

Therapy Today

For counselling
and psychotherapy
professionals

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Yoga as therapy

International: a letter from Sweden

Rhona Cameron on the couch

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BACP House
15 St John's Business Park
Lutterworth
LE17 4HB
T: 01455 883300
F: 01455 550243
TEXT: 01455 560606
MINICOM: 01455 550307
W: www.bacp.co.uk
W: www.therapytoday.net
E: therapytoday@bacp.co.uk

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E: therapytoday@bacp.co.uk

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Editor
Sarah Browne
01455 883317
E: sarah.browne@bacp.co.uk

Deputy Editor
Catherine Jackson
01455 206369
E: catherine.jackson@bacp.co.uk

Reviews Editor
Catherine Jackson
E: reviews@bacp.co.uk

Associate Editor for Supervision
Bernice Sorensen
E: bernice.sorensen@gmail.com

Associate Editors for Groupwork
Linda Watkinson
E: ls_watkinson@yahoo.co.uk
Samantha Tarren
E: samantha.tarren@warwick.ac.uk

Production Co-ordinator
Laura Hogan
01455 883361
E: laura.hogan@bacp.co.uk

Advertising Manager
Jinny Hughes
T: 01455 883314
E: jinny.hughes@bacp.co.uk

Advertising Officer
Will Jones
T: 01455 883319
E: will.jones@bacp.co.uk

Advertising Assistant
Vicky Bourgault
T: 01455 883398
E: vicky.bourgault@bacp.co.uk

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Esterson Associates

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- Promote the understanding and awareness of counselling and psychotherapy throughout society
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- Provide support for counsellors and those using counselling skills, and opportunities for their continual professional development
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E: julie.camfield@bacp.co.uk

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Sarah Browne
Editor

I remember being very irritated by one of the other mothers at the primary school gates when she used to insist that her children tell her three good things about their school day. I tried it once with my kids but they just laughed. I struggle with certain aspects of positive psychology and the happiness agenda. It can feel so contrived and it seems increasingly irrelevant and inappropriate to be talking about happiness when so many people are struggling for survival. It's as if we have all dropped down a level or two in Maslow's hierarchy of needs so that the pursuit of happiness is now a luxury a great many cannot afford. But, as our news feature 'Happiness for all' reports, the Government is busy measuring our wellbeing and life satisfaction. And, although times are tough, the average level of contentment with life in the UK is reported as being seven out of 10 (although almost half of unemployed people rated their life satisfaction as below average).

It would take a huge paradigm shift in politics and values before governments really start to prioritise wellbeing and currently our world leaders are more focused on rescuing failing economies than anything else. But what is encouraging about the happiness agenda is that people are finally beginning to really understand that consumerism isn't the answer and that, as the income gap between rich and poor grows ever larger, life satisfaction and mental ill health are likely to worsen.

Perhaps in future yoga will make it onto Richard Layard's Action for Happiness list of 50 action points for happier living. In our cover feature, Jane Ryan updates us on the latest research into the neurobiology of yoga and mental health. In a world where, she reminds us, emotional disruption is increasingly endemic and attachment relationships are often broken or insecure, yoga may be 'an emerging prescription' to help us self-regulate.

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Survey shows JSA claimants have worse mental health

Mental health problems are nearly twice as common among people seeking work than in the general population, a study commissioned by the Department for Work and Pensions reveals.

Nat Cent interviewed over 2,000 people at the start of their claim for Jobseeker's Allowance (JSA) in early 2011 and re-interviewed 1,279 of them after three months. They found that 14.7 per cent had severe neurotic

symptoms – nearly twice the rate (8.5 per cent) in the general population. More than a fifth (22.6 per cent) had a common mental disorder (CMD) such as anxiety or depression.

Jobseekers with CMD were less likely to find work during the three-month study period and were more likely to have low confidence in their chances of finding work. They also sent out fewer job applications. However their state of mental health was dependent on factors

almost entirely unrelated to their employment status, such as the level of social support available to them and traumatic experiences in their lives.

