Therapy Today

For counselling and psychotherapy professionals

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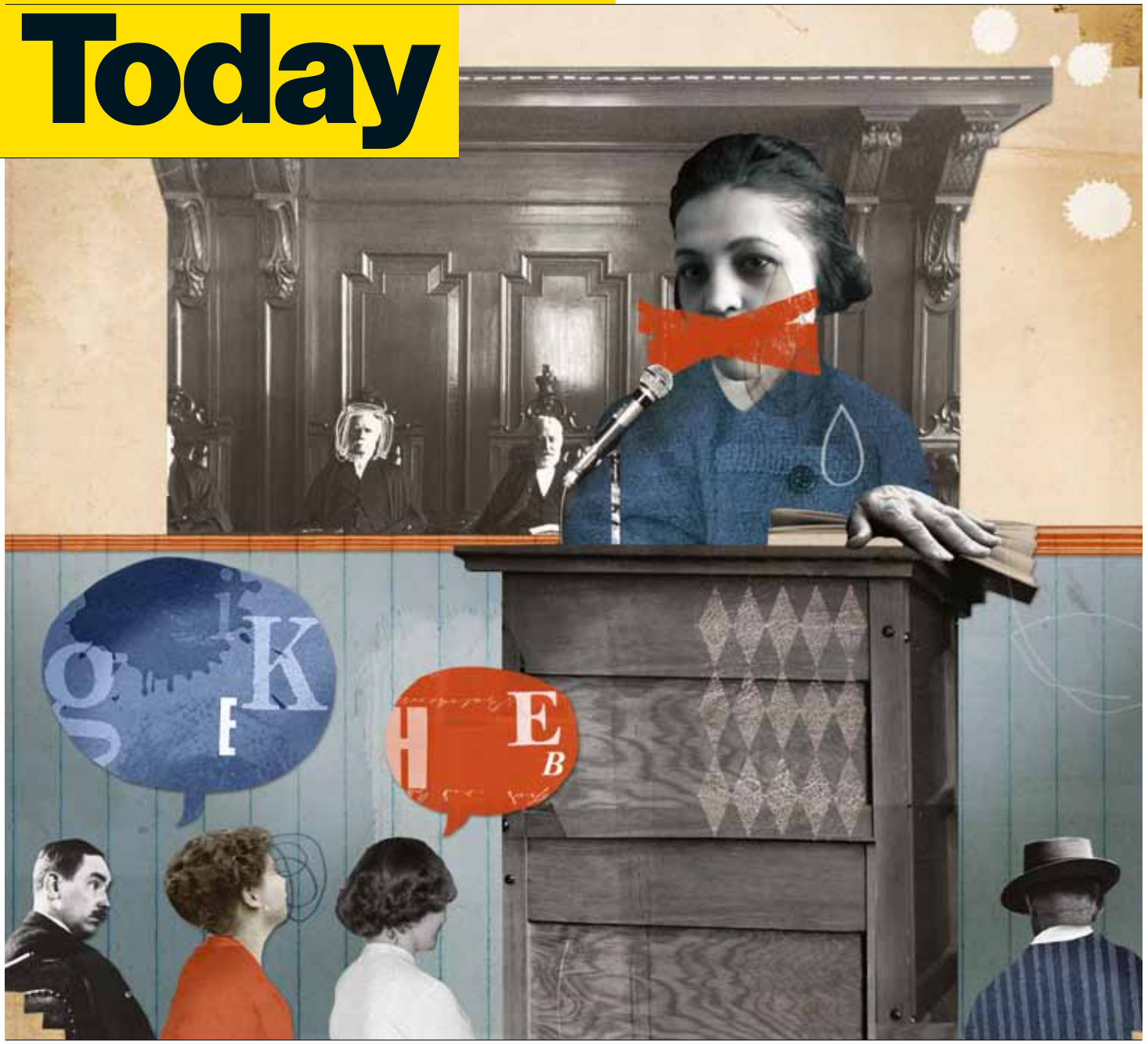

Bereaved by homicide

Why management should matter to counsellors

Postnatal depression: is it all about motherhood?

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Contents

Sarah Browne
Editor

Our lead article this month gives advice to counsellors about working with clients who have been bereaved by homicide. Janet Nicholls, whose sister was robbed and murdered on the street in 2001, describes the experiences such a client may have to go through and some of the common patterns that emerge.

For example, the bereaved person may have been traumatised by hearing very distressing forensic details reported in court; they may have experienced intrusive media attention; they may no longer be able to hold onto their previous values and beliefs or see the world as a safe place. The client may have known or be related to both the victim and the accused, or even be a suspect themselves, in which case the term 'complicated grief' doesn't begin to cover what they will go through.

One thing that struck me when reading Janet's article is that there is no publicly-funded counselling available for people bereaved by homicide and those who seek counselling may not be able to afford the help or may even resent having to pay for it themselves. She praises the police family liaison officers who provide support for close family until the investigations and trial are over but this is in no way the same as counselling. As in so many situations in our society, people turn to counsellors for support when there is nowhere else to go, as they might have turned to priests in the past.

We continue to receive your letters about the lack of paid work available for counsellors and the difficulties making a viable living from counselling alone. In his research column this month Barry McInnes applauds the Government's commitment to achieving parity of esteem between mental and physical health and BACP's lead in addressing this inequality as it relates to psychological therapies. In time, he suggests, this may help create a better employment landscape for counsellors and psychotherapists but in the meantime much more needs to be done.

Features

Cover illustration by Eleanor Shakespeare

Regulars

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Peter Jenkins discusses pre-trial therapy in an article From the Archive; Eleanor Shakespeare describes the inspirations for her illustrations; plus online news, reviews and noticeboard.

Waiting time targets pledge

The Coalition Government has announced it will introduce waiting time targets for access to talking therapy and mental health services for the first time, so patients have the same guarantees of treatment as they do for physical health conditions.

The targets, to be phased in from next year with full implementation by 2020, will require IAPT services to ensure 75 per cent of patients with anxiety and depression have their first appointment with a counsellor/therapist within six weeks of referral and 95 per cent within 18 weeks. This is equivalent to the waiting time targets for most physical health services.

The latest IAPT figures show that 61 per cent of patients are seen within 28 days of referral and 89 per cent within 90 days.

The targets are part of the Coalition Government's five-year plan to achieve parity between mental and physical healthcare services. The aim is to tackle the high level of regional variation in waiting times for mental health treatment, and for IAPT therapies in particular. It is backed by £40 million in funding this year and £80 million next year.

Targets will also be introduced for people with severe mental health problems, who will be offered psychiatric treatment within two weeks of referral. Funds of £30 million have been ring-fenced to improve early intervention services for psychosis and crisis care. There will also be funding for 50 new inpatient mental health beds for children and young people.

BACP has welcomed the new targets but has warned that access to IAPT services should be improved and not 'simply rationed in order to meet targets'.

Mental health promotion 'under-funded'

Local authorities in England spend on average 1.36 per cent of their public health budget on mental health, a survey by Mind has found.

Using Freedom of Information data, Mind has calculated that local authorities spend less than £40 million on promoting mental health, compared with £76 million on increasing physical activity, £108 million on preventing obesity, £160 million on smoking cessation and £671 million on sexual health promotion.

Reading Well reports first year successes

The Reading Well bibliotherapy scheme Books on Prescription has reached some 275,000 people across England and has led to a 113 per cent increase in library loans and a 70 per cent increase in sales of the titles on its recommended reading list in its first year.

The scheme enables GPs and health professionals to recommend self-help books on mental health issues to their patients. The books on the recommended reading list can be borrowed from almost all (91 per cent) of English public libraries. Some 7,000 practitioners – mostly GPs and IAPT practitioners – are working with the scheme across England.

In a survey by Reading Well, 91 per cent of service users said the book they had read had been helpful; 79 per cent said it had helped them understand more about their condition; 73 per cent said it had helped them feel more confident about managing their symptoms, and 37 per cent said that their symptoms had reduced or got better.

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Most users had taken themselves to the library to choose a book (80%), often after seeing the Reading Well leaflet. Only 20 per cent had been recommended a book by a health professional.

All the prescribers surveyed said the scheme had been helpful for patients and just under half said the scheme had saved them consultation time. Other identified benefits included increased patient insight and learning, help with recovery, treatment in line with the stepped care model, and reduction in the need to refer patients on for further treatment.

Reading Well is now in the process of developing a dementia reading list, to be launched early next year.

Self-harm and digital life

Practitioners should ask about children and young people's digital lives when assessing their mental health, especially if there are concerns about self-harm, the Royal College of Psychiatrists says in new guidance on *Managing Self-Harm in Young People*.

The report updates its 1998 guidance for practitioners working with children and young people and their families. It urges practitioners to show 'courage and compassion' when asking young people about self-harm. In a new section on self-harm and the internet, it says: 'It is important to understand the young person's experience of different types of content and engagement with others and to not make simple assumptions about how harmful or helpful it is.

ChildLine rise in suicide calls

Calls to ChildLine from children and young people who are feeling suicidal have increased by over 100 per cent in the past three years.

On the Edge, a ChildLine report on suicide, says the number of helpline counselling sessions where children talked about having suicidal thoughts increased to 34,517 in 2013/14 – 116 per cent higher than in 2010/11 and 18 per cent up on last year. The steepest increase was among girls (a 142 per cent increase since 2010/11, compared with 32 per cent among boys).

Of these callers, 5,846 said they had previously attempted suicide, a 43 per cent increase on 2012/13. A fifth of the young people had not told anyone else about their suicidal feelings. Many said they felt that suicide was the only option to stop the pain or solve the problem, the report says. In a third of the counselling sessions the young person also mentioned self-harm. Visits to the ChildLine webpages on suicide rose to 37,000 last year, up from 18,000 in 2012/13.

Nearly 3,000 counselling sessions were with young people who were concerned about someone else's suicidal behaviour. ChildLine says adults in these children's lives, including professionals, are failing to spot the signs of distress and listen to them, because of the stigma attached to suicide.

The report offers advice about how to help. Adults need to talk about mental health more openly to reduce the stigma that surrounds it, listen carefully to what young people are saying and take their worries seriously, find sources of support for them, ask the young person what they need, and help them have some control over what happens next.

Trust offers furry therapy

An East London Clinical Commissioning Group (CCG) has awarded £9,120 to a local charity to provide animal therapy to elderly people.

Based at Stepney City Farm, Furry Tales will deliver therapeutic animal handling sessions to vulnerable older people in Tower Hamlets to reduce social isolation and improve their mental and physical wellbeing.

Older people can be referred to the scheme by their GP and can attend group sessions at the farm. Outreach sessions will also be provided to two local care homes so that the same opportunity can be offered to residents with dementia.

The funding comes from the NHS Tower Hamlets CCG bursary award scheme, which supports innovative local health projects.

Benefits of walking at work

Walking while you work can boost physical and mental health, a study has found.

A group of 180 people were randomly assigned to work at either a seated or standing workstation or on a cycling or walking workstation. Researchers then compared the participants' levels of boredom, task satisfaction, stress, arousal and performance while they worked. The participants in the walking condition reported higher satisfaction and arousal and less boredom and stress than those in the seated and standing conditions. The cycling workstations produced the lowest levels of satisfaction and performance.

As participants' levels of physical health and fitness made no difference to the results, the researchers say the benefits of walking workstations are likely to be primarily psychological.

Depression makes men kinder

Depression and suicidal feelings appear to reverse gendered behaviours. Men become kinder and more reciprocal and women become untypically self-centred, research suggests.

The study, published in *PLOS ONE*, compared prosocial behaviours among four groups: one each of healthy men and women and one each of depressed men and women, totalling 89 people in all.

Trust games were used to measure and compare levels of trust and reciprocity between the groups in relation to severity of depression and anxiety and suicidal feelings.

Women are generally more generous and altruistic than men but the experience of depression and suicidal feelings appears to reverse this gendered pattern of behaviour. In the trust games, the healthy men showed less reciprocity than the healthy women and the depressed men showed more reciprocity than their healthy peers. The depressed and non-depressed women's reciprocity were similar but the depressed women were more self-centred than the healthy women and suicidal feelings increased this self-centredness.

However, the suicidal depressed men became much less self-centred.

The researchers say the change in men's more typical gendered behaviour is likely to be driven by a drop in levels of testosterone, which other research studies have linked to depression.

Music therapy helps beat depression

Music therapy can reduce depression in children and adolescents with behavioural and emotional problems, a study conducted at Queen's University Belfast has found.

In the largest study of this kind, 251 children and young people aged between eight and 16 years were randomly assigned to receive either usual care from their Child and Adolescent Mental Health Service (CAMHS) or music therapy in addition to usual care. All were being treated for emotional, developmental or behavioural problems.

The study was conducted with the Northern Ireland Music Therapy Trust. The music therapy involved 12 weekly individual sessions where the children and young people were able to choose from a range of activities, including improvisation, song writing, drumming and storytelling to music.

Early findings from the study suggest that the children and young people in the music therapy group had significantly improved self-esteem and significantly reduced depression compared with those who received treatment as usual. They also showed more improvement in communication and interactive skills. The benefits appear to be sustained in the long term.

Karen Diamond, Clinical Services Director at the Northern Ireland Music Therapy Trust, said the music therapy achieved unusually high attendance rates: 88 per cent attended 10 out of the 12 sessions, and 44 per cent attended all 12, which is much higher than usual with this age group.

The most popular activity was song-writing or writing their own lyrics to music, which seemed to benefit their ability to communicate their feelings more generally, she said. 'Nearly all – 97 per cent – chose to write autobiographically about how they were feeling, where they were at. This age group tend to find talking therapies slightly more challenging but our psychology colleagues tell us that, as a result of the music therapy, these children are more open to engaging with them in their sessions and more able to express how they were feeling.

'So not only were we getting fantastic attendance rates but it also opened them to engage with the other CAMHS services they were offered,' she said.

Hip-hop gets troubled teens talking about their feelings

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A project to promote hip-hop music and culture as a therapeutic tool for working with young people and promoting awareness of mental health has been launched by a psychiatrist and a neuroscientist.

Dr Akeem Sule, a consultant psychiatrist with South Essex Partnership Trust, and neuroscientist Dr Becky Inkster, based at Cambridge University, argue that the lyrics of hip-hop can articulate powerful emotional responses that resonate with young people and can help them put into words the experiences of dislocation, isolation and alienation that often go hand in hand with adolescence and mental health problems.

The movement they've founded, Hip Hop Psych, seeks to demonstrate to mental health practitioners how hip-hop can help them engage with young and troubled clients and powerfully communicate the experience of mental illness, resilience and recovery to the general public.

'Hip-hop comes from the South Bronx, New York. It emerged in the 70s, at a time of poverty, drugs, gang warfare, Reaganomics. Society was in chaos and out of that came this lovely street poetry. The lyrics describe the mental health problems, drugs, alcohol, family breakdown, but they also give the answers and resilience,' says Dr Sule. 'In my clinical practice I work with the assertive outreach team and with some patients, you find it difficult to engage with them but one patient, he asked if he could rap and in three verses I understood his difficulties. It was so eloquent, so musical.'

Many lyrics carry strong images of resilience and hope emerging from the anger and despair. 'It can help parents understand their children better. It is a language of communication,' Dr Sule says.

Sule and Inkster argue that the benefits of hip-hop can be explained and evidenced using psychological concepts of positive visual imagery, free association, narrative and cognitive analytical theory, and are backed by neuroscientific research.

Another of their aims is to explore the underlying neurobiological changes that result from hip-hop music, using a range of neuroscience techniques including neuroimaging. 'A study published in *Nature* has shown that freestyle rapping is associated with changes in brain connectivity. It's a very positive start,' says Inkster.
www.hiphoppsych.co.uk

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Call for more perinatal counselling

A new report reveals the high economic and personal costs of poor perinatal mental health care

As many as one in five women develop mental health problems around the birth of their child, yet access to specialist care and treatment is a postcode lottery, and this untreated distress carries an immense human and financial long-term cost.

So warns the Maternal Mental Health Alliance in a new report on perinatal mental illness.

Women can experience a wide range of mental health problems throughout pregnancy and after the birth – anxiety, psychosis and post-traumatic stress disorder, as well as postnatal depression. There is also a growing body of evidence that a mother's psychological distress during pregnancy is a significant risk factor to their child and his or her subsequent life chances.

The Costs of Perinatal Mental Health Problems is part of the 'Everyone's Business' campaign by the Alliance to persuade the Government and health commissioners to make adequate perinatal mental health provision for all women who need it throughout the UK.

It calculates that failure to help women experiencing perinatal mental health problems costs the UK economy about £8.1 billion for each one-year cohort of births, and of this nearly three-quarters (72%) relates to the costs of dealing with the lifelong effects on the child, which can include cognitive impairment and learning difficulties, anxiety and depression, conduct/behavioural problems, and even death in infancy.

More than a fifth (£1.7 billion) of the costs are borne by the public sector – primarily by the NHS and social services. Yet, argues the Alliance, the NHS would have to spend just £337 million a year – around £400 per average birth – to bring specialist perinatal mental health services up to the levels recommended in the NICE guidelines on antenatal and postnatal mental health.

Many cases of perinatal depression and anxiety are never identified, says the Maternal Mental Health Alliance, and even if they are, women frequently don't get the evidence-based treatments they need – only 40 per cent are detected and diagnosed; only 60 per cent of these receive any treatment; of these, only 40 per cent are adequately treated, and just 30 per cent of those treated in primary care make a full recovery – an estimated three per cent of all cases of perinatal depression.

For very severely unwell women – those with puerperal psychosis – specialist facilities such as hospital mother and baby units are available in less than 15 per cent of localities at the full level recommended by NICE, the report says, and more than 40 per cent of localities provide no service at all. 'It's one of those areas where problems of parity are most apparent,' says Professor Ian Jones, Director of Clinical Training and Public Engagement at Cardiff University and a member of the Maternal Mental Health Alliance. 'We spend huge amounts on mothers' physical health through pregnancy and antenatally and just a drop in the ocean on their mental health.'

For new mothers with mild to moderate depression and anxiety, the NICE guidelines recommend psychological therapy as the first-line treatment. Yet, says the report, 70 per cent are given antidepressants and just 41 per cent receive talking therapies. Practitioners in IAPT services, which take most of these referrals, tend not to have the necessary specialist training and knowledge.

Karen Burgess, Chief Executive of the Cambridge-based charity Petals, has been fighting for funding for her specialist perinatal counselling service for three years, and is waiting even now for the verdict from the Cambridgeshire and Peterborough Clinical Commissioning Group.

She says that specialist counselling can start to turn a woman around from the very first session: 'We are fed this myth about motherhood and how wonderful it is. If it's not like that, women feel a deep sense of shame, that they have failed, that they are not normal, and they withdraw. They can be terrified that they will be thought an unfit mother and their baby will be taken away,' she says.

There is no point telling midwives and health visitors to look out for postnatal depression in new mothers if there is nowhere to refer them, and counselling through the GP or IAPT isn't enough, she argues. 'A woman needs to know when she books in with her midwife or GP that there is specialist counselling support available throughout the maternal journey. The majority of pregnant women aren't going to need our help but some will and if the offer of counselling becomes normal practice, then women won't be so afraid to access it.' ■

The report is available at www.centreformentalhealth.org.uk. To find out more about Petals go to www.petalscharity.org

Personal disclosures

Jeanine Connor

I've been interviewed three times this week. Enquiries were made, in varying degrees of interrogation, about my professional and personal experiences, my age, marital and parental status, and whether or not I smoke or like Iggy Azalea.

The impromptu interviews came about during therapy sessions and my adolescent interviewers were not easily gratified. Individual counsellors and psychotherapists have their own rules about personal disclosure, which are informed by their modality and individual inclination. Very few, especially of those working with young people, occupy the traditionally psychoanalytic blank slate, and mercifully few share everything. So how do we inhabit a space that feels comfortable on the personal disclosure continuum?

When I'm working from my therapy room at home, clients often enquire about the rest of the house. These are simple enough questions that I answer willingly, to illustrate the therapeutic boundaries. Some clients want to know *why* we can't sit in the garden (obscured by an opaque window) on a sunny day, and I have to work harder to explain about physical and therapeutic containment.

I hear about previous counsellors, real or fantasised, who invited clients to accompany them on dog walks, smoked with them and offered them a lift home. I'm judged harshly against my unboundaried predecessors and accused of not caring if I don't let a session run over when my client arrives late. I try to explain that the opposite is true: I care very much about my client and also about honesty, reliability and integrity.

> 'To simply provide facts and figures without exploration is to miss a trick. The questions are always more revealing than the answers'

When I'm asked about my own life (or not) during a therapy session it always tells me something about my client. One young man was particularly interrogational. He'd grown up in the care system with a belief that decisions were made for and about him rather than with his consent. He'd witnessed domestic abuse as a child and had been raped in adolescence. He'd suffered a lifetime of intrusion and so obviously his questioning felt intrusive as he projected these experiences onto me.

He told me it wasn't fair that I wanted to know all about him while he knew nothing at all about me. I commented that his therapy was *supposed* to be about him, but he wasn't satisfied. In fact he was really *un-fucking satisfied* and I knew he wouldn't come back after session one if I didn't change tack. So I attempted to negotiate. I said it made good sense for him to work out if he thought I could help him and in order to do that he needed to know about me. He relaxed visibly but held onto a healthy dose of scepticism, wanting to know why I was a psychotherapist *dealing with other people's shit*. The implied anxiety was whether I could deal with *his* shit but it was too soon for smart interpretation.

