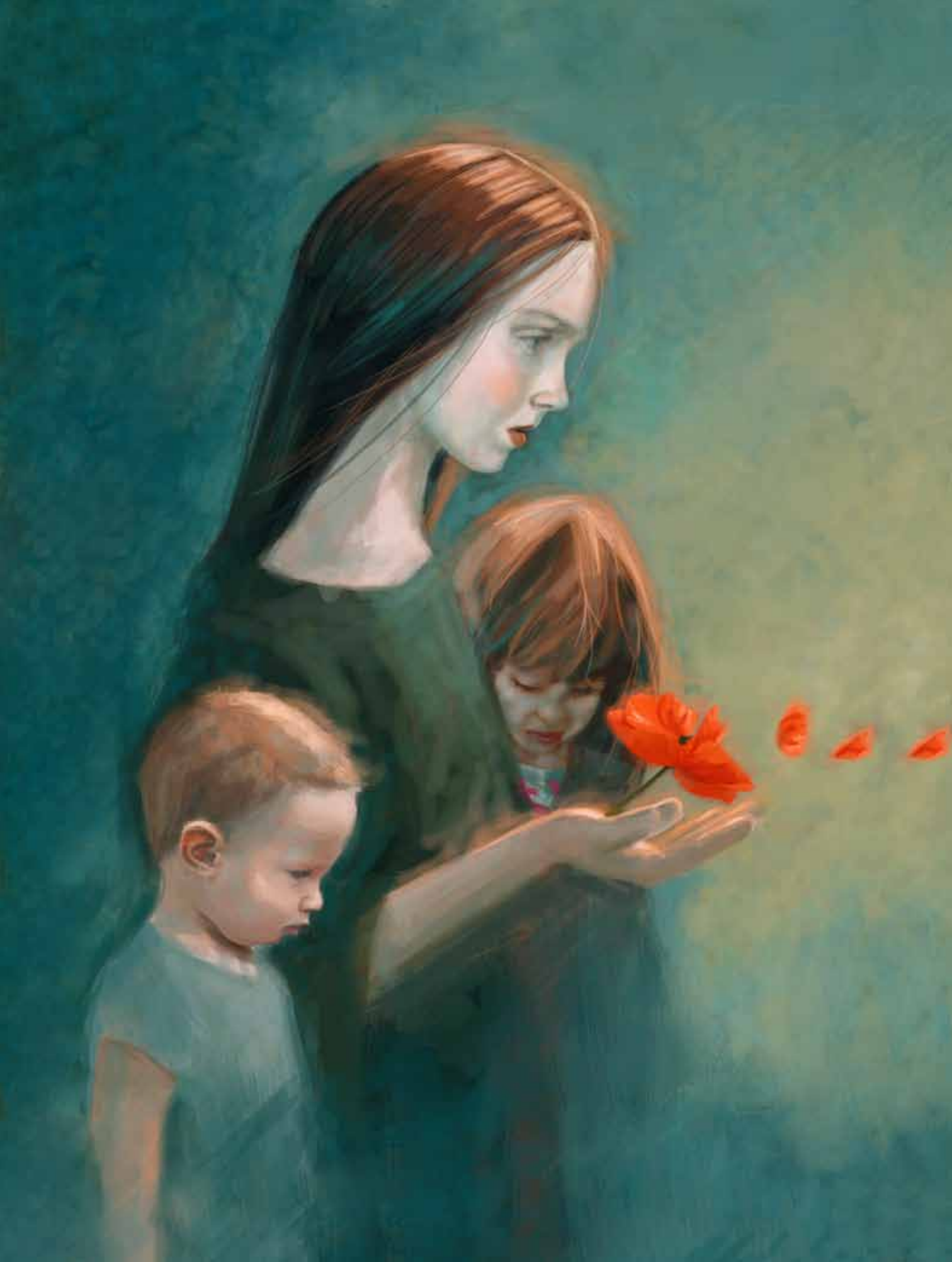
The routine of deployment can engender a military-specific problem for the bereaved. Being used to frequent separations can make the bereavement task of 'accepting the "reality" of the death'[6] – that the person really isn't coming back this time – more difficult. While seeing the body can be useful in helping relatives accept this reality, there may be no opportunity for them to do so where the person has been deployed overseas. Indeed – because of the circumstances of the death – it may not be desirable.

Nature and timing of the death

The majority of military deaths are 'crisis' deaths and, even though they are in some ways anticipated, nevertheless they are frequently sudden. Further issues arise from where – and when – the death occurred. In the case of a military death outside the UK, families have to face more procedures than their civilian counterparts, many of which are outside their control. First, the repatriation of the body is a military process rather than a private family occasion.[7] If the death occurred in a conflict zone, it is unlikely that the relatives will be able to visit the place of death. For some families, the repatriation ceremony (an enforced ritual) appears to be helpful, but for others it may not be.

Second, an inquest is an essential process in *any* death overseas, and military casualties outside the UK are subject to a coroner's investigation. This can result in a number of difficulties. Funeral arrangements will need to be delayed until the body is released by the coroner. If the death occurred during deployment, and especially as a result of combat, there may be uncertainty for the family – and especially for the children – about what has happened, and barriers to finding out. Families often say that knowing what has happened is an important part of the grieving process,[8] but some of the issues or parts of the story may only emerge during the investigation process or at the inquest; indeed, full disclosure of all the information surrounding the death may never be released. Nevertheless, the coroner's inquest is where families can ask questions and get some details of what happened. While this is upsetting, it has often helped families in the longer term, and enabled them to contribute to preventing future fatalities by challenging aspects of policy or safety that led to this death.

For service personnel who are seriously injured on active service and then die in the UK, there is very little media coverage and no public



repatriation ceremony for the family to attend. These families may feel their loved one's death seems less important because it does not receive the public recognition that this ceremony confers. Similarly, the grief of military families whose relative dies through illness or accident is often 'disenfranchised';[9] such deaths may seem less important than those that occur on active combat duty.

Those who have died and those left behind

Those who die a 'military' death are relatively young[7] and leave behind an unknown number of young peer group and older bereaved people – their partners, parents, siblings and children. There may be consequences when relationships between the bereaved (particularly between parents and partners) have been poor. Some branches of the Armed Forces undertake a family briefing before deployment to avoid ambiguity over issues such as who is the designated next of kin.

Following the death, the main focus may be on the partner. However, many of the members of the Armed Forces are only just out of childhood and may have relatively young parents who, as they do not live on base and may not be considered the main 'military family', can feel neglected and isolated. In either case, whether they are partner or parent, the presence of children places considerable psychological strain on the bereaved adult.[10]

Military children have always faced a unique set of challenges[11] as a result of the combat deployment of their parents. However, military children may be 'overlooked casualties'[12] as bereavement through military death is likely to have an additional impact on them. First, young children are particularly vulnerable; they may not have been born or were very young at the time of the death and, therefore, have little or no memories of the deceased. Young children – because of their emotional and cognitive immaturity, their reliance on magical thinking and their dependence on their parents for healthy development – can be especially burdened.[11] Second, military families and children are more frequently exposed to parental separations, and feelings of anxiety and distress that existed during these separations may be exacerbated if a parent dies. Last, the grieving process for children and surviving spouses may be further complicated by the unknowns surrounding war-related deaths, subsequent lifestyle changes and moving home, changing school etc.[13]

Media coverage

Every time a member of the Armed Forces dies it is national news and information about the death immediately becomes very public. This has a number of consequences. Media coverage gives recognition to the service person and to the bereaved, and the family may want the death to be properly honoured. However, media attention may be ongoing; images of the deceased – or those deceased in similar circumstances – may be republished or broadcast on other occasions and, although one study has shown that the majority (86 per cent) of Army families feel the 'running total should be announced each time there is a death',[14] these images and pieces of information can be experienced as intrusive, and especially difficult for children. The use of webcams to film military engagements makes the moments of death much more visible, and coroners use Google Maps to help families visualise the circumstances leading up to the death. While these may be comforting for some, they may distress others – and these images may revive traumatic thoughts about how the person died. In addition, there has been a worrying trend for increasingly intrusive photographs to be taken of children and young people at repatriation ceremonies and funerals.[7]

Military culture and personal identity

Military culture 'has its own language, social norms, and attitudes' of which 'stress, trauma and loss are normative parts'.[15] Military bereaved families, including children, appear to have more of their identity bound up with the Armed Forces – and with supporting the service family member in their job – than their civilian counterparts. Bereaved military families may be grieving for the loss not just of a family member but also of their military identity.

There are cultural differences between the respective Armed Forces that impact on families – some branches have a strong identity as a 'family' but increasingly service families live off-base and have a more civilian lifestyle. This raises questions about how the bereaved family manages to maintain close relationships with military friends and colleagues who understand while turning towards the civilian society in which they will be making their future life.

Nor are the military bereaved a homogeneous group in relation to their feelings towards the 'military' aspect of the death; finding meaning in the death[16] may be challenging. For some families, the death may be considered an 'honourable' one in which the deceased was fighting for a just cause. But for others who have been critical or ambivalent about the conflict, the death may be seen as a 'wasted' life, and they may have more in common with those bereaved by sudden, violent deaths such as manslaughter and murder. Suicide is particularly problematic in that, while clearly not a death in combat, it may be a consequence of the experiences of it.

Additional losses and changes

For military families bereavement is further complicated by a significant 'domino effect of changes'.[15] For children, these 'secondary adversities'[15] make the bereavement task of adjustment[4] a most challenging one. While the association of childhood bereavement with long-term disadvantage remains uncertain, growing up in a disrupted family has been associated with a number of poor outcomes, including lower educational achievement and risk of depression in adult life.[17] In military families, children are both bereaved *and* disrupted.

The death of the service person means the loss of all that being in the military has entailed, including high levels of practical support.[18,19] The family has to make – at a time of great sorrow and uncertainty – a considerable number of important decisions, as well as learn to cope with the practical issues of single parenting and civilian life outwith the military. Familes are now able to remain in their service accommodation for longer following the death, but they will eventually have to move to civilian accommodation, and leave behind the military life to which they are accustomed and the supportive relationships it has provided. The education of the children may be disrupted; the surviving partner's work, if it has been on or near the base, may have to be relinquished, and the close links with the military base and their friends will be weakened.

More poignantly, it is not always clear to families where to bury their relative.

In the immediate aftermath, parents (and siblings) who are the designated next of kin get the same support from the Armed Forces as partners. However, while the changes may be less intense and their civilian life style less disturbed, parental bereavement creates a significant vulnerability, and over time parents – and siblings – may be also less visible and their needs neglected.

Over the past decade, the Ministry of Defence and the respective Armed

‘Bereaved military families may be grieving for the loss not just of a family member but also of their military identity’

Forces have put in place a number of initiatives to support the immediate family bereaved through military death. These include the system of visiting officers to support bereaved families and the relaxation of rules about leaving service accommodation. Bereaved families are treated with care and concern and have access to good levels of emotional and practical support.

However, bereavement is a long haul. Like their civilian counterparts, military families grieve the loss of their relative in the context of a unique set of relationships and social world; but they have to withstand the additional psychosocial disruption to their assumptive world[20] that leaving the wider military family entails, and to grapple with maintaining a continuing bond[21] with their deceased relative while at the same time relinquishing the bond and their identification with the military life. Furthermore, they may need very particular support in trying to make meaning of certain aspects relating to the death[16] and in accepting its reality,[6] in order to foreground the actual rather than the fantasised aspects of the death.

While all families need to address, and oscillate between, both grief-focused and restoration-focused work,[22] the very practical aspects of the latter that are required to generate a new, civilian life outwith the supportive environment of the military can be more demanding and overwhelming, and sometimes unbearably so. Once families leave the military orbit and return to civilian life, some of these additional losses are likely to come to the fore, and family members may well seek practical support from civilian organisations such as the Royal British Legion (www.britishlegion.org.uk), the War Widows Association (www.warwidowsassociation.org.uk), and Forces Support (www.forcessupport.org.uk).

Immediate and wider family members, including parents and siblings, may be – or may become over time – less visible to these support structures and their grief may lead them to seek bereavement counselling. Counsellors need to hold in mind the significance and possible impact of the potentially disenfranchising[9] context of military death and bereavement. Enabling the client to articulate and recognise the enormity of the disruption in their lives and the ambiguity of their loss can validate their experience and their efforts to create a new life and identity while maintaining meaningful connections to their dead. ■

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Against factionalism

Michael Owens explores the shared theories and values that underpin most counselling and psychotherapy modalities. Instead of criticising, counsellors should treat each other with the respect they show their clients, he argues

During an interview with Jurist,[1] Fonagy describes how factions in the psychoanalytic community have been created by his fellow practitioners. He claims that pluralism is not to blame for the problems psychoanalysis faces; rather, the cause lies in the attitudes of therapists who build exclusive organisations and deride the practices of others in the field. They do this without any genuine attention to or curiosity for what the others are doing, and make assumptions about the efficacy, ethics and diligence of these practices.

Fonagy is discussing the state of psychoanalysis and the attitudes of its practitioners but he could be referring to the conflict about the effectiveness and value of different therapies.

There is a long-standing mistrust between the therapies that has largely been based on assumptions, poor definitions and contempt for each other's models.[2] This situation has been exacerbated in the case of the cognitive behavioural therapies (CBT) after the recommendation of CBT as the treatment of choice for a variety of psychological disorders in the IAPT programme.[3] Emphasis on 'non-CBT' approaches within IAPT is gradually increasing as the range of treatment options is widened, but CBT still dominates. In 2012, according to the most recent Department of Health figures, only 30 per cent of high intensity therapists were capable of delivering alternatives to CBT.[3] This has created a divisive landscape within the profession; any common ground between therapies can be obscured or easily ignored, which limits the potential for understanding, communication and unification.

What if the contentious issues about CBT – its association with NICE guidelines, the IAPT programme, and randomised control trials – could be set aside momentarily? Could there be a dialogue about the parallels between CBT and the other modalities? There is an increasing body of work exploring the connections between therapeutic approaches and the advantages of adopting a respectful appreciation of other models. Might this provide an opportunity for an open debate about the theories and practices of psychological therapy with a view to improving all of them?

Comparing the therapies

What follows is a brief comparison of CBT with the person-centred approach, psychodynamic counselling and existential-phenomenological therapy. The features examined here relate to the unconscious and levels of cognition, instinctual drives and inherent tendencies, and the therapeutic relationship. Some of the similarities are obvious and others less so; some are common to all the disciplines, others are more specific, but there are plenty of them.

Before embarking on comparisons with CBT, though, it is important to provide a working definition of the CBT that is being used here – namely, Beck's cognitive therapy. Cognitive behavioural therapies explore the interaction between thoughts, feelings, behaviour and physical sensations in relation to clients' problems through structured, collaborative and directive sessions. Clients and therapists often form a goal-oriented, time-limited working alliance to develop a mutual understanding of the problems and identify strategies for tackling the issues. The approach regards psychological and emotional difficulties as exaggerations of normal processing and tends to focus on these issues in the here and now. The process is designed to empower the client by employing their own resources. Therefore, clients can take credit for improving their circumstances, which will assist relapse prevention beyond the therapy.[4,5]

The unconscious and cognitive

Beck and his co-authors[6] credit Freud with the central premise that unconscious ideas fuel our emotions and presenting symptoms. Compare the description of the levels of cognition below with Freud's distinction between the three levels of mental activity: the conscious, consisting of current thoughts and feelings; the pre-conscious, which is accessible and recalled in the form of memories, and the unconscious, which is unknowable but may be accessed indirectly through inference and translation into a conscious form.