Two thirds of all the JSA claimants surveyed for the study believed that employment is better for your health, although jobseekers with CMD were more likely to have a negative view of work and were less optimistic about the future. *Department for Work and Pensions*

School-based counselling recommended

School-based counselling should be part of a package of measures introduced in schools to promote and safeguard children and young people's mental health, says new guidance for headteachers.

The guidance, *Resilience and Results: how to improve the emotional and mental wellbeing of children and young people in your school*, has been produced by the Children & Young People's Mental Health Coalition to help headteachers establish a whole school culture of positive emotional wellbeing. It will be sent free to all schools in England.

The guidance spells out the individual, personal and academic costs of not taking care of pupils' mental health and emotional support needs. It also suggests a range of services that could be bought in to help schools in this role. It cites a Place2Be economic analysis that found that school-based counselling saves £6 for every £1 spent on the service. The guidance also gives advice on commissioning school-based counselling, and the need to check practitioners are trained, qualified and receiving supervision.

Mick Atkinson, chair of the Schools and Colleges Workstream for the Children & Young People's Mental Health Coalition, said: '*Resilience and Results* will give teachers the tools they need to really embed emotional and mental wellbeing in their school cultures.' www.cypmhc.org.uk

US psychologists launch pro-therapy campaign

The American Psychological Association (APA) has launched a national media campaign to encourage more people to try psychotherapy as an alternative to antidepressants.

An estimated one in 10 Americans have depression and mental ill health is one of the top three reasons why Americans seek medical treatment. The number of prescriptions for antidepressants more than doubled between 1996 and 2008, from 55.9 million to 154.7 million.

The APA is broadcasting an animated video series about a fictional drug called Fixitol. The videos parody adverts used by the pharmaceutical industry to market antidepressants to the public. Direct marketing of medicines is legal in the USA. The APA is backing up the media



campaign with information leaflets for the public on depression. These explain how psychotherapy works and how to ask their doctor about a referral to a psychotherapist.

'We get a lot of information about drug therapy from commercials and pop culture, but we hear much less about the

alternatives,' Katherine Nordan, executive director of professional practice at APA, said. 'We hope that, with the right information, more people with depression will explore their treatment options to create a plan that gives them the skills they need to manage their condition.'

www.apa.org/psychotherapy

Children 'need to reconnect with nature', inquiry finds

Parental fears are the main barrier that prevents children going outdoors to play, an inquiry by The National Trust has found.

In a poll of over 400 parents of children aged under 13 years conducted for its Natural Childhood inquiry, 'stranger danger' was named by 37 per cent as a barrier to their child playing outdoors, 25 per cent blamed 'lack of safe nearby outdoor places to play' and 21 per cent blamed 'too much traffic'. Nearly half the parents (45 per cent) said 'more local safe places to play' would most encourage them to let their children play outdoors and explore more where they lived. Other improvements frequently mentioned by parents were 'more supervised play spaces' (32 per cent) and 'more activities organised by schools or youth groups' (31 per cent).

Children themselves also included traffic risks in their list of barriers to playing outside. But other commonly



mentioned reasons were the possible danger of activities like climbing trees and their parents' worries that they might 'slip and catch cold' if they went out in the rain.

The National Trust says much more could be made of smaller, everyday opportunities close to home for children to 'connect with nature on their doorstep' and that parents should draw more on networks of family and friends,

especially grandparents, to help get children outdoors more. Learning and playing outdoors also needs to become a bigger element of the typical school day.

Fiona Reynolds, Director-General of the National Trust, said: 'The worlds of conservation, government, education and child welfare need to work together with families and communities to find solutions.'
www.nationaltrust.org.uk

Australia launches 'Family Focus'

The Australian Government is funding a national programme to prevent mental illness in the children of parents with depression and/or anxiety.