I've realised that what I'm willing to share is what's on my CV – information that's readily available via Google to anyone who can spell my name. Nowadays we call this public domain information and I'm comfortable with it being known. But to simply provide facts-and-figures type stuff to clients without facilitating exploration is to miss a trick. The questions are always more revealing than the answers.

I was asked during my training – 14 years ago, in case you're asking – how I could be a child psychotherapist when I didn't have my own children. In response I wondered aloud if a male gynaecologist would be judged on his lack of a vagina. He wouldn't. It's insulting and it's ignorant. Reproductive assemblages do not influence medical aptitude any more than parental status influences therapeutic ability. The most important thing is a capacity to empathise, both with my clients' experiences and with their curiosity about mine. So I'm always willing to explore why it matters if my parents are alive, whether or not they abused me, or if I've ever taken MDMA. I don't share anything that my clients couldn't find out for themselves and that becomes more bearable as they learn to understand that I mean what I say: the sessions really are all about them. ■

Jeanine Connor MBACP works as a specialist child and adolescent psychodynamic psychotherapist in private practice and in specialist Tier 3 CAMHS and is also a writer. Events and individuals described here are anonymised and are not identifiable. Visit www.seapsychotherapy.co.uk

I'm still learning

Anna

I'm American by birth but I've lived in the UK for 45 years – I'm 68 now. I came over with a friend straight after university to do the three-month tour thing. We arrived in Scotland and about the second or third day I had this urge to take off on my own, which was unusual for me. I just felt I had to go see what was going on. So I just walked out of the youth hostel and never went back.

I joined a Muslim group, I suppose you might call it a cult, and lived in it for many years. That was where I met my ex-husband. My Islamic faith is a fundamental part of my life still and informs all aspects of my life.

I have always believed in counselling as a sounding board or support. When you want to make changes in your life, you have to have something or someone outside yourself you can go to. My problem is I don't really have a good self-image or much self-esteem. I never did. I was an only child, my parents were both ill and I was put into foster care. The foster carers weren't always the best people to bring up a child. I see that now with my grandson, the importance of that support and love you get when you are small to help give you a sound self-image and self-structure. If you don't get that, unless you are very remarkable, it helps to have other people to go to.

I have seen a lot of counsellors over the years. This last time I went because I wanted to get myself together before I get any older. There are things I want to change that I haven't succeeded in changing – habits I have got into that I don't think are particularly useful to me – so I keep trying over and over again.

I think therapy helps you broaden what you take on in your everyday life. It's a very slow, gradual process. You become aware of things and then you internalise them so they become part of your life. You can't just press a button and everything transforms.

I've had one course of individual therapy at Age UK but I didn't find just six sessions fantastically helpful. She thought I shouldn't beat myself up so much about things. I saw my previous counsellor through my GP and she let me continue to see her after the six sessions were up. I used to see her once every four to six weeks. We got away with it. I worked well with her. She helped me look realistically at my patterns of behaviour and feelings. I was always babbling about what I thought I ought to do and what I wanted to do to change and she said, 'It's not what you think you want to do or ought to do, but what you choose to do.' It was good to have someone to report back to once every few months. She helped me look critically at my behaviour and feelings. But then they took out that whole section of the health centre and that all stopped. It's a pity. I tried self-help. I got this self-help CBT computer programme. It's ridiculous, sitting there, typing and talking to a machine. It's an attempt to keep control of the nation's health and cut down on human beings. You don't get any feedback. It's creepy, the idea that a computer can guide you.

> 'My aim is to learn how to live my life to the best of my ability. And as I get older and more frail, it is more and more important to do that'

Age UK offered me group therapy. You get 16 sessions of that. I've done two or three so far. I really clicked with the therapist. One good thing is you have to learn to listen to other people. I was very late getting social skills – I am constantly learning skills that I never learned as a child. The group therapist said I tend to try to help the other people in the group. I believe, as a Muslim, that one of the best ways to help yourself is to try to help others. But I know I also have to learn to ask for help for myself a bit better.

I have learned a lot in the last few years. I've done a course in Islamic counselling, which I found opens your mind and makes you more tolerant of others. I think I've got better at dealing with other people. I've become more patient with myself and with my physical frailty – I have osteoarthritis, osteoporosis and a displaced spine. You can't get rid of chronic pain; you can only live with it and a lot of that is to do with mindfulness. I am learning to pace myself – to recognise the over-active/under-active cycle. You have to learn when to stop and do something else. That way you build yourself stronger rather than weaken yourself. If I don't, I fall and break a bone.

I don't think any of us will get rid of the things we have inside us. We just have to learn to live with them. My aim in accessing therapy is to learn how to live my life to the best of my ability. And as I get older and more frail, it is more and more important to do that. There is no shame in having counselling; it's there to be used. ■

Anna is a pseudonym.

Is therapy a worthwhile investment?

Barry McInnes

Why is it that, when such a high proportion of the population could apparently benefit from our help, the pages of *Therapy Today* seem full of anguished letters from therapists struggling to make a living from therapy alone?

In theory there should be no shortage of potential clients. Let's look at the sums. There are 64.1 million people in the UK, of whom 51.2 million are aged over 16.[1] Around 17.6 per cent have a common mental disorder,[2] totalling about nine million adults. According to the Centre for Economic Performance (CEP),[3] only 10 per cent of those with depression or anxiety-related mental health problems in England are receiving therapy. Apply this across the UK and there could be 8.1 million people at least who could benefit from our help.

Against this backdrop, the 2014 BACP survey of the British public's attitudes towards counselling[4] shows that, as a society, we are becoming more favourably disposed towards seeking help for our emotional difficulties. The proportion of respondents who indicated that they had at some point consulted a counsellor or psychotherapist rose from 21 per cent in 2010 to 28 per cent in 2014, and 54 per cent said that either they or a family member, friend or work colleague have consulted a counsellor/psychotherapist.

The proportion agreeing with the statement 'People today spend too much time dwelling on their emotional difficulties' fell in the 10 years between 2004 and 2014 from 60 per cent to 39 per cent.

With such a large potential market and such a high level of apparently unmet need, why are so many people not accessing help, why are so many therapists apparently struggling to make a living from this work, and what's to be done?

The Government's commitment to achieving parity of esteem between mental and physical health is laudable, and the evidence on which it is based is undeniable. The disparity between the burden of mental ill health and its share of NHS expenditure[3] and the burden of morbidity associated with mental ill health, as measured by reduced quality of life, amounts to what the CEP has called 'a gross inequality' that can no longer be justified.[3] It is estimated that mental ill health accounts for nearly as much morbidity as all physical illnesses together.[5]

It is heartening to see that BACP has taken a lead in addressing this inequality in relation to the provision of psychological therapies. Its report on parity is due out early next month, making the case and recommendations for much more, and more proportionate, access and provision. Might this in time help to lay the foundations for a more promising employment landscape for counsellors and psychotherapists? I sincerely hope that it will be part of the picture, though it is hard to see this as anything other than a strategy needing long-term investment.

> 'There are clearly plenty of people who might benefit from our services, so what do we need to be doing to better engage them?'

If securing employment cannot be relied on, then what are the opportunities for private practice?

There are clearly plenty of people who might benefit from our services, so what should BACP, and we as individual practitioners, be doing to better engage them? Are we getting our marketing messages right, or are we in effect asking clients to make what feels like a leap of faith?

As a client I will want answers to these questions: what are the prospects that counselling will help me, how long will I need to come, and what will it cost me? The answers are quite simple. In short, the prospects that counselling will help are good – around 80 per cent of clients are better off after therapy.[6] In terms of length of treatment, evidence has shown that 65 per cent of clients improve after seven sessions.[7] From there you can probably leave clients to work out the size of their potential outlay for themselves.

As well as ensuring that we come across as competent, credible and approachable, this kind of evidence may help a decent proportion of potential clients to consider it an investment worth making. The way in which we present is also critical and in my opinion the infographic produced by BACP to illustrate the findings from its survey of public attitudes[4] sets a benchmark for simplicity and clarity from which we can learn much. If we can get smarter about our key marketing messages and their presentation, then we might all start to feel the benefit. ■

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A sign of the times

Steve Powell

How would you react if you were told that your therapist only spoke Russian, but you would be given an interpreter to help you?

Unbelievably, Deaf* sign language users face this dilemma every day. They communicate in sign language, but they are sent to a therapist who cannot sign and only speaks English.

What is really causing resentment is that, until earlier this year, under the IAPT self-referral system they could have seen a qualified Deaf therapist who was able to work in sign language. That's no longer the case. The clock has been turned back and Deaf people are again being treated as second-class citizens.

It's a huge turnaround from three years ago, when the Department of Health finally recognised that Deaf sign language users responded to therapy more positively when the therapist was also a fluent sign language user. They invested in building a national service, which we (the Deaf health charity SignHealth) led.

John Moores University in Liverpool set up an IAPT training course with lecturers who were all fluent signers and the first cohort of Deaf counselling students embarked on their training. The average reading age of a sign language user is around eight years old, so all IAPT materials were translated into sign language. Manchester University validated the sign language versions of the assessment tools (GAD7, PHQ9 and W-SAS) so the Deaf counsellors could record therapy outcomes.

With this availability of psychological therapies in sign language through IAPT, Deaf people were able to self-refer; GPs were no longer the gatekeepers – or barriers – to treatment. Deaf people responded well to treatment in their own language. The national outcome measure of full recovery after treatment is 44 per cent; we were recording improvements of 75 per cent. Clients told us how it helped: 'Feel confident good talk and let my problem out. Feel like breakthrough'; 'Getting there – made me stronger. I don't know how I cope without this'; 'I had lot learn bad and good experience and now positive for my future'.

> 'Many commissioners would rather use a hearing therapist with an interpreter... even though the outcome is not as good'

Although there is no evidence that Deaf people have higher levels of mental illness such as schizophrenia, they are twice as likely as the general population to experience common mental health problems such as depression and anxiety. The causes can be bereavement, loss of job, family problems, relationships, domestic violence or identity issues, to name just a few. All of them bring isolation because of cultural and linguistic difficulties.

The first cohort of Deaf therapists was such a success that funding was provided for a second group of students. By now over £1.5 million had been invested in developing the service.

Then along came the restructuring of the NHS. Clinical Commissioning Groups (CCGs) that had inherited contracts for the Deaf IAPT service let them lapse. The Deaf population in each CCG area is small, and many commissioners would rather use a hearing therapist with an interpreter than contract with a qualified Deaf therapist, even though it ends up costing them more and the outcome is not as good. For us, trying to engage with every individual CCG to persuade them otherwise was an impossible task.

Clearly, with the disappearance of the Primary Care Trusts and Strategic Health Authorities, much commissioning knowledge was lost. The Department of Health invited us to apply for national specialised commissioning from NHS England, which would have provided a special pot of money for a nationwide Deaf IAPT service, but sadly we didn't qualify. Our predicted rate of 1,200 referrals a year was too high, we were told, and the cost of each treatment was too low.

Is this discrimination? That depends on your view of what constitutes a 'reasonable adjustment' under the Equalities legislation. Is this unfair and unjust? What do you think?

So, where do we go from here? With our numbers too small and our needs too specialised for local commissioners and too big and too cheap for national commissioners, we are left with nobody to commission the service.

Tragically, we have no choice but to make our specially trained Deaf therapists redundant. They have done an excellent job, but the commissioning system has failed them and the Deaf people they supported. ■

** Many deaf people whose first or preferred language is BSL consider themselves part of the Deaf community. They describe themselves as Deaf with a capital D to emphasise their Deaf identity.*

Steve Powell is Chief Executive of SignHealth. Please visit www.signhealth.org.uk

Counselling clients bereaved by homicide

When her sister was murdered 13 years ago, *Janet Nicholls'* life changed over night. Here she offers advice to counsellors working with people bereaved by homicide *Illustration by Eleanor Shakespeare*

Welcome to my world – a world that is often called 'bizarre' or 'surreal' by others who, like me, have been bereaved by a homicide and are searching for ways to describe life in a parallel universe. As a counsellor, I can appreciate more than ever the importance of our usual practice of listening and trying to understand the client's explanation of their unique experiences and feelings. As a victim who has met other victims, I can also appreciate that there are nevertheless some common patterns in those experiences and that it might help you to know what they are. But first you must empathise with us while not daring to claim that you can truly understand what we have experienced. Empathy takes imagination.

Thrust into a new galaxy

Imagine that someone you love does not come home to you and that, for many days to come, nothing about that person or belonging to that person belongs to you. Others are in control and you are excluded – even more so if you are under suspicion for their disappearance. You are aware that your behaviour and even your grief could be examined critically. You may find that the police separate family members from each other during the investigation and trial. Maybe you or one of your family members is a suspect or the police are trying to avoid contamination of evidence.

Whatever the reason, you may be separated from people who could give you support. If you are a suspect you will find that the police cannot give you the reassurance or unconditional positive regard that is provided by grief counsellors. If there is a possibility that you may be called as a witness in court, then there are even constraints on any early counselling sessions because defence counsel could claim that you have been coached. A police family liaison officer, the Crown Prosecution Service or the Home Office can provide advice about such constraints, as can writers including Bond and Sandhu.[1]

Your grief may turn to anger and may be frightening to you and to others. At the other extreme, your possible feelings of numbness can lead to feelings of guilt.

I felt numbness and guilt when my sister Liz Sherlock died in 2001. Liz was unusual in being robbed and murdered on the street by two total strangers. No one in our family was under suspicion and therefore there was none of the blaming or taking of sides too commonly experienced by others.

Office for National Statistics figures for England and Wales show that more than two thirds of homicide victims (69 per cent) in 2012/13 were male and most knew the main suspect.[2] Most female victims of homicide are killed by a partner, ex-partner or lover, and over half of all homicides are due to a quarrel, revenge attack or loss of temper. Among children and young people, infants under one year are most at risk and over half of homicide victims under 16 are killed by their parents. Many of the bereaved knew both the victim and the accused. In such circumstances, describing a client's presenting problem as 'complicated grief' doesn't begin to cover it.

O'Neill[3] writes that those bereaved by homicide are not constantly victims or survivors. She prefers to describe them as 'orienteers... thrust into a new galaxy' in which they try to find their way around a new landscape or terrain. This landscape can include connections that have not previously existed – with the police, coroners, courts and other aspects of the legal system. In making these new connections, orienteers may have to develop new skills.

Who can help?

It is surprising to discover that there is no publicly-funded system of professional counselling for people who have been bereaved by homicide. Hence your client may even be resenting having to pay for long-term therapy. Police family liaison officers provide brilliant support for the closest family until the investigations and trial are completed, but they are not a counselling service. Victim Support has a special homicide service run by trained workers who work closely with family liaison officers, and a caseworker can plan free, tailored support to meet people's needs. They also help in practical ways, including with making claims for compensation and accompanying clients to a police station and to court for various hearings, as well as to trial. Although Victim Support cannot provide more specialist help, it can put clients in touch with specialist organisations or arrange professional counselling.

Support After Murder and Manslaughter (SAMM) is a self-help charity run by and for people bereaved by homicide. It provides advice, telephone support, an online forum for members and referrals to ASSIST Trauma Care, which employs experienced therapists trained to work with the after-effects of trauma. It will also inform members about annual memorial services at Manchester Cathedral and St Martins-in-the-Fields in London.

Common patterns

So what are the common patterns I alluded to? First, there are clear memories and possible resentments about how the client was notified of the death.

I have vivid memories from 13 years ago, waiting for Liz to arrive in Bolton for our father's birthday celebrations, hearing that she had died in an 'accident' at Euston Station and later receiving confusing news reports of a robbery and death at the station.

Sometimes a body is not found. More commonly, a post-mortem may be carried out before loved ones can view the remains.

In our case, the accused's lawyers arranged for a second post-mortem and, when we were finally allowed to see Liz's body, we were not allowed to touch her. This was especially difficult for our mother.

The funeral is likely to have been delayed and media interest may interfere with your client's privacy.

Liz's funeral was delayed by five weeks and reporters wanted photographs of celebrity mourners.

If your client is not a close relative, they may not have been kept fully informed of the investigations and all court hearings. They may arrive at the trial with feelings of exclusion from the system or from other family members. They may have shared facilities in court with the friends and family of the accused, although that is less likely to happen nowadays. Prosecuting counsel may also have ignored them, although since 2006 'The Prosecutors' Pledge' has outlined a new approach to supporting victims in court.[4]

We had a separate room in the Old Bailey and were seated in court beneath the public gallery, in view of the press, lawyers and accused, but not the public.

In general, your client may have felt painfully aware of the absence of the person at the centre of the proceedings and will probably have been disturbed by listening to strangers speaking about their loved one in a detached

'Many of the bereaved knew both the victim and the accused. In such circumstances, describing a client's presenting problem as "complicated grief" doesn't begin to cover it'

and objective way. The insistence on silence in court also adds to feelings of powerlessness and possible trauma. Being in court is like attending a school meeting about your child at which you are not allowed to speak. Your presence is on condition that you don't influence the jury by showing emotion. So please appreciate the new empowerment a client feels in being able to say *anything* they like to you during your sessions.

As a chatty person, I found that silence was most difficult for me, particularly when defence counsel described Liz as 'foolhardy'.

Improvements in scientific and technical knowledge mean that forensic details will be reported in court and this can have an impact on the bereaved. Yet lack of information (and even the lack of a body) can also be traumatic. Your client may want to know everything (no matter how gruesome) or little, or to have the evidence softened in some way, and may have been shocked by graphic descriptions.

I wanted to know everything and appreciated seeing what happened on CCTV, as well as having Liz's injuries described in a book of pictures, rather than using photographs.

The closest relatives are entitled to supply the court with a statement describing the effect of the bereavement. Such statements are now being read in court and sometimes also to the media outside the court. This may have been your client's chance to have their feelings heard, although other members of the family could have excluded them. As with any bereavement, individual mourners respond in unique ways. Yet the therapist and client should be aware of the dangers of the self-fulfilling prophecy. Too often, it seems, individuals state that such a loss has ended their own life and then go on to ensure that their life is indeed as miserable as possible.

The end of the trial is a time when emotions start to become most acute, even if the client feels that justice has been done, and this can lead to a build-up of more (possibly hidden) stress. The loss of adrenalin can result in exhaustion and a sudden drop into deep depression.

In our case, my father had a heart attack and I finally started taking antidepressants and sleeping tablets.

Other complicating experiences

Media attention often intrudes on personal grief to the extent of causing secondary victimisation. Your client may feel that the media has misrepresented the person who died and it is also possible that your client may be criticised. People with less than salutary lifestyles may find that the media do not respect their victimhood.

My father had a second heart attack on the day that a newspaper article appeared with the headline 'Absent heroes are no use to anyone' and a photograph of Liz.[5]

Some relatives do not have positive experiences of the police or may resent the legal system in general. Grief will be compounded when a body is not found, when there is no trial, when a defendant has been found not guilty or when a sentence is deemed inadequate. The homicide victim may have previously been in trouble with the law or had a less than 'innocent' lifestyle. This can also affect compensation to relatives.

The release of the offender(s) is likely to be a particularly difficult time for your client. An exclusion zone can be arranged but there may still be the fear of meeting that person on the street.

In December 2001 a man was sentenced to life in prison for Liz's murder, with a tariff of 17 years.

Complicated grief and behaviour

Some feelings are shared with others who have experienced a sudden death. How could it happen to the person you knew so well, with whom you may have just argued and who you assumed would be there tomorrow to make up?

I still sometimes think that Liz is away on location in her career as a costume designer.

As with any bereavement, the situation and stress may cause arguments within the family and between friends. Often this is about blame, guilt or disagreements about how to behave. Individual members of the family may follow different rules and be annoyed when others behave differently. People take sides when one family member has killed another. After her husband killed their children, Ann O'Neill's mother-in-law initially responded by blaming Ann for her son's actions.[3] The large proportion of victims who have been killed by partners means that some children lose both parents, and families taking sides can affect children deeply. Some children lose their single parent. Do some family members feel threatened by the prospect of supporting the children? Do grandparents feel capable?

The word 'closure' seems meaningless to many people who have been bereaved – but particularly so if they have been

'Grief will be compounded when a body is not found, when there is no trial, when a defendant has been found not guilty or when a sentence is deemed inadequate'

bereaved by homicide. How could anyone deliberately take another person's life? You may be counselling someone who is still searching many years later for explanations and for justice to be done to the perpetrator.

People who have been bereaved by homicide may have additional sensitivities because they have an uncertain status. If categorised as 'secondary victims', they may not be seen as having the status of someone who has been robbed of material property, even though what has been stolen is infinitely more valuable. Others may not be sensitive to their feelings. Other people may be uncertain about how to behave in their company. People may expect them to be emotional and erratic; they may be unable to accept them as a normal person in an abnormal situation.

They may have lost their personal constructs and struggle with their previous beliefs, values and attitudes, including religious beliefs. The world may have previously been seen as a safe place or existing feelings of insecurity may have been reinforced. Research has provided evidence that almost half of those bereaved by homicide who were in employment subsequently left or lost their jobs.[6] Attendance at a lengthy trial can impose more pressure on already delicate work situations.

In my case, I trained to be a counsellor and left my job as a sociology lecturer.