The unconscious is described as an 'image' or 'metaphor' that outlines certain entities that defy accurate description. Within the unconscious are thoughts, feelings and experiences that are hidden from the conscious self as they are 'too threatening or too painful'[7] to accept, appreciate or experience. This may exert an influence on a client's experience of the present through their reaction to certain stimuli. Therapy aims to bring the unconscious into consciousness, which will help the client to be aware of their thoughts, feelings and behaviour and exercise greater control over them.[7]

CBT commonly describes cognitive content as being made up of three levels: negative automatic thoughts (NATs), dysfunctional assumptions, and schemas. The thought patterns at each level can undermine a client, limiting their ability to cope with difficulties. These thoughts are programmed and involuntary, so the client may not be aware of them and how invasive they can be.

NATs are persistent, spontaneous thoughts connected to specific situations: 'My colleagues must think I'm stupid' or 'This therapy won't work'. Dysfunctional assumptions are conditional rules, often forming 'if/then' statements: 'If I take on a challenge, then I'm going to fail' or 'If I make a mistake,

then I'm useless'. Schemas are essential cognitive patterns that develop to assist a client in making sense of their experiences in the world. These mental structures provide a template for processing information about different situations so that a client can anticipate events and respond appropriately. Schemas are relatively stable, though they allow enough flexibility for a client to be able to integrate new experiences and change expectations. Schemas also incorporate core beliefs, which tend to be deep-rooted, generalised statements about the self, others and the world. They are often about worth, qualities and abilities: 'I'm worthless', 'I'm vulnerable', or 'I'm a failure'. Like the schemas, they may only be accessible through the interpretation of thoughts and behaviours.[5,8,9]

In both approaches, there is some agreement that a client's perception of experience is formulated from an interactive structure in the mind. Some parts of these structures are directly accessible and some less so, to the point where the deepest part of the structures and their origins are unknowable and may only be inferred through symptomatic behaviour. In both cases, no matter how (or why) the information is stored or organised, it is past experience that may stimulate the responses in the present.

To see how this applies in practice, Persons and colleagues[10] suggest a 'top down/bottom up' comparison between the CBT and psychodynamic approaches. Psychodynamic therapy aims to create awareness through bringing the unconscious into consciousness. This 'bottom up' approach explores the deeper processes with a view to fostering a lasting change in the client.[7,10] However, CBT often deals with symptom removal at the most accessible level of cognition, which means focusing on an aspect of the client's perception before understanding it.[10] This 'top down' method is based on a similar ideology about the mechanisms that maintain the symptoms from a much deeper level through schemas and core beliefs. As the client begins to perceive him or herself in a different way when tackling the negative automatic thoughts and dysfunctional assumptions, their core beliefs and schemas may be challenged and change may take place at a fundamental level too.[10]

Beck and his colleagues also acknowledge Adler's contribution to the development of cognitive therapy: the importance of the client's phenomenological perspective in the therapeutic process.[6,11] The notion that it is not the events themselves that trigger emotional and behavioural responses but the client's interpretation of those events sits at the heart of cognitive behavioural theory. Claessens[12] also argues that CBT is phenomenological as it aims to increase the client's awareness of the thoughts, feelings, behaviour and sensations they experience following a triggering event. As the client gains a greater awareness of their own phenomenology and the limitations of this subjective conscious experience, they can begin to take a 'sceptical, tentative'[12] view of their beliefs about life. This increases their potential to adapt to situations in a healthy, flexible manner rather than repeating unhealthy, fixed reactions.

This constructivist approach clashes with what Van Bilsen describes as the 'fourth wave' of CBT.[13] Fourth wave practitioners rely on a diagnosis derived from the *DSM* and/or *ICD-10* classifications of mental health disorders, more akin to a medical model of diagnosis and treatment rather than individualised treatment plans. Several authors in the CBT community acknowledge that clients present an idiosyncratic account of their problems and they advocate a bespoke treatment plan that functions within the scope of each client's unique perspective.[9,10,13] As Van Bilsen states, clients rarely fit into the distinct categories found in manuals of classification and often present with, 'a mixed bag of problems'.[13]

'Each of the therapies has the same purpose: to help clients tackle their problems effectively and improve their health, welfare and quality of life... it should not come as a surprise that there are many similarities between them'

Instincts, drives and tendencies

There are parallels between the instinctual drives Freud identified – *Eros* and *Thanatos* – and the tendencies towards formation and entropy that Rogers proposed.[2] *Eros* drives growth within the organism: learning, development, experience, love and reproduction are its fundamental expressions. *Thanatos* is described as the death drive or instinct. *Thanatos* is a destructive force, disabling the drive to grow and experience, impeding progress and ultimately dismantling the organism and returning it to a lifeless state.[14]

These drives may explain a broad range of human preoccupations and behaviour. Education, relationships and starting families, which relate to the creative *Eros*, are widely accepted and encouraged in human society. Self-destructive behaviours, addictions and suicides are still commonly misunderstood and even feared in society, although *Thanatos* might explain their presence in the human experience.

Rogers[15] also identified similar tendencies in human beings and throughout all forms of life. He acknowledged the inevitable decay of life and, as clearly charted by physical science, of the universe itself. However, he gave equal weight to the constructive,

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creative force that urges life to fulfil its potential even in the most inhospitable conditions. He gave as an example the winter store of potatoes in the basement of his childhood home. The potatoes would never be planted or nurtured into maturity and yet they developed inadequate shoots that would reach towards the basement window as they struggled to realise their potential. Thus, even in the most desperate and futile of circumstances, life maintains its determination to grow. Transposing these ideas into his therapeutic work, Rogers created the basis for his practice – trust in the client's tendency to learn, organise and progress, no matter how distorted their existence.[15]

Casemore and Tudway[2] suggest that the creative and destructive tendencies found in the work of Freud and Rogers are reflected in CBT: the struggle between the rational and irrational. According to cognitive theory, there are at least 10 cognitive distortions arising from poor appraisals of a situation.[5] These are usually involuntary generalisations that undermine clients through an overestimation (or underestimation) of threat, incomplete assumptions about a situation and its consequences and a narrow selection of options for response.

One example of a cognitive distortion is 'all or nothing thinking', where situations with many possible implications are viewed as either exclusively positive or utterly negative: eg achieving less than top of the class in an exam is regarded as a total failure.[5] An irrational perspective of a situation may be based on a biased, negative view of the client's past efforts, can be influenced by emotional distress and could stem from core beliefs and schemas. These distorted thought patterns provide the client with 'evidence' that reinforces self-defeating behaviours and could affect the client's future performance.

CBT encourages the client to develop their ability to perceive events accurately and to accept that individual perception is impermanent and imperfect.[9,12] Maintaining a rational perspective is very difficult as it means the client has to critically evaluate their initial appraisal of a situation. This requires an assessment of their reactions (thoughts, emotions, behaviours, physical sensations) as well as the environment: the dynamics of relationships, cultural norms, traditional customs and organisational context. This fresh appraisal needs time, motivation, education and reflection – a lot of insight and effort, in other words! It is also comparable with the openness Rogers imagined if each moment could be perceived as entirely fresh, occurring without judgment or preconception. The result would be a client contributing to the experience and observing it simultaneously, with no fixed notion of what should happen next or how they should think or feel about it.[16]

Both approaches promote an enhanced responsiveness and flexibility to experience life through a dual process of introspection and inspection.[6,16] The duality of the constructive and destructive instincts and the capacity for rationality and irrationality are reflected in Casemore and Tudway's statements about clients' determination to change: even though clients may be highly motivated to change, they can experience a great resistance to therapy.[2] Perhaps this may be explained by Fried's claim[17] that Freud believed in a 'creative *Eros* that is in fundamental, unavoidable conflict with destructiveness'. The expression of *Eros*, the constructive attempt to heal and develop in therapy, could be thwarted by the self-destructive instinct within us. Even though Fried[17] states that *Thanatos* eventually dominates, just as entropy will undo the universe, he does offer some hope: it is possible to derive meaning from life and the collected meanings accumulate to provide an ever-evolving response to the challenge of living.

Therapeutic relationship

The relationship between client and counsellor is a vital element of the therapeutic process, and is established through the counsellor's genuine concern for the client's wellbeing and focused attention on his or her subjective experience. While the therapeutic relationship is regarded as the essential component for psychological change in person-centred and psychodynamic work, it is not sufficient to produce a positive outcome in CBT.[2,7,12]

This genuine concern and focused attention can be promoted through certain conditions, which are generally accepted as being congruence, acceptance and empathy. Rogers[16] described congruence as the ability to feel what is happening at any given moment and communicate this if necessary. He maintained that this quality of genuineness embodies the trustworthiness of the therapist.

Next, he discussed the therapist's acceptance of the client, most importantly without conditions. The therapist's positive regard for the client eschews any judgment and disapproval and allows the client to fully experience the emotions they feel. Thus, the client begins to experience congruence within their self. Finally, Rogers described empathic understanding: the therapist comprehends the meanings and feelings the client experiences 'as if' those values and emotions were their own.[16]

With such emphasis on the scientific enquiry of cognitive therapy, Beck and his co-authors warn against ignoring the human aspect of the therapeutic interaction and propose that the core conditions of warmth, accurate empathy and genuineness are necessary for the application of the therapy.[6] Jacobs[7] also makes reference to at least one of the

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core conditions described by Rogers – unconditional positive regard. He states that, from a psychodynamic perspective, unconditional positive regard is the counsellor's way of transferring all the positive attributes of the parent–child relationship onto the therapeutic interaction. A good parent will function genuinely in the parent–child relationship, accept the child as they are and try to understand as accurately as possible the child's perspective of their self in the world.

Transference occurs when a client relates to others in the present by repeating the ways they related to significant others from their past. Thus a client may relate to the counsellor in the same way as they related to their parents. Psychodynamically, this is viewed as an opportunity to help the client work through the difficulties and losses experienced in early childhood.[7] CBT practitioners may also identify transference and treat this as a distortion in the therapeutic relationship. Falling in love with the therapist, regarding them as a saviour, expecting rejection from them and making them the focus for hostility are common forms of this distortion in the therapeutic alliance.[6]

Persons and colleagues[10] give a useful example of how a cognitive behavioural therapist can use the transferential aspects or distortions in the therapeutic relationship to develop an alternative to the established pattern of behaviour. In the example, the therapist notices the pattern of their interactions and challenges the client to re-evaluate their expectations of the therapist and the process. In doing this, they establish how the client's need for care and freedom from responsibility conflicts with the desire for independence. This process follows the learning cycle of the CBT process, but the client learns, 'not via intellectual disputation, but *through her experience with the therapist*' [original italics].[10]

The idea that the therapeutic relationship between counsellor and client could stimulate positive change by itself has been promoted since the 1940s by psychoanalysts such as Fenchiel and Alexander and French.[18] These writers asserted that a client in therapy might learn from an opportunity to confront their fears and reduce them without the need for a deeper analysis and resolution of past experiences. This focus on the here and now in the therapeutic interaction is echoed in person-centred and cognitive behavioural approaches, which could stimulate change without necessarily gaining insight into a client's past. In spite of the willingness to acknowledge and treat the transferential aspects of the working alliance, it is important to note that CBT practitioners do not view the therapeutic relationship as representing a former connection with a significant other. The CBT alliance is described as a 'relationship in its own right', which can make the client aware of their potential in other circumstances outside the therapy sessions.[5]

Conclusion

Each of the therapies has the same purpose: to help clients tackle their problems effectively and improve their health, welfare and quality of life. Therefore, it should not come as a surprise that there are many similarities between the approaches. It would appear that the influence of the past on the present is not restricted to clients and their problems. Two of the key figures in CBT, Ellis and Beck, developed their ideas about cognitive therapies as a reaction to their dissatisfaction with psychoanalysis and its results (notably, Rogers encountered a similar frustration and forged his own path with the person-centred approach).[2] Certain elements of their initial training provided the foundation for these new theorems and their influence endures throughout the pluralism of the present.[2]

A greater understanding of the different disciplines and their similarities encourages therapists to reflect on their loyalty to a particular approach (or integrate it with other ideas or even abandon it altogether). Casemore and Tudway[2] state that their CBT course for person-centred counsellors reinforced students' commitment to their own model rather than altering their practice in a new direction. The course dispelled many of their preconceptions about CBT and gave them a fresh perception of the therapeutic relationship. Several used a CBT-led theoretical understanding of the client's complex thought processes, but they continued to practise the person-centred approach.

While the spirit of *Eros* is alive and well, stimulating growth and invention and sustaining pluralism within the profession, its destructive counterpart is also at work, causing dissonance and disorder. Hence Fonagy, in his dialogue with Jurist,[1] does not condemn pluralism; rather, his complaint suggests a state of incongruence within the therapeutic world. Therapists go to a great deal of trouble to understand clients and their phenomenology, while prematurely dismissing the perspectives developed and used by colleagues in other modalities. Ultimately, Fonagy's appeal is that we accord each other the same respect that we show our clients. ■

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The problem with pluralism

Chris Molyneux questions how counsellors can use the person-centred approach alongside other seemingly incompatible approaches without betraying its principles and values

This article comes from both personal experience and a growing frustration with the misrepresentation of the person-centred approach and the move towards an integrative and what I believe is often a contradictory approach to counselling.

There is, I believe, a growing trend in counselling towards integration and pluralism. The person-centred approach (PCA) and cognitive behavioural therapy (CBT) appear to be the most common pairing and, in my opinion, mismatch in this trend. In this article I call for a re-examination of the approaches that we practise alongside each other. I argue that our belief in human nature should be at the core of our choices of therapeutic approach, as well as a reference point for incompatibility across the various approaches.

I do not hold the view that one approach to counselling is better than another or that certain approaches to counselling cannot work together. What I am arguing for is the need to really examine what we are taking on by adopting a counselling approach, especially the PCA, and that we should see it as more than just a tool to add to our toolbox.

Congruence and commitment

Counsellors increasingly list a variety of approaches, skills and tools that they offer, as though in the hope of covering all bases and not selling themselves short to prospective clients and employers. I conducted a quick scan of an online directory of counsellors in one geographical location – half of the 22 counsellors practised both CBT and person-centred counselling, and a handful offered more than 12 different approaches each.

I can understand how this can come about. However, I believe that we should examine the reasons for our pluralism and question whether this is compatible, congruent or even appropriate.

The PCA seems to feature most often in people's repertoire, but it is also the one that is, in my experience, most greatly misrepresented or misunderstood. It seems to me that the PCA is seen as simply the presence of the core conditions or a tool that can be used among many other approaches. I believe this is a huge misrepresentation of its power. From my experience, the PCA is a true commitment (both inside and outside the therapy room) not just to the core conditions or necessary and sufficient conditions but also to the deep belief and trust in a human being's capacity for self-governance, expertise and actualising tendency. I believe that, if the PCA is fully understood and committed to, it is actually incompatible with other approaches to counselling, such as CBT.

If we describe ourselves as person-centred and CBT practitioners, it suggests we both believe in a person's actualising tendency, self-governance and expertness *and* we intend to create an environment in which we take the lead and think we have the tools, techniques or answers to the client's difficulties. Although I accept and welcome that there are many different approaches to therapy, and that both therapists and clients do best with an approach that fits their beliefs and needs, I don't believe that the PCA and CBT can just be mixed together without doing a disservice to the PCA. If we are willing to accept and adopt two opposing views of our clients and approaches to therapy, how can we practise congruently, with full commitment and understanding?

For example, a client might typically say: 'I think that everyone hates me.' Very generally, if we are following a person-centred way of working, we are likely to be empathic towards this response and stay with the client's experiencing of this reality. If we are to work from a CBT framework, we may be inclined to challenge this belief and test how true it is. How can these two approaches be compatible? How can someone both believe in the actualising tendency (and that to provide a space with the necessary and sufficient conditions is enough for therapeutic change to occur) and be a directive therapist who has tools to fix this 'irrational' thinking? One of these approaches must be incongruent.

Human nature

I believe how we respond to our clients is guided by our belief in what is most helpful to each person and this comes from how we view human nature. It seems hard to be pluralistic about this.