The Family Focus programme is based on an intervention developed in the US that is said to have achieved a 40 per cent reduction in mental illness in children in families where a parent has depression.

Family Focus aims to build child and family resilience by taking a 'shared family' approach and helping children accept and understand their parent's mental health problems. The programme comprises a free psycho-education DVD for the family to watch together and follow-up with a trained practitioner if needed.

The free online training will be rolled out nationally by mental health charity Children of Parents with Mental Illness (COPMI). It aims to train 50,000 mental health and social work professionals and GPs to provide family support.

Children in families where a parent has depression and/or anxiety are known to be at higher risk of low school achievement, relationship problems, substance abuse and/or low self-esteem, in addition to developing mental health problems themselves.

A public awareness campaign will also be launched early in 2013, supported by the national defeat depression campaign *beyondblue*.
www.copmi.net.au

Save the Children raises funds for UK families

Save the Children, the international child poverty charity, has launched its first ever campaign to raise money to support disadvantaged children in the UK.

A new report, *Child Poverty 2012: it shouldn't happen here*, highlights findings from a survey of 1,500 children and 5,000 parents about the effects of the recession on their lives. More than half the poorest children said

their parents were unhappy or stressed because of lack of money and nearly one in four of the poorest parents said they were arguing more or snapping at their children because of worries about money. One in seven of the poorest children said they had to go without a warm winter coat and new shoes and almost one in five said they missed out on school trips because their parents

couldn't afford the cost. Four out of five parents said they had to borrow more money for essentials such as food and clothes.

'Witnessing the financial worries of their parents is placing an impossible burden on children, when they should be concentrating on school and their future careers,' a spokesperson from Save the Children said.
Save the Children

Poorer middle-aged men at higher risk of suicide

Middle-aged men from disadvantaged backgrounds are at higher risk of suicide than men from higher socio-economic backgrounds, the national helpline charity Samaritans says.

In a new report, *Men and Suicide: why it's a social issue*, Samaritans says some 3,000 middle-aged men take their own lives each year and men from low socio-economic backgrounds living in deprived areas are 10 times more likely to die by suicide than men from high socio-economic backgrounds living in the most affluent areas.

It says men in this age group are vulnerable for several reasons. They tend to compare themselves against a 'gold standard' that prizes power, control and invincibility and feel shame if they can't match up. Changes in the labour market have meant that working-



class men have lost their pride and identity along with their jobs in the traditional manufacturing industries. Samaritans also argues that men in mid-life today are more likely to live alone and lack the social or emotional skills to fall back on when going through a rough patch.

Stephen Platt, Samaritans' trustee and Professor of

Health Policy Research at the University of Edinburgh, said: 'We need to acknowledge that men are different to women and design services to meet their needs, so they can be more effective. But we also need to look at the economic and social inequalities that contribute to people wanting to take their own lives.'

www.samaritans.org

Young people prefer to talk to friends

Young people prefer to talk to friends and family about their problems, rather than a school counsellor, new research shows.

The study, by researchers at the universities of Strathclyde and Glasgow Caledonian, aimed to find out what stops young people accessing school-based counselling services. It used previously collected data from 1,346 young people (girls and boys) attending secondary and grammar schools in Belfast and

Glasgow between 2004 and 2008. Asked why they might not want to talk to a school-based counsellor if they had a problem, the most common answer was that they were worried that other pupils might find out what they said to the counsellor. The second most common reason was 'Feeling that there are other people you could talk to', and the third was 'Worrying that other pupils might find out that you are going'. Fourth was 'Not wanting to talk to a stranger'.

Focus groups echoed these main reasons: 36.6 per cent of the young people interviewed said they would talk to other people; 13.6 per cent said they didn't want to talk to a stranger. However, nine per cent said they didn't know what a counselling service was or did. Girls were more likely to say they could cope without a counsellor's help; boys were more likely to be worried about being seen as weak. *British Journal of Guidance & Counselling*

Briefly...