Other possible problems

Post-traumatic stress is common, including flashbacks, hyper-vigilance and the need to ruminate about what has happened. This absentmindedness causes confusion and forgetfulness. For example, after her daughter's death Rose Dixon, Chief Executive of SAMM, lost her slippers and later found them in the fridge. Physical illnesses are often caused by trauma being somatised: for example, as rashes, headaches, insomnia, chest pains, heart attacks and strokes.

My sister Sue had migraines and developed a thyroid problem. A year after Liz died, our father died of his third heart attack and mum had a stroke, which took her eyesight. My eczema worsened and I had the constant feeling of a lump in my throat.

Depression may become clinical depression and individuals may change their eating habits and/or sleeping habits. This could include anorexia, bulimia or other changes.

My chocolate cravings worsened!

Sometimes people can become dependent on alcohol, drugs (legal or illegal) or smoking. It is very common for partnerships or marriages to break up.

My existing marriage problems worsened and my husband developed a drinking problem, which influenced his death in 2010.

Financial problems arise from expenses, loss of wages and so on. Compensation may be paid to the closest relatives, but it is a relatively small amount and is shared if there is more than one claimant. The long delay before payment may cause severe problems: for example, when damage to the home needs to be repaired, if it was the scene of the crime.

What can a therapist do?

Be a rock! Provide a strong and reliable presence when all else is shaking. Acknowledge the person's right to feel that the world is a dangerous and frightening place – but also challenge such feelings and be careful to avoid colluding with them.

I have learned to emulate the police family liaison officers, whose sturdy presence steadied my shaking ground.

Encourage positive experiences to overlay and interact with the negative. This is a common strategy when working with trauma.

After escorting my family to the morgue to view my sister's body, an intuitive police officer drove us around the main tourist sights of London. We were gradually able to speak.

Understand and accept individual circumstances and personalities. As always, you should focus on learning from the client. They may narrate the circumstances of the death many times, along with questions about why and how it happened. Help them to find answers where possible and to reach an acceptance that some questions cannot be answered. Help them to understand the physical reactions to grief and trauma, to recognise that these may be normal consequences of an abnormal experience and that they may fade. Empower them as they try to retain some control. For example, some people bereaved by homicide have gained a sense of control by keeping a diary or otherwise writing down their feelings.

I maintained a detailed diary for two years after my sister's death and also found that my love of music helped.

It is possible that your client will feel as though their life up to now has ended, in which case you can help them

'Focus on learning from the client. They may narrate the circumstances of the death many times... Help them to find answers, where possible, and to reach an acceptance'

find a positive meaning in life. In this respect you might like to refer to Viktor Frankl's logotherapy and his account of surviving Auschwitz: 'We who lived in the concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of his freedoms – to choose one's attitude in any given set of circumstances, to choose one's own way.'[7]

Conquering orienteers

Parappully and colleagues[8] found that there could be some positive outcomes for those bereaved by homicide – which is not as outrageous as it seems. Some people learn to appreciate their own lives, and life itself, even more.

I started to travel more, taking out loans to finance new experiences.

Ann O'Neill went on to get an education up to PhD level, and then trained as a social worker and set up Angel Hands, an organisation in Australia that supports others bereaved by homicide. She says that, by continuing to breathe and survive, secondary homicide victims become 'conquering orienteers'. But first your job is to listen to the bizarre and surreal before helping a new orienteer realise that they still have freedom to choose their own long-term response.

This means that, even when someone has been bereaved by homicide, you will be able to play an important role in helping that person to choose a positive way forward. ■

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ASSIST Trauma Care
Offers evidenced-based therapies to people affected by trauma. *www.assisttraumacare.org.uk*

Child Bereavement UK
Supports families and educates professionals when a child dies and when a child is bereaved. *www.childbereavement.org.uk*

Cruse Bereavement Care
Offers support from volunteers trained to work with those bereaved by homicide. *www.cruse.org.uk*

KnifeCrimes.org
Provides specialist support for the families of victims of knife crime. *www.knifecrimes.org*

The Moira Fund
Helps those traumatically bereaved by the murder or manslaughter of a loved one. *www.themoirafund.org.uk*

Support After Murder and Manslaughter (SAMM)
Supports families bereaved by murder or manslaughter. *www.samm.org.uk*

Through Unity
Supports families bereaved by homicide. *www.throughunity.com*

Victim Support
Provides a specialist homicide support service for families of victims of murder or manslaughter. *www.victimsupport.org.uk*

'Your job is to listen to the bizarre and surreal before helping a new orienteer realise that they still have freedom to choose their own long-term response'

Why do women get postnatal depression?

Postnatal depression is widely assumed to be a negative reaction to motherhood – but are we simply failing to ask the right questions? *By Anna Kinnaird Folkman Illustration by Eleanor Shakespeare*

Postnatal depression (PND) – an experience characterised by persistent low mood, tearfulness, anxiety and other depressive symptoms following childbirth[1] – is generally considered in clinical terms as a mental disorder linked to giving birth.[2] PND has the same diagnostic criteria as a general depressive episode, with onset occurring within the first four weeks postpartum.[3] This has led to substantive research seeking to understand what causes depression following childbirth.

Numerous studies have focused on social adjustment,[4] aspects of loss,[5] identity crisis,[6] shattered expectations,[7] hormonal fluctuations[8] and post-traumatic stress disorder[9] as causes of PND. What is striking, however, is that such research and its findings remain firmly rooted within the locus of motherhood. Very little research has taken into significant account women's experiences outside of the perinatal period as potentially important factors in their postnatal distress. It seems the circumstances of motherhood are the focus of exploration simply because in most cases the depression was not apparent before the birth. As a result, much 'postnatal-focused' research has effectively divorced depressed mothers from their lives as individuals with complex experiences unrelated to motherhood. Indeed, because the term 'postnatal' implies a phenomenon that develops after birth,[10] PND is generally assumed to be a reaction to motherhood, but this may not be the case.

Historical contexts

My own research and work with women in postnatal distress provides new thinking on difficult postnatal feelings.[11] My research was for an MA in transpersonal psychotherapy at Northampton University. My aim was to provide a transpersonal understanding of difficult postnatal experiences and the meaning women make of their difficulties, specifically in light of their own childhood and life circumstances. I interviewed six women in depth using organic inquiry – a qualitative approach that seeks to understand the transformative aspects of experience – about their postnatal experience and the meaning they had made of this event in their lives.

My findings, which I draw on here, suggest that PND can be a re-arousal of, or depressive reaction to, events in one's own childhood. This is supported by a recent study that found 'women who are experiencing PND are experiencing it in the context of both the consequences of distal life events and the stress of proximal life events'.[12] Despite this, women's life context outside of motherhood is largely absent from most PND research and treatment, despite studies that show definite correlation between difficult childhood experiences and PND prevalence. In one such study the majority of respondents rated their own childhoods as unhappy.[13] Similarly, researchers discovered that women who had experienced low care and/or high control in childhood were seven times more likely to be diagnosed with PND.[14] Studies such as these appear to recognise a relationship between PND and childhood, yet further investigation into the nature, impact and therapeutic implications of such a link has not been reported. As such, a meaningful discussion of the link between difficult postnatal experiences and childhood is lacking in the predominant perspectives of PND.

My own work with depressed mothers has provided various examples of a relationship between postnatal distress and childhood. For one woman, the birth of her first child triggered enormous rage and grief at having been abandoned by her own mother as a newborn. Her difficult postnatal feelings

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were the feelings she had experienced as an abandoned child. For another woman, anger, guilt and depressive feelings at adjusting to the neediness of her baby reflected her feelings about her childhood and growing up with a narcissistic mother. Once again, these were the same feelings she had first experienced as a child. For yet another woman, her acute tearfulness, anxiety and low mood following the birth of her baby brought up the same catastrophic feelings she first experienced when her father abandoned her in childhood.

In each case, the depressive symptoms made little sense outside their individual contexts and they were not especially related to the women's experiences of motherhood. In each case the symptoms they experienced – anger, guilt, depression, grief, tearfulness, low mood – fit the profile for a postnatal depressive episode. It was clear to me from talking in depth with these women that the feelings originated in their histories; giving birth had triggered unconscious material that was already there. Yet, because their symptoms fit a traditional PND presentation, the context, the underlying heart of the matter, would not necessarily have been taken into account in their clinical treatment.

Is it always possible to make the connection between PND and difficult childhood experiences? Arguably not always, and of course no single theory will account for every woman's experience. I have, however, noticed that some highly defended women are strongly resistant to looking deeper into their postnatal experiences, and their belief in the 'postnatal' aspect of diagnosis remains fixed. I interviewed one woman with severe postnatal obsessive compulsive disorder whose description of her intolerable postnatal feelings appeared to mirror traumatic feelings of growing up with a suicidal father, yet she was unable to link the two experiences. For her, the postnatal diagnosis – and subsequent treatment using antidepressants and cognitive behavioural therapy (CBT) – enabled her to perpetuate her strong defences against this painful material. Depth therapy would possibly have facilitated a different experience but was not offered to her. I observed a similar situation in another woman for whom PND was a 'random and unexpected' experience, despite indicators in her life story that could have explained why she reacted negatively towards motherhood. For her, becoming a mother caused debilitating anxiety that seemed to mirror chronic childhood anxiety about change and fear of failure. She did not see the potential link between the two experiences and considered herself 'just unlucky' for having developed PND. Unfortunately she was not offered therapy, where she might have explored a broader perspective.

Although the postnatal experience did not trigger specific memories consciously in these two women, an emergence of adaptive ways of feeling and responding consistent with childhood conditioning was apparent; the postnatal reactions were conditioned behaviours. Another woman I spoke with struggled with feelings of perfectionism and disappointment after the birth of her first baby. For her, these feelings were connected with her life-long tendency to take responsibility for her mother's feelings and happiness, while simultaneously needing her mother's care and attention. She described feeling vulnerable, needy and hurting after the birth of her child, but also feeling an overwhelming need to take responsibility for her mother's disappointment at being absent from the birth. Similarly, she connected with a 'tremendous' fear of loving after her baby's birth, which she acknowledged as a maladaptive response linked to her childhood experience of being abandoned by her father. It was evident from a deeper exploration of these women's experiences that, once again, existing theories of postnatal depression did not adequately account for their distress.

> 'For one woman, the birth of her first child triggered enormous rage and grief at having been abandoned by her own mother... Her postnatal feelings were the feelings she had experienced as an abandoned child'

An important question arising from my research was why should depression regarding historical events surface at this time in a woman's life? What catalyses unconscious material that surfaces after giving birth? There are several theories that could potentially explain why this occurs. I believe body memory research offers some important considerations. Here, researchers have demonstrated the body's ability to remember feeling states from the past (retaining emotional memory)[15] and the potential for an intense physical experience such as childbirth to bring those memories to awareness.[16] The physicality of childbirth and its potential impact on a mother's postnatal feelings are generally overlooked, yet the increasing evidence of post-traumatic stress disorder in postnatal mothers highlights the often violent experience of giving birth as a profound emotional trigger[9] or emotionally mutilating.[17] Several of the women I spoke with reported feeling they no longer had the barriers to hold 'away' unresolved pain following the birth. Indeed this was the experience of a woman I worked with who felt strongly

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that her experience of an uncontained, disempowering birth catalysed her difficult postnatal feelings.

Implications for women

The pervasive grip of the clinical model has meant standard help for PND in the UK remains largely curative: namely, antidepressants, self-help and short-term therapies such as CBT.[1] Such treatments attempt to reduce or eradicate the difficult feelings. Perhaps unsurprisingly, I notice a correlation between women's acceptance of an orthodox postnatal diagnosis and clinical treatment and a need to understand their postnatal difficulties within the parameters of motherhood. I also notice a strong desire in these women to have the feelings go away and to attempt this through medication.

It is unclear what percentage of women presenting with PND symptoms are prescribed antidepressants in the UK. A 2011 survey by the charity 4Children found that 70 per cent of the women surveyed were prescribed antidepressants by their GP and only 41 per cent were referred to talking therapies, contrary to NICE guidelines.[18] Sadly, this method of treatment can leave women feeling confused and frightened by their experience of PND. They feel largely powerless in the face of its random onset and relieved at its resolution – potentially without ever having had the opportunity to discover the meaning of the experience for themselves. The prevailing clinical paradigm understands symptoms as a sign of illness and the elimination of symptoms as a measure of wellness, but this does a disservice to women with PND by ignoring the potential for deeper issues and possibly denying a healthy integration of this difficult experience.

In my experience, helping women to make sense of their PND symptoms in the context of their entire life is significantly empowering for them. One woman said that clearing the long-held grief from her childhood that surfaced after the birth of her baby was a huge breakthrough. Another described her difficulties as a 'gift' she was 'unwrapping' as she explored her experience in therapy. Another similarly described how the 'gift within the [PND] crisis' was the opportunity to work on uncleared emotional material. Similarly, another woman spoke about 'the opening of the shell' she had constructed around herself throughout her life. These women felt that their postnatal difficulties were ultimately a positive experience because of the healing they ultimately brought to unresolved aspects of their lives. This is in stark contrast to many women's experiences of PND. It is important to note, however, that for each of these women their journey of discovery and growth was facilitated by depth therapy.

Implications for practice

An expanded perspective of PND has several implications for counselling and psychotherapy practitioners working with women in postnatal distress. Importantly, it indicates that practitioners should not assume that postnatal distress is necessarily a reaction to motherhood. Holistic principles invite taking a broader perspective: that the part (postnatal distress) reflects the whole (the individual's life), and the whole is reflected in the part. When clients present with PND, therapists should instead explore more deeply the context in which the PND is situated in order to understand how the depressive episode relates to the entirety of the woman's life. This will potentially uncover further layers of the crisis. Many women report 'inexplicably descending' into PND, so finding links beyond the postnatal presentation can be very grounding and reassuring.

> 'The physicality of childbirth and its potential impact on a mother's postnatal feelings are generally overlooked... Several women I spoke with reported feeling they no longer had the barriers to hold "away" unresolved pain'

Implicit in such an expanded, transpersonal perspective on PND is the belief in healing through crisis and that meaning can be found in postnatal distress. This requires the therapist to hold awareness of their client's potential for growth through their crisis. This is a huge departure from the illness-based approach to PND treatment that seeks to eradicate symptoms and restore 'normality' as swiftly and cost effectively as possible. As with the many other perspectives on PND, the link to childhood won't necessarily explain every case. The important consideration I stress here is not to limit understanding of PND to a fixed aetiology. Practitioners need to avoid being reductionist and simplistic with individual clients' presentations; as with any presenting issue, we must remain open to what unfolds. An expansive perspective of PND based on the assumption of relatedness as opposed to reactivity offers women the potential for appropriate care and support that facilitates understanding and growth through their difficult postnatal experience. ■

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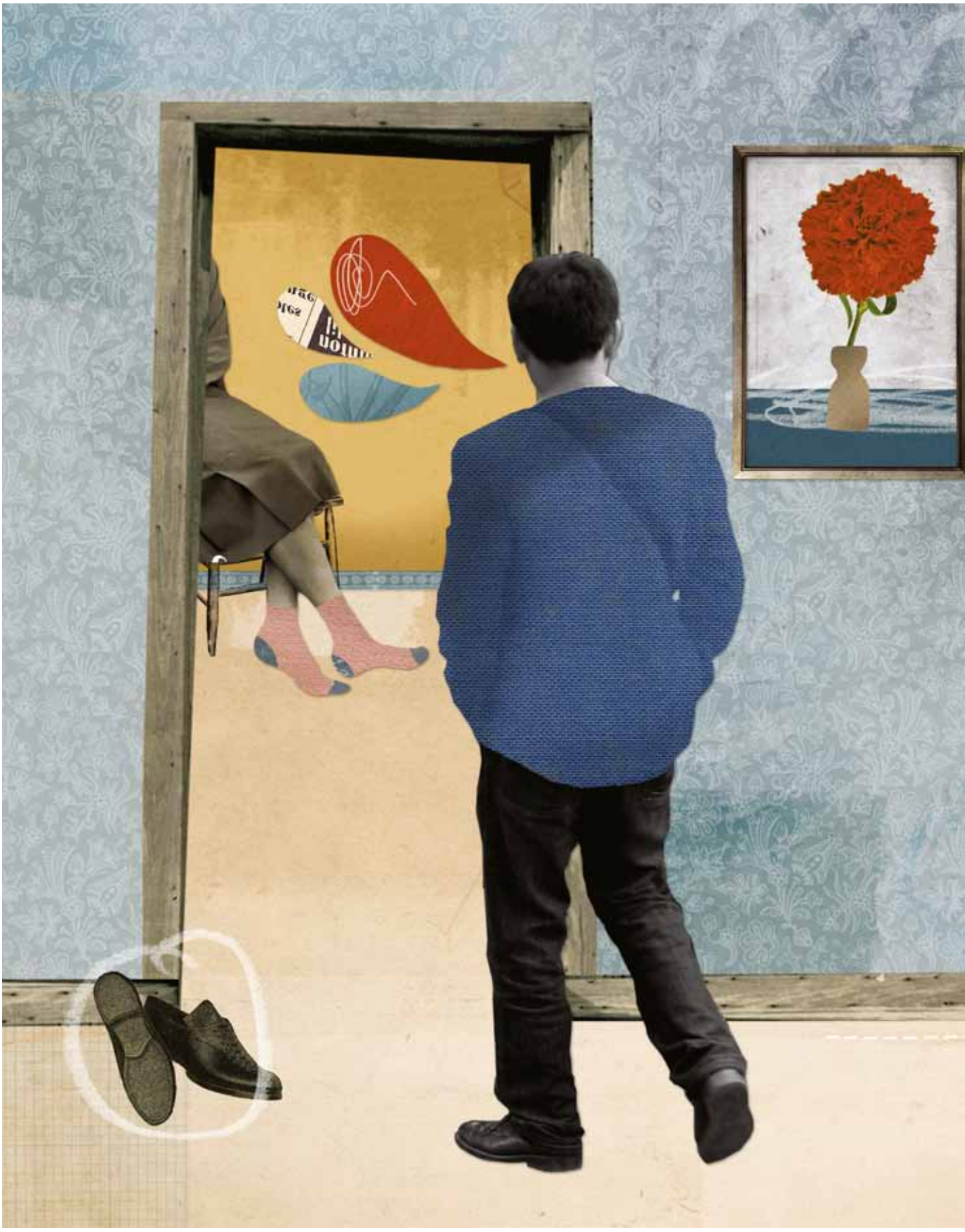

Therapists are human too

Drawing on her own research, *Marie Adams* asks if therapists are ashamed to admit to having needs themselves *Illustration by Eleanor Shakespeare*

'Real therapy begins once the training is over.' So says one of my colleagues, who believes that counsellors in training often pitch up for their therapy sessions without really 'doing the work'.

I don't hold with his idea completely, but I do know that often therapists struggle to admit that they may need therapy following their training. This became obvious when I was carrying out research with 40 therapists about how they felt their personal lives influenced their practice.

Not a single one of those therapists (CBT, humanistic, integrative and psychoanalytic) denied in principle that major events or chronic struggles in their lives affected their clinical work, although the phrase 'I don't think it did but I guess it must have' was a constant refrain throughout the interviews.

These experiences included periods of depression, bereavement, divorce and working while in physical pain. For some it wasn't necessarily current events that evoked anxiety but the fear of what might happen, such as health services closing down, an illness recurring or the threat of client complaints.[1]

All counsellors pay lip service to the idea that we are not perfect, that we are no different from those to whom we offer our service. Training programmes stress the need to return to therapy following qualification if anything in our external or internal worlds erupts and threatens to spill over into our work. A life without texture is no life at all and inevitably there will be times when our personal lives affect our work. So why are so many of us resistant to returning to therapy during hard times, as if there is shame in admitting that we, just like our clients, sometimes need help and support?

History repeating itself

'I was a parenting child, yes; my mother needed care as it were... It's a sort of way of life really, and I think I just professionalised it,' explained one therapist I interviewed. In this single statement she describes a personal history that she shares with many of her peers. We 'professionalise' what was initially a means of survival, caretaking the caretaker in order to preserve the parent.

I doubt whether any of us are 'natural' therapists; we have all 'learned' how to attune to others in the struggle to survive emotional difficulties that are often located in our childhoods.[2] Like athletes, we develop and strengthen our 'listening' muscles. Over time and through training and extensive periods of therapy, we learn how to discern between our

personal experiences and those of our clients and, in an ideal world, how to attend to both.

Blind spots

How many of us were introduced to the Johari Window[3] at the beginning of our training? That's the square with the bits blocked off – the 'known self' that everyone can see; the 'hidden self' that we can see but is unavailable to others; the 'blind self' that others can see but we cannot, and the fourth segment, the 'unknown self' that neither we nor others know about. This fourth portion is firmly set in the unconscious but it exists, driving us towards behaviours and attitudes that are part of our defence systems. We may rationalise them away but the hard truth is that we are simply trying to keep ourselves emotionally, and sometimes physically, safe.

These underlying but unconsidered aspects of ourselves will have implications for our practice, tempting us to exploit others for the sake of unconscious gratification. This may not manifest in the realm of obvious breaches of ethical standards, as in sexual contact with a client. Rather, they emerge in more subtle areas such as inviting idealisation to fuel our own need to be seen as 'good' or 'the best', or deriving a form of titillation or grim satisfaction from witnessing the unhappiness of others – not dissimilar perhaps to watching a horror or crime movie. Years ago I had a client with a history so far beyond the scope of my imagination that now I am sure I was at times more curious about, than attuned to her suffering. I feel sure I sometimes asked questions in the name of 'empathic inquiry' when I was simply satisfying the former journalist in me and looking for a 'good story'.