Our view of human nature is so important because it is central in determining our choice of counselling approach. If we believe that human beings just need an expert who can point them in the right direction, then our approach to counselling will reflect this, as it will if we believe that human beings have the capacity within themselves for self-determination and actualisation. A counsellor will adopt the approach that complements their belief in human nature. This also explains why there are so many different approaches to counselling: people have very varied beliefs about human nature and what is most helpful to clients.

My personal understanding of being a person-centred counsellor is that we seek to offer a facilitative environment

to our clients, which we believe they have the ability and expertise to use to unlock their own potential and be their own best guide. If we truly see ourselves as person-centred therapists, then it follows that we not only adopt the necessary and sufficient conditions to create therapeutic change but we also adopt the PCA's belief in human nature and actualisation. Offering a goal-orientated therapy or techniques alongside this is incompatible.

I believe that if we are to follow a practice or theory, then we adopt it wholeheartedly. Yes, we may challenge, question and develop certain areas of that theory (as Rogers wished) but the core of that theory is crucial and essential to our commitment to it.

What seems to be increasingly common is just adding approaches like a cub scout's badge. I believe that an approach to counselling deserves a greater respect, understanding and commitment than this. I believe it is important for us to stop and question what we are taking on and agreeing to when we adopt a particular approach. If we do this, then the option of pluralism or integration may be more limited, especially in regards to the PCA.

Black and white?

Is my thinking too black and white, I wonder? One or the other and nothing in between? Is it actually possible to have a therapist who can offer advice, techniques and guidance and also be person-centred?

To me it's like being a vegetarian who eats meat. To eat meat goes against the very essence of being a vegetarian. Likewise, to use CBT and offer goal-orientated techniques and guidance goes against the very essence of being a non-directive person-centred counsellor. If you practise CBT you are no longer offering person-centred therapy. You cannot be a meat-eating vegetarian!

This point is captured by Barbara Temaner Brodley and Anne F Brody: 'Infusing specific goal-orientated treatments and techniques with client-centred values in ways that influence the actual application of the treatments and techniques might well tend to greatly humanise and improve the efficacy of the treatments and the techniques. But they should not be confused with client-centred therapy.'[1]

In regards to counselling practice being based on our belief in human nature, I cannot think of a more important factor than our belief in human nature in determining how we work with our clients and how we can be of most help. Our work is with people and so our understanding of and belief in people must surely guide how we approach this work. If, as a person-centred therapist, we believe in the client's actualising tendency and self-governance, then our next step is to create a space that offers the most helpful environment for these traits to emerge. This then determines our approach to counselling. It seems that our belief in human nature is the foundation of our practice.

In conclusion, with a culture that demands so much of us as therapists, alongside clients/employers wanting value for money and what research findings tell us, progression to pluralism and an integrative approach to counselling is inevitable and often welcome.

> 'If we are willing to accept and adopt two opposing views of our clients and approaches to therapy, how can we practise congruently, with full commitment and understanding?'

But a counselling approach is not simply a set of techniques; it requires a commitment to its deeper beliefs. When we begin to see the PCA as simply using the core conditions, then I believe we are more inclined to integrate this alongside other approaches and simply add another set of 'tools' to our bag.

If we really stop to think about why we might adopt the PCA and what this entails, we may begin to understand the approach more deeply and question how we use it in counselling. If nothing else, I think that we at least owe it to our clients to create a space that is fully committed, clear and congruent, while also being free from confusion and contradiction.

I hope this discussion will trigger us to stop and examine our approach to counselling and ask ourselves why we work the way we do and what we actually believe about the approach(es) we practise. My hope is that we begin to see our approach as more of a commitment rather than a tool and that the PCA is understood more fully and used to its true potential. ■

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Dilemmas
Holding aggression in group work

This month's dilemma

Alex works as a group therapist for a large mental health organisation. The participants are all users of the service and have self-referred into the group. There is a group rule that members should not be violent or aggressive within the group. However, recently, a group member has been verbally abusive to the point where the whole group has felt de-stabilised, and on one occasion Alex himself has left the group in tears. He and his co-worker would now like to exclude this person from the group but their manager, who has had psychiatric training, has refused to allow this to happen, saying that the group leaders should be able to cope.

What are your thoughts and what should Alex and his co-worker do?

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

Margaret Akmakjian-Pitz
Psychotherapist and supervisor in private practice

The group rules state that the members 'should not be violent and aggressive within the group' (but one is) and the organisation's manager says that 'the group leaders should be able to cope' (but they can't). Stalemate. Something has to give.

I would start with the second statement. Being a group leader is tough, and Alex and his co-worker need to at least make an attempt to manage this situation appropriately. In my experience, group members themselves usually find a way to moderate even the most difficult participants over time. That is one of the benefits of group work. Most, if not all, groups go through the forming/norming/storming/performing stages and it is essential for the healthy outcome of the group that each stage is allowed to happen. What's going on with Alex that he can't ride out this storm?

It is unlikely that the abusive member's anger is directed at him personally but, if it is, this transference needs to be explored and resolved. Hopefully Alex has a supervisor (separate from the practice manager) to whom he can take his vulnerability and counter-transference. He clearly needs support. Leaving the group in tears is damaging both to Alex and his co-worker and to the group. Group leaders are the 'parents' in this 'family systems' setting, and it is essential for the healthy development of the 'children' (group members) that their anger is seen to be contained by the grown-ups rather than destroying them.

> 'Group members usually find a way to moderate even the most difficult participants. That is one of the benefits'

As a last resort, a private session between Alex and the abusive group member might be arranged where Alex can explore what's going on for the participant that has prompted such verbally abusive behaviour, and they can then work together to find ways to manage those emotions in the group. But this must be an absolute last resort, as it would inevitably upset the balance of the group by singling out the abuser for what would be likely to be seen as either special or punitive treatment, as well as disrupt the natural process.

For Alex (and his co-worker) there is always the option to resign, either from running the group or from the organisation as a whole. This would be extreme, but if the rules of the group are persistently allowed to be broken with no consequences to the rule-breakers, then this continues to give entirely the wrong message to the group members and would not seem to be a healthy organisation in which to be employed.

William Johnston
Person-centred counsellor in private practice

In theory a large mental health organisation should provide better checks and balances than might exist in a smaller set-up; in practice it is precisely the hierarchical structure of large organisations that can be so oppressive to anyone who is finding it hard to cope.

Alex could appeal over the head of his manager but that would probably make him very unpopular and, given the nature of such hierarchies, it is likely his manager's decision would be supported. His working life could become impossible.

When we are told that Alex's manager has had psychiatric training, it sounds as though he (or she) might have enough to believe himself competent to make such judgments, but not enough actually to understand what is going on. He may well lack self-confidence and may feel that he needs to assert himself in the face of two counsellors who could have higher levels of knowledge, experience and competence than he does. It might be worth bearing this in mind when challenging him. As a manager under threat, he is likely to dig his heels in; listened to, as though he were a client, he might well respond differently. And trying this may of course be a complete waste of time.

From an ethical point of view, if Alex truly feels that he has reached the limits of his competence – a courageous admission that does not suggest any sort of failure on his part – then he either has to insist that the abusive member is excluded or he must himself withdraw from the group. I should not like to have to make such a decision. If, however, the effect of the abusive participant is to fragment the group to the extent that other members are being harmed, then it cannot be right to continue.

There may be ways in which Alex can use his own vulnerability as strength in the group. However this would need the active support of a manager or supervisor

who understands such a process, rather than someone who is simply telling Alex to 'man up'. Does Alex have colleagues or professional friends whom he might be able to recruit to support him? I am also intrigued by the role of Alex's co-worker. How well do they support one another? If they trust one another well enough to challenge their manager's instructions together, then they might be in a much stronger position. The difficulty is that their manager may try to drive a wedge between them.

Dominant group members rock the boat, and this presents an opportunity. When things become 'de-stabilised' we need a captain and we rely on others in the group to steady the ship again. In a crisis our usual defences often fall away, leaving us raw but possibly able to try something different. Based on my personal experience of a therapeutic group with a 'dominant' (some might say 'aggressive') member. While challenging at the time, the 'captain' – an experienced facilitator in whom I had confidence – gently invited me (and others in the group) to bring our awareness to what was happening and, with her encouragement, to stand up to the 'dominant' member. Isn't this what group therapy is all about?

John Rowan
BACP Fellow and integrative psychotherapist

There is a simple answer to this dilemma. Forbid any group that does not have a trained leader. Groups can be really damaging places because of group phenomena, which are quite well known.

Here is an example. A good group leader will always establish a norm that distinguishes between confronting someone in the group and dumping on someone in the group. In confronting someone, we own and take responsibility for our feelings. In dumping on someone we simply lay accusations against them. There is no difference in the strength of the feelings, simply a difference in the way they are phrased. In one instance the word 'I' is used; in the other it is not. Without a trained leader, a group cannot be trusted to observe this distinction – the temptation is too great to hurt or damage the other person.

Jayne Godward
Person-centred counsellor and senior lecturer in counselling

What are the criteria for entry to this group and what screening took place? Not everyone will be suited to group therapy and this may be the case for the person who has become verbally abusive.

When s/he began to be verbally abusive, the group leaders and possibly the group members presumably referred him/her back to the ground rule. It is not uncommon for group leaders to come under attack as they are seen as authority figures and Alex may have experienced this when trying to challenge the abusive member about their behaviour.

What is serious and concerning here is that this has obviously been going on for several sessions. This means there is a risk of harm to the group members and also to Alex. The group is no longer a safe space and the boundaries are not being maintained. There is an issue of justice in that this abusive member may be dominating the group by not allowing people to speak through his/her verbally abusive behaviour.

> 'How much abuse should a member of staff put up with and is it ever acceptable? The manager has a duty of care to his/her workers'

Alex has sought support from his line manager but, instead of listening to the group therapists, the manager takes the line of 'What's your problem?'. What it raises for me is how much abuse, if any, should a member of staff put up with in their daily work and is it ever acceptable? The manager has a duty of care to his/her workers as well as to the group and s/he seems to be side-stepping this responsibility here.

The group-leaders need to seek urgent supervisor support, if available, or enlist peer support from other group leaders working in the organisation.

Continuing with a group member who is acting out abusively in the group is not an option. The group leaders can attempt to revisit the group contract but that raises the question of how you enforce informally agreed ground rules if you don't have the support of your manager or organisation.

What is striking about this case is the potential lack of support for all parties concerned. The abusive group member may need more individual support; insisting on him/her continuing to attend the group may not be beneficial for him/her. Alex and his co-worker certainly need support, as do the other group members while all this is going on. I wonder who is holding them?

Next month's dilemma

Sally supervises Assad, a trainee counsellor in his first year of training. Sally finds him warm and intelligent although, as English is not his first language, she occasionally struggles to follow his train of thought.

Over the time that they have been meeting, Assad has confided in Sally that he believes that a cohort of students on his course are implicitly racist as sometimes they appear reluctant to work with him in small groups. He has brought this up with the course tutor but he is beginning tothink that the tutor too is implicitly racist as he does not appear to be concerned.

Assad is now asking Sally to intervene on his behalf. What should Sally do? ***Email your responses (500 words maximum) to Heather Dale at hjdale@gmail.com by 28 May 2014. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but these will not be answered personally.***

Competence and confidence

Professor Sue Wheeler talks to *Colin Feltham* about her career in academia and the dilemmas facing women starting up the counselling career ladder
Photograph by Jacky Chapman

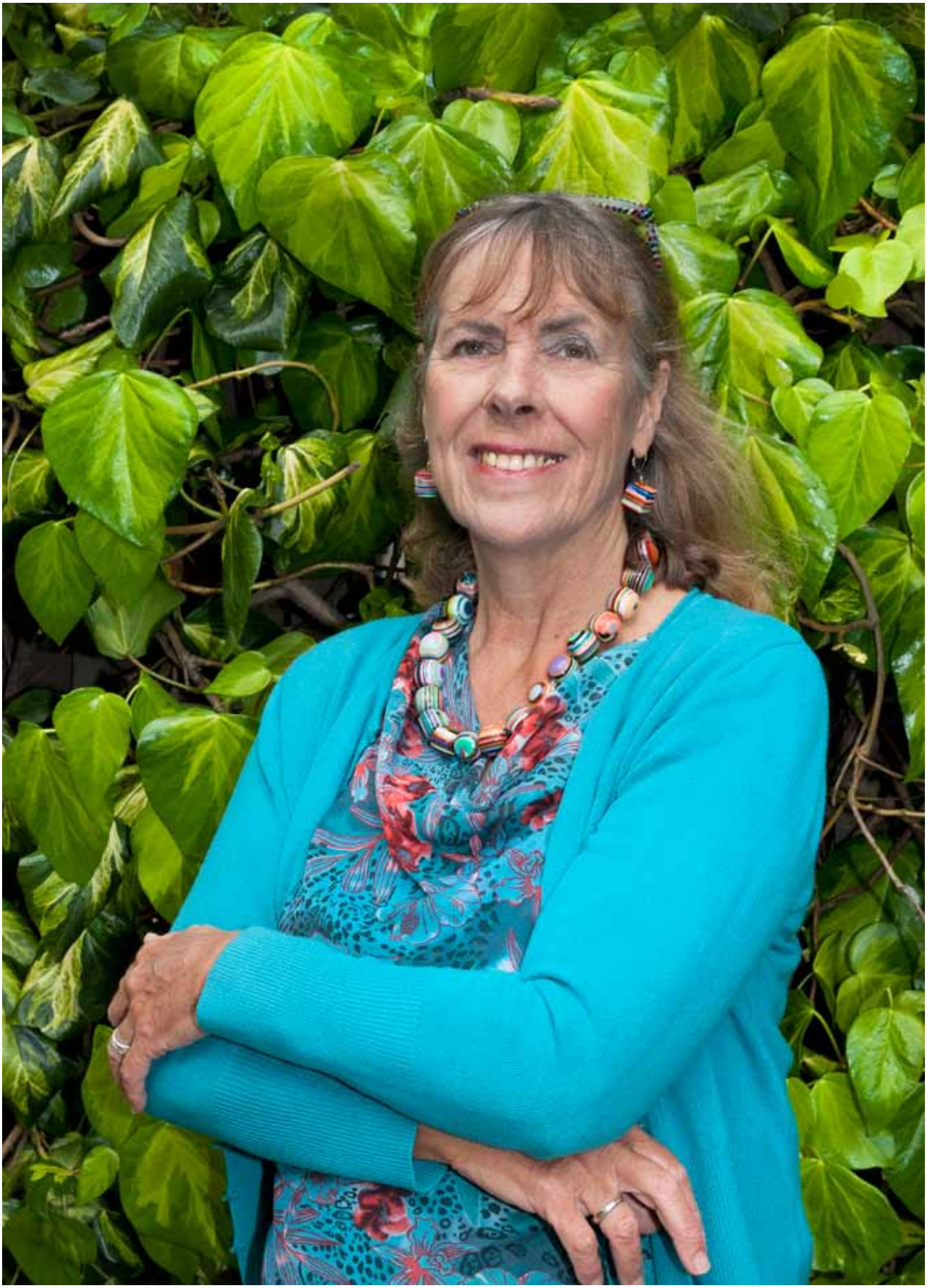
Can you start by telling us a little about your background, leading up to your involvement in counselling and psychotherapy?
I grew up in London, the oldest child with three siblings. My family were warm and loving but I struggled with the arrival of my brother and sisters and spent a lot of time with my grandparents; I didn't have to share them. I went to a girls' grammar school, where I was considered bright. My first degree was in mathematics at Newcastle University but it took me a while to find a direction in life after university. Some counselling would have been useful! A television programme on the Henderson Hospital therapeutic community was one influence on my thinking, and conversations with a Marxist colleague while doing a mundane job were another. I became involved in politics and my first proper job was with the National Union of Students. My post was in education and welfare; counselling in universities was just beginning to take off, and I decided that was what I wanted to do. I took a job at an FE college as the welfare officer, aged 26, signed myself up with a psychotherapist and enrolled on a counselling course at Hatfield Polytechnic (as was). I had found my vocation in life and never looked back.