- One-to-one support from a therapist, if only by email, adds an extra dimension to cognitive behavioural therapy (CBT) that online self-help CBT lacks. A randomised controlled trial of 80 college students compared eight sessions of therapist-delivered email CBT with a computerised, self-administered CBT for depression programme. Only the therapist group reported feeling supported and validated, which they said came from the email contact with the therapist. *Counselling Psychology Quarterly*

- Clients do better long term if the therapist follows the treatment protocol, a meta-analysis of randomised controlled trials of psychodynamic psychotherapy has found. Outcomes from 46 trials involving 1,615 patients showed that when treatment manuals and fidelity checks were used, clients achieved better outcomes.

Psychotherapy

- The Sixth Annual New Savoy Conference on psychological therapies in the NHS takes place next month, 29–30 November in London. The theme is 'The state of the therapy nation'. Norman Lamb, Minister for Care and Support, will take part in a question time session on parity of emotional and physical healthcare. www.healthcareconferences.uk.co.uk

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Are we listening?

Alison Faulkner

'Evidence regarding overestimation of the efficacy of antipsychotics and underestimation of their toxicity, as well as emerging data regarding alternative treatment options, suggests it may be time to introduce patient choice...' So say four leading psychiatrists in a recent issue of the *British Journal of Psychiatry*.¹

This article states what people with severe mental health problems have been saying for years: antipsychotic medication does damage to people, causes physical health problems and makes it difficult to think and feel.

It goes on to suggest that people with a diagnosis of schizophrenia should be afforded more choice: not just a choice of medication, but also the choice to refuse medication and to be given access to alternatives.

More significantly perhaps, the article exposes the shortcomings in our evidence base: research is not as objective as we assume it is and the evidence for the effectiveness of antipsychotic medication is thin.

Whatever their diagnosis, surely everyone should be treated with the basic respect that says you can have a say in your own treatment? That many people are not treated in this way says a lot about our mental health services.

This isn't an easy argument: antipsychotics have long been psychiatrists' first response to psychosis. To this day, people with a diagnosis of severe mental illness may not be offered talking therapies and may also not be listened to well. Even the above-mentioned article refers to people 'without insight' resisting medication. And yet, given the unwanted effects of the drugs, it seems to me that

they are showing considerable insight in so doing.

CBT is increasingly recognised as an effective intervention for people with a diagnosis of some form of psychosis. I suspect that this too has something to do with 'insight'. CBT is a more solution-focused therapy. Psychotherapists who practise the more psychoanalytic forms of therapy have tended to seek clients who have what they refer to as 'insight' or 'capacity', and are less likely to work with someone who has a diagnosis of psychosis. However there are many other forms of psychological therapy than just these two.

There is a long history of interest in the 'talking therapies' among service users and user groups, which is reflected in studies of service users' views. What is more difficult to determine is whether this reflects a genuine demand for psychological therapies, or whether it reflects people's need for mental health services to adopt a more humane response to them: to respect and listen to them. Does it reflect the oft-repeated call for 'someone to talk to'? All too often we hear that people in inpatient wards are largely left to their own devices, not encouraged to talk about what is happening to them and not listened to.²

When I was involved in a survey of service users' views of therapies and treatments some 15 years ago,³ it was

'Surely everyone should be treated with the basic respect that says you can have a say in your own treatment?'

no surprise to find that people with a diagnosis of schizophrenia were the least likely to have been offered talking therapies. Conversely, a large majority of participants, regardless of diagnosis, wanted 'someone to talk to' – someone who would listen to them and believe them – particularly in a crisis but at other times too, in order to make sense of their lives and their difficulties. Of course psychological therapies can offer this – perhaps particularly person-centred counselling – but so can other things. Many people value the support of peers – people who have similar experiences and difficulties and who listen to them and respect them and offer suggestions based on experience. Peer support is increasingly seen as a valuable resource for people using mental health services.⁴