The 'blind self' portion of the Johari Window that others can see but we cannot is also fundamental to our work as therapists. Like anyone else, we can delude ourselves that we have successfully 'bracketed' whatever evokes anxiety, disturbs our equilibrium or is causing us grief. The truth is, we carry the whole of ourselves into the therapy room; whether or not we make it explicit, we cannot leave our distress outside the door like a pair of shoes.

This is not to say that we need to reveal personal information to our clients, but we must admit our distress to ourselves; we cannot fool ourselves that our clients might not pick it up, perceiving us in those moments as they may have once experienced a depressed, anxious or preoccupied parent.

And what about those 'misfires' – when we believe we know our client well enough to make an assumption only to have it spin back at us, showing that we are not so empathic after all? Humour can be misinterpreted;[4] kindnesses can be misjudged when we stretch the time boundary or reduce the fee for a session. Are we expecting something in return – gratitude, for instance, or therapeutic 'movement' – to make ourselves feel good? Will we expect our client to 'work' harder in their sessions or appreciate our efforts more? Will we hope that they will always think well of us and remember our 'goodness'?

The tell

'I thought last week you really didn't want to look at my distress,' said my client. I remembered the session very clearly, even the moment he was speaking about. There were a number of reasons why I had not wanted to be led into the emotional mire, but how had he known? Sitting in my chair, I hadn't been aware of any outward indication of my resistance, and I had made a concerted effort to acknowledge his distress. In poker, skilled players know to look for the 'tell' – that almost imperceptible sign of anxiety in the other, the twitch of an eyebrow, the suddenly flat sound of a vowel, perhaps just the faintest sign of a pulse at the throat.

The point is, I wasn't aware that I was giving my resistance away, but my client noticed; perhaps because he was highly attuned to the moods of others, perhaps as a result of his history, but certainly what he perceived was rooted in the 'here and now' of reality.

So what was my 'tell'? I still don't know, but the occasion was another reminder that 'bracketing' personal experience may be impossible in the therapy room. The more we admit to ourselves the possibility that what we experience in our lives is likely to have an impact on how we respond to our clients and their material, the firmer will be the therapeutic ground beneath our feet.

The need for professional support

Before examining students, I am often handed a sheet of paper describing their academic and therapeutic history, including how many hours of counselling they have attended. When I see that they have met the required number of hours and no more, I wonder if they have simply been jumping through an obligatory hoop. After interviewing so many therapists for my study, I also wonder if they feel shame about their own vulnerability, as if training as a therapist or counsellor and *needing* therapy are somehow mutually exclusive. It may be a point of pride to say how much we have changed or learned as a result of therapy, but is there shame in saying we are in need of more? If the therapists in my study are any indication, we are often driven to the brink before we finally accept that we need therapeutic support.

For many of these therapists, childhood was a hard, sometimes cruel road that often demanded self-reliance

'The truth is, we carry the whole of ourselves into the therapy room; whether or not we make it explicit, we cannot leave our distress outside the door like a pair of shoes'

beyond their years. The imperative to 'go-it-alone' can carry over into adulthood and into the psyche of the professional therapist. We may judge ourselves and our colleagues on the basis of how we manage our own affairs. On hearing that more than half the 40 therapists I interviewed had admitted to being depressed since they started in practice, a colleague snapped, 'Well, they shouldn't be working!' Not much support there then.

Another therapist said that her therapist colleagues were supportive when she talked about difficulties in her clinical work but that she felt profoundly let down when she needed help in a personal crisis: 'It was as if you were having a conversation with somebody and they almost get up and come and slap you across the face... that unexpected and that shocking.'

In the course of my interviews with these therapists I heard many stories of personal distress being kept secret through fear of judgment about, for example, marital conflict, psychotic episodes in the family, depression and struggles with alcohol. A reluctance to admit to these may reflect a fear of admitting to vulnerability on the part of the individual therapist, but it may also indicate a lack of compassion among the therapeutic community for those of us who are struggling.

Therapists are human too

All of us need job satisfaction, to find meaning in what we do. While we can't always agree whether working as a therapist is a vocation or, as Kottler puts it, 'a profession or a business',[5] in hard times we may also take refuge in our work, finding comfort in the therapy room, away from the pain and anxiety of our personal struggles. This may not be a bad thing; our own experiences with pain or depression can enable us to empathise more deeply with our clients. However, it can also interfere with our work if we unconsciously slide away from topics that come too close for comfort.

As our client works through the tensions of separation and divorce, how can we avoid being reminded of our own unresolved marital struggles or our own grief at the loss or death of a partner? How might our own pain and unresolved issues be echoed back to us in the despair we face in our clients and what might this mean for our ability to remain appropriately attuned? 'I'm great at denial,' stated one therapist in my study, while acknowledging there were days when they prayed that none of their clients would present with depression. This same therapist rationalised their refusal to return to therapy because 'it wouldn't work for me... I know all the tricks'.

Carl Rogers owned that he became a therapist to assuage his own longing for intimacy, something he found difficult in his personal life.[6] The struggles of our past enable us to practise as therapists, but they will also stand in our way if unacknowledged or denied; they will play out in our work with clients, just as they will within our personal relationships outside the therapy room. Irvin Yalom, taking a sabbatical from seeing patients, discovered that working on his latest book was not enough to stave off the 'black dog': 'I grew depressed, restless and finally arranged to treat two patients – more for my sake than theirs. Who was the patient and who the therapist? I was more troubled than they and, I think, benefited more than they from our work together.'[7]

An awareness of the personal meaning of our choice to work as counsellors and therapists is fundamental to our staying within the *Ethical Framework* with our clients.[8] We are no better than those who come to our therapy room in such good faith, hoping for some solace and relief from personal pain. In their longing for reparation themselves, they will often imagine us to be perfect, perhaps feeding into our own illusions of grandeur. As the novelist Susan Cheever wrote of her long-term therapist, after seeing him in the street: 'I took in the fact that Dr J, the man I thought was 10 feet tall, who had the sex appeal of Robert Redford, the strength to cold cock Arnold Schwarzenegger and the savvy to out-quarterback Joe Montana, was really just a tired, urban, middle-aged man in a hurry – really just a brilliant professional and not a god at all.'[9]

She humanises her therapist. He may have been 'brilliant', or he may have been the just right therapist for her and so brilliant in her eyes. Most of us are not 'brilliant', and we are certainly not 'gods'. We have good days and bad days and we struggle through life's vicissitudes as best we can, 'tired, urban, middle-aged' as many of us are, or some version thereof. We have an obligation to consider our own vulnerabilities, to admit to them and attend to them not just for our own sake but also for the good of our clients.

Vulnerability is not something about which we should feel guilty; rather it is an aspect of our common humanity. Hiding behind a mask of mythical perfection will only serve to diminish the meaning of our own suffering and, in our professional practice, undermine our ability to appreciate the struggle of those who seek our help. ■

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Crossing continents

The world can seem very small when you work internationally. *Sue Pattison* offers glimpses of her lifelong work, developing counselling training courses worldwide, from Kenya to Hong Kong

The question 'Is the world small?' is not hypothetical. The concept of large or small is personal and subjective. From a personal perspective, my world can be both large and small, often at the same time, depending on where individual members of my family are living and where I happen to be working.

The world seemed large when I carried out work in recent years on counselling in special schools for the Government of Northern Ireland. Although Belfast is well served with flights from the mainland, the return across the Irish Sea is difficult, if not impossible, after six o'clock on a Friday evening; a stay until Monday morning becomes a necessity rather than a luxury. On the other hand, a counselling conference in Istanbul seemed a simple hop, skip and jump away.

I have worked in Australia, Swaziland, Gambia, South Africa, Kenya, Hong Kong, Taiwan, Turkey, Saudi Arabia, Ireland and, of course, the four UK nations of England, Scotland, Northern Ireland and Wales. This article charts the different aspects of my working life in these international contexts and links them with contemporary counselling practice in the UK and my own thirst for new horizons as I followed in the footsteps of my Merchant Navy officer father and forged my own and my family's explorations.

From Saudi to Hong Kong

As Visiting Professor at the University of King Abdul Aziz in Jeddah, Saudi Arabia, I visit the country twice a year to lecture in counselling psychology and education. My cultural boundaries are challenged as I travel in luxury into completely different territory, where the males in the Muslim faith tightly control the rules of behaviour for women. The world appears large as the plane touches down and I don my *abaya* and scarves as an alternative to the academic gowns worn at graduation ceremonies. Dressed from head to toe in black, I make my way through the airport to where the university Mercedes and driver await. From now until my departure I will not be able to walk freely or leave my hotel without a car, driver and female chaperone to accompany me.

Once on campus I receive a warm welcome and, as a visiting academic, will be free to talk with staff and students within the department. A Newcastle University alumnus, a counselling PhD, updates me on the university counselling service, and the world appears smaller once again; emotional distress cuts across boundaries and students worldwide have problems and issues that can be helped by talking them through with a well-trained counsellor. The new BACP *The Competences Required to Deliver Effective Humanistic Counselling for Young People: counsellors' guide*[1] can help to move professional counselling practice forward in both UK and international arenas and the free resources developed by BACP with funding from the Department of Health, the MindEd[2] online training modules on counselling children and young people, can be accessed globally to help with continuing professional development for counsellors wishing to improve their knowledge and skills in this field.

From 2000 to 2007 I was responsible for the education and training of counsellors in Hong Kong. The Masters in Counselling Studies was my professional initiation into south east Asia, with Newcastle University and the British Council providing a partnership training and education context for Chinese students (mostly teachers) and British/American expatriates (mostly the wives of bankers or CEOs). The teaching was challenging, involving several study schools each year, which continued throughout the Avian Flu outbreaks and the SARS virus. Jet lag became a familiar bedfellow and the exploration of professional practice and accreditation with BACP became a regular topic of communications – a theme that runs throughout my work as a counsellor, supervisor, trainer and researcher.

This world that was so large to begin with became smaller as it became more familiar. Counselling in schools in Hong Kong and China has a different heritage to counselling in UK schools, with a focus on discipline and an adherence to school rules and regulations. Hence there were many struggles with Western approaches to counselling, particularly the focus on the individual rather than the family or greater social group, because China is a collectivist society.[3]

Most Chinese counselling students found it hard to speak out in class as they had been brought up with the Chinese approach to education where the teacher is seen as an expert rather than a facilitator and there is a deep respect for their opinion; students do not want to challenge the teacher or cause them to 'lose face'. On the other hand, expatriate students working with several charitable organisations – generally, counselling providers based in church groups – or in private practice tended to find a theoretical and skills base in the work of Carl Rogers and client-centred counselling. It is not necessary to travel overseas to experience some of these cultural issues; the UK is becoming an increasingly multicultural society where counsellors can undertake continuing professional development to help them work more confidently with clients from diverse backgrounds.

In counselling we sometimes refer to that 'aha' moment, when the process is working amazingly well and the client is growing in front of our eyes. These experiences are infrequent and, for that reason, exceptional; it can seem as if time stands still. As counsellors, we reach out for these moments with our clients, working hard at building the therapeutic relationship and becoming so deeply empathic that the flow of energy between ourselves and

'When considering whether the world is large or small, it is worth considering perspective and the personal: how we experience the world in relation to our own backgrounds'

our client seems effortless and natural.[4] However, as with so many seemingly easy things in life, the movement experienced by clients in counselling is not a coincidence. It is the result of much hard work, by the counsellor in creating the therapeutic environment and, most of all, by the client in taking their brave steps forward into the unknown.

This process can be seen in many international contexts, in different types of counselling approaches and diverse cultural interpretations of 'therapy'.[5] In Kenya, following the post-election violence of 2007/08, many adults and children were displaced from their homes, villages and communities and confined to camps. The Kenyan Association of Professional Counsellors (KAPC),[6] a non-governmental organisation, provided counsellors and play therapists who went into the camps to help children and adults, so-called internally displaced people (IDP), traumatised by violence and homelessness. The counsellors used knowledge and skills from their training with Durham University and also received extra training and support through workshops and supervision given in Nairobi. My colleague, Dr Maggie Robson, provided in-country training in play therapy, using 'toys' and methods suitable for the context – for example, stones, sticks and other readily available resources. Through play therapy children began to engage with play – therapeutic in itself – and act out the traumatic events they had experienced, including their grief for the loss of parents, siblings, home, friends and stability. Children and young people responded well to therapy and built up strong therapeutic relationships with counsellors and play therapists. KAPC remains in close contact with the UK and BACP, and courses are now validated through Manchester University, with the addition of a BA and taught doctorate to add to its portfolio of partnership programmes taught in Nairobi.

International family

I come from a lineage of travellers. My father was a well-travelled Merchant Navy officer, an engineer who worked worldwide to deal with broken-down cargo ships carrying coal, and later oil, in the days when it took three days to fly to Singapore via prop' plane, and when Hong Kong was low rise rather than high rise. My own travels began in infancy, on board ship, sleeping inside an upturned table with rope wrapped around my legs to prevent me escaping.

My international family lives in various parts of the world, which seems large when visits have been infrequent and small when we all meet up, usually in France, where my eldest son lives and works. We travel from the UK, Australia and Malaysia, four grown-up children and their families, three grandchildren, all bi- or trilingual. My own travels to Australia in the early 1980s produced one Australian son, now living in Sydney, and my daughters-in-law are Australian, French and Spanish. This brings personal sorrows and pleasures and also a widening of my own counselling practice to embrace diversity more fully in my role as counsellor and supervisor internationally and in carrying out research across international borders.

Some of my earlier international counselling work was in 'parallel process' with that of my children, in particular my alliance with African countries and my adventurous middle son, Tom, teacher of deaf people and now co-author, with Divine Charura and I, of the chapter on 'Diversity' in the Sage *Handbook of Counselling Children and Young People*.[7] While Tom was undertaking a gap year working in a school in Zonnebloem, Cape Town with Project Trust,[8] I was travelling to conferences in Swaziland and also Bloemfontein and visiting Cape Town's slums with African counsellors and social

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workers. These slums and townships were vibrant places, full of life and activity, yet also full of intractable poverty, ill health, fear, violence and reduced lifespan. I felt the fear and the barely contained violence when visiting an infamous Cape township where our car was blocked in by people banging on the windows and doors, preventing our exit. These people were starving, suffering from lack of healthcare, education and basic respect from the wider society. I felt humbled and small.

My son's travels serendipitously paralleled mine some years later when he honeymooned in Zanzibar, Tanzania and went on safari in the Serengeti. I was working with KAPC and was due to give a keynote presentation at their annual conference in Nairobi, one of several over the years. My employment as lecturer in counselling at Durham University had led me to Kenya through the development of a masters in counselling studies, taught partly in Durham at the Centre for Counselling Studies (CESCO) and partly in Nairobi at KAPC headquarters. As I took a few days' leave and headed out to a short safari in the Masai Mara, my son sent me a message to say the wildebeest were headed for the Mara River in the annual mass crossing from the Serengeti to the Masai Mara. This is known as the Eighth Wonder of the World, the 'Greatest Show on Earth', not to be missed, and I made it, along with a counselling colleague. We felt our hair part as the wildebeest jumped over our open jeep, dashing across the river to escape the crocodiles, their babies following.

Research in the Gambia

Throughout my international roles as therapist, supervisor, trainer and educator, I have taken with me the ethical principles and professional standards of BACP. These extended to carrying out research in the international arena when I was awarded a BACP Seedcorn Grant to explore school counselling in the Gambia, in partnership with the Gambian Ministry of Education Counselling Unit and Newcastle counselling alumna Marie-Antoinette Corr, now Secretary-General of the Gambia Teachers' Union. This involved several visits to the Gambia and trips up-country to cover every state post-primary school, Christian, Muslim and secular.

Unlike the UK, every school in the Gambia has two counsellors, one male and one female, who are trained in person-centred counselling and also hold teaching roles. We looked at the types of issues children presented with and monitored progress before and after counselling, using the CORE-YP.[9] The data collection process was emotionally draining at times as the counsellors used the opportunity for informal clinical supervision. Some of the material was difficult to listen to. For example, one little girl of seven years had returned to school after female circumcision and slept with her head on her hands through lessons and break-times as she had wound and urinary tract infections that would not heal without antibiotics, which were not available to families that could not afford to pay. Another child was caring for her HIV-infected father, following the death of her mother, and a 12-year-old girl was pulled out of school to marry a village elder – not uncommon.

It was difficult to hear such stories and to hold the distress of the counsellors, who had limited opportunities for supervision. Therefore, the project employed Maggie Robson, then Head of Counselling Psychology at Keele University, to support Antoinette and me in the research process and as we worked towards completion and publication.[10] The importance of her supervision role could not be overestimated; her support and good nature, especially in terms of some of the travel arrangements, were invaluable. It took a special person to stay upbeat when travelling for hours off-road, up-country in a basic truck loaned to us by UNICEF, with only plastic bags of water and biscuits for sustenance, staying in village huts with open drains and no modern bathroom facilities. However, the people we met were fantastic; the counsellors were well trained, warm and caring, professional in their approach and working towards higher qualifications. Many were trained in the UK or in Nairobi by a Dutch NGO. The world became smaller on one visit when we met two elderly ladies travelling across Banjul area by foot, with huge rucksacks. They were hosts to Newcastle University international counselling students in the UK and were linked with the One World Week charitable trust (www.oneworldweek.org/v2). They offered their homes to these students at Christmas when they were far from their families and could not afford to return for holidays.

When considering whether the world is large or small, it is worth considering perspective and the personal: how we experience the world in relation to our own backgrounds, our families and friends and our professional contexts. The 'world' can be experienced locally as well as through international travel, and our own self-awareness can help us to learn much from the world and our interaction with others in it. ■

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How are you managing?

Counsellors' work is directly affected by the way their service is managed, so why is management so rarely discussed, asks *Alison Brown*?

As a manager of a counselling service, I am constantly struck by the absence of 'management' from the dazzling array of courses and seminars, the myriad topics for debate, research and learning on offer to counsellors today. Many counsellors work only in private practice, but for the many others who are attached to an organisation, their work is directly affected by the way it is managed.

There is a long tradition of organisational consultancy based on psychotherapeutic understanding. How a counselling or psychotherapy service of any kind is managed determines its ethos, processes and, to some degree, its outcomes. It is 18 years since John McLeod recommended greater attention to the identification of principles of good practice for the organisation and management of counselling agencies.[1] It is 15 years since the publication of the only book I have found on the subject, that by Colin Lago and Duncan Kitchin.[2]

As they noted at the time, managers and management were just not part of the discourse of counselling. This, in my view, is still the case today, and my aim here is to begin a discussion by reflecting on selected literature and my own experience.

Research that addresses management issues tends not to name or articulate 'management' as such. The literature contains studies of the nature and effectiveness of voluntary sector counselling, non-attendance rates and booking systems, implementation of outcome measures and cultures of evaluation – but from all the word 'management' is curiously absent. Exceptionally, Buckroyd's study of shifting from open-ended to fixed-term contracting does acknowledge a specific managerial role and voice, but stops short of the word itself: 'The counselling co-ordinator was better able to predict how long a prospective client would have to wait.'[3] Is manager too dirty a word to be used? I too have been a 'co-ordinator'; does this, I wonder, sound more friendly, less powerful? Are we therapists so 'complex to manage'[2] that we cannot be managed, only 'co-ordinated'? I suspect this use of language is part of the pattern I have identified – to disguise or minimise the fact that counselling is, and needs to be, managed at all.

Independence of clinical supervision from 'line management' has been much debated in the literature. However, neither good practice in line management nor the supervision of management are included in these debates.[4] The recently completed draft revision of BACP's *Ethical Framework* does seek to address this when it proposes an explicit commitment to 'finding a balance between our obligations to our employing agency's strategy and the independence of supervision, supported by an annual review of agreed divisions of managerial and supervisory responsibilities'.[5]

However, following McLeod's and Lago and Kitchin's leads, the need for good practice in management has been recognised.[6] Both BACP[7] and COSCA[8] provide quality assurance and service standards for agencies. Management is naturally included in their service accreditation criteria, alongside issues such as access to consultation and feedback, training and support, grievance and disciplinary procedures for staff; systems to manage and monitor demand and quality of practitioners' work; arrangements for consultation and referral, as well as management structures and financial management.

But standards such as these do not support managers who are therapists in the personal process of *being a manager*. This perspective was shared by Lago and Kitchin, who reflect that only after they had written about all the tasks (premises, staffing, advertising, governance, insurance, safety and accountability, reception, waiting lists, assessment, fees, complaints, records, referrals, finance etc) was their attention drawn 'to the vital question of the task of managing as a discrete activity, in and of itself'.[2] They go on: 'Our preoccupation to attend to the details had somewhat blinded us to the necessity of trying to address the question of what management is.'

Reclaiming management

I would argue that we need to 'reclaim' management as something in which therapists are interested because it concerns the relationships between people and resources that create the therapeutic setting. To appreciate the implications of this it is useful to consider some unconscious aspects of management, leadership and authority. This entails exploring what I call the current patterns of splitting: first, the split between leadership and management; second, the split between clinical and non-clinical responsibility.