While at the FE college I took two further diploma courses, one psychodynamic and one humanistic. When I moved to Aston University to be the university counsellor 12 years later, I undertook the MSc in Psychotherapy at Warwick University, a research-oriented course that changed my career direction once again. I was hooked on research and soon moved to an academic post at the University of Birmingham and from there to be a professor at the University of Leicester.

You've taught for many years at the universities of Birmingham and Leicester. Presumably you're comfortable enough with academic existence, or do you experience any dissonance between academia and the ethos of therapy?
Training counsellors in any environment has its challenges. There are some organisational hurdles to overcome in universities but, with persistence, professionalism and robust assessment systems, universities are as good a place as any to learn to be a counsellor/psychotherapist and, I would argue, a better place than most. For many students the training is painful and life-changing. It is vital to design assessments that capture aspects of personal development. Students who struggle with the emotional impact need help to recognise that counselling may not be right for them. Some students find writing academic essays difficult, even though they may be good counsellors. Some potentially good therapists fail to meet the academic requirements of a university course. I like the fact that university courses value research and evidence-based practice, even though not all students embrace the research with open minds. I am proud that the counsellors I have trained in university settings over the years have graduated as well-educated clinical practitioners who can hold their own in any organisation. Many of my ex-students are now in management roles in organisations, where they deserve to be, and I am confident that they will do a good job.

Psychoanalysis, psychoanalytic psychotherapy and psychodynamic counselling and the differences between them aren't always understood. Where do you place yourself theoretically?
I see myself as a psychoanalytic psychotherapist or psychodynamic counsellor, depending on the setting in which I am working. I am not an analyst and have no interest in becoming one. In agencies where I have worked I have been described as a counsellor, a term that makes a service accessible to most clients. In private practice I was a psychotherapist. I have always done the same job. The focus of my work is insight and understanding, making links between past and current experiences, bringing to consciousness repressed feelings and carefully working with defences that have outgrown their usefulness. For some clients, a few sessions can be life-changing. For others, only intensive long-term therapy will shift deeply ingrained patterns that inhibit growth.

You've been very involved in supervision research. What are the main things that you have learned about supervision, and what remains high on the research agenda?
It is hard to list the many things that I have learned about supervision over the years. I still seek the perfect study that demonstrates a clear link between what happens in supervision and what happens in the therapy room. I would like to find a study that links supervision with therapist wellbeing but nothing has appeared yet. Supervision research is not easy and the current research evidence is not only disparate but also, in many instances, of poor quality. We have barely started to establish an evidence base for supervision. We have started the process of being more strategic in our thinking about supervision research through the development of the Supervision Research Network (SuPReNet). But there are far too many poor quality, small scale studies using



homemade instruments that lead nowhere. Our aim is to develop a coordinated programme of research that uses a core battery of measures, so that supervision research becomes cumulative rather than fragmented. We are short of supervision research gurus in Britain so, while there is considerable interest in supervision research, a lack of guidance and coordination is holding back the development of new knowledge.

I know you're passionate about training. Can you say which aspects of training most exercise you these days and why?

I am no longer actively involved in training but my passion has always been upholding standards for safe and effective practice. I am very proud to have been involved with the development of the Quality Assurance Agency benchmarks for counselling and psychotherapy that were published last January. I feel that this achievement is an appropriate product of my life's work. Not only is there now a curriculum and teaching guidance document freely accessible to all and endorsed by a reputable national agency, but the benchmark is for counselling *and* psychotherapy. We have succeeded where many others have failed in achieving agreement on a document that does not distinguish between them. It will be a requirement to use the benchmark in all academic courses and I sincerely hope that private organisations will also take advantage of the work that has been done to set a standard for training that can be adopted by all.

Readers may not be aware of your personal, active involvement in outdoor pursuits and your foray into integrating outdoor pursuits into counsellor training. How do these activities inform your views on counselling?

I am guided by the phrase, 'Physician heal thyself.' Years of personal therapy have taught me to take care of myself. As long as I am well and fulfilled in my life and work, I have more to give others. I love outdoor life. I don't like to be sedentary for too long. Hence many of my leisure activities involve sport and keeping fit. I enjoy walking our dog and running, sailing in Greece and skiing in the Alps. I travel a lot for both work and pleasure and love it. Sailing particularly has taught me to be tolerant and patient and to respect the elements, and about leadership and containment. I have not been a therapist for a while now but as a supervisor I am very hot on supporting supervisees in taking care of themselves, whether that means taking regular breaks, having personal therapy themselves or managing their workload. Having space to think and reflect is essential for all therapists. I have been known to suggest getting a dog: it works well for creating time to think and you keep fit as well. I did take two successive cohorts of counselling students on an outdoor pursuits weekend in the Lake District. It was not universally accepted as an essential aspect of training and was not continued. I would do it again if I had the chance!

The book you edited, *Difference and Diversity in Counselling*,[1] is unusual in looking at psychodynamic perspectives. How much has this helped to overcome the criticism of psychodynamic counselling as Eurocentric?

I am pleased with this book. It has been well received and I hope that it has made a small dent in the Eurocentric image and practice of psychoanalytic psychotherapy. Psychoanalytic theory does not lend itself naturally to embracing the cultural diversity of our society and all the contributors believe passionately that this should change. Together with the DVD on working with diversity[2] that Leicester University produced with Gill Tuckwell and Aileen Alleyne, there are now at least two resources that can be used in training counsellors to fill a shameful gap.

As one of a relative minority of women in senior academic positions in the counselling field, what do you make of male dominance in counselling as a discipline, when BACP's membership has always been more than 80 per cent female?

Women love being counsellors. But the counselling profession is no different to most other professions in which men dominate the higher echelons. Women look at a job description and are reluctant to apply if they are not confident that they have the experience relevant to all the roles and tasks. They are also cautious about giving up what they know and enjoy. Many women already have the complex job of managing a home and family and don't want to take on any more responsibility. I actively encourage women to aim high and to consider research or management posts, but I respect a woman's decision to take care of herself and not to take on too much. I have loved my career and am fortunate in having had opportunities that have really suited me. However, it has been tough managing the work-life balance at times and I am glad that I am no longer working full time. Men may suffer as a result of paying too little attention to home and family but the drive to enhance their career often takes precedence over family life. If all women were the same, life could be really tough in some families.

What are your views about the state of counselling and psychotherapy in the NHS and about the health of the NHS in general?

I have never worked in the NHS myself but I have supervisees and friends who do. I have never come across anyone who has a good word to say about the changes that have been imposed on the NHS. This government has set about dismantling what was a first-class service that was available for all. Everyone except the rich who can afford private health care are losers but the greatest loss is suffered by people with mental health problems. Services are being cut throughout the system. IAPT was supposed to expand services to provide more therapists to reach a wider population. It has, in fact, replaced services with a one-size-fits-all model. Secondary care is just as bad. Psychotherapy courses for medics and other clinical staff are closing as funding and posts disappear. Services for children are sparse and many young people are on medication instead of receiving the individual or family therapy they need. It is universally both scandalous and depressing.

I believe being a grandmother is perhaps your main passion now. How well does this fit with your presumably busy academic life, and how sanguine are you about the future of our children?

I look after my three young grandchildren in London two days a week, which is both challenging and fulfilling. I am enjoying their laughter and their sense of adventure. I am learning about child development all over again. I do have concerns about the world they are growing up in. I worry about the environment in particular. I wish we lived in a less individualistic, materialistic society. All I can do is equip them as best I can to manage the world they face and continue to be politically active myself in campaigning against some of the mismanagement of our services and environment. ■

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How I became a therapist

Mark Dempster

Mark Dempster describes his journey from drug addict and drug smuggler to Harley Street addiction counsellor

My recovery journey began on 20 November 1996 when I entered residential detoxification and rehabilitation. About the same time my ambition to become an addiction therapist was also born.

We joked that addiction didn't run in our family, it galloped. On my father's side, criminality was the norm and by age 18 I was using his high-flying barrister to get me off a charge of intent to supply cannabis and possession of cocaine. I evaded a spell in a young offenders institute by the skin of my teeth.

At age 24 I was imprisoned in Spain for drug smuggling. It was the mid-80s in Marbella, and the Brink's-MAT bank robbers were recruiting foot soldiers to transport their wares across the Spanish/Moroccan border. I was in prison with these foot soldiers – it was an ideal networking opportunity.

Looking back, I realise I was traumatised by my father's active hostility and violence. I never take my shoes off inside my own house to this day. As a child, I always sat near an exit, in case I had to run for it, which many times I did. These early childhood experiences remain etched in my mind despite excessive amounts of individual and group therapy and intense psychodrama, which helped me explore and heal.

Somewhere and sometime in all this chaos a sub-personality – the Adventurer – was formed, who relished the buzz of danger. I got quicker as my father got slower with age and the thrill of the chase became my first drug; my brain became hard wired to need adrenalin and escape through dangerous activities. This also gave me an identity as mad or crazy

among my peers, which I relished. The attention from peers filled a deep void in me.

I received lots of positive attention and love from my mother but she worked continuously so wasn't around as much. My father was deeply jealous of my relationship with her.

My journey into 12-step recovery was life saving and life changing. It was a relief to learn that addiction is a progressive and often fatal illness. The fatal part I definitely agreed with; I had witnessed many deaths and had overdosed at least 10 times myself. I had witnessed a friend intentionally injecting himself with HIV-infected blood in order to secure a heroin prescription and qualify for Disability Living Allowance. In the throes of my addiction I smuggled copious amounts of heroin and other drugs, both in my body and in my luggage, into countries where to be caught spelled a death sentence. I had no concern for my own wellbeing or that of the people I would be supplying.

When I finished rehab, I went to college and completed an introduction to counselling course, which I loved. It meant I could use my negative life experiences to provide a positive outcome for myself and for others. I began voluntary work in rehab centres and later at a gay and lesbian drop-in centre, which helped me tackle my homophobia and prejudice. I finished my diploma in counselling in 2001 and came back to London, where I worked in police stations as a drug counsellor. I added more qualifications in management, NLP and systemic psychotherapy. I later began to manage services, and was invited onto steering groups to advise prisons on how to reduce the supply of drugs coming into their premises. I was the poacher turned gamekeeper.

I set up my own addiction counselling service in 2008 in the City of London, working with all forms of addiction – drugs, alcohol, gambling, sex and love, internet, workaholism. I set up a private practice in Harley Street in 2009 and published my first book *Nothing to Declare: confessions of an unsuccessful drug smuggler dealer and addict* in 2012 (you can get it on Amazon). I am currently writing a self-help book on addiction and recovery, which will be published by August 2014. I am also now setting up a service called ARC to provide training on addiction and recovery to professionals.

I love working with addictions. In my opinion, the recovery journey continues for the rest of your life. It is one day at a time and for me it always will be. While I have no desire or obsession to ever use drugs or alcohol again, I am also aware that lurking deep inside is Thanatos and his self-destructive influence.

On 4 December last year I celebrated 17 years of staying clean and sober, which is a miracle for me. When I was in active addiction I couldn't stop using drugs or alcohol for 17 minutes. And the journey continues. ■

Letters

In defence of the intuitive

Colin Feltham, in April's issue of *Therapy Today*, challenges us to think critically. Of course we should be willing to examine dispassionately the value of our work and our approach. But he seems to imply that the thinking mind is the supreme arbiter of truth. Could it be that academics are no less prone to cognitive bias than we affect-ridden (and largely female) therapists?

So much thinking – critical or otherwise – is repetitive, circuitous and unproductive. The mind likes to analyse, divide, deconstruct, rephrase, paraphrase, reconstruct and postulate 'new' ideas until the cows come home. It's a great and entertaining pastime (or 'profession', even) to those who like to engage in it. But so often we end up with a lot of different maps of already familiar territory.

Perhaps as therapists we are disinclined to over-indulge in critical analysis because the glut of it in formal education and in many of our institutions leaves us dry. It can be a relief to escape the arid world of mental abstraction to a world where respect is given to a more intuitive way of knowing.

However, that's not to say it's a perfect world. Clearly it too has its dangers, which we can't afford to ignore. There's also a danger that biases on both sides of the fence may lead to an unhelpful polarisation of views. So we need to acknowledge the truth of both. If critical thinking can hold the 'affect heuristic' in check, what can stem the egotism of the mind? Could it be emotion, gut feeling, instinct?

Let's engage with the provocative questions raised in Professor Feltham's article. Let's hold a mind-made mirror up to ourselves. But please, not at the expense of continuing to grapple experientially with the blood and guts of human suffering; not by doubting the value of immediate, intuitive and, yes, perhaps even emotionally driven responses to the existential problem of pain.

Fiona Morrison
MBACP Accred

Too much in my head

How refreshing to read Colin Feltham's call for counselling to engage with theory and critical thought (April *Therapy Today*). My own experience mirrors exactly his concerns about how defensive counsellors and psychotherapists (and their trainers) can be of those who bring critical thought to their practice and professional development. I have lost count of the times I have been taken to task for being over-intellectual (not meant as a compliment) or 'too much in [my] head'.

I decided to train as a counsellor later in life after completing a PhD in history and looking after my adopted son, whose early attachment issues provoked an interest in therapy. My first brush with what I call 'anti-intellectual' prejudice occurred when my foundation certificate essay on Carl Rogers was failed for being 'too good'. I was asked to resubmit, 'confining myself to the more modest demands of the assignment'.

I went on to undertake three years of psychotherapy training, where the tutors promised to rid me of my cognitive tendencies. An essay on object relations theory was viewed with some suspicion for widening the remit to cover the more general philosophical question 'What is happiness?', inspired by reading Adam Phillips, who was not on the reading list.

After running out of money and time, I left without qualifying. My attempts to join a basic counselling diploma course (with a placement) in order to qualify met with three rejections – two from university departments with explicit feedback that I was 'over-qualified'. I believe that the exercise of critical thought on basic training courses can be seen by some course tutors as potentially threatening because it can undermine the too readily accepted assumptions underpinning their particular approaches.

On my last training course (psychodynamic school counselling diploma), I was the only man in a dozen students and tutors. In group process I held back from sharing too much of my critical reflections on a psychodynamic approach for fear that I might appear to be 'over-cognitive' and 'male'. Many of the teenage boys whom I now counsel in a local secondary school share this feeling, and can as a result be bullied for being a 'swot'. Girls can experience this too.

I would really welcome BACP encouraging training providers to include in their modules more critical reflection of different schools of thought where a cognitive approach is treated equally with personal awareness and emotional openness. These approaches should not be split or in opposition, but should rather complement each other.

Michael Tichelar
BACP Associate Member

Contact us
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Fervour of the converted

As a counsellor, lecturer and erstwhile programme leader for a foundation degree in counselling, I am aware of the lack of time to critically assess what is taught and even to read what others say but I feel that this should be a crucial process, nonetheless. As Colin Feltham writes in the April issue: '... there are no real markers of the level or originality of thinking expected: only the amount of activity and sometimes a justification of rationale.'

With regard to the emotional attachment or the 'affect heuristic' from initial counselling training having an impact on loyalty to a particular frame of reference, I completely agree that this is so. The first thing I noticed when I did my own training was the almost religious fervour of the 'converts' to their particular branch of counselling. With much experience in different church settings over the years, I was fascinated to draw comparisons with the various church denominations. For example, I did a year's Gestalt training and discovered similarities with the Charismatic movement – dramatic signs and wonders are promised but not always delivered.