Access to psychological therapies has perhaps improved for some people (mostly those with depression and anxiety) with the greater availability of CBT. However, this brings with it another complication. If we are concerned about patient choice, then why should someone not have the same choice about the type of psychological therapy they engage in? These days we are led to believe that CBT is the only form of therapy that is effective and has the research evidence to support it. But have these researchers been asking the right questions, are they free from the kinds of reporting bias mentioned earlier, and do they involve service users in their research? I wonder. ■

Alison Faulkner is a researcher, trainer and mental health service user.

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In the client's chair

I needed to make sense of my story

Amy White

My mum began a relationship with my stepfather when I was seven years old. He had previously been in our lives as he was the uncle of my real father, who left when I was three years old. At the time this relationship began, my mum was vulnerable, a single parent with two small children. He was violent to everybody in the family.

As an adult, when thoughts or feelings arose about sexual abuse I told myself to stop thinking it, that it wasn't true. I managed most of the time to block out the memories. Following a hysterectomy a few years ago, I kept having flashbacks. It felt overwhelming. My thinking and memories were very disorientated and chaotic. I remembered incidents from when I was 15 and then some from when I was seven. I desperately wanted to understand what was happening and to try to make sense of my story.

I first saw a general counsellor but she said that she didn't know what else she could do for me. That was a negative experience for me; I thought then that no one could help me, but she referred me to My Sister's Place for specialist therapy.

It took me a long time to begin to trust my therapist at My Sister's Place as I felt that she wouldn't be able to help me either. Eventually I did come to trust her and trust the therapeutic process.

I saw her for 39 sessions over a period of two years. It was very intense. We used EMDR, lots of inner child work, CBT and creative work such as letter writing and poems. The EMDR helped bring the traumatic memories to the surface so I could then begin to put my story into some kind of

'I used to think that my mum didn't love me enough to protect me and so I'd do everything I could to be the "perfect" daughter'

order and work on ways of dealing with the issues.

My therapist encouraged me to make creative items that were symbolic for me. For example, when I was struggling to overcome the self-blame, I made a stick that symbolised how harsh and judgmental I was on myself. It reminded me to keep challenging my thinking and to let go of any blame for what had happened to me. When I did that, I literally let go of the stick, physically as well as emotionally. That was something we did a lot of work on.

Sometimes I would think her suggestions were a little off the wall but then I would realise that actually there was a purpose to them and they did work.

My mum knew I was attending therapy sessions and initially I told her it was connected to childhood issues. Eventually I disclosed the sexual abuse to her and my close family, which was very difficult. My mum does believe me but she isn't open enough to want to discuss things further.

It wasn't easy to accept and cope with what has happened but I no longer have flashbacks or situations where I feel out of control. The door at My Sister's Place remains open for me if I need further sessions or just to check in, which feels like a safety net.

My life has changed dramatically. I am more

confident and I no longer have to please others in order for them to accept me. I have acknowledged that what happened was not my fault. I used to think that my mum didn't love me enough to protect me and so I'd do everything I could to be the 'perfect' daughter. I don't do that anymore.

A year ago I was in a very dark place and I was close to taking my own life. What stopped me was the thought that I would see my therapist in the next few days. I thought, I'll wait until the session and see how I feel then. I really feel as though My Sister's Place has saved my life and that of my family and I would tell anyone in the same position as me to seek specialist support from a dedicated service. They hear these kinds of stories every day and no one will be shocked by what you say – that's important.

When I had my final session I initially felt like I was walking on air. I then spent the next few days crying and thinking, 'What's just happened?' This did pass though. My life is not perfect but I realise that I am a strong, courageous and independent woman who has faced some terrible issues but has come through to the other side, still in one piece. This has been a long and slow process but one that I value and am so grateful for. ■

Names have been changed to protect the writer's identity. Amy White is a pseudonym.