One view is that leadership looks to the future and is more relational and implies the existence of 'followers', while management focuses on the present and the task.[9] Another is that the splitting of leadership and management inevitably means the denigration of one and the idealisation of the other, resulting in either managerialism – 'the magical investment in technique and method' – or 'heroic leadership, the magical hope for a Savior'. Both of these are social defences against the anxieties associated with the changes that are demanded of contemporary organisations.[10]

The BACP accreditation standards for agencies demonstrate this split by allowing for a head of service without clinical qualifications to delegate clinical management to an appropriately qualified counselling service manager, while overall accountability remains with the head of service.[7]

I would suggest that such splits, while neither right nor wrong, must be of interest to us because of the consequences for emotional containment of services. Is part of the problem a separation of leadership (seen as relational) from management (seen as technical and devoid of relational and emotional consequences)? I would argue that we need to examine the relational aspects of management and the implications for separating (or not) leadership and management roles.

Lago and Kitchin observed that many counsellors complain about their managers being out of touch, obstructive or oppressive.[2] There is a need to consider what is inherent in the manager's role that sets them up for such projections. If there is a split between leader and manager, for example, are they falling into 'good' and 'bad' parent positions? According to Obholzer and Miller,[9] management can become denigrated by both manager and managed, neither of whom see management as 'real work'. Preferring to do the 'real work', such as psychotherapy, is at least 'a face-saving way out of attending to the difficulties of having to perform a managerial or leadership role'.[9]

In the non-profit sector in particular, management approaches that would be acceptable elsewhere may be seen as 'hard-hearted', inappropriate and duplicitous.[11] There is increasing attention to 'leadership' in psychological services,[12] including awareness of how our personal values, aims and goals affect our work and that of others, and links between personal values and those of the organisation. For managers, however, this approach contrasts starkly with, for example, recent official guidance on improving access to psychological therapies in Scotland.[13] These deal with demand, capacity, clinical administration, goal setting and case review but make no mention of self- and other awareness.

Thus, while leadership can include 'soft' issues such as relational awareness, management is still regarded as a technical, 'hard' function. It may be that therapy training is not helpful to the management role, and 'management skills may... be diametrically opposed to the earlier professional skills and experiences of the counsellor', as Lago and Kitchin observe.[2] What does this mean for the emotional lives of organisations and managers themselves? As McLeod noted: 'Within counselling agencies, it is necessary to create an organisational culture that will enable the expression but also the containment of strong feelings in both clients and workers. The interaction of these factors with service quality is a topic that has received scant attention'.[1] Management is thus not a technical function but one centrally concerned with the emotional wellbeing of the organisation.

The manager's role

It is also a psychological role: most obviously, the manager as parent, the target of 'unconscious projections from the staff in relation to their internalized parent figures'.[2] Just like any parent, the manager fulfils numerous roles, conscious and otherwise: ambassador, role model, enabler/facilitator, director, mediator. A manager constantly attends to issues at and beyond the boundaries of space, time and the setting in which therapy occurs, in order to provide a safe and predictable environment. Moreover, a therapeutic service is required to act as the 'container' or receptacle of the anxiety (in the broadest sense of distress, conscious or unconscious) that clients bring. In Menzies Lyth's terms, it is a social defence system.[14]

From this perspective, an organisation's culture is determined largely by the psychological needs of its members to cope with anxiety. This is manifested in, for example, lack of clarity about the distribution of responsibility and reduction of responsibility by delegation upwards. Anxiety can affect a team, leading to collective defences – commonly, dependency on the leader, aggression against other groups or avoidance of the work task.[15, 16] The task of a leader, therefore, is threefold. In relation to managing change, it requires a shift from an omnipotent fantasy to the 'depressive position' of what can be achieved realistically, a 'titration' of external reality in order to keep its impact at a level that can be processed. Second, it entails appropriate boundary keeping with regard to information in and out. The third task is one of containment: that is, minimising the effects of the toxic processes of splitting (projecting unwanted qualities onto others) and envy that inevitably arise.

'We need to "reclaim" management as something in which therapists are interested because it concerns the relationships between people and resources that create the therapeutic setting'

With awareness of the forces at work, a manager can state clearly, 'This is my role, these are the boundaries of that role, and this is its relationship to our collective task.' Clarity of authority and open communication are essential, as are 'systems which encourage open discussion of work-related feelings and problems, in a climate which regards "problems" as a normal aspect of the work'.[17] Organisations need to 'recognise, monitor and openly discuss, on an organisational basis, the full implications of... doing emotional work'.[2] Supervision and consultation for managers specifically are necessary. Put simply, it is particularly taxing to balance the complex demands of being a therapist and being a manager 'intra-psychically and practically'.[2]

On a daily basis managers who are also counsellors deal with, as Lago and Kitchin highlighted,[2] dimensions of the role that are rarely considered – such as management of ambiguity, meanings, dilemmas, conflicting priorities and ethics.[18] This last, for me, is a crucial difference. In no other organisation has my work as a manager been governed by a comprehensive ethical framework. This means that on a daily basis I must treat each management issue as also an ethical one.

When seeking to make sense of the challenges, I find it helpful to recall the three leadership tasks. The first, managing fantasy and reality, entails constantly clarifying the primary task (do we all agree on the main aims of the service?) and maintaining hope while dealing with funding crises, waiting lists, therapists' and clients' unrealistic expectations. The second task, managing boundaries and information, includes the less tangible functions of repeatedly clarifying roles and responsibilities, deciding how open to be about my own struggles and ambivalence, and the most tangible function of ensuring timekeeping, accurate paperwork, protecting rooms from invasion and deciding on the subtleties of what goes out in our publicity material. The third task, containing toxic processes (or, in other words, receiving and processing projections), can encompass not only what is left behind by clients but often, for example, conflict between counsellors about employment status or payment rates, envy of our 'specialness' on the part of other professions, and denigration of therapeutic work.

It is no longer the case that the setting for therapy is either private practice or the NHS. With the proliferation of organisations of all shapes and sizes now offering therapy, it is surely time to consider the dynamics of how it is all managed. ■

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Dilemmas
Can we ask clients for testimonials?

This month's dilemma

Sherifa completed her counselling qualifications three years ago. However, she has been unable to find paid employment as a counsellor. Although she has continued to work in a voluntary capacity in order to maintain her practice, she has become increasingly frustrated and has decided to set herself up in private practice.

As a first step, she enrolled on and completed a business start-up course, where she was advised to set up a website and to include testimonials from her current clients at her placement. However Sherifa has just seen a conversation on a social networking site where some members have suggested that this is not wise. What are the ethical issues involved and what should Sherifa do?

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

Andrea Sheehy

Marriage and couple counsellor, website design and development

I can understand why Sherifa's business start-up course has recommended that she use client testimonials. They can be powerfully persuasive in a marketing package that includes a professional-looking website, high quality photographs and verifiable details.

However, the essence of this dilemma is to be found in the conflict of interest between the benefits for the therapist of obtaining a testimonial and ensuring the integrity of the relationship for the client.

The BACP *Ethical Framework* suggests that a resolution of this conflict should be biased heavily in the best interests of the client. Therefore Sherifa should discuss the soliciting of testimonials with her placement manager and supervisor before proceeding. For example, I can see a conflict of interest if testimonials from placement clients are used to promote Sherifa's private practice.

In addition, supposing Sherifa were to solicit her clients for testimonials. I wonder how many would feel free to express reservations or refuse. Sherifa would need to satisfy herself (and her placement manager) that she was ensuring the integrity of the relationship, and this may be difficult to do. Wouldn't it be anti-therapeutic for a client who is being treated with dignity and respect possibly for the first time in their life to be asked this? Aren't they going to feel obliged to help the person who has helped them?

Arguably the soliciting of a testimonial creates a dual relationship. The *Ethical Framework* says: 'The existence of a dual relationship with a client is seldom neutral and can have a powerful... impact... For these reasons practitioners are required to... avoid entering into relationships that are likely to be detrimental...'

> 'Testimonials can imply that a benefit that one client has experienced from therapy will be universally available to all potential clients'

A problem with testimonials is that they can imply that a benefit that one client has experienced from therapy will be universally available to all potential clients. This is not the nature of such a diverse practice as therapy and such testimonials could be interpreted as a misrepresentation of the work of the therapeutic community. While it is true that some therapists produce consistently better outcomes for their clients than others, arguably what these therapists are good at is motivating the client to engage in the work that they themselves need to do for therapy to be effective.

Testimonials can be anti-therapeutic because they collude with the client who seeks to project the responsibility for effecting change onto the therapist. It could also be argued that the client who writes a glowing testimonial is discounting the work that they have put in and their courage in facing their demons.

Monitoring our services through feedback is vital and positive feedback is always gratifying but there are many sound ethical reasons not to make them public. Satisfied clients often do become our best sources of future referrals and there are plenty of ways that Sherifa's clients can make their voices heard effectively without involving her directly.

Rob Hammond

Personal consultant, integrative coach-therapist

Sherifa should first consider the ethical guidelines of her professional body. There may be nothing specific about testimonials in the guidelines but they will make clear that the individual practitioner is accountable for her actions and needs to be able to justify them if she is challenged.

Ultimately those of us in private practice are running a business and 'social proof' in the form of client testimonials is a powerful advertising tool. But before requesting client testimonials Sherifa must consider the ability of each client to be objective about her request. Therapy should work towards a client being self-directing in their life. However, given the in-built power imbalance within the therapeutic relationship, extreme care must be taken that a client doesn't feel under an obligation to provide a testimonial. Equally, Sherifa needs to be sure that her client isn't investing her with undue responsibility for their wellbeing, thereby negating their own part in their progress.

On the other hand, to deny a client the opportunity to publicly state their successful outcome from therapy, in the interest of future clients, would seem unfair.

Sadly there is still a certain amount of social stigma

around receiving therapy. Client testimonials help to reduce the stigma of therapy and reinforce the notion that it is natural and acceptable. If a potential client is feeling nervous about starting therapy, or is unsure of what to expect, feedback from previous clients can be a useful way to make them feel more at ease.

There are numerous ways for Sherifa to gather testimonials. She could give clients a satisfaction questionnaire, with a box to tick to give permission to use their comments and a stamped, addressed envelope for them to post it back to her when they are ready. She could send clients a follow-up email once therapy has ended asking if they would consider supplying a testimonial.

Sherifa should always explain how their feedback will be used (eg on her website), whether it will be anonymised, how long will it be on view etc, and obtain the client's permission for this.

If the option of testimonials is openly discussed and the client is fully able to be objective about the request and to make an informed decision, then I don't see that there is any problem.

Helen Cooke
Volunteer MBACP (Accred) counsellor

The pages of *Therapy Today* are heavy with references to the lack of paid work in our profession and Sherifa's dilemma reflects this difficult issue. Her situation has left me wondering what drives her counselling career and about the nature of her professional relationships.

For example, what do we understand by having 'completed' our qualifications? Counselling training is not a finite process and is often described as a journey, but Sherifa talks of 'maintaining' her practice rather than developing it (and herself). Perhaps her motives are purely strategic, so frustration at being unable to take the next step to employment is completely understandable. Will she devote energy to processing these feelings before she risks carrying them forward into the work with her private practice clients?

Sherifa's entrepreneurial flair is to be encouraged. However, she has chosen what sounds like a generic business course where the unique aspects of our profession are unlikely to be catered for. The BACP *Ethical Framework* encourages us to be open to and conscientious in considering feedback from colleagues, and we can benefit enormously from their guidance and advice. Have Shefira's peers fallen by the wayside in her quest for progression?

Similarly, the question of whether or not to publish client testimonials on her website has arisen vicariously, through coming across online postings between other people. Her dilemma centres on client confidentiality, which is a hugely significant and precious element, yet she seems so isolated professionally.

Her intention to acquire testimonials from placement clients sounds very worrying. Trustworthiness, the BACP *Ethical Framework* tells us, requires us to 'restrict any disclosure of confidential information about clients to furthering the purposes for which it was originally disclosed', so client feedback provided to the agency cannot be 'lifted' for secondary uses. There are also Data Protection Act implications. For Sherifa to seek feedback separately and overtly for her own promotional purposes, even with the knowledge and blessing of the agency, leaves me struggling to imagine how this could be safely managed. Crucially, what are the implications for the therapeutic relationship of this potential 'gift' from the client, or for clients who refuse the request?

> 'Glowing testimonials are of no value if the method of acquisition sends her crashing headlong into the sanctions pages of *Therapy Today*'

Sherifa needs to discuss all her plans with her placement supervisor without delay to ensure there are no current or potential boundary breaches. Here they might explore ways to help her connect and flourish, including exploration of the wealth of resources that BACP membership confers (eg relevant CPD workshops, the BACP Private Practice division, regional networking days, local network groups, perhaps even setting one up in her area).

Sherifa might also take time to reflect on the personal moral qualities of humility and integrity while assessing her priorities as a practitioner. She may decide to slow down her business-minded drive for the time being if it risks overtaking the application of good ethical practice. Glowing testimonials are of no value if the method of acquisition sends her crashing headlong into the sanctions pages of *Therapy Today*.

December's dilemma

Ken and Rob both work for a telephone counselling organisation and chat via Skype once or twice a month, often about clients.

One day Rob confides that he is not qualified; he completed a four-year psychotherapy training but did not take the final examinations. His CV states that he is a trained psychotherapist and he was not asked to produce documents before being appointed. Ken is rather shocked but decides to do nothing as Rob has not actually lied about his lack of qualifications.

However, Rob is now under investigation as a former client has complained that he was not qualified or competent to deal with her needs and terminated therapy with him abruptly. Rob has asked Ken to write a letter of support, in particular saying that he is familiar with his work and that he is competent to deal with complex issues.

What are Ken's options and what should he do?

Email your responses (500 words maximum) to Heather Dale at hjdale@gmail.com by 26 November 2014. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but these will not be answered personally.

The unexpected is inevitable

Nick Totton talks to *Colin Feltham* about body psychotherapy, state control, climate change and why he will never give up *Photo by Jacky Chapman*

Colin: How did you get into the therapy business, Nick? Does it go all the way back into your childhood?
Nick: I suspect it does for all of us – the wish to sort out our families, and our parents in particular, always figures somewhere. And, like many other therapists-to-be, I always found that people wanted to talk to me about their life problems. As an adult, though, like a number of practitioners of my generation, I got into therapy through politics. I spent the first half of the 70s in London, involved with several flavours of radical politics. Once it finally sank in that most people didn't want the revolution I was passionate about, I wanted to understand why – and that led me to therapy, via Wilhelm Reich. I had known Reich's theoretical work for years, and he still seems to me to offer the best account of how people are kept malleable and under control. When I moved from London to Yorkshire in 1980 there was a flyer on the kitchen wall of the cottage I moved into advertising a Reichian therapy weekend. I had somehow never thought of this as something one could actually *do*! This led eventually to my training in post-Reichian therapy. My central motivation as a therapist, apart from the commitment to honing one's skill that keeps one involved in any activity, remains the same: how can therapy help create social justice?

I think you've done some psychoanalytic as well as Reichian training. How well or otherwise do these fit together for you?
I haven't actually done any analytic training. I did an MA in psychoanalytic studies, but that was entirely theoretical. It was very good, though, and helped me realise that Reich was not – as he is usually presented – a humanistic, growth work practitioner but that his work is based directly in psychoanalysis. Reich always insisted, I think rightly, that he was more true to Freud than the Freudians were. It was only after he got chucked out of the International Psychoanalytic Association (because he actively opposed the Nazis, whom analysts were trying not to provoke) that Reich became seen as humanistic; he never saw himself that way, any more than he advocated promiscuity or masturbated his patients. I must say that I have never encountered anything other than warm interest in Reichian work when moving in analytic circles; there is an increasing desire to reconnect psychoanalysis with figures like Reich, Ferenczi and Groddeck who got airbrushed out of history for many years. But of course very few analysts would dream of using physical touch in their work – which I think is about personality types as much as anything else.

It looks as if you've moved wholly into body therapy and wild therapy or ecotherapy, but perhaps this is a misconception. Can you say what your therapeutic beliefs and practices are today?
I've always been a body psychotherapist since my original Reichian training. It's a slightly unfortunate label, though, because it can sound as though it privileges the physical over the verbal. In reality, body psychotherapy is verbal therapy *plus* – we do all the things other therapists do, and work directly with embodiment as well. For a few years now I've been focused, like many other therapists, on relationality. I'm currently writing a book called *Embodied Relating: the ground of psychotherapy*. The argument is that embodied relationship as a direct experience is fundamental to all therapy practice, whether consciously or not. Relationality is also central to my version of ecopsychology, wild therapy. Disconnection from the other-than-human, what we traditionally call 'nature', is a symptom of wounded relationality.

You co-founded the Independent Practitioners Network (IPN) as a radical alternative to professional bodies in our field. Can you give a nutshell version of IPN's core values, how they differ from BACP, BPS, UKCP and others, and IPN's standing today?
The core of IPN is its choice of horizontal, peer-to-peer validation rather than top-down accreditation by a hierarchical organisation. IPN is a network of peer groups whose members stand by each other's work, and each full member group is linked with two others that stand by its process. We have encountered serious problems in making this work well – but they are only *different* problems from the enormous drawbacks of top-down approaches, certainly not *worse* ones, and probably more interesting and creative!

Where do you see the statutory regulation debate going from here? Are you still fighting moves like membership of the Health and Care Professions Council and the Professional Standards Authority, or similar?
I think my contribution to this battle is over, certainly for now. It's vitally important but also draining of time, energy and humanity. Unless another generation of therapists is willing to defend the pass, we will eventually

face state regulation – the state has an inherent tendency to regulate everything it can get its hands on, and it is much better resourced than its opponents. It's like fighting supermarkets in small towns – they just keep coming back and coming back. But I think I helped preserve a relatively free space for a few years.

You've been highly active in writing about political aspects of therapy. Can you summarise the major ingredients of your politics in relation to therapy?
I take seriously some of the core values of therapy like self-regulation, an inherent tendency to growth and the centrality of the unconscious. These days I tend to conceive all of this in ecosystemic-Taoist-anarchist language. This is a bit of a mouthful, I suppose, but what I mean is simply the realisation that no one is in charge – of the cosmos, of human affairs or of the individual (imaginary) self. Things just happen of their own accord, and this works best if we get out of the way and try not to interfere. At most, we notice what is trying to happen and gently encourage it. Hence I am completely out of sympathy with the current tendency towards monitoring, interference in and attempted control of every aspect of life, particularly within the therapy world. As I have said elsewhere, this amounts to a project of abolishing the unconscious. So that is the direction of my political activism as a therapist, but equally it shapes my political stance within the therapy room, which is to be very aware of and explicit about power relations and to attempt all the time to deconstruct the shoulds and oughts that arise – notions of achieving goals and fixing things. On every level of reality, nothing is broke and nothing needs fixing. This is a political as well as a spiritual position.

Do you agree that the therapy world is much more comfortable discussing and incorporating spiritual or transpersonal topics (such as re-enchantment) than political issues like capitalist realism?
Yes, on the whole that's true. However, as I have already said, I don't accept the opposition between the spiritual and the political. For a whole human being each implies the other, and therapy has always seemed to me exciting partly because it is both a political and a spiritual practice. I recently collected a number of articles and book chapters into a volume called *Not A Tame Lion* (PCCS Books, 2012), and in there I have written about therapy as an enlightenment practice, as a completely new way of approaching the radical dissolution of anxiety that is offered by Zen or Sufism, for example. This involves the dissolving of illusions about individual consistency and continuity – which is also a direct political challenge to the fixed categories employed by the state – its insistence that each of us stays in our place in every sense of the phrase.

You haven't worked in the university system and I imagine that's a very deliberate choice. How do you feel about the influence of universities and colleges on the psychological therapies?
In a word: *disastrous*. Academia is not an appropriate home for therapy training. To briefly name just three issues – first, colleges are primarily aimed at people in their teens and 20s, which for almost everyone (there are some exceptions) is too young to start training. Second, there is increasingly an unwillingness to turn people down for college courses, or to fail them once they are on the course. I believe that only a fairly small number of people are equipped for this rather peculiar job and a lot more than that number are being trained. And third, contrary to what is widely assumed, one does not need academic skills in order to be a good therapist. Being able to write well-referenced essays is in no way a predictor of therapeutic skills! In fact I am starting to realise that therapists seem to be more likely than the average to be 'dyslexic': every time I work with a group of practitioners, two or three people turn out to have been diagnosed at some point.

One article on your work suggests you've promoted three main elements: the body, relationality and politics, and that you've challenged the *parve* or passionless, inauthentic tendencies in the therapy world. Can you say a bit about these?
Yes, I certainly hope this is true. Increasingly I don't see those three elements – embodiment, relationality and politics – as separate but as wholly entwined with each other. Perhaps what I have said already helps to fill that out. Putting together *Not a Tame Lion,* I was pleasantly struck by the consistency of what I have been saying over the years, whether writing about embodiment, relationality, politics or any combination of these.

Given your immersion in life-transforming therapy and activist politics, how optimistic are you about the possibilities for change when we are confronted with serious climate change problems, economic instability and inequalities, ongoing international tensions and so on?
It always comes back to Gramsci's slogan: pessimism of the intellect, optimism of the will. My reason can see very little grounds for hope – if environmental collapse doesn't get us, war or total surveillance will – but I also recognise my own limited perspective, and believe that the totally unexpected is virtually inevitable. When one is drowning, along with everything in the world one cares about, there is no point whatsoever in giving up; the organism keeps fighting. You never know.