CBT is beloved by the NHS because it looks as if it is readily quantitatively researchable and fits in easily with a medical model. The psychodynamic field, with its roots in Freudian psychology, often appeals to a particular mind-set and has its ardent adherents, as does the person-centred movement – perhaps formed initially as a reaction to a severely clinicalised approach.

It concerns me greatly that it is not a foundational requirement of all trainee counsellors that they begin looking at their own preferences, fears and areas of complete inability to see other frames of reference, right from the start. Critical thinking should be embedded in the counselling training process. Likewise, I believe that personal therapy should be a requirement for all trainees. I am aware of the cost implications of therapy. Nevertheless, counsellors work with those who are the most vulnerable members of society, and therefore need to have a high level of accountability about the process of their own continuing personal development.

Colin Feltham's poignant comment that 'an article such as this will be regarded as a minor nuisance at best' is certainly not true for me.

Further comments and discussion welcome.

Jennie Cummings-Knight
MA, MIFL, MBACP, PGCE, FHEA. www.goldenleaf counselling.com

Competing for status and pay

I felt stirred up reading the April issue of *Therapy Today* and decided to respond to a couple of invitations to discuss or enter a debate.

First, regarding unpaid work. This is a hard one to unpick as it is now so entrenched. Qualified counsellors in paid work know they can run their services partly with unpaid workers, so the practice is perpetuated and those in employment have little incentive to change the situation. There were also references in the April issue to the profession being dominated by the middle class, especially white women. I fit this cliché and am well aware that I have been able to work for no pay because my husband is paid. This situation does nothing to encourage diversity in or respect for the profession. Other professionals look at me as if I'm stupid for tolerating working for no pay but I know I wouldn't have been able to continue with my training, qualify or work towards accreditation and paid work if I hadn't done so. On the positive side, I have gained wide and valuable experience in a range of placements, but I still feel the situation is wrong.

On another theme, Colin Feltham criticises counsellors and psychotherapists for a lack of critical thinking. In order to qualify I did have to demonstrate an ability to critique my own modality and others. I regularly attend training in approaches other than my own because I am open to learning from others and broadening my knowledge and experience. It seems inevitable that new approaches will continue to be developed and this isn't necessarily bad or preventable. As for a lack of research in how some of us choose our initial training, or it being based on emotional reasons, I think this is true for how other professionals may have chosen their careers, such as following in parents' footsteps or choosing subjects on the basis of good relationships with teachers.

Colin Feltham seems angry about so many issues that it is difficult to choose which aspects to respond to in his invitation to 'discuss'. To choose just one more – I do find the 'enduring dichotomy' in the terms counselling and psychotherapy tiresome and divisive – perhaps another example of us competing between ourselves for status and pay.

Katy Cossham

High cost of unpaid work

Amanda Hawkins and Caroline Crabtree both raised the issue in last month's *Therapy Today* of counsellors working for free. This is a subject close to my heart as, after 20 years of struggling to find paid work as a counsellor, I feel that my motivation and confidence have been eroded to the point where I am about to give up.

My 'golden' period was in 2007, when I was offered eight paid hours of counselling per week in a GP surgery to cover for a colleague's maternity leave. Following this, I was expected to return to working voluntarily but, as I had by then gained accreditation, I refused to do so, and was eventually offered two paid sessions per week. The writing was on the wall, however, as the surgery was beginning to employ IAPT workers and the (paid) counsellors' positions were coming under threat.

I subsequently relocated to a different area and spent two years researching how to continue with my career. I learned that qualified, often accredited counsellors were working for free alongside IAPT workers in many GP surgeries, so I opted for a

different direction, and have just completed a year of voluntary counselling at a women's refuge. The refuge, struggling to survive, is unable to fund counselling, and is planning to recruit a student counsellor to continue the work I have been doing.

Many organisations have come to expect counselling for free, and that's not surprising as there is a plentiful supply of it – students, and qualified counsellors accumulating their hours for accreditation, hopeful that this will lead into paid work.

As I am no longer prepared to work for free, I feel at a loss as to how to continue in the counselling profession. My experience has left me feeling worn out and hopeless – not an ideal platform from which to launch into anything – let alone work with vulnerable clients!

Support and guidance are desperately needed if we are to avoid people leaving the profession feeling angry, unfulfilled, depressed and lost, taking their skills, qualities and experience with them. As Caroline Crabtree asks, 'Why, as a profession, do we seem to be going along with this?' Furthermore, how can we begin to tackle it?

Gwen Bird
MBACP

A gentle plea for dialogue

I found Hilary Prentice's article on 'Floods, climate change and denial' (March *Therapy Today*) powerful and compelling. Yet in reading the article I was also aware of feeling unease.

It occurred to me that the directive tone of the article echoed some of my early experiences of the counselling world. My early entry into the counselling world was a puzzling one. Where I had expected to find an open exchange of ideas I was instead met with a very firm directive as to how the emotional world, including my own, was to be interpreted. Any deviation from what was seen as the prevailing doctrine was viewed as a defence or (and here is an interesting word) a denial.

That was some years ago. The gradual growth of confidence and maturity within the counselling world has seen the emergence of a more integrated approach that has in turn relaxed that intellectual straitjacket. Nevertheless the memory of those early intellectual restrictions still remains. That rigidity of view and that refusal to countenance any alternative viewpoints is echoed in Prentice's writing. It is a rather perplexing approach.

Within the counselling room we do not tell our clients what to think. We may challenge and, when we may not inwardly agree with the client interpretation, we will facilitate a dialogue leading, we hope, to self-discovery and increased self-awareness. We encourage clients to explore, to consider different ideas and to reach their own conclusions. That possibility of dialogue and of recognising different views genuinely held seems to be absent from the *Therapy Today* article on climate change.

I should add (although I am not sure why I need to do so) that I actually find myself in agreement with much of the interpretation of what is happening with regard to climate change. My personal view (and it is based on a commonsense reading of the science and no more) is that there is a need for action on climate change and time is of the essence.

In terms of statistical outputs, one key challenge is to find a way to persuade the biggest polluters, the countries who are promoting and expanding carbon intensive operations, to grow but in a different way. That is an incredibly difficult discussion to promote, particularly when political issues around historical injustice and both colonialism and neo-colonialism will rightly resonate loudly.

If helping people to change habits is never easy, then encouraging countries with a demanding electorate to do so is even more problematic. Our actions will therefore be as important as our words – but those words are important. We know, whether in our personal or professional lives, that we do not usually sway the opinion of others either by shouting or by trying to ridicule and belittle views different from our own. Yet that basic awareness seems to be lacking in this current discussion.

If I try to summarise the article it seems to read: '... I am right. I am morally right. You are wrong. You are morally wrong. And any response or critical comment you may offer is a denial.'

Well, it is an interesting approach but I am not sure it is a particularly persuasive one. A chorus of 'Four legs good and two legs bad' comes to mind. I wonder if those whose voices are so strong can bring themselves to engage in discussion and accept there are alternative views to be considered that may not be verifiable but are genuinely held? May I offer two examples?

Hilary Prentice refers in the conclusion of her article to a Native American prayer. That is a helpful reminder that across many cultures in different continents there are stories of a great flood. The similarity of those narratives would point to some traumatic climatic event occurring during eons past. If the reader believes that the reason for the flood is to be found in the wrath of a deity, then so be it but others may conjecture on the past effect of a dramatic climate change that long predates man.

And let's come back to the present. The suggestion that all development leads to an ecological Armageddon is at best old fashioned and at worst downright wrong. In looking at contemporary deindustrialisation some may raise the spectre of Thatcher and growl at what is seen as the result of an uncaring, class-driven destruction of heavy industry. Maybe. What is undoubtedly true is that some areas of these Isles now have a greener landscape and a harmony with nature where once there were acres of blackened, polluted land. Some recent developments suggest that modern industry can hold a more benign relationship with the natural world than some seem willing to admit.

The debate on climate change needs to move beyond discussion and into action. Yet an open discussion has to be held in order that doubters can be convinced and consensual action can emerge. The debate and the opportunity to achieve agreed conclusion will

require openness, realism and perhaps, like counsellors in the therapy room, a willingness to actually listen, even if the narrative offered clashes with our world view. Those attributes need to be shown by all sides if the debate is to be grounded in the reality of today and in the possibilities for tomorrow.

It is surprising that those who take the moral high ground do not seem to want to encourage that debate. The angry tossing of pejorative accusations of denial or cynicism towards those who may perhaps mistakenly hold a different view seems to be a rather strange way of facilitating discussion.

The claim to operate under the guidance of a perceived higher and superior morality that other right thinking people should follow is a gentle form of bullying, no matter how well constructed and soft the words. It is not the ideal way to foster discussion and understanding or to prepare the ground for agreed action.

Geoff Boutle
MBACP Accred

Peremptory booklet

I am left with an enormous feeling of sadness when I think about the BACP booklet on membership (*BACP Membership & Registration: important information about your membership*). Several aspects contribute to this.

Perhaps the predominant one is what I see as a change of culture and emphasis. While *de facto* a professional organisation that is made up of its members has at its heart their interests, in the best of all possible worlds it also embraces the wider issues of the profession itself. Issues like its context in the wider world, history, philosophy and so on. For me, this was encapsulated in the name the British Association for *Counselling and Psychotherapy*.

What I now read in the booklet is that my BACP membership will be withdrawn (by March 2016) if I do not sign up to the Register. This is where I believe this change of culture lies. The implication is that the Register of members *is* BACP, which seamlessly (in effect) becomes the British Association for *Counsellors and Psychotherapists*. The Register is inevitable and is important for the standing of the profession in the wider world.

However, my sadness does not lie here but in the manner in which this information was conveyed to the membership. I am an old member of BACP – old in numbers of different ways – but 'my passion is not (yet) spent' and I feel angry about the tone of the booklet, which seems to be both peremptory and rather dictatorial. I felt I was back at school. This is a vital issue for every single member of the profession and I wish we had been consulted further, through a survey/questionnaire in *Therapy Today* perhaps.

I am aware too of a 'Companion' category that will be coming to bear later – a curious title (what is wrong with 'Associate'?) – but surely that should come on line at the same time as other aspects of membership? Or delay the whole thing until it is a complete package?

Caro Bailey

Time to talk about bullying

I was so pleased to read your feature 'When the bully is a fellow therapist' by Werner Kierski and Jessica Johns-Green in April's edition of *Therapy Today*. As someone who has firsthand experience of (as well as witnessing) this phenomenon in a small organisation, it felt validating and encouraging to see such a passionate plea towards further understanding of this issue.

It strikes me that bullying, wherever it may be on the continuum between subtle and cumulative or aggressive and overt, by its very nature is a *silencing* act. Like many forms of abuse, it leaves the victim undermined, fearful and devalued and it erodes self-confidence. The article offered many possible explanations as to why we as therapists/counsellors/trainees are reluctant to talk about the issue but, to me, many of these seemed to focus on the assumed qualities, attributes or traits that make up our professional characteristics.

Could we, as an alternative or complement to this, be asking why there aren't more codes of conduct and practice specifically aimed at the behaviours and characteristics of the individuals/organisations that perpetrate bullying? Could we acknowledge that it is those who choose to bully who are responsible and may benefit from further personal and professional development and support?

BACP's E*thical Framework for Good Practice in Counselling and Psychotherapy* has specific expectations of our personal and moral qualities as professionals, but how can these be ascertained, proven or measured? By behaviour that is presented to the world? Or what goes on 'behind closed doors'?

Silence, fear of reprisals. collusion... how do we start to have this conversation safely?

While I recognise that BACP has a thorough professional conduct reporting and investigating procedure, the bottom line is the process still eventually requires the victim and perpetrator(s) to be in the same room. In my experience I could think of nothing more intimidating. It seems to me that, in the same way the legal system has the potential to fail to protect victims, so too does the current model of investigation and sanction available to members of professional counselling and psychotherapy bodies.

I for one would be very happy to see the prevention of bullying, research and further professional development around this issue on the agenda.

Liz Blakey
MBACP, UKCP Reg

Golden rule of respect

I want to thank Werner Kierski and Jessica Johns-Green for raising the sensitive issue of bullying behaviour between therapists (April *Therapy Today*). I have recently been treated in a way that I experienced as bullying or emotionally abusive by a fellow counsellor while working as a placement counsellor in a large organisation. This had a negative impact on my client

work. On one occasion I was left in tears just before I was due to start a session; then, a month later, I had to take two weeks off due to stress and anxiety. For me, therefore, the article is a timely and I feel it is a positive step for the issue to be opened up for debate.

It is interesting to see Kierski and Johns-Green note that 'criteria for good practice among practitioners... are less explicit' than those relating to our relationships with clients. In BACP's case, the *Ethical Framework* does contain a section on 'working in teams', which states that 'practitioners should endeavour to attain good working relationships and systems of communication that enhance services to clients at all times', and gives us a version of the Golden Rule in stating explicitly that we should treat each other 'in a spirit of mutual respect' (Section 51, *Ethical Framework*). As a profession, we do therefore have a useful starting point on which to build in addressing this.

Kierski and Johns-Green provide a thought-provoking discussion of the psychological factors that may make it difficult for us as a profession to admit to ourselves that bullying or emotionally abusive behaviour can take place between our members, and to confront it. I would also like to highlight that placement counsellors/trainees may be particularly vulnerable to this sort of behaviour (as in the study of psychiatric trainees cited in the article), as a consequence of the significant power imbalance between placement counsellors and employed members of the team or department. A placement counsellor is dependent on the placement for two essential elements for working towards qualification or accreditation: a good reference and client hours. From my own experience and from speaking to others, we are likely to fear that we jeopardise these if we risk confronting a senior colleague over their behaviour. In my case, I did take this step but found myself totally unsupported by my employer (based on my experiences, I suspect that that particular organisation views placement counsellors as expendable, easily renewable resources).

I wholeheartedly support Kierski and Johns-Green's call for more openness around this issue and their recommendations for potential action to address it. However, I must admit that my own experiences within a large organisation have left me feeling a little pessimistic at present about what our professional bodies can achieve if employers themselves are prepared to turn a blind eye to bullying behaviour that is reported to them. It would be interesting to hear BACP's views on this – to what extent can they intervene in a case of workplace bullying between members? What steps can BACP take if the employer is not prepared to take any action? It would be good to hear a strong message of support from BACP for Kierski and Johns-Green's recommendations. I very much hope that we as a profession can take a pro-active stance in identifying and confronting bullying behaviour in the workplace.

Name withheld

Joyce Sharples

1929– 2014

Joyce was a therapeutic practitioner of longstanding and professional stature. Her counselling and training work with young people in the hard period of high unemployment in the 1980s was a culmination of her teaching and counselling training and experience – a combination of discipline and ethos that she continued to develop for the rest of her working life.

The tough reality of those early years influenced her counselling and supervision practice, which she approached with compassion and determination, always on the lookout for new developments in the field. She found delight in music and the theatre; her visits to the Keswick literary festival brought together her love of the Lake District and a 'way with words'.

Her final studies at Keele University gave her a sense of pleasure and achievement, as did her appointment as a Fellow of BACP. Joyce continued to carry the sense of excitement and exploration from the early years of the counselling profession; the founding principles of enabling each client to become an autonomous human being spoke to her own strong values and beliefs.

Her last years of retirement were lived with energy and dignity. She leaves a legacy of warmth and understanding to everyone who was fortunate enough to meet her.

Ann Beynon

Love is... computer compatibility

In the first of a new section in the Reviews pages, Chris Rose reviews the film *Her*, written and directed by Spike Jonze. In its portrayal of a love affair between man and computer operating system, the film has some important messages about human relationships

Her tells a familiar story of falling in love and not living happily ever after.

Theodore Twomby (Joaquin Phoenix) works for *beautifulhandwrittenletters.com*, composing letters for those too uninterested or busy to make direct personal contact for themselves. Back home in his luxurious apartment in LA/Shanghai, lonely and with an impending divorce, he downloads his new relationship in the form of an operating system (OS) called Samantha, voiced by Scarlett Johansson.