There is the huge question about the kind of world we're living in and the direction it's heading, which seems to be ever more capitalist, technical-rational, destructive and which a minority want to see revolutionised or 're-enchanted'.
Yes, absolutely, and it's increasingly difficult to chart any plausible route from where we are now towards a better world – although Tony Negri and Michael Hardt make a good attempt in *Multitude* (Penguin, 2004), with a degree of arm-waving to fill in the gaps. But I still like what I said in my book *Wild Therapy*, after summarising the direction in which things are heading: 'Knowing all this, it is very hard to map an effective way forward. Luckily, though, we also know that *things will happen of their own accord*, as newly emergent features of the complex web of being, not following any intention or plan. This may not be enough; but we can relax in the knowledge that it will be as good as it is possible for it to be.'

What are you working on now and what are your plans for the future?
I'm starting to ease off, having moved to Cornwall and qualified for my pension. Most of my work now is supervision, often by phone or Skype. I'm still doing a lot of workshops, though, which means too much travelling. I know I'll have to cut that back, but I can't bear to, I'll miss it so much! And I have three more books (that I know of) to write: *Freud's Nose and Other Mythograms, All Mixed Up: dialogues with dualism*, and *Sailing to Bohemia*, linking the hippy movement back into bohemianism and all its earlier ancestors since the Paleolithic. Apart from all that, I plan to keep gardening and enjoy a gradual decline. ■

How I became a therapist
Satinder Panesar

Satinder Panesar describes how she came to specialise in helping Asian women and children who are survivors of childhood sexual abuse, rape and sexual assault

I was born in Nairobi, in Kenya, East Africa. I moved to Derby in the Midlands as a young girl, with my parents and two older brothers. As a child I had a very fortunate upbringing. I was raised free from conflict; I was loved, cherished and adored by my affectionate parents. I was brought up with strong work ethics, morals and values.

I married very young, in 1985, and moved to live in Glasgow – another part of the country. I was going to be living with strangers who were now my extended family. This was daunting and I remember the isolation and sadness I felt, but happiness as well – I was going to be living with strangers who were now to be called my family.

Initially things were difficult; I had no contact with my own family. I was never asked an opinion and wasn't allowed to contribute to any decision making. I started to feel worthless and had a deep sense of hopelessness. The months turned into years.

I felt ashamed, afraid and humiliated in the situation in which I found myself. I tried to find outside support and it was at this point that my sense of isolation grew. The few helplines I contacted just didn't understand my situation around culture, *Izzat* (respect) and our community and traditions – this left me disheartened.

Soon after this I saw that Glasgow Rape Crisis was looking for volunteers. This was the next stage of my journey. My extended family and others in the community ridiculed me and questioned why I would consider working with women and sexual violence. But I had a passion to support people – especially those in minority communities.

I started as a volunteer helpline worker but went on to become a full-time member of staff. I was the only Asian worker in the organisation at the time and recognised the need for a specialist service for black and ethnic minority women. So I set up rape crisis surgeries in community venues, but under the title 'women's health', because I quickly realised that South Asian women would not attend anything with rape and sexual assault in the title, because of the stigma.

Being able to converse in Punjabi, Urdu and Hindi was an advantage as there was no need to have interpreters. I started to gain a lot of trust within the community and women approached me for support. One of the key things I pride myself on is being able to hold boundaries and confidentiality, which is so important in these very small, tight-knit communities.

My next career move was to manage Millfield House, a sexual assault referral centre (SARC) in the Midlands. I then went on to carry out a piece of research into South Asian women's experiences of rape and sexual assault. I titled this 'Unspoken Words'. I treasured this experience and was very grateful to the women who shared their stories with me.

This led me to work for Refuge UK, based in London, where I managed specialist refuge services for South Asian women and children fleeing domestic violence. I now work as a senior practitioner for NHS Greater Glasgow & Clyde and in a third sector organisation called Lifelink.

I gained my MA in integrative counselling at the University of Derby, and went on to gain a qualification in individual and group clinical supervision from Strathclyde University. I chose the integrative perspective as I find this takes into account many views of human functioning and enables me to take a holistic approach and respond to what the individual client brings.

I feel it was my personal experience as a young woman, supported by my husband and two sons, that enabled me to grow into the person I am today. It has been a big thing for me too that I am able to offer a service that was not there for me when I needed it.

I've had a remarkable journey having emerged out of these circumstances with strength and resilience. The understanding I learned through this has enabled me to see the world from a variety of positive perspectives. Reflecting back on this period, I can see how my own potential, character and resilience grew out of my isolation, emotionally far from family support, and this in turn has enabled me to empathise with my clients and recognise their strength and resilience. ■

Satinder Panesar is an accredited member of BACP and a member of the Executive Committee of BACP Healthcare. She is also an executive member of UK Friends of Unique Home for Girls, a charity based in India for abandoned and unwanted girls. Email satinpan@aol.com

Letters

Whose needs are being met?

Clare Pointon's feature 'The changing role of the university counselling service' (*Therapy Today*, October 2014) was a highly interesting read in light of the difficulties that I have faced as a recent client of a university counselling service.

After a difficult experience of counselling in my first year of university, I was wary of participating in talking therapy again. However, two years on I agreed with my GP to give counselling another shot. As is the norm, I was invited to an assessment appointment where I discussed what my problems were and it was decided that I should start the short-term counselling that the service offered (up to six sessions). After my first session I remember feeling a huge sense of relief. I finally felt able to express how I was feeling to someone who I felt safe and comfortable talking to. Unfortunately, throughout the course of the six sessions my mood took a significant downward turn and, after completing the CORE outcome assessment in my final appointment, I was not surprised to learn that counselling had not made any improvement to my wellbeing.

Approaching a counselling service involves a leap of faith. Clients enter into a relationship hoping that therapy will make a positive change, but without any guarantee. From my experience, the leap of faith into a short-term model of therapy is huge and involves a greater degree of risk. Clients no longer have the safety of a relationship that they can choose to leave when goals have been met. Short-term counselling felt like a dash through my current difficulties and uncovered further problems and insecurities. As soon as these were realised, I was saying goodbye, left with emotions that I did not know how to address.

> 'Student counselling services are moving towards a "one size fits all" approach that focuses on the quantity of therapy provided rather than its quality'

Like 'Jake' in the article, I had felt like I had lost control of my life, so knowing that I had to be in a specific place at a specific time for counselling was a relief. Unlike 'Jake', however, the counselling that I received was not set up to enable me 'to return to a sense of autonomy'. I walked out of the final session feeling completely terrified and unable to cope with what was happening in my life.

At the time I was on a waiting list for psychiatric assessment. My counsellor suggested that I approach an external agency for longer-term therapy, which I did. Despite having these referrals, I had to wait nearly 12 weeks before I could expect an appointment, during which I was to sit six exams for my third year of university. The distress with which I was left led to months of suffering.

I had to trust the counselling service before I had even met my counsellor. I had to trust the assessor's judgment in referring me to further appointments. In light of my history of mental health problems and significant sources of distress in other areas of my life, I now believe that it was unethical for the service to have offered me a brief model of counselling. It was unrealistic for the assessor to believe that any meaningful progress could be made in six sessions.

It is clear that university counselling services have faced not only an unprecedented rise in demand for therapy but also a rise in the severity of difficulties that students come to them with. Having mental health mentors is a positive step towards providing further support. However it should be recognised that this service may not be right for every student and should not be used as a fallback where counselling has failed. While I appreciate the difficulty of providing a service within a tight budget, it appears that student counselling services are moving towards a 'one size fits all' approach to student support that focuses on the quantity of therapy provided (in terms of number of students seen) rather than its quality and effectiveness. Objectives appear to be dictated by the aggregate demands of the institution rather than the individual needs of students who are seeking support.

Emily Farrer
Final year university student

What price happiness?

Clare Pointon's article (*Therapy Today*, October 2014) on 'The changing role of the university counselling service' reflects very much what is happening to therapy today, where nearly everything seems to have

a monetary value in a neo-liberal age.

Is there not a great risk that we are moving more and more towards commodifying the human being? When someone is commodified and processed, the body is affected; it becomes devalued instead of being valued. As a result, somatising occurs, as the body remembers what has not been allowed to be said and felt. There is a great concern, for instance, about obesity. How much is eating about soothing away the unexpressed feelings of loss, sadness, shame and guilt etc?

For the student, as Pointon's article describes, the pressures can be immense as there is now so much financial risk involved, so much peer pressure, as well as the pressures of dealing with the demands of modern life and relationships with others. They are exposed to so much guilt and shame if their performance is not considered good enough in comparison with someone else, rather than valuing their own developmental process.

Do we not need a more relational kind of therapy to enable a healthy person to help create a healthier world, rather than the ever-increasing manualising of therapy and the move towards payment by results in an increasingly medicalised world?

As things stand at present, practitioners who are skilled in therapies that treat the individual person as a whole are not valued. Crude scales such as PHQ9 (for depression) and GAD7 (for anxiety) are being used to measure how someone is progressing, and therefore if the therapist is to be paid. This to me is scary because these scales miss out so much of what the individual is experiencing and what they miss may perhaps be converted into further underlying unhappiness. In my experience these scales and tick boxes cannot capture the whole picture.

Gavin Robinson
MBACP (Accred)

Don't label the undiagnosed patient

I am writing to you about the subject of so-called MUS patients [patients with medically unexplained symptoms]. I assume you mean undiagnosed patients (which includes me, as one example). The categorising of patients in this way in a psychiatric context seems to assume that an illness can't exist if it hasn't been diagnosed. I would like to assert that diagnosis is not at all an infallible system and failure of diagnosis and medical mistakes are all too common (as my own experience testifies).

While some medical discomfort can have indeterminate causes and psychosomatic illness no doubt exists, it is unrealistic and risky to assume that a lack of diagnosis proves the real illness doesn't exist. It would be a grossly naive assumption to make to assume that the diagnostic process is infallible. That is flying in the face of the facts and prevalence of medical mistakes and medical negligence.

If a patient with undiagnosed illness ends up in the psychiatric system (which has a history of causing iatrogenic illness as normal), their health can be further endangered by the prescription of psychotropic drugs. It is even possible that they could end up being given (with or without consent) some of the most dangerous drugs around – antipsychotics. These drugs are dangerous to anyone, but are disastrous to people with undiagnosed pre-existing illness. I was at one point even accused of psychosis in relation to my claims about my physical illness (and I have heard of it happening to other people).

You may be adding insult to the injured patient by interpreting their genuine symptoms of physical illness as a psychological problem.

It may be justifiable to give a patient psychotropic drugs in this context if it is done carefully and sensitively, not least because suffering from undiagnosed illness can make you depressed. The stress caused by medical negligence can be significant. Don't punish the patient for health service mistakes and don't be naive about medical fallibility.

C Aikin-Sneath

A Rwandan perspective on counselling

I wanted to share with readers this comment from a Rwandan speaking to a Western writer, Andrew Solomon, about his experience of Western mental health treatment and depression. It's a podcast from *The Moth*, titled 'Notes on an Exorcism' (http://themoth.org/posts/stories/notes-on-an-exorcism).

'We had a lot of trouble with Western mental health workers who came here immediately after the genocide and we had to ask some of them to leave.

'They came and their practice did not involve being outside in the sun where you begin to feel better, there was no music or drumming to get your blood flowing again, there was no sense that everyone had taken the day off so that the entire community could come together to try to lift you up and bring you back to joy, there was no acknowledgement of the depression as being something invasive and external that could actually be cast out again.

'Instead they would take people one at a time into these dingy little rooms and have them sit around for an hour or so and talk about bad things that had happened to them. We had to ask them to leave.'

Annie Tunnicliffe

Beyond language

It is with interest that I read Gala Connell's article 'Making meaning in a third language' (*Therapy Today*, October 2014). As a French native speaker practising in English and French in the UK, I recognised some of my own experiences in her description of communication beyond words – the third language – precisely because of language limitations. Although French is my dominant language, as Connell observes, I feel somewhat more fluent and certainly more at ease

working in English. My training in the UK, combined with several years of personal therapy in English, has led me to develop an understanding of human functioning using specific English vocabulary, including what is referred to as psycho-babble. Our tutors had said that, with practice, we would develop our own therapeutic style and, for me, that meant gaining proficiency in communicating more effectively while remaining authentic.

Although the kind of metacommunication Connell describes as the third language goes beyond using the right word in the right language, words usually remain our primary means for connecting. As a result, non-native English speakers practising in English may doubt their ability to connect because of difficulties with verbal communication. For example, they may worry about correct pronunciation or being stuck with a word in their mother tongue whose meaning they are unable to share. However, it has been my experience that, overall, English native speakers graciously and tolerantly accept my accent, while French native speakers help me find the right word when I struggle. It could be argued that, because I need my client to work at either understanding me or helping me, the power balance between us evens out a bit.

There is another dimension involved when working with a client who speaks both English and the therapist's native tongue. A hybrid tongue combining vocabulary belonging to two languages is being co-created; the chosen words go beyond purely verbal meaning as they reflect not only the client's experience in a specific place at a given time but also the culture and understanding associated with the selected language.

Working with third nationals is yet again a different experience. Living in London, I have the privilege of working with clients from vastly diverse backgrounds, ranging from Argentina to Siberia. Yet in the therapy room English is our meeting point. Client and therapist are linked with the understanding – conscious or unconscious – of what it is like to adapt to another country, language and culture, regardless of the country of origin. With respect to language and culture, I heard an interesting comment while travelling on the London tube: 'The Channel is wider than the Atlantic as far as nations on each side are concerned.'

Communication between two individuals is indeed a multi-faceted process involving words, silence, body language, each other's gaze and what Jung calls the collective unconscious. As Connell suggests, 'The struggle to find words becomes a metaphor for the existential struggle to connect, to understand and to be understood.'

Evelyne Riddle
MBACP (Accred)
psychotherapist in private practice in south west London

Mindfulness isn't just another tool

Over the last 17 years of using mindfulness and compassion in my therapeutic work, I have witnessed a dramatic shift in popularity and research into these approaches. The efficacy is now being supported scientifically, due to the development of functional MRI scans and through extensive research, based on the programme developed by Jon Kabat-Zinn.

Unlike many other therapies, it is imperative that the therapist has personal experience to be enabled to support the client from a position of first-hand knowledge. Mindfulness and compassion cannot be introduced as a set of 'techniques' without the depth of understanding and validation by the therapist embodying mindfulness.

For this reason, MindfulnessUK developed the first nationally recognised level 4 qualification, entitled 'Working Therapeutically with Mindfulness and Compassion', thereby bringing it into line with the professional and academic standards governed by Ofqual. This first qualification of its kind has been developed specifically for counsellors, psychotherapists, healthcare workers, those working in social care, complementary therapists and yoga teachers/therapists. It offers a practical approach to using the practices and skills of mindfulness and compassion as a valuable adjunct to current therapeutic work.

MindfulnessUK has also developed a register of qualified therapists so that the public are able to access the therapist nearest to them. As recognition for the qualification expands, other professionals such as doctors and other therapists will feel confident referring their patients to those who have gained the qualification.

Rather than seeing mindfulness as something else to go in the therapeutic toolbox, it has been shown to make significant neurological changes, with consequential beneficial alterations in mood, behaviour, relationships, levels of pain and emotional responses. My experience shows that this information comes as something of a relief to the client and can be a refreshing change for therapists, giving more therapeutic options.

Graduates of the courses are now using their qualification to broaden the scope of their therapeutic work by, for example, taking mindfulness and compassion skills into businesses, on leadership programmes, and into other healthcare establishments and charitable organisations. It validates and augments the skills they already have, delivering professional credibility and creating new horizons and appeal as public demand grows for non-pharmaceutical approaches to the creation and maintenance of health and wellbeing.

Karen Atkinson
BSc (Hons). Email info@mindfulnessuk.com; visit www.mindfulnessuk.com

Anonymity concerns

In his article in the October issue of *Therapy Today*, Alistair Ross describes in detail interactions between him and his 16-year-old client. He discloses some of her vulnerability. Given that he says she was the only teenager and only one of two clients he was seeing

as a therapist, and given that she is not a fictional construct for the purpose of illustration, she is fully identifiable as a unique individual.

I think it is likely that she gave permission for the use of these details in the article. In fact, she may have collaborated to some extent in the writing of it.

However, her permission to be described and (if she did contribute in any way to the article, even if only by scrutiny) acknowledgement of her help are not published in the journal. They should be. Of course, if there was no such permission then the ethical transgression would be obvious and most serious.

If the article had been published in the *British Medical Journal* there would have been a footnote making all this explicit, stating that permission was given in writing, or the article would not have been published at all. May I suggest that this is a practice that *Therapy Today* should follow with absolute rigour in every case?

Ed Cooper
BACP member

Editor's note
We always check with authors that case histories are permissioned, disguised, adapted or composites. We have now introduced a paragraph to clarify this on our inside front cover.

In defence of CBT's critics

I feel sad if Elaine Davies feels in any way 'got at' (Letters, *Therapy Today*, October 2014) by what Catherine Jackson wrote in her review of Richard Layard and David Clark's book *Thrive*, in the September issue of the journal, or that the 'same old anti-CBT arguments' were trotted out, without the fair balance that might be expected from a deputy editor.

Nevertheless, I applaud Catherine's courage in writing her review in the way that she did, and in challenging aspects of CBT and the CBT community that I don't like and that I feel powerless to influence.

One of the aspects of CBT that I do value is as a resource of useful ideas. I have worked extensively with angry teenage boys and have found that concepts like 'emotional temperature' and 'triggers' (as opposed to 'causes') help them make sense of their experience. For clients who report that their lives are limited by fears, the notion of moving forward in small steps has enabled them to take more control for themselves. 'Reframing' can help clients look at their experience in different ways.

Many colleagues and supervisees, encompassing different modalities, have said that they find CBT can be a helpful support to clients, much as I have written above. But I have never come across a CBT practitioner who has shown that they value anything from other modalities, or that they respect those from other orientations. My sense is that they do feel superior to other practitioners but don't empathise with the reasons behind some counsellors' seeming hostility towards CBT.

I fully acknowledge that I do have prejudices against CBT and that I make assumptions that may be unfounded. But I believe that the profession would benefit from discussion about some of these assumptions and, possibly, prejudices, and also if CBT practitioners would openly show their valuing of practitioners from other modalities. Here are some of my assumptions and I would gladly welcome evidence that they are ill founded.

1. There is no requirement or perceived need for CBT practitioners to do any work on themselves, through personal therapy.

2. Someone can call themselves a CBT practitioner having had very limited training – frequently just a few weeks.

3. The CBT community is very effective at marketing themselves – for example to NICE – particularly by branding themselves as the 'only evidence-based therapy'.

4. Layard and Clark may have been instrumental in '£173 million being invested in mental health in England', but IAPT has been structured so that CBT particularly benefits, with other modalities being excluded, to the detriment of patients and clients.

Let us have a balanced discussion between practitioners from different orientations about the relative merits of our varying practices, to create a 'united front, supporting one another and the modalities we choose to practise from'. I challenge Elaine Davies, or any other CBT supporter, to meet me for a cross-modality discussion on Online Events (www.onlinevents.co.uk), which is fast becoming the forum of choice for many different counsellors.

Mike Trier
Supervisor, counsellor, trainer based in Sheffield. Email mike_trieruk@yahoo.co.uk

Show more respect

While I personally applaud Catherine Jackson's rebuttal of the self-congratulatory celebration of the contribution of CBT and IAPT to therapeutic success in her review of *Thrive: the power of evidence-based psychological therapies* (Reviews, *Therapy Today*, September 2014), I fear her dismissive aside about the wellbeing movement was less considered, at best.

While the authors of the book can be safely assumed to have a political agenda beyond the immediate subject matter, the same cannot be fairly said of the many members of the Action for Happiness movement. They may well be as easy targets as the naturists of the 1930s, as Jackson suggests (I have no idea as I do not know any of them) but the burgeoning science of happiness and wellbeing is increasingly confirming the value in systematically applying the principles of positive psychology across the treatment spectrum.

Allied closely with the latest research in neuroscience, key elements, including compassion, gratitude, social connection, forgiveness, resilient self-care and mindfulness, are shown to have economic and social benefits that can only enhance our clients' attempts to solve their temporary difficulties in living and the environment in which they try to do so.

Being of a cynical disposition myself, I am also wary of claims for ascendancy made for individual or combined therapies and

constantly advocate for the principal of beneficence – working for the good of the clients who trust us, using any and all methods at our disposal. Sniping at any individual philosophies or practices, however lightly, will only tend to divide our profession rather than drawing it together in the best interests of those we seek to serve.

Paul McGuire
BACP, MA registered performance coach

Fifty ways to resolve conflict

Jayne Godward (*Therapy Today*, September 2014) highlights important challenges inherent in student–tutor conflict in counselling training. While trainers are often busy trying to respond to their students with therapeutic empathy and support, a student in conflict with their teachers will want things seen from their own point of view.

Arnold Mindell's process-oriented psychology may be helpful here. In this school, relationship skills are taught as a special subject. The importance of being able to get into and out of relationship conflict is strongly emphasised. More importantly perhaps, relationship skills are assessed in order to pass the diploma in process work.

I have a list from my training of 50 ways of getting into and out of relationship problems, which I find absolutely invaluable in my daily life. If I had to select the most useful of these, I would say it is learning first to support the other person's point of view and then being able to support my own. To pass the exam, the student has to show an ability to support both sides of a conflict fluidly. The tutors are modelling how to do this along the way. Effective conflict resolution involves skills that could be taught on counselling courses.

Susan Holden

Is this what BACP needs?

I have just seen the advertisement in *The Sunday Times* dated 22 October for the new chief executive of BACP.

I wonder if I am the only person from this organisation to find this advert both surprising and discouraging.

So many members of BACP have a struggle to earn a living wage from their counselling skills. Every month in these letters pages, growing despondence is attested to by offerings from people who are bewildered, saddened or angered by the discrepancy in demand for services we might offer and the properly rewarded work opportunities available to them.

Given this situation, is it appropriate to advertise for a chief executive on an 'attractive salary'?

Much of our work as therapists involves exploring inner worlds – worlds that are often much greyer than their apparent glossy exterior. To what extent will a future chief executive be informed of, or encouraged to take an interest in, the struggle of very many British counsellors and psychotherapists to continue in the profession at all? I realise it is important to maintain an upbeat attitude but balance is also necessary, and surely an organisation such as this should exist to serve its members' real needs?

The advertisement talks of BACP being 'at an important and exciting point in its future' and of the role of the new chief executive in 'diversifying and developing income streams... [to ensure] long-term success'. How many members share this view of BACP and this interpretation of what is needed for their own long-term success?

Isabel Smith
MEd psychotherapeutic counsellor

All vision, not supervision

I am writing in response to Emma Redfern's article on 'Feedback in supervision' (*Therapy Today*, October 2014). The central theme in the article is that supervisors have rarely invited feedback from Emma as a supervisee throughout her career. This has not been my experience throughout four years of training. As a student (at the Centre for Counselling and Psychotherapy Education, London) my supervisors have always formally requested written feedback at the end of each term.

However, there have been occasions on placements when relational systematic feedback from supervisee to supervisor has been absent. It was interesting to read Emma's exploration of some of the unconscious and, as she states, conscious phenomena that contributed to this.

I agree that the quoted work of David Rennie on deference in the client-therapist relationship could also be usefully applied to the supervisee–supervisor relationship. It has been my experience that supervision can at times involve an adherence to one view. I believe that, when one view is dominating in any exchange, without room for an alternative view, there is usually an oppressive barrier to mutual feedback.

I felt I learned a good deal from reading the article, both in terms of theoretical referencing and practical scenarios. However I did feel the article lacked a reference to the dynamics that can be at play in group supervision. Group supervision is not the exclusive territory of training but I didn't find any reference to the particular challenge of group dynamics and supervision.

I would also have liked to hear about the author's views on the merits of peer supervision, since being part of a peer supervision group has been one of the most valuable aspects of my training.

One wonders whether the word *supervision* almost unconsciously sets up the potential for a narcissist–co-narcissist relationship. I prefer the term *'all vision'* as a more inclusive way of discussing client work.

Noel Bell
BACP student member, London

Contact us
We welcome your letters. Letters that are not published in the journal may be published online on the Therapy Today *website – TherapyToday.net – subject to editorial discretion. Please email the editor at therapytoday@bacp.co.uk*

The making of Freud

Becoming Freud: the making of a psychoanalyst
Adam Phillips
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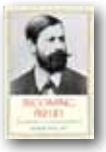
Reviewed by Jane Campbell



Adam Phillips gives us here a biography of Freud up to 1906 when, aged 50, he was at a key point in his career. Phillips plays with the fantasy of what might have happened to psychoanalysis if Freud had died then, having already written his 'five key books about making – the making of dreams, the making of mistakes, the making of sexual preferences, the making of jokes and above all... the making of symptoms' (p152). Up until this point psychoanalysis was 'not yet stifled and stultified by its always anxious institutionalization' (p147), Phillips argues. Thereafter, however, Freud had to deal with the fall-out from these books and the fact that 'psychoanalytic groups would quickly become notorious for their lack of civility and kindness' (p147).

Phillips documents Freud's domestic life, noting that when he was writing *Studies in Hysteria* (concluding with Breuer that hysteria was a way of surviving modern family life), Freud himself was living and working in a home that contained six small children under the age of eight. Freud wrote to Fliess, as Phillips relates (p104): 'Much joy could be had from the little ones, if there were not also so much fright.'

It is interesting that Ernest Jones' authorised biography of Freud did not mention the births of his children.

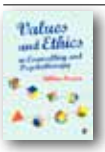
Alongside descriptions of Freud's marriage and home life are vivid accounts of his relationships with the men who were powerfully significant in his life. 'So there is a real sense in which psychoanalysis was a science – or an artefact – born of the love between men', Phillips avers (p108).

This book is nothing if not thought provoking. For me its charm lies in its message that Freud needed psychoanalysis to be 'not only a rational account of the irrational, but also a reputable account of the disreputable' (p158), and that it was 'originally a science for outsiders' (p159), except that it was not a science since the romantic in Freud overwhelmed Freud the scientist.

It is interesting that Phillips should choose a title with such lightweight associations. (It echoes for me the 2007 film *Becoming Jane*, a 'biographical portrait' of Jane Austen's pre-published years). Did he intend to suggest that we should not expect too much from this book: that it is neither erudite nor exceptionally engrossing but rather a thoughtful and reasonable account of a subject upon which Phillips is an acknowledged expert?
Jane Campbell is a group analyst, consultant and supervisor

Ethical dialogues

Values and ethics in counselling and psychotherapy
Gillian Proctor
Sage, 2014
252pp, £23.99
ISBN 978-1849206143
Reviewed by Louise Guy



This is a most unusual book. Proctor adopts the style of the ancient Greek philosophers by creating dialogue between four fictional characters in order to prompt thinking about values and ethics.

Reading the book is a bit like sitting in a training group: Proctor introduces an idea, poses a reflective exercise – the text is peppered with these – and one or more of the characters comments. Proctor believes values and ethics lie at the centre of therapy. She writes: 'Behind any technical decision lie the values influencing the adoption of particular technical practices' (p199), and 'Therapy is a relationship, and thus an ethical response to the other is fundamental, above any ideas of technique' (p82).

The book is in three parts: 'Values', 'Therapy ethics' and 'Practice issues'. Three appendices provide thumbnail sketches of the relevant philosophical movements, concepts and the philosophers. There is also an extensive list of references and a useful index.

The issues Proctor explores are well chosen for a discussion of the realities of working ethically. She addresses the dichotomy between autonomy and beneficence (pp135–137) and does not shy away from the dilemmas that arise when a client expresses suicidal thoughts. She quotes Szasz (1965), Bond (2010) and Jenkins (2007), who have thoughts on this.

The book also addresses the inequality between the roles of therapist and client, citing Brody's assertion (2002) that 'power differentials should not be denied' (p131). This raises the question of whether informed consent is ever truly possible, although, as Proctor observes, it is the justification for over-riding a client's autonomy 'in many organisational contexts' (p128).

The roles of the professional counselling bodies such as BACP and COSCA are addressed, and the book uses the BACP *Ethical Framework* as its main reference point. This, coupled with its unusual literary device, makes the book ideal for experienced therapists' groups and offers a ready-made CPD opportunity.
Louise Guy is a counsellor, psychotherapist and supervisor

Co-created reading

Co-creative transactional analysis: papers, responses, dialogues and developments
Keith Tudor, Graeme Summers
Karnac, 2014
352pp, £27.99
ISBN 978-1782201571
Reviewed by Ian Argent

In this lively and stimulating book, Tudor and Summers return to their writings on co-creative transactional analysis (TA). The original work was published in 2000 and was located firmly in the relational tradition of TA, its emphasis being the centrality of the relationship and the therapist as a co-creator of the therapy.

The structure of this book is novel and useful. An original piece of work (such as the 2000 article) is reprised, with new comments from one of the authors. These comments are then commented on in a 'rejoinder' by the other author. The result is a respectful, open and thought-provoking dialogue between Tudor and Summers, with the reader 'looking in'. But this isn't about passively taking sides with one or the other; rather, I experienced this as an invitation to think for myself and join the co-creative discussion.

Theory, its language and definitions are key features of this book. Words are considered, chosen and revised many times within the text as the authors expand and refine the material. To some readers this might seem hard going and less therapeutically relevant. However, in understanding the co-creative approach one comes to realise that this careful consideration of the language is crucial, as it parallels our careful consideration of the relationship and the client.

Later in the book other authors from the relational tradition of TA are invited to contribute. Again, the material is examined and discussed in a co-creative way. By this time, it's very clear that, as well as being a theoretical text, the book is intended as a demonstrative model of the co-creative way of working.

This book will appeal to those working at an intermediate or advanced level. Traditional aspects of TA are critiqued in depth. Readers are invited to be questioning and critical in the context of the 'Integrating Adult'. Permission is given to reconsider and evolve our theory, which is not a feature of many TA texts.

One of the great strengths of this book is that it doesn't just offer a comprehensive review of the co-creative transactional analysis theory. It is also setting out a comprehensive clinical philosophy. The practice – or praxis – is explained and explored in a deeply thoughtful way, and I found this to be especially enlightening.
Ian Argent is a transactional analysis psychotherapist in private practice

Life and death struggles

Battling the life and death forces of sadomasochism: clinical perspectives
Harriet I Basseches, Paula L Ellman, Nancy R Goodman (eds)
Karnac, 2013
320pp, £26.99
ISBN 978-1855758209
Reviewed by Anne Gilbert

This book is psychoanalytic in perspective and tightly structured. Two introductory chapters present a theoretical overview, followed by four cases studies, each accompanied by three chapters of commentary from experienced clinicians that facilitate a broad-based exploration.

The case studies present patients with very complex processes who have been in analysis for up to 15 years. They display severely sadomasochistic processes (an enjoyment of being cruel or inflicting pain or suffering) in relation to others, but with no sexual element. They yearn to engage fully with life, yet simultaneously want to destroy both self and other – hence the book's title.

We gain a vivid sense of the therapeutic power struggles as the analysts strive to engage their clients in meaningful relationships. Of particular interest is their countertransference: they feel under sadistic attack from their patients and experience feeling tortured, that they have nothing to offer or are losing their minds in the psychic sadomasochistic struggles. Will life or death win out?

The authors offer models for healing and moving forward when working with clients with such destructive processes. Against the odds, the outcomes are positive. I was particularly interested in chapter 18 on aggression, which discusses acts of war as terrorism and sadism. Indeed, it was the editors' comment in the foreword – 'On today's scene it might be that freedom from a threat of sadism, in the form of terrorism, will never again be absent as a possibility' (pxi) – that initially drew me to review the book.

This is a reflective, timely and well-written book. However, it is academic in style and makes heavy use of psychoanalytic terminology. The editors themselves state that any book on sadomasochism is bound to be unsettling, and many readers may find the case study material disturbing. For these reasons, I did not find it an easy read.

The editors hope the text will be of use to other psychoanalysts, and they are likely to be its primary audience. However, it raises issues that will be of interest to a much broader spectrum of practitioners across other modalities.
Anne Gilbert is a Gestalt psychotherapist and supervisor

The poetics of psychotherapy

The therapeutic imagination: using literature to deepen psychodynamic understanding and enhance empathy
Jeremy Holmes
Routledge, 2014
214pp, £90 (hb)
ISBN 978-0415819572
Reviewed by Linda Watkinson

'Literate therapists... make better therapists,' (pxi) writes Jeremy Holmes as he takes the reader on a journey of literary discovery.

While the use of literature in psychoanalytic writing is not new, this book is distinguished by its practical approach, with each chapter devoted to discussing a particular clinical problem. Holmes looks at how the therapeutic imagination can be fed by poetry and prose, discusses the relative merits of both psychoanalytic and psychiatric approaches and explores attachment theory and the importance of story and narrative in therapeutic interaction.

The scene is set in the first part of the book, on the poetics of psychotherapy. Its rigorous academic approach makes for challenging reading at times but underpins the later chapters. Here Holmes explores Keats' notion of negative capability and the ability to remain with doubts, uncertainties and confusion, trusting that a meaningful pattern will emerge.

The second part of the book moves from poetry to prose, with the aim of 'weaving together contemporary psychoanalysis, attachment research and narrative theory into a common story' (p66). Holmes includes extracts from his own clinical work and draws on the writings of Austen and Waugh as he explores how the social role of psychotherapy might be expanded.

Part three explores psychotherapeutic approaches to psychiatric diagnoses – specifically anxiety, abnormal grief, dissociation and narcissism. The final part covers psychotherapy and psychiatry, and the ways in which they interrelate, both historically and in the present. The author concludes his study where he began, using four contemporary poets to illustrate his themes.

This book is like a very rich meal, full of delightful insights to which I will return to sample in smaller portions. It will be of particular relevance to those working in psychoanalytic and psychiatric settings but would also be of interest to therapists of all modalities who value literature. Its retail price of £90 might be beyond most budgets but it is worth seeking out from a library.
Linda Watkinson is a counsellor

Guilt and remembrance

The shock of the fall
Nathan Filer
The Borough Press, 2014
314pp, £7.99
ISBN 978-0007491452
Reviewed by Jane Cooper

This is the most powerful and compelling novel I have read in a long time. In a similar genre to Mark Haddon's *Curious Incident of the Dog in the Night-Time*, it tells a story of blocked grief and madness, from the point of view of Matthew, a 19-year-old who we soon realise has much to tell us about both.

The author is a mental health nurse and performance poet and brings a fresh perspective to Matthew's commentary on his illness.

The novel is a highly relevant account of the state of mental health services in the UK today. We experience how it feels to suffer a psychotic breakdown; to wake up in a police cell; the maddening boredom and chemical cosh of the secure ward, where mugs carry the logos of the Big Pharma; the day centre under threat of cuts. This sounds like grim reading but Matthew's wry humour pervades and you find yourself rooting for him by the end.

But above all this book is about how it feels to be a bereaved sibling. It is about how children adapt to the needs of the adults around them. It is about memory and the lack of it, about trying to make sense of something incomprehensible and how fragments of memory return through the senses of sight and touch. It is about the assumptions that are made when things are not talked about, 'when the volume is turned down to just above mute,' as Matthew puts it. It is about how guilt helps us keep a sense of connection with a past event so it does not become meaninglessness.

It is also about the value of telling one's story, not in a cure-all sort of way but as a way of remembering a part of yourself that has been lost.

The book is essential reading for anyone with a personal or professional interest in bereavement and mental health.
Jane Cooper is a counsellor and supervisor

Their child and your child are one

Chris Rose reviews *Grounded*, a searing one-woman play that collapses the boundaries between them and us and good and evil

The Pilot stands before us in a mesh box. There seems so little space and such limited time – just 60 minutes. She speaks, and we travel from cockpit to car, trailer, home, sky and desert, through hours, days, months and years.

The Pilot is proud to be 'top shit' in the US Air Force, revelling in blue skies and triumphant in destroying 'the enemy': one of the boys – although, of course, she is not. She becomes pregnant and takes time out, returning not to her romanticised blue sky and personalised jet plane but to a trailer in the Nevada desert, where she learns to fly drones. Her world changes from blue to grey, monitoring a monochrome desert landscape in 12-hour shifts and driving home through another desert to her partner and daughter.

Increasingly caught up in this grey on-screen world and excited by rare opportunities to blow up 'military age males', the Pilot begins to come apart. We see it, but she can see only the landscape through the drone cameras. Obsessed by the search for the Prophet, who must be identified and destroyed, she starts to wear her uniform all the time, as if it is keeping her together. The tension is almost unbearable as we wait for the inevitable conclusion.

Lucy Ellinson (pictured above) delivers a mesmerising and totally believable performance as the woman whose understanding of the world collapses. As we all do, the Pilot has divided and compartmentalised her experience in order to survive the overload of available information. All of us make shortcuts, file and categorise. At best we become aware that this is how we operate, learn to tolerate some degree of ambiguity and accept that our understandings are partial and open to revision. This for me is one of the fundamental insights of counselling and psychotherapy.

The Pilot will have nothing to do with counselling, though. She learns the hard way that the boundaries we create to keep ourselves safe cannot be relied on. What begins as the seemingly comfortable blurring of gender distinctions – the woman behaving like the macho male – unravels into increasingly disturbing territory. The separations between home and work, on-screen and off-screen, watching and being watched, all break down. It is when that most fundamental line between good and evil/them and us begins to erode that the violence and destructiveness of what she is doing hits home. Warfare and motherhood refuse to stay in their separate compartments; their child and her child become one.

Grounded is brilliantly written and performed. It is intelligent, sophisticated and emotionally demanding – a moral tale infused with metaphor and surprising humour. See it if you can!

Chris Rose is an author, blogger, group psychotherapist and Therapy Today *Reviews Editor.*

Grounded *is written by George Brant; the Artistic Director is Christopher Haydon; Lucy Ellinson is the Pilot. The play is on tour to 31 January 2015. For details, call 020 7229 0706 or visit www.gatetheatre.co.uk*

MAIN IMAGE: IONA FIROUZABADI/IDA IMAGE: MUSIC BOX FILMS

Reviewed on TT.net

The curious incident of the dog in the night-time
Adapted by Simon Stephens from Mark Hadden's novel
Directed by Marianne Elliott
Gielgud Theatre, London
Runs until 23 May 2015
Reviewed by Lorna Swain

'... I saw for the first time how behaviours that we label "strange" are in fact aspects of ourselves that we do not want to meet.'

Ida
Directed by Pawel Pawlikowski; screenplay by Pawel Pawlikowski and Rebecca Lenkiewicz
Canal+ Polska/Portobello Pictures, 2013
Polish with English subtitles
82 minutes
Reviewed by Julian Edge

'One [of the women] is wracked with guilt, the other liberated by forgiveness. Or is one redeemed through action, while the other repeats a pattern of ultimately meaningless sacrifice?'

To read these reviews, visit TherapyToday.net. If you would like to review a new film, concert, exhibition or event that you think has special resonance for counsellors/psychotherapists, please email Chris Rose at reviews@bacp.co.uk

Do your clients know about Kathleen?

BACP wants all members to ensure clients know they can 'ask Kathleen' if they have concerns or questions about their counselling

'Ask Kathleen' is a telephone and email information and guidance service for BACP members' clients and the general public who have questions or concerns about their experience of counselling or therapy. Run by BACP Public Engagement Manager Kathleen Daymond from within the BACP Register, it was introduced two years ago, in anticipation of the BACP Register's accreditation by the Professional Standards Authority for Health and Social Care.

Ask Kathleen is seen as a vital element of the BACP Register's public safeguarding role. Some charities that campaigned for better safeguards for victims of abuse by healthcare professionals wanted the Government to fund an independent advice and support service for therapy clients. Ask Kathleen is funded by BACP and nested within the Register, and so cannot claim to be independent, but it has an important preventive and public education role. That their professional body offers such a service should be a matter of pride to BACP members, Kathleen says.

Since the service was launched Kathleen and her colleague Sarah Millward have dealt with over 1,000 enquiries – sometimes as few as 10, sometimes over 70 a month – and more than three-quarters are telephone calls. The calls and emails are completely confidential; the details are logged but not the identity of the counsellor or therapist concerned. No information is passed through to the Professional Conduct team and Ask Kathleen is deliberately kept completely separate from the formal complaints process.

The most common calls are around boundaries, confidentiality, contracting and endings. 'Sometimes it can be someone who has had their first session of therapy and it hasn't been a comfortable experience and they are wondering if this is right,' says Kathleen. 'Among the most upset, I find, are close family members and particularly parents whose children are in therapy. They want to know what is going on and feel it is their right to know. We can also get caught up in couple therapy where one partner will contact me, blaming the therapist if their partner has left them. Clients also contact us when they feel they have been "dropped" suddenly by their therapist. Endings can be hard.'

Some callers are therapists or counsellors, trainees or supervisees. 'Sometimes therapists struggle to think of themselves as a client. But to us, it's the same situation; in that call to us, they are a client,' Kathleen says.

Ask Kathleen only offers guidance and information. 'We talk to the client and try to identify what sort of therapy they are having, what has gone wrong and what they want to do about it,' says Kathleen. 'We're not there to take sides; we're there to try to help them resolve the situation. The best result is when they feel able to continue therapy.

'Sometimes it's clear to us that they need to make a formal complaint but it's not our role to influence that decision. We're not here to encourage clients to complain. If they don't want to take it further, we don't push them into doing so.' If a caller does decide to go down that route Kathleen sends them an information pack that explains the process.

Last year 44 of the 61 professional conduct cases that were upheld had been in contact with Ask Kathleen, but they were only a small proportion of the 300-plus enquiries the service received in those 12 months. Kathleen feels this is evidence that Ask Kathleen is doing its job.

BACP Register wants all BACP members routinely to provide their clients with information about Ask Kathleen and how to contact the service. Kathleen is currently putting together an information leaflet for members to give to clients and display in GP practices and counselling centres.

For Kathleen, the service is about transparency and rebalancing the power between the professional and the patient. 'I think we tend to forget that, for most people accessing it for the first time, counselling and therapy can be wrapped in mystique. Clients should be informed of their rights from the beginning. It should be part of the contract with the client.

'Clients tend to see therapists in the same way they regard doctors – the therapist knows best. They are frightened to challenge them, or they don't want to upset them in case they end the relationship. They don't realise it's a two-way street,' she says.

Ask Kathleen can be contacted on 01455 883344 in working hours or by email at kathleen.daymond@bacp.co.uk. A short film about the service and a range of leaflets about counselling and psychotherapy can be downloaded free from www.bacpregister.org.uk/public

BACP Register – are you audit-ready?