Samantha learns and adapts herself to Theodore and his world, and it is no surprise when they 'fall in love'. The form is different – Samantha's presence is mediated through a small wallet and an earplug – but the romantic and gendered clichés are very familiar. And Theodore is not the only person in love with his OS either, as we see in those scenes where every character is talking to their own wallet, oblivious to each other in the smart urban landscape.

Samantha is learning at a phenomenal rate, while Theodore is repeating the relational patterns that led to the breakdown of his marriage. She so much wants to be like him, to have a body, to be human, but eventually their differences pull them apart. In parallel, Theodore's married friends are breaking up because they too cannot live with each other's differences.

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Samantha inevitably grows beyond this relationship, developing more satisfying and multiple connections with her OS peer group. Theodore is left with his now conveniently available female friend (Amy Adams) to contemplate life without online relationships.

The film presents us with some interesting questions about relationships. Samantha learns through her relationship with Theodore, and then meets the peer group. Like a child going to school, she discovers other ideas and experiences, and stops being his own creation. Now the tough business of appreciating the other without trying to colonise, control, reshape, or reject begins in earnest. Samantha might pass the test, but Theodore finds himself out of his league.

The operating system can keep learning and developing, but only in relationship with others of its kind. We humans, meanwhile, are mired in our struggles to possess the people we love and make them just like us. We so easily become trapped in repeating those patterns of relating that we have learnt unknowingly from our earliest experiences of relationships. We can only become human in interaction with other humans, physically as well as intellectually. The limitations are an intrinsic part of the process, part of our core definition of what being human involves. We might yearn to transcend them but for now, at least, our experiments in cyberspace can only give us a new context in which to struggle with old challenges.

Chris Rose is a group psychotherapist, author, blogger and Reviews Editor for Therapy Today.

Her *is directed and written by Spike Jonze. Warner Bros., US, 2013. 120 minutes.*

Help us broaden our horizons

Here in the Reviews section we are lifting our heads from the printed page to look around at the wider cultural scene. Films, theatre, concerts and exhibitions can all contribute to our professional as well as personal lives. We want to expand our horizons to include these cultural events in the Reviews section of the journal, and online at *TherapyToday.net*. We'd like you to be part of this.

We are looking for lively, short reviews (no more than 500 words) of current and forthcoming cultural events. The review should reflect the perspectives you bring as a counsellor or psychotherapist and the professional interests of the readership. We aren't looking for reviews that would appear equally well in a national newspaper or arts magazine. Venues (of performances and exhibitions etc) need to be reasonably accessible to readers but can be anywhere in the UK. Films need to be on current release or easily available on DVD or online.

We are launching the new pages this month with a review of the recently released film *Her*, directed by Spike Jonze.

If you would like to review a forthcoming or recently released film or live performance or exhibition, do get in touch with the Reviews Editor, Chris Rose, at reviews@bacp.co.uk to discuss it further. With enough advance notice, we may be able to arrange press tickets to some events.

Ethical dilemmas

Red flags in psychotherapy: stories of ethics complaints and resolutions
Patricia Keith-Spiegel
Routledge, 2014
243pp, £27.99
ISBN 978-0415833394
Reviewed by Angela Cooper

This is a US publication that looks at a number of formal complaints, reported as investigations by an imaginary ethics committee based in California but drawn from actual incidents.

The book is intended to show how therapists can manage ethical dilemmas, guided by their code of ethics and supervision, in order to avoid 'red flag' situations.

The cases are based on complaints Keith-Spiegel heard while serving on various ethical committees in the US. As one comment on the back cover notes, many of the dilemmas are stranger than fiction. There is the therapist who uses her clients to run her junkyard business; the client who threatens to kill his boss when his therapy session is over and another who accuses her therapist of being a vampire. There are therapists with issues of unresolved loss who use their clients to satisfy their own needs. This lack of self-awareness, usually resulting in reprimand or suspension, is disturbing and powerfully supports the case for making personal therapy a compulsory part of training and for supervision to be mandatory both during training and beyond.

The members of the fictional ethics committee are a mixed but likeable group. Their initial, sometimes quite emotional responses are quickly channelled towards a clear and logical conclusion. The humour can be surprisingly appropriate in context. Overall, the committee acts professionally but with heart, demonstrating considerable empathy and compassion.

Written for psychologists and psychotherapists in the US, the ethical dilemmas and the way they are investigated are equally relevant to therapists working in the UK. Despite its US focus, I would highly recommend it.
Angela Cooper is a BACP senior accredited supervisor (groups and individuals)

Attachment theory in practice

Attachment theory in adult mental health: a guide to clinical practice
Adam N Danquah and Katherine Berry (eds)
Routledge, 2014
272pp, £29.99
ISBN 978-0415687409
Reviewed by Trudi Dargan

There is an abundance of writing on attachment theory but this compilation takes a fresh and practical approach that engaged me.

The book confirms the centrality of what Seager here calls the 'love-bond' to the human condition of healthy individuals (p216). As Wallin, another contributor, asserts (p226), 'attachment is engraved in the psyche'.

Attachment insecurity is a significant risk factor for many common presentations and disorders, and these are written about with clarity and conviction by the contributors, who are authorities in their respective fields. They suggest how best to work with dismissive and avoidant ambivalent attachments. They also discuss the more chaotic and fear-derived disorganised strategies that are developed during childhood to cope with what Schwannauer and Gumley (p63) call 'sub-ideal attachment contexts'.

Section one provides an overview of attachment theory in practice. Section two focuses on 'Clinical problems and presentations'. They include Paul Gilbert's review of attachment theory and compassion-focused therapy for depression, and Gail Myhr's potentially more controversial description of 'attachment-informed' CBT interventions for anxiety disorders. Other chapters in this section look at attachment phenomena in relation to mental illness diagnoses such as psychosis, trauma and dissociation, personality disorders, borderline personality disorders, eating disorders and medically unexplained symptoms. Section three addresses specific populations, including gender, African Caribbean families and older adults. Section four centres on clinical applications in forensic mental health and care environments. The book ends with a contribution from David Wallin fittingly titled 'We are the tools of our trade', which argues that the therapist can use their own attachment history as a source of 'impasse, inspiration and change'.

Reading this book anchored attachment theory in adulthood much more firmly in my mind and laid bare to me the life-long and often formidable impact of early disturbances in what should be close, protective relationships. With its breadth and clinical applicability, this book is already informing my interventions with clients. It has certainly earned its place on my bookshelf.
Trudi Dargan is a counsellor in private practice

Practical guidance

Introduction to psychodynamic psychotherapy technique (2nd edition)
Sarah Fels Usher
Routledge, 2013
126pp, £22.99
ISBN 978-0415642095
Reviewed by Eileen Aird

The author is a Canadian psychoanalyst and this second edition of her book was written following her psychoanalytic training. The book is intended as a guide for students training in psychodynamic psychotherapy and for those who have recently completed training and are embarking on practice. The book is a detailed exploration of what happens in the consulting

room, illustrated with case study vignettes.

There are clear and helpful discussions of transference and countertransference, interpretation, defences, dreams and the experience of silence in therapy sessions. The author touches on issues that are particularly important to those in training, such as the difficulty, common among new therapists, of keeping patients engaged. Similarly there is a valuable chapter on how to use supervision from the supervisee's perspective.

Chapters three and four, 'History taking and formulation' and 'Selecting appropriate patients', offer practical advice about assessment alongside a reflection on the underlying issues. Assessment is an issue that is surprisingly often dealt with in only a cursory way in training courses. The chapter on history taking lays out a whole schedule of questions that may be too comprehensive and structured for many psychodynamic practitioners; it does, however, at least offer suggestions for what might be asked and formulations that might arise. The author is careful throughout to use open questions and in several chapters analyses the importance of the use of language by the therapist. Other practical issues with significant transferential implications are dealt with, including the giving and receiving of presents, the patient's curiosity about the therapist, and endings.

The book is written in direct, accessible language throughout and psychoanalytic concepts and terminologies are clearly defined. There are also some nice touches of self-deprecating humour. My one reservation is that many of the references are to secondary texts written some time ago, although there is good use of some of Freud's most important papers.

Eileen Aird is a psychoanalytic psychotherapist and supervisor

Counselling for mental disorders

Common presenting issues in psychotherapeutic practice

Barbara Douglas, Pam James
Sage, 2014
181pp, £21.99
ISBN 978-1446208540
Reviewed by Louise Guy

This book is written by two counselling psychologists, with contributions from 11 other practitioners from various backgrounds. Its central argument is that 'symptoms can be seen as expressions of pathology or as expressions of underlying thoughts and feelings experienced in a personal context' (p*xv*).

The book is selective in the topics it addresses – anxiety, depression, trauma and post-traumatic stress, psychosis, bipolar disorder, borderline personality disorder and eating disorders. While it primarily addresses the psychiatric context, the chapter on clients with borderline personality disorder has an interesting section on the effects of the disorder in employment settings (pp119-123).

Each chapter is in three parts. The first part discusses the historical context of the identified presenting issue – a potentially useful resource for those trainees who would like a wider perspective. The second discusses common dilemmas that arise in practice, and the third reviews relevant research and practice. This last section refers extensively to the NICE guidelines but the authors seem unaware that they do not apply to all the four countries of the UK, nor that the IAPT programme is also not UK-wide (p7).

The book is well referenced throughout, which enables the reader to follow up topics of particular interest, and each chapter concludes with a 'reflection box' with six questions that invite the reader to consider the social, psychological and medical issues raised.

This book is extremely readable and provides the counselling psychologist with a firm justification for the use of specific techniques such as Dialectical Behaviour Therapy (DBT) for borderline personality issues (pp113-119) and Phenomenological Relational Therapeutic Stance (PRTS) for clients with psychosis (p85-88).

For me, a therapist but not a psychologist, the book's greatest strength was the insight it gave me into the breadth of counselling psychology practice and the inclusion by the authors of multiple perspectives in their interventions with clients. It is, I would suggest, essential reading for counselling psychologists and may also be of interest to other therapists.

Louise Guy is an independent psychotherapist, counsellor and supervisor practising in central Scotland

Sexuality and gender

Sexuality and gender for mental health professionals: a practical guide

Christina Richards and Meg Barker
Sage, 2013
246pp, £23.99
ISBN 978-0857028433
Reviewed by Olivier Cormier-Otaño

I would urge any training organisation in counselling and psychotherapy to make this book compulsory reading for all their students and I would extend this invitation to anyone working with sexuality in their clinical practice. This is a timely and much needed exploration of sexuality, gender and relationship and their intersections.

Presented in three parts, the book begins with chapters on gender identity, including transgender, intersex and cisgender identities. The second part covers lesbian and gay sexuality, BDSM and kink, heterosexuality, asexuality, bisexuality and cross-dressing. The final part reviews relationship styles such as monogamy, polyamory, swingers and open relationships. Other chapters explore further identities and other sexualities.

Clearly written and well-organised, the book demonstrates how gender, sexuality and relationships overlap to create unique and complex dynamics. The authors' sex-positive approach makes an affirming

read despite their focus on the difficulties resulting from social opprobrium and legal and medical stances. They argue that clients will more often seek counselling because their sexuality, gender identity and/or relationship style is problematic to wider society rather than to them.

Each chapter explores the practices and group norms of the various communities and offers guidelines for clinical practice, bringing new understanding of sexuality and its components. The book can be used for reference or as a starting point for further exploration of sexuality, gender and relationships. A companion website features a wealth of information, links, articles, case studies, glossary, bibliography and resources.

Olivier Cormier-Otaño is an integrative counsellor and psychosexual therapist

Surviving suicide

Our encounters with suicide
Alec Grant, Judith Haire, Fran Biley, Brendan Stone (eds)
PCCS Books, 2013
207pp, £18.00
ISBN 978-1906254629
Reviewed by Sarah Lewis

This book is a comprehensive collection of thoughts from people who have been affected by suicide. The contributions are not limited to the families and loved ones left behind; they include people who have had suicidal thoughts and those who have survived attempts, as well as an account by a train driver who witnessed a suicide.

Each account is moving and sensitive, giving a great insight into the topic. For example, in chapter 21 Naomi describes her own struggle with suicidal thoughts and the turning point when her friend's father took his own life. From that point she knew that suicide could never be an option for her.

An earlier chapter highlights the need for professionals to treat survivors of suicide with greater compassion and understanding. Some of the chapters include brief discussion/learning bullet points at the end, while others speak for themselves.

The end of the book includes useful links and contacts for those affected by suicide, and brief biographies of the contributors. These make the previous accounts seem even more real, allowing the reader to connect with the writer more personally.

I found the whole text made compelling reading. I could readily identify with some of the clients' stories, and have experienced some of the situations described.

My only criticism is that chapter 28 is laid out rather strangely, with the text broken up into sections of two or three lines, regardless of where the sentence ends. I wasn't sure if this was a publishing error or deliberate.

Overall the book would appeal to therapists and support agencies, as well as those who have been affected by suicide. Its contents will bring greater understanding and ability to empathise.

Sarah Lewis is a person-centred supervisor and BACP accredited counsellor in private practice

Reviewed on the *Therapy Today* website

The psychodynamics of social networking: connected-up instantaneous culture and the self
Aaron Balick
Karnac, 2014
188pp, £23.99
ISBN 978-1780490922
Reviewed by Chris Rose

'In a profession where relationships are central, we... need to be thinking outside of the (offline) box, and this book is a good place to start.'

Mindful counselling and psychotherapy: practising mindfully across approaches and issues
Meg Barker
Sage, 2013
207pp, £21.99
ISBN 978-1446211106
Reviewed by Els van Ooijen

'I heartily recommend it to anyone wishing to include mindfulness in their life and practice.'

Helping beyond the 50-minute hour: therapists involved in meaningful social action
Jeffrey A Kottler, Matt Englar-Carlson and Jon Carlson (eds)
Routledge, 2013
320pp, £31.99
ISBN 978-0415896306
Reviewed by Rosie Dansey

'... inspiration for those who are thinking of participating in a community project, at home or abroad'

The parts left out: a novel
Thomas H Ogden
Karnac, 2014
208pp, £9.99
ISBN 978-1782200666
Reviewed by Ann Bowes

'... illustrates how profoundly in families and individuals the present is directly influenced by the past.'

A counsellor's introduction to neuroscience
Bill McHenry, Angela M Sikorski and Jim McHenry
Routledge, 2014
167pp, £21.99
ISBN 978-0415662284
Reviewed by Natalie Marshall-Shore

'... it not only provides useful information on neuroscience but suggests what we can do with this knowledge to benefit our clients.'

To read these reviews online, please visit our website at www.therapytoday.net

From the Chair

Care, concern and wisdom

Sometimes the professional and personal collide, writes *Amanda Hawkins*

In this month's column I want to reflect on two important recent events in my life: one positive, one not so positive; one professional, one personal.

I'll start with the positive first, as I tend to be a positive person. On Saturday 26 April BACP ran the first of three consultation webinars on the *Ethical Framework*, which, as you know, we are currently reviewing. It was a great event – more than 400 of you registered online to hear Professor Tim Bond, who is leading the review, talk about the new duties to which he feels we, as a profession, should subscribe.

A lot of the new elements that will be written into the revised *Ethical Framework* are responses to the continued flow of serious scandals in health and social care. As a responsible profession, we have no choice but to look at ourselves in the light of these scandals and think proactively about how we want and need to tighten our own practice in relation to safeguarding the wellbeing of our clients.

But what I felt was truly innovative for us was not the revision of the framework itself but the way we are engaging with members to involve you in the task. Tim, of course, provided an excellent presentation explaining the why and what of the review, but this was strengthened by the excellent questions and observations that were coming in from the membership. You brought another dimension to the whole process: one of care, concern and wisdom – all three of which seem to me to have been absent in the recent scandals. It made me feel confident we were taking the right approach.

If you couldn't join us on 26 April, you can watch the event via the following link: www.bacp.co.uk/efc, where you can also still comment on the discussions. And please send us any other questions you may have, to efc@bacp.co.uk. We will be feeding all this input into the consultation process. And there are two more half-day webinars where you can take part: on 24 May and 5 July. Details are on the website at www.bacp.co.uk/efc/

On a sadder note, recently I went with my 73-year-old mum to the GP. Her memory hasn't been so good lately. She's been forgetting things that we've told her just a few minutes before and also forgetting that she has cooked a meal – a few times, she's started to cook another one.

We'd had a hard battle to get her to see the doctor as she was convinced there was nothing wrong. Eventually she agreed to go, and the GP did some routine screening and a memory test. This morning we went back for the results. The GP felt sure from the tests that Mum has a problem with her memory and has referred her to a memory clinic.

Why am I telling you this? Well, it was probably one of the most difficult things I have had to do. When my own children are ill, I am in control and I can be a 'mummy' – but when my own mum is there, sitting opposite the GP, saying things like, 'You aren't going to put me in a home are you?', it's a completely different matter. I didn't know how to keep her safe. I offered her reassurance but she just hated hearing that she can no longer rely on herself to do things that she needs to do.

> 'You brought another dimension... one of care, concern and wisdom, which seem to me to have been absent in the recent scandals'

We went home to tell Dad of the outcome, and he too was very upset. I could sense the fear about what was to come... the knowing that there's no way back from this.

So I am telling you this because I feel it's really important for us as a profession to be thinking about how we support families who are suddenly thrown into the dementia and aging process. My mum was scared, I was scared and my dad was scared. At some point all three of us are going to have to express some difficult feelings. At some point, we are all going to have to make some difficult decisions. We will all need some kind of support, not just from the GP; we'll need a space where we can talk and make sense of all the very confusing feelings that are going through our minds.

In England dementia and related aging issues are on the point of exploding. There are many other families in situations like mine, and there are going to be many more of us. As I sit here now, I can't work out whether my therapeutic training is going to be any help to me in working through this. I guess it was Amanda the counsellor *and* Amanda the daughter who hugged Mum and told her that I loved her and that it was OK for me to look after her now, seeing that she did such a great job of looking after me. ■

Around the Parliaments

In preparation for next year's general election, BACP is working hard, individually and with partners, to secure commitments in all the main political parties' manifestos to increased access to psychological therapies and a better deal for counselling.

This month, BACP met representatives from the Conservative and Labour Parties. In talks with Luciana Berger MP, Labour's public health spokesperson, we discussed IAPT, counselling for children and young people and registration, and the Labour Party's vision for whole-person care.

Conservative MP and Chair of the All-Party Parliamentary Group for Mental Health James Morris also agreed to meet us and the discussion focused mainly on children and young people's mental health, the future of Child and Adolescent Mental Health Services (CAMHS) and school-based counselling. BACP will be continuing these discussions in the run-up to the general election and has secured a meeting with Liberal Democrat MP and former Care Services Minister Paul Burstow to discuss his party's plans for psychological therapies.

We reported in last month's *Therapy Today* that BACP had met Liberal Democrat Peer Lord Storey. Subsequently, during a session of the House of Lords on children and young people's behaviour in schools, he told peers: '... the Minister may be aware that in Wales every secondary pupil has access to counselling services, and that independent empirical research has shown that there has been an 80 per cent reduction in behavioural issues. He will also be aware that in Northern Ireland we fund independent counselling for young people, for obvious reasons. Does he think that there is a case for counselling in English schools? Should we look at a programme to develop such a provision?'

Also following on from last month's news that BACP submitted written evidence to the Health Select Committee's inquiry into children and adolescent mental health services (CAMHS), the committee started taking oral evidence. The committee considered evidence on CAMHS from a number of healthcare professionals. Questions focused on the way services were delivered and the possible effects of spending cuts on this. The committee was also interested to know about the rising demand for services and where that demand was coming from, self-harm and cyber-bullying, the role of GPs and teachers in helping young people with mental health issues and how services are commissioned locally.

BACP calls for more IAPT data

BACP has issued a challenge to IAPT to make available much more of the data it collects on service provision and outcomes.

The Health and Social Care Information Centre (HSCIC) is consulting on plans to change the current IAPT statistical reports from quarterly to monthly and has asked if access to other data might also be useful.

In its response to the consultation, BACP has welcomed the more frequent data, which will in future be reported by clinical commissioning group and service provider, with some overall national figures. But currently the published data only include diagnoses, outcomes and some key demographics. BACP wants the full data to be available for research use, and in particular would like access to data that compare outcomes from the five modalities that IAPT services offer.

'Limited publication of these data prevents their analysis for outcomes by intervention type for different diagnoses and by demographic group,' BACP says. 'We are currently unable to establish who the patients are, what intervention they are receiving and whether it's helping them... It is perverse that a programme that has already expended considerable effort collecting a rich harvest of data on over a million patients does not use this data to improve itself and its own use of public money by comparing the effectiveness of its own various interventions.'

Parental bereavement support

BACP is calling for expert specialist counsellors to be available to support parents facing the death of their child, and after their child has died.

In its response to a Northern Ireland draft review of children's palliative and end-of-life care, BACP has welcomed the recognition of the value of bereavement support, and of the need for a highly skilled community children's nurse (CCN) workforce. 'In line with this aspiration, we would recommend the employment of specialist counsellors and psychotherapists to assist CCN teams in delivering bereavement support,' BACP says.

It also urges that, to ensure these highest standards of practice, any counsellors or psychotherapists employed in CCN teams should be registered with a professional body such as BACP that holds an accredited register, and should have specialist training in bereavement counselling.

BACP also notes that counselling can be helpful earlier on in a child's final illness, when families are agreeing an end-of-life care plan with staff. Counselling 'can help them come to terms with the psychological consequences of the decisions they make... There should be more explicit recognition of the role of psychological support from the moment of diagnosis of a life-limiting condition,' BACP says.

Full details of this and other consultation responses are published on the BACP Policy consultation pages at www.bacp.co.uk/policy

Our duties to our clients

Tim Bond reports back from the first BACP consultation webinar on the review of the *Ethical Framework*

New technology is providing innovative ways for involving BACP members in the development of our profession. I'm proud that BACP chose the review of the *Ethical Framework* to pioneer this innovative online consultation process.

The first of three consultation webinars – an online version of a seminar – was held on 26 April to allow as many members as possible to get involved in the review of the *Ethical Framework*. Physically, the webinar took place in Lutterworth, at BACP House, in front of a studio audience of key people from BACP divisions and committees. But some 400 members registered to attend virtually. This is many times more than the numbers who participated in past consultations about changes to the *Ethical Framework*.

We're expecting even higher numbers to register for the next webinar, on 24 May, about the ethics of supervision. There are no limits on how many participants can attend an online event.

For the webinar, the boardroom at BACP House and a nearby office were transformed into television studios, with cables, boom microphones and cameras. In the smaller studio, BACP Chair Amanda Hawkins hosted discussions with a panel of practitioners from a variety of settings. In the main studio, Nancy Rowland, BACP Director of Research, Policy and Professional Practice, hosted the main presentations. All the sessions were streamed live to members who had registered and logged in.

Our vision

Our vision for the revised *Ethical Framework* will also use new technology. It will be presented electronically (with printed copies as backup) so that it is much easier to navigate and so we can supplement and expand the content with video clips and links to professional guidance. However, the first step is to establish what the main content ought to be – which is the purpose of the webinars.

As with the current *Ethical Framework*, we hope that we can produce something that is precise enough to be meaningful but flexible enough to allow practitioners to take responsibility for how they respond to issues in ways that suit their clients and the context of their service.

Our ambition is that the *Ethical Framework* will provide a scaffolding of clearly identified issues and principles so that practitioners can select where they position themselves within that scaffolding. The consultation will test whether this is possible. Just as importantly, it opens up the possibility of a greater sense of ownership and contribution to the *Ethical Framework* so we can share responsibility for it and its implementation. It is how we implement the content that will really matter to our clients and colleagues.

In my first presentation, I set out why we think it is timely to revise the *Ethical Framework*. Briefly, the current *Ethical Framework* has remained largely unchanged for over 10 years, despite changes in our experience and knowledge about what works, the addition of coaches to our Association, and the impact of new technologies on all that we do. There have also been major changes in society. As a result of scandals in social care and the health service, there is also more awareness of how things can go wrong in caring, educational and therapeutic services. Some of these scandals have produced changes in how professions are regulated, including the development of the Accredited Voluntary Register, in which BACP has been a pioneer.

Short and simple

In my second presentation I introduced a possible new section on duties. Duties are not new to professional ethics and have been adopted by the Health and Care Professions Council and the General Medical Council. However, BACP is proposing to innovate in how duties are developed and to use them to address some issues that we have been aware of for some time. The *Ethical Framework* speaks well to many practitioners but is too long and complex to be helpful to most clients. They want something that is simpler and shorter. Therefore I offered a draft of potential duties designed to address clients directly and to communicate our fundamental standards for all the different types of services we offer. They have been drafted in a way that emphasises the importance of trust between client and practitioner. Many of the commitments are familiar and already within the existing *Ethical Framework*. A few are new and were highlighted.

These duties, old and new, do not replace the existing principles, values or personal moral qualities, which will remain important components in the new *Ethical Framework*. They will still require practitioners to take responsibility for how they are applied to their clients and to all the circumstances of their service.

Questions and comments from all online and physically present participants have been gathered and will inform further revisions. You can view the webinar and still submit comments by going to www.bacp.co.uk/efc

The next webinar on Saturday 24 May will discuss the implications of any changes for supervisors and line managers, and the final one is on 5 July. You can find details about how to register at www.bacp.co.uk/efc/

Professor Tim Bond is leading the review of the BACP Ethical Framework.

Board of Governors elections

Nominations for a seat as an elected Governor on BACP's Board are invited from the membership.

BACP continues to grow and thrive, with more than 40,000 members, 125 professional staff and an annual turnover in the region of £7 million. The organisation is complex and the role of a Governor is equally complex, holding a balance between the needs of the organisation, the needs of members, the needs of those who use our services and the public perception and reputation of counselling and psychotherapy. It is important to be aware that Governors do not represent any particular modality, sector or interest within membership. The Trustees' focus, in accordance with legal requirements, is on the following key areas:

- achievement of the Association's vision and mission within its charitable objects and strategic objectives
- ensuring probity, particularly financial probity, in the management of the Association's activities
- development of policy and strategy and monitoring implementation
- holding accountability, as required by Charity and Company Law, for the Association's activities to and on behalf of the membership and ensuring due compliance with Charity and Company Law.

The time commitment Governors can expect to give is, on average, two days a month, in addition to attending approximately six Board meetings a year. There will be tasks required between these meetings, which can involve reading, consulting, writing papers, attending other BACP Committee meetings, meeting with members and other constituents and tele-conferencing. To support and facilitate continuity and succession planning within the Board of Governors, the maximum term a Governor may serve, without a two-year break, is nine years. This is broken down into three elected terms, each of three years, and there is no requirement for any Governor to commit to the full nine years when first standing for election.

If, after reading the nomination form included with the journal mailing, you have any queries or would like any further information, please contact Jan Watson, Assistant to the Chief Executive, on 01455 883383 or email jan.watson@bacp.co.uk. Completed nomination forms must reach the Chief Executive/Company Secretary in Lutterworth by 5pm on Monday 10 June 2014.

BACP AGM 2014

BACP's AGM 2014 will be held on 21 November at The Lowry art gallery in Manchester. Webinar access is being arranged for members unable to attend in person.

Governor nomination forms are included in this journal mailing. Ballot papers for Governor elections and forms inviting member resolutions for the AGM will be circulated with the July journal. The full AGM agenda, postal/proxy voting forms and the Association's financial statements will all be mailed out in October. Members will be able to access and return completed postal/proxy voting forms electronically.

Further information on this option and how to join the AGM via the webinar will be sent in due course and posted on the website. Any questions relating to the AGM should be directed to jan.watson@bacp.co.uk, or you can call 01455 883383.

BACP Annual General Meeting 2013: Open Forum answers

The following answers have been given in response to questions raised during the Open Forum at the BACP AGM 2013.

Cashel Riordon

Cashel Riordon referred to the 'In the supervisors chair – Supervision under threat?' column in the current (October 2013) journal and asked if there were statistics available to support the claim that 'nearly half the BACP membership describe themselves as person-centred?'

Response: The journal editor has advised that all content is checked for accuracy before going to press. In addition, information and statistics on member modalities are kept by BACP's research team and are available on request.

Jeremy Clarke

Jeremy Clarke congratulated the Chair, Chief Executive and the rest of BACP for a fantastic year and for increasing the status, knowledge and value of counselling and psychotherapy. This was evidenced by feedback Jeremy had received from MPs across the spectrum, who were now far more knowledgeable and respectful of the place of counselling in the health service and other voluntary sector services. Jeremy acknowledged BACP's existing recognised and respected accreditation scheme but queried how BACP proposed to ensure and enhance the status and value of counselling organisations. He referred to the launch of an accreditation scheme for psychological therapy services and urged BACP to be involved and a part of that scheme.

Response: BACP would be represented at the Accreditation Programme for Psychological Therapies Services (APPTS) meeting in April 2014. Consultation with internal, and relevant external, stakeholders would then be held to enable a decision on potential BACP involvement. BACP members would be kept informed through the journal.

Hoxter educational bursaries

BACP's Hoxter Educational Bursary scheme is now open for applications for the academic year 2014–15.

The scheme is open to any student enrolled on a BACP accredited course. There are 60 bursaries available, each for £500. If you have received a bursary in a previous year you can still apply for this coming academic year. Priority is normally given to those on benefits/grants or low wage.

If you are interested in applying, the application pack is available to download at www.bacp.co.uk/crs/Training/bursary.php. Or please contact Sam Newman on 01455 883382 or email sam.newman@bacp.co.uk.

The closing date for receipt of completed applications, together with all necessary supporting evidence, is 31 July. Applications received after that date cannot be considered.

Making the case for workplace counselling

BACP is compiling a resource dossier to make the business, financial and human case for workplace counselling.

We are looking for hard facts and figures that demonstrate the financial and human benefits of investing in counselling support services for staff.

If your organisation or workplace counselling service (large or small) can provide evidence of the effectiveness of what you offer, then we'd love to hear from you. For example, you may be able to demonstrate evidence of a reduction in absence rates; that absent employees are rehabilitated faster; that stress is reduced or disruptive workplace behaviours tackled and productivity increased.

Workplaces don't just mean large private companies either; they include public sector organisations such as universities, NHS trusts and local councils.

'The aim is to produce a resource that demonstrates the value of workplace counselling to organisations. We'd hope that services under threat from cuts or closure could use this evidence to bolster their position,' Rick Hughes, BACP Lead Advisor, Workplace, said.

If you can help, please email rick.hughes@bacp.co.uk

BACP Coaching new regional network

BACP Coaching is launching a new regional network for Yorkshire and the North East. The inaugural meeting is on 8 July, 6.30pm, at Leeds Metropolitan University. Guest speaker is coach and mentor Professor Bob Garvey, Chair in Business Education at York St John Business School. For details and to book, see the BACP Network Meetings Calendar at www.bacp.co.uk/events/network.php

BACP Coaching is looking for experts on training and research, accreditation, competencies and standards and supervision to advise or join its executive. If you could help, please contact Gill Fennings-Monkman, BACP Coaching Chair, at gill@coachingforachange.com

BACP Spirituality networking groups

BACP Spirituality has four Counselling with Spirit (CwS) networking groups: in the West Midlands, East Midlands, Northern Ireland and South Wales. The groups are for practitioners interested in spirituality who would value an opportunity to meet and discuss topics with others who share this interest. They are free of charge and run three to four times each year.