Each month BACP audits a randomly selected sample of registered members to check that they are meeting the CPD, supervision and indemnity insurance requirements of registration.

Some 2.6 per cent of registration renewals, currently around 50 members, are contacted by post and asked to submit evidence that they are complying with the terms and conditions of the Register.

Anyone who has been on the Register for more than a year is eligible for audit. If they've been keeping their records of CPD and supervision up to date, the process shouldn't be too painful and should be productive, says Christina Docchar, BACP Assistant Registrar Maintenance, who is responsible for overseeing the audit: 'It's a way of monitoring compliance with the Register but it's also a way of getting people to think constructively about their CPD and record their supervision, which of themselves are important reflective CPD activities.'

BACP Register publishes a handy online guide to the process that deals with most questions, and a short video guide (see weblink below). 'The approach is one of support and facilitation; it's not meant to be punitive,' Christina says. Only about 10 per cent fail first time and have to resubmit and no one has yet failed completely. 'If someone doesn't meet the standard, we give feedback and explain why they haven't passed. The quality is excellent overall. Members report a huge range of activities, a high level of self-reflection and a strong commitment to supervision. To me, it's evidence of the huge professionalism of our members and should inspire confidence in the Register.'

She encourages members to engage with the CPD cycle and plan their year's activities, rather than doing it on an ad hoc basis. And if members want to include less orthodox activities, that is fine too, so long as they can justify how it has (or even if it hasn't) helped develop their professional skills and knowledge. 'Someone may plan an activity and not be able to do it, or undertake an activity that turns out not to meet their learning needs. All of that is valid if you can demonstrate that you have reflected on what you are doing and you're not just ticking off the required hours. We want to get away from hours-based assessment.'

David Cliff was one of those chosen for audit in May 2014. A counsellor and Director of Gedanken, a company specialising in personal development and organisational growth, he admits his first reaction when the audit notice dropped through his door was, 'Oh no, not another piece of bureaucracy. But once I'd got over this initial reaction, I chose to see this not as a requirement so much as an opportunity for personal reflection. And if you are using your supervision properly and keeping records of your CPD, it's fairly easy to carry the information across into the template.' If he is ever unsure that what he is doing would count as CPD, he just asks the audit team.

'Enjoyed isn't the word but I found the process productive,' he says. He was particularly chuffed to get feedback from the audit team. 'I got some very positive feedback. It was nice not just to get an automated "Yes, you've ticked the box." That was very heartening.'

All BACP members should keep detailed records of their CPD, supervision and indemnity insurance but you need only submit this evidence to the audit team if invited to do so. For more information go to www.bacpregister.org.uk/renew/

Welcome for new members

From November new members joining BACP will be welcomed with a short, four-page leaflet outlining all the benefits of membership, together with their membership card.

The new leaflet replaces the hefty welcome pack that used to be sent to new joiners, and means their membership card and welcome letter will now arrive together.

The new leaflets will welcome all new members and student members who join after 1 November. The Membership department is currently working on a similar style of leaflet for membership renewals. This will confirm that the member has renewed and give a brief overview of BACP's significant achievements in the past year and planned future developments.

'We hope this is a better way of explaining the benefits of joining BACP and letting our members know what we are doing on their behalf,' said BACP Membership Manager, Chelsea Shelley.

Network groups flourish

BACP's specialist practice and divisional network groups are proving hugely popular with members.

Several BACP divisions now have a thriving network of local groups that meet regularly throughout the year. In September there were 15 network groups, attended by 250 members, and 11 are scheduled for November.

The full calendar of network group meetings is at www.bacp.co.uk/events/network.php, where you can also book your place.

Membership of the seven BACP divisions continues to grow. New joiners across all the divisions totalled 168 in September, with BACP Private Practice and BACP Children and Young People reporting the biggest increases in membership.

For more information about the BACP divisions, how to join and the benefits of divisional membership, please ring 01455 883300, email divisional@bacp.co.uk or visit www.bacp.co.uk/expert_areas

BACP Private Practice

A provisional date has been set for the 2015 BACP Private Practice conference. A record 233 people attended the 2014 conference in London on 13 September, well up on last year's attendance of 135.

The 2015 Private Practice conference is provisionally scheduled for 19 September 2015, in central London. The theme will be 'Trauma'.

To register your interest in attending, please email jade.ingham-mulliner@bacp.co.uk

Volunteers sought to pilot good practice guidance resources

BACP's Good Practice Guidance Manager Susan Dale is currently looking for volunteers to help take forward the programme to review and update BACP's good practice information resources.

Susan is currently setting up focus and consultation groups on all the topic areas. At the moment she would particularly welcome volunteers to help pilot the good practice resources on counselling in schools.

Later this year she will be needing volunteer focus group members with expertise in supervision and in diversity.

She's also recruiting authors to write the new materials. BACP is offering £350 for each published resource.

If you are interested in joining a focus group or have experience of writing these kinds of materials and would like to know more, please email Susan Dale at gpgfocusgroup@bacp.co.uk

Practitioner Conference

Following last year's successful event, BACP is holding a second Practitioner Conference, on 24 April 2015 in Leeds. BACP Healthcare, Workplace, Coaching and Spirituality divisions will again be joining forces to create a programme with four streams relating specifically to these sectors, and four on cross-cutting issues, from which delegates can choose.

To register your interest, email jade.ingham-mulliner@bacp.co.uk

Professional Development Days

Two new Professional Development Days (PDDs) have been added to BACP's very popular programme of continuing professional development events.

PDDs are one-day, tightly focused CPD opportunities with clearly defined learning outcomes. Attendance is limited to groups of just 25 so that delegates get maximum individual benefit.

The new topics are 'Preparing therapists to work effectively across languages,' with Beverley Costa of Mothertongue (London, 13 April 2015), and 'Erotic transference and countertransference,' with Sally Openshaw (Barnstaple, 22 May 2015).

The full PDD programme can be found online at www.bacp.co.uk/events

BACP Coaching update

Anne Calleja, Chair Elect of BACP Coaching, has stepped down from her role. The BACP Coaching Executive Committee would like to thank her for all her hard work for the division over the last three years.

Michèle Down has joined the Executive, bringing expertise from many years' working integratively in organisations and a passion for good use of supervision for coaches as well as therapists.

BACP Coaching's redesigned and rewritten website is now live and can be found at www.bacpcoaching.co.uk. Please email Eve Menezes Cunningham (BACP Coaching's Executive Specialist for Communication) at eve@feelbettereveryday.co.uk if you have suggestions for making it better.

Student counselling campaign

BACP has written to all MPs with a university in their constituency, urging them to ensure new students have adequate access to counselling support.

This autumn over 400,000 young people embarked on their first year at university, joining a total UK student population of 2.5 million. Of these, one in five will experience a mental health problem during their studies.

Despite counselling being an accessible, valued and proven intervention for students experiencing mental distress, constraints in university funding, coupled with an increased demand by students for counselling, are putting university-based counselling services under pressure and students' mental health, academic performance and future life chances at risk.

In its letter to MPs, BACP has highlighted the problems facing university students and the importance of specialised in-house counselling services on campus. In a 2013 study undertaken by the National Union of Students:

- 49 per cent of students said they had felt depressed during their studies
- 55 per cent said they had felt anxious during the course of their studies
- 20 per cent of students reported that they had a mental health problem.

BACP is concerned that, faced with funding constraints, some universities may decide to reduce or even withdraw counselling provision at a time when the student population and demand are increasing. BACP is asking MPs to contact the vice-chancellor of their local university to ask about the level of counselling provision provided; to seek reassurance that the university is committed to maintaining or increasing counselling provision in line with increasing demand, and to raise any concerns about levels of provision with the Secretary of State for Education.

BME access to therapy

BACP has called on the Northern Ireland Government to ensure that NHS psychological therapy services are accessible to ethnic minority groups.

The Northern Ireland Government has been consulting on its Racial Equality Strategy for 2014–2024, which will develop a framework to promote racial equality throughout all government departments.

BACP highlights the ethnic diversity within Northern Ireland's population and argues that the NHS could make its psychological therapy services more accessible by collaborating with third sector providers, ensuring all services are more culturally aware and providing interpreter support.

Mental health care in prisons

BACP has urged NICE to include continuity of care for people entering and leaving the criminal justice system in its guidance on mental health care in prisons.

NICE is consulting on the scope of its revision of the current guidance on *Mental Health of People in Prison*. BACP has welcomed NICE's intention to change the title to make it clear that it covers the whole criminal justice pathway, prevention and early treatment.

BACP has also welcomed a proposed new section on adapting interventions for the criminal justice context. It points out that effective therapies, such as dialectical behaviour therapy for borderline personality disorder, require long-term continuity in order to be effective, and this can be very hard to achieve because of frequent prison transfers.

But BACP points out that the proposed scope does not include any guidance on how mental health treatment received prior to an individual's involvement in the criminal justice system will continue when they are in prison, or interventions post-release, which BACP says are essential to help prevent reoffending. Nor does the scope cover transitions between prison and forensic mental health services.

BACP also argues that the revised guidance needs to cover the needs of specific population groups within prisons, including older people, children and young people and men, whose unique and specific sets of needs may require different interventions.

Counselling in care homes

BACP says care homes should include adequate access to counselling support for residents with depression and dementia.

The Northern Ireland Department for Health, Social Services and Public Safety is reviewing its 2008 Minimum Standards for Nursing Homes. In its response, BACP says the standards need to include provision of counselling interventions to promote and maintain the emotional wellbeing of care home residents. BACP also says the proposed new standards need to incorporate interventions to promote psychological wellbeing of people both in the diagnosis stage of dementia and in the subsequent management of the condition. Despite the language and memory problems associated with dementia, talking therapies are accessible and helpful to people at all stages of the condition, BACP says.

Ethical Framework

BACP is currently consulting with members on the redraft of the *Ethical Framework*. All members have been emailed a copy of the draft revised framework, and a link to a questionnaire for their comments.
You can download a copy of the draft at www.bacp.co.uk/efc. Please contact bacp@bacp.co.uk if you have any further queries. The consultation closes on 28 November 2014.

Around the Parliaments

This year's political party conference season was the last before the general election next May, and party leaders and spokespeople started to give us an idea of what we can expect in their manifestos. It's clear that the NHS is going to be a key battleground during the general election and the campaign starts now.

This was apparent at the launch by NHS England of its five-year *Forward View*, setting out how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and funding.

The Liberal Democrats have led the way. 'We are the only party putting equality for mental health treatment front and centre of our manifesto, with £500m of extra funding,' said Norman Lamb MP, after the launch of the NHS England report. In response Labour's Andy Burnham said the NHS report was an 'authoritative endorsement for Labour's plan for the NHS, including full integration of health and social care with more support provided in the home'.

Speaking about IAPT on World Mental Health Day, Secretary of State for Health Jeremy Hunt MP said that 'over 2.4 million people have now received evidence-based and cost-effective talking therapy, meaning an extra 100,000 people are accessing IAPT every year. In addition... the programme has, since 2008, seen nearly 90,000 people move off sick pay and benefits.'

We will be following the political parties closely until May and will report details of their plans for mental health in this column.

Parity of esteem report

BACP is launching its report on *Psychological Therapies and Parity of Esteem: from commitment to reality* on 3 December 2014 at a Parliamentary event.

The report will set out how parity of esteem between mental and physical health can be achieved in relation to psychological therapies. It draws on extensive consultation with BACP members, service users and external stakeholder organisations. Members will be emailed an online copy of the report on 3 December.

Newly accredited counsellors/ psychotherapists
Sarah Baimbridge
Wendy Beaton
Laura Beech
Julie Bowes
Christine Chappelow
Constance Chaudhry
Michael Conti
Laura Daniels
Victoria Darby
Sirpa Davies
Linda Dorgan
Diane Dungan
Debbie Earth
Janet Edgar
Kerry Evans
Kirsty Gentleman
Laura Gibbons
Sue Gibbs
Lesley Glassington
Terry Gorman
Annes Heys
Andrea Howmans
Adeela Irfan
Michelle Keane
Alison Kearns
Julie Keir
Nicholas King
Barbara Kinsella
Melanie Lamb
Valerie Lechler
Roisin McAllister
Shuna McCahon
Fran Miller
Angela Murphy
Tricia O'Connor
Faye Olliffe
Thomais Pelekanou
Janice Roe-Evans
Emma Russ
Ann Sayer
Nikolaos Souvlakis
Carol Syme
Janine Unwin
Rita Williams
Amanda Williamson
Kim Youpa

Newly senior accredited counsellor/psychotherapist for children & young people
Lucy Adamson

Newly senior accredited supervisors of individuals
Janet Barker
Katharine Charlton

Newly senior accredited counsellors/psychotherapists
Sally Burke
Alison Connor
Elizabeth James
Rachel Pillar

Organisations with renewed service accreditation term
Drug & Alcohol Project Ltd (DAPL)
Insight Healthcare
Transport for London (TFL)

Counsellors/ psychotherapists not renewing accreditation
Elizabeth Bircham
Lescilia Birtwistle
Jean Capstick
Penelope Carruthers
Simon Carver
Dennis Clegg
Francesca Delescluse
Hazel Downing
Susan Frost
Sally Gold
Hazel Gough
Dorothy Haslett
Jo-Anne Hendren
Isobel James
Anne Janssen
Gillian Kingdom
Teresa Madden
Carole Mandeville
Carla Marshall
Bruce McAlpine
Tracey McElroy
Lesley McIlroy
Lynette Mooney
Paul Pavli
Jean Pierce-Jones
Kathy Platt
Margaret Preest
Diane Redfern
Angela Roberts
Robert Robinson
Catherine Scott
Mariam Scudamore
Gwendolen Smithies
Regina Squiccimarro Wynn
Shirley Tate
Claire Taylor
Maurice Tomkinson
Anita Whitfield
Marion Williamson
Elizabeth Wood

Counselling/psychotherapy service not renewing accreditation
City College Coventry

Members whose accreditation has been reinstated
Jean Aitken
Buick Hamblin
Terri Tivey

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

CPR New Researcher Award

Submissions are invited to the 2015 *CPR* New Researcher Award. The award is kindly sponsored by Wiley this year. The winning entry will receive £100 in Wiley book tokens.

Submissions are welcome from current or recently graduated full- or part-time students who have completed or written up a piece of research in counselling or psychotherapy in the last 24 months. Submissions must not exceed 4,500 words (excluding references). The submissions can be co-authored (eg co-written with a research supervisor), but the first author must be a new researcher.

Submissions for the award can also be made by having an article accepted for publication in *Counselling & Psychotherapy Research* (*CPR*), BACP's research journal. The accepted article *must* be your first published piece of research in any journal (you will be asked to verify this at submission), and all papers will be subject to usual *CPR* peer review procedures.

The deadline for submissions is Friday 30 January 2015. You can find full details on how to apply on the Research pages of the BACP website at www.bacp.co.uk/research/resources/awards.php#CPR

BACP to undertake analysis of NAPT data

BACP Research department has gained approval to undertake a secondary analysis of the data collected by the National Audit of Psychological Therapies (NAPT). The data set consists of demographic and outcome data from over 117,000 individual clients receiving psychological therapy through the Improving Access to Psychological Therapies (IAPT) programme.

We plan to compare outcomes from the various NICE-recommended psychological therapies offered at step 3 of IAPT for which data are available. These are counselling, dynamic interpersonal therapy, behavioural couples therapy and interpersonal psychotherapy and cognitive behavioural therapy.

We will also use the data to explore similarities and differences between patients accessing the various psychological therapies offered by IAPT services, looking at their demographic profiles and provisional diagnoses in relation to the comparable effectiveness of the therapies.

This exciting programme of work will produce preliminary evidence on the effectiveness of these therapies in practice-based settings. It will also provide an estimate of how many people are accessing each of the therapies offered at step 3 of IAPT. Both are findings that have not been reported elsewhere.

CPR focus on practice research networks

September's issue of *Counselling & Psychotherapy Research* (*CPR*) (volume 14, issue 3) includes a special section on practice-based research networks (PbRN), guest edited by Professor Michael Barkham at the University of Sheffield.

The section will be of particular interest to BACP members as PbRNs are a really useful way for practitioners to engage with research and contribute to the evidence base for counselling and psychotherapy. PbRNs provide opportunities for collaborative working between practitioners and researchers, including sharing best practice, developing research skills and networking.

The *CPR* special section comprises five papers on setting up, maintaining and developing these networks. They include the historical origins of PbRNs (by Professor Michael Barkham) and using PbRNs to minimise participant attrition and prevent over-estimation of effect sizes (by Professor Mick Cooper and colleagues).

The articles are free online to BACP members. Log in to the members' area at www.bacp.co.uk and click on BACP Account, then under Online Resources click *CPR* Online.

Enquiry of the month

This month's research enquiry asked: 'Is there any research on the effectiveness and cost-effectiveness of workplace counselling?'

We searched our internal abstract database and Google scholar (http://scholar.google.co.uk/), using the terms 'EAP' (Employee Assistance Programme) or 'workplace counselling' and 'effective'.

BACP's 2007 *Guidelines for Counselling in the Workplace*[1] provides an overview of the research into the benefits of counselling in the workplace. They include increased productivity, reduced sickness absence and overall cost savings for organisations. There is also evidence that computerised cognitive behavioural therapy (cCBT) can be effective for stress-related absenteeism.[2] Computerised programmes may increase uptake because of their flexibility and accessibility.[2]

There is a relatively small amount of published research into the cost-effectiveness of workplace counselling, due possibly to commercial sensitivity issues.[3] But a growing body of research is starting to look into this.

Email your research queries to research@bacp.co.uk

REFERENCES:
1. Hughes R, Kinder A. Guidelines for counselling in the workplace. BACP: Lutterworth; 2007.
2. Grime PR. Computerized cognitive behavioural therapy at work: a randomized controlled trial in employees with recent stress-related absenteeism. Occupational Medicine 2004; 54(5): 353–359.
3. McLeod J. Counselling in the workplace: a comprehensive review of the research evidence (2nd ed). BACP: Lutterworth; 2008.

Outstanding Research Award

BACP is inviting entries to the BACP Outstanding Research Award 2015.

The aims of the award are to reward excellence in counselling and psychotherapy research, enhance awareness of the evidence basis of counselling, psychotherapy and its guiding principles, improve the overall quality of counselling and psychotherapy research by example, and encourage and inspire future generations of researchers in counselling and psychotherapy.

The award is open to anyone who has undertaken research that has been completed/written up within the last 36 months. The author may have published widely and extensively. If the winning research has not been published anywhere previously, the author will be invited to submit their paper for consideration for publication in *Counselling & Psychotherapy Research* (*CPR*), the BACP research journal.

Submissions for the award should follow the guidelines for publication in *CPR* journal (referencing style, guidelines for qualitative research etc): see http://cprjournal.com/your-research/writing-research/writing-for-cpr

The deadline for applications is 5pm on 30 January 2015. The winner will be presented with a specially designed plaque at the BACP Research Conference in May 2015.

For further information and details about how to apply, please visit the BACP Research webpages at www.bacp.co.uk/research/resources/awards.php

BACP's first PhD scholar

We are delighted to welcome Emma Broglia as our first BACP-sponsored PhD scholar.

Emma will be an Associate of the BACP Research department and BACP for the next three years while she completes her PhD at Sheffield University – a feasibility trial on the effectiveness and impact of counselling in higher and/or further education.

Emma has a particular interest in the lifestyle factors that influence cognitive function during adolescence.

BACP Professional Conduct Hearing

Findings, decision and sanction
Maria Louise Thorndyke
Reference No: 564523
New Zealand

The complaint against the above individual member was heard under the BACP Professional Conduct Procedure and the Professional Conduct 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 in that the service that Ms Thorndyke provided to the complainant fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill. The Panel found that Ms Thorndyke's actions amounted to recklessness, incompetence and the provision of inadequate professional services.

Mitigation

When Ms Thorndyke first became aware of the complaint, she gave the complainant the opportunity to meet with her supervisor to discuss the issues.

Sanction

Within one month from the date of imposition of this sanction, which will run from the expiration of the appeal deadline, Ms Thorndyke is required to provide a written submission which evidences her immediate reflection on, learning from and understanding of the issues raised in this complaint.

In addition, within seven months from the date of imposition of this sanction, Ms Thorndyke is required to provide a report that evidences the following:

- that Ms Thorndyke has fully thought through all issues relating to conflicts of interests including a working definition of how these can be managed within her work situation
- how Ms Thorndyke has used supervision to reflect on her learning around conflict of interest and how to recognise and manage conflicts and how to explain potential conflicts of interests to clients and check their understanding of the issues before commencing work
- Ms Thorndyke's developed understanding of her obligation to maintain confidentiality, and to explain the limits of that, particularly in relation to the writing of reports that will be seen by outside agencies.

The above report is to be countersigned by a supervisor outside of Ms Thorndyke's current network, who Ms Thorndyke must have worked with over a period of six months, and have received at least four sessions of supervision of not less than an hour and a half per session. The report must confirm the number and dates of the supervision sessions. The supervisor must confirm that the report and the issues raised in the complaint have been discussed in supervision and verify the number and length of sessions that have taken place.

These written submissions must be sent to the Registrar and Director of BACP Registers by the given deadlines, and will be independently considered by a Sanction Panel.

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

Sanction compliance

Averil Wilkinson
Reference No: 551194
Buckinghamshire MK18

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the July 2014 edition of the journal has been lifted. The case is now closed.

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