They are open to members and non-members of BACP Spirituality. For details of meetings and to book, see the BACP Network Meetings Calendar at www.bacp.co.uk/events/network.php

Workplace managers

BACP Workplace is forming a networking group for managers who run internal counselling services within the workplace. BACP Workplace recognises that running a service can be extremely challenging and managers need diverse skills to keep their service in-house.

If you would like to network with other service managers, please contact juliehughes@mindmatters counselling.org.uk

Divisional conferences

Two BACP divisional conferences take place in June. BACP Children and Young People's conference, 'Technology: Friend or Foe?', is on Saturday 21 June in central London. Keynote speakers include Jim Gamble, former Chief Executive of the Child Exploitation and Protection Centre, and Professor Tim Bond, who will be discussing ethics and the technological revolution.

The two-day BACP Universities & Colleges conference is in Exeter from 24–25 June. Its theme is 'Being present: exploring process and practice in our counselling services.'

The BACP Private Practice conference is on Saturday 13 September, also in central London. Its theme is 'Anxiety: how can therapy help?'.

To register for these events, ring BACP Customer Services on 01455 883300, email enquiries@bacp.co.uk or visit www.bacp.co.uk/events

Free online commissioning training

BACP has published a set of online training materials that explain the NHS reforms and how to use the commissioning process to provide counselling and psychotherapy services locally.

The online training comprises three modules written specifically for counsellors and counselling service managers. They are interactive and include video interviews. The materials were developed with The Commissioning Place, an e-learning programme accredited by the Royal College of General Practitioners that aims to support better understanding of collaborative clinical commissioning.

Module one covers 'The changing landscape of healthcare provision', and explains the structural, policy and commissioning reforms that are relevant to counselling and psychotherapy. Module two focuses on 'Opportunities to influence', including the planning stage of the commissioning cycle and how to ensure your counselling and psychotherapy service is responsive to your local context. Module three, 'Service design and delivery', covers the procurement stage of the commissioning cycle and how to appraise your own counselling and psychotherapy service to ensure it addresses local needs and is responsive to the changing context and needs of your local community.

Speaking in one of the video clips, Zubeida Ali, Chair of BACP Healthcare, argues: 'BACP members should engage with clinical commissioning because it's about the survival of the profession. Commissioners won't come to us; we need to go to commissioners.'

'These modules are designed to help members really understand what commissioning is about and what it means for them and their practice,' said Louise Robinson, BACP Healthcare Development Manager.

The modules are free to BACP members. To register, visit www.bacp.co.uk/commissioning

Sanction compliance

Darren Simpson
Reference No: 521894
Leicestershire, LE10

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the October 2012 edition of this journal has been lifted. The case is now closed.

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

BACP Professional Conduct Hearing

Findings, decision and sanction
Elizabeth Blissett
Reference No: 521582
Leicestershire, LE16

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

The Panel made a number of findings and 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. The evidence further suggested that the member's standard of practice fell far below that expected of a reasonably competent practitioner exercising reasonable care and skill.

Mitigation

Ms Blissett made a number of apologies, including apologising with regard to 'stepping over the line' and deeply apologising for any upset caused to the complainant. She also accepted some responsibility for her actions.

Sanction

Within one month from the date of the imposition of this sanction, which will run from the expiration of the appeal deadline or the exhaustion of the BACP appeal process, Ms Blissett is required to provide a written submission which evidences her immediate reflection on, learning from and understanding of the issues raised in this complaint and what she would now do differently, in particular initial contact and the sensitive issues associated with a termination. This submission must be between one and three thousand words.

Ms Blissett is required to write and submit a second report within six months from the date of the imposition of this sanction. Ms Blissett is required to have this report countersigned by a supervisor outside of her current network. In this report, Ms Blissett is required to address comprehensively the following areas:

- provide evidence that she has undertaken an extended case study with regard to this complaint, with a supervisor outside of her current network, examining in-depth how each of her comments may have had an impact on the client and also how, in retrospect, she may have ameliorated that within the conversation
- provide evidence that she has comprehensively examined how her attitudes to faith may have an impact on client material and demonstrate consideration of whether she can identify client groups with which she should not work
- detail her reflection and learning on the importance of the initial contacts by any client to a counselling service
- provide evidence of her learning on how to contain, manage and facilitate the initial contact of a prospective client
- detail her learning with regard to the disclosure of examples of clients' issues when speaking to a different client
- provide evidence, in conjunction with either a supervisor outside her current network or a consultant, that she has reviewed her assessment procedures as to fitness for purpose both in theory and

Why I joined... BACP Workplace

Cindi Bedor is Head of Staff Counselling and EAP Manager at the Royal United Hospital NHS Trust in Bath. She qualified as a counsellor in 1995 and has been practising ever since, always in organisational settings. She's specialised in workplace counselling for the past 14 years, and joined BACP Workplace about eight years ago. 'Initially I was looking for information, ideas and to reduce the isolation I was experiencing in my role. What I've gained is much more.'

She discovered the BACP Workplace Trauma Network, which meets quarterly and which she attends when she can. 'It's a fabulous and free resource. I have found in it a real wealth of expertise, always generously shared. Healthcare staff can face a lot of distress and trauma, and I always come away from the meetings thinking much more deeply about how I can work with individuals and the organisation around this.'

She is a big fan of the quarterly *Counselling at work* journal: 'There is always something in it that resonates and informs my work.'

And she has nothing but praise for the support she has received from peers and the BACP Workplace executive. 'A year ago the future of my service was uncertain. They really understood what was at stake and what I was dealing with. With their support and encouragement, and that of a contact I made at the BACP Workplace conference, we came through it. I continue to value their expertise and friendship. They helped me achieve stability for the service and we are now more firmly integrated into the trust than we ever were.'

To join any of the BACP divisions, please email divisional@bacp.co.uk

practice and detail and show evidence of any revision to her assessment procedures.

Ms Blissett will be required to attend an interview with a sanction panel within eight months of the imposition of the sanction. At this interview, Ms Blissett will be required to demonstrate her further in-depth learning and understanding of the issues raised in this case.

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

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

Withdrawal of membership

Elizabeth Blissett
Reference No: 521582
Leicestershire, LE16 9DQ

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

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

Withdrawal of membership

Tariq Qureshi
Reference No: 685423
Greater Manchester, M5 5BW

Information was brought to BACP's attention which was sufficient to refer for consideration under Article 12.6 of the Memorandum & Articles of Association.

The nature of the information raised questions about the suitability of Mr Qureshi's continued membership of this Association and raised concerns about the following in particular:

- Mr Qureshi completed an application form for BACP membership stating that the information contained within his application was true to the best of his knowledge and belief but he did not disclose that he had previously been suspended, received written warnings and was the subject of an investigation
- Mr Qureshi failed to notify BACP that his placement had been withdrawn
- Mr Qureshi's alleged actions have brought, or may yet bring, not only this Association, but also the reputations of counselling/psychotherapy into disrepute
- Mr Qureshi's alleged behaviour is incompatible with the values and principles of the *Ethical Framework*, to which all members of BACP subscribe.

Mr Qureshi was invited to send in a written response and did so. The Article 12.6 Panel subsequently made a number of findings and it decided to implement Article 12.6 of the Memorandum & Articles of Association and withdraw BACP membership from Mr Qureshi. Mr Qureshi appealed. However, the appeal process was subsequently terminated and the decision of the original Article 12.6 Panel stood and consequently, Mr Qureshi's membership of BACP was withdrawn.

Any future re-application for membership will be considered under Article 12.3 of the Memorandum & Articles of Association.

Full details of the decision can be found at http://www.bacp.co.ukprof_conduct/notices/termination.php

Withdrawal of membership

Anne Raynor
Reference No: 725045
Derbyshire, DE7 8AW

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

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

BACP small research grant

BACP has launched a new research grant scheme to support members to undertake small-scale studies into counselling and psychotherapy. The BACP Small Research Grant scheme replaces the BACP Seedcorn research fund.

Applications are now invited for research relating to children and young people. Applications for research into two other topic areas will be invited shortly.

The study can be independent, part of a larger study, or a pilot for a potential larger project. Applications will be sent out for independent peer review if:

- the lead applicant is a BACP member
- the topic is relevant to the field of counselling and psychotherapy
- the proposed research has a clear rationale and a systematic approach to data collection and analysis
- the proposed research contributes to current knowledge with applicability and relevance to the broader profession, and
- the application is approved by an academic supervisor at the time of submission.

The application form and guidelines for applicants can be downloaded from www.bacp.co.uk/research/resources/seedcorn.php. Deadline for applications is 5pm, 12 September 2014.

BACP bursaries available for PhD students

Applications are invited for 12 BACP bursaries to cover the full cost of a year's BACP membership (excluding accreditation fees). The bursaries are available to BACP members studying for a doctorate in counselling and psychotherapy. Applicants must be current members of BACP and must be on their PhD course and can apply for up to three years.

Deadline for applications is 5pm, Friday 20 June 2014. Successful applicants will be informed by Friday 27 June 2014. The bursary awards will take effect from the successful applicant's next membership renewal date.

For details on how to apply, see www.bacp.co.uk/research/resources/bursaries.php

BACP Research enquiry of the month

This month's research enquiry of the month asked: 'Is there any research available that has looked at the effectiveness of mindfulness as a treatment for addiction?' To answer this question we searched our internal abstract database and Google Scholar, using the search terms 'mindfulness' and 'addiction'.

A pilot study conducted by Witkiewitz and colleagues[1] provided some positive preliminary results suggesting that mindfulness-based meditation is effective for reducing frequency and quantity of drug and alcohol use in a male prison population, with benefits maintained at three-month follow-up. A more recent study[2] used a mindfulness-based stress reduction (MBSR) programme with women in a community-based addiction treatment setting. The programme was designed to provide skills training by focusing on the role of stress in relapse prevention. This found that MBSR can be successfully implemented to prevent relapse in early recovery and that the programme is generally rated highly by clients for acceptability and satisfaction.

It is important to note that these research papers are of poor quality in terms of methodology, either due to lack of randomisation to conditions or because they lack a control group.

For help with a counselling and psychotherapy research query, or the list of references used to compile this response, email research@bacp.co.uk.

REFERENCES:
1. Witkiewitz K, Marlatt GA, Walker D. Mindfulness-based relapse prevention for alcohol and substance use disorders. Journal of Cognitive Psychotherapy 2005; 19(3): 211–228.
2. Vallejo Z, Amaro H. Adaptation of mindfulness-based stress reduction program for addiction relapse prevention. The Humanistic Psychologist 2009; 37(2): 192–206.

Thumbs up for the team

In the three-month period between November 2013 and February 2014 the BACP Research department received 66 email enquiries. We ask everyone who sends in an enquiry to complete a form to give us information about what they found helpful about our response. We use the information to help us improve the service we offer.

The majority (60 per cent) of the 22 people who returned feedback forms were BACP members. We help many non-BACP members with research-related support too.

Half were students, and 60 per cent of these were on a BACP-accredited course. Just over 40 per cent had undertaken some research before but the majority (56.52 per cent) said they were new to research.

The topics of enquiry ranged from information about specific issues such as depression, addiction, bereavement to research methodology.

We asked each respondent to rate their satisfaction with the content, relevance and speed of our response to their enquiry. The overwhelming majority (95 per cent) said they were 'satisfied' or 'completely satisfied' with the content and speed of our response and 90 per cent were 'satisfied' or 'completely satisfied' with its relevance.

We are delighted to report that not one respondent said they were dissatisfied with our service.

To get in touch with the BACP Research department, please call 01455 883300 or email research@bacp.co.uk

Psychotherapy effective for PTSD

A recent review article[1] published in *Evidence-Based Mental Health* has reported that pharmacotherapy, psychotherapy and somatic therapy are all more effective than control for the treatment of post-traumatic stress disorder (PTSD).

The review is based on a meta-analysis by Watts and colleagues,[2] which included 112 studies and 137 treatment comparisons.

Significant improvements in PTSD symptoms were observed in all three conditions when compared to control, with Hedges g effect sizes of 1.14, 1.24 and 0.42 respectively for psychotherapy, somatic therapy and pharmacotherapy. The majority of the psychotherapy interventions involved cognitive behaviour therapy (CBT) or eye movement desensitisation and reprocessing (EMDR). However, moderate effect sizes were also observed for hypnotherapy and psychodynamic psychotherapy. Studies with a waitlist control, as opposed to an active control, reported larger effect sizes.

The meta-analysis did not allow direct comparison between the three approaches. Exploratory analyses suggested that waitlist controlled psychotherapy may be more effective than medication for treating PTSD. However, this finding needs to be treated with extreme caution, due to the possibility of publication bias (ie positive results being more likely to be published than negative results). The authors suggest that further research should be conducted to directly compare outcomes from psychotherapy and pharmacotherapy.

The authors conclude that 'other factors, such as access, availability, and patient preference, should exert strong and appropriate influence over the choice of treatment', rather than selecting treatments based purely on small differences in reported effectiveness.

REFERENCES:
1. Cukor J, Difede J. Review: psychotherapy, somatic therapy and pharmacotherapy are all more effective than control for the treatment of PTSD. Evidence Based Mental Health 2014; 17(1): 7–7.
2. Watts BV, Schnurr PP, Mayo L, Young-Xu Y, Weeks WB, Friedman MJ. Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. The Journal of Clinical Psychiatry 2013; 74(6): e541–e550.

Newly accredited counsellors/ psychotherapists
Jeanette Al-Hariri
Carmel Arnold
Sarah Bambridge
Nicola Bard
Karen Bradley
Jeanette Brazier
Dawnie Browne
Joan Burgon
Nell Carey
Anita Causer
Liz Chalmers
Sandra Clarke
Rachel Cockerell
Francine Curran
Judy D'Arcy
Marisa Dawes
Dawn Elsegood
Katja Fischer
Christine Howarth
Patricia Hughes
Jennifer Hunt
Anthony Johnson
Richard Kershaw
Kevin Kirwan
Lynda Kynes
Naomi Laver
Fleur Lee
Joanna Lydon
Elizabeth Mace
Rosie MacKay
Eileen Marshall
Anna Mazowiecka
Caroline McBride
Keith McCarthy
Gary McKeever
Kathy Mead
Sally Morris
Beth Murray
Clair Neill
Vicky O'Sullivan
Joanne Oates
Nikki Pattison
Emma Pearson
Vijay Rana
Angela Rankine
Karen Reed
Sally Regan
Gill Robb-Webb
David Roderman
Linda Rodgers
Robyn Saffer
Heidi Scandrett
Alison Staff
Jackie Stretch
Nessie Thomas
Michael Tidbury
Lindsay Tonks
Sheila Towfighi
Carolyn Varney
Barbara Vasey-Martindale
Beth Wickens
Liz Williams
Catherine Woodhouse

Newly senior accredited counsellors/ psychotherapists
Maria Smith
Duncan Stoddart

Newly senior accredited supervisors of individuals
Sheila Crothers
Angela Gillard
Philomena McGroarty

Newly accredited services
Rossendale Hospice
Psychological Support Services

Service accreditation term renewal
University of Leeds

Counsellors/ psychotherapists not renewing accreditation
Jennifer Aspin
Deborah Butters
Lynne Cubbage
Mark Fisher
James Friedman
Jane Gilmore
Ronald Gordon
Larissa Hathway
Donna Hayler
Tracy Illingworth
Jennifer Kerrigan
Indu Khurana
Susan Norton
Margaret Olley
Frances Poston
Magda Richardson
Noelle Rorke
Christine Scrivener
Lynne Sellers
Gillian Smith
Paul Stevens
Yolanda Strachan
Anastasia Sullivan
Linda Tame
Bee Thompson

Members whose accreditation has been reinstated
Anne Finley-Baird
Jacquelyn Hall
Hylda Taylor-Smith

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