My Sister's Place counselling service offers a specialist trauma-focused therapeutic service to women aged 16 years and over who have experienced or witnessed interpersonal violence and abuse. Visit www.mysistersplace.org.uk

Mental health by numbers

Rachel Freeth

'If, on a scale of one to 10, where 10 represents your mood at its best and one at its worst, what number would you give yourself now?'

This question is quite often asked in mental health settings. I know it is also asked by some counsellors and psychotherapists. The usual rationale is that it provides a benchmark against which improvement or deterioration in a person's mood can be evaluated. Regular scoring may even become part of a client's 'mood diary'.

There is a proliferation of various questionnaires, rating scales and forms of measurement in the mental health field. They are also increasingly impacting on the therapy profession.

Gathering numerical data via rating scales now seems indispensable to much research and evaluation of technologies (both drugs and therapies). It is at the heart of quantitative evidence-based research.

A numerical score may be used to determine care pathways and has become part of risk assessment processes. An example here is the numerical thresholds used with the PHQ-9 (Patient Health Questionnaire) that influence whether GPs refer patients with depression to secondary mental health services or IAPT (Improving Access to Psychological Therapies) services.

In organisations such as the NHS, numbers are demanded to enable resources to be targeted, greater operational efficiency and, ultimately, greater economic productivity. In other words, a number has practical, organisational utility (as well as the potential to be manipulated

in an era of cost cutting). Numbers equal payments.

It is easy to see, then, that numbers have become powerful. I would argue that they have now become a tyranny.

As far as I recall, I have never, in either of my roles as psychiatrist or counsellor, asked someone to rate numerically their mood or other aspect of mental functioning. I have been pondering why not, and even more why I so strongly dislike the thought of doing so.

I dislike processes and questions that attempt to objectify what is ultimately subjective. It is not just because they are flawed endeavours; such questions completely overlook the difficulties of understanding and agreeing what is meant by mood, or the complex nature of mental experiences.

Numerical evaluations of this sort are also an example of the shallow simplification that seems to be at the heart of much mental health care, allied to the reductionism that chokes holistic, individualised care.

More philosophically perhaps, rating scales turn mental *processes* into concrete *states*, although snapshots in time may still be useful.

My basic objection though, is that a number really tells me very little about the nature or meaning of someone's actual experience. It doesn't

help me to empathise. For me it has little therapeutic function. In saying this, I know that I naturally favour the language of descriptive words and concepts and how these are used to symbolise mental experience. However, my clinical practice also bears out that it is generally more helpful to invite people to find a language for their emotions and to articulate their thought processes. The clinical encounter then becomes a journey of open exploration to which both contribute. I do of course recognise that this is not every patient's preferred journey. Some individuals prefer the numerical metaphor.

Perhaps the preceding paragraph reveals why some clinicians prefer to ask patients to rate their mood with a number. Journeys of open exploration of subjective mental processes take time and sensitivity. Numerical ratings can be done in a moment, with little emotional engagement. This begs the question, whose agenda is being served – that of the patient or the busy clinician with limited time (and perhaps, for some, limited interest)?

When feelings, thoughts, perceptions and behaviours are neatly captured with a number, I now find myself wondering what is being masked and what illusions are being created. I also think a culture that increasingly desires and demands scoring systems and measurement is one that is unable to tolerate, let alone revere, the complexity, ambiguity and mystery of human being.

Let us be clearer about what our attachment to numbers is saying about our values and be honest about their limitations. ■

A culture that demands scoring systems and measurement is one that is unable to tolerate the complexity of human being'

Happiness for all

As evidence grows of the direct links between social inequalities and mental wellbeing, *Catherine Jackson* talks to people in counselling and public mental health about what makes people happy

Next month (November) sees the second anniversary of the launch of the Office for National Statistics (ONS) annual subjective wellbeing survey. The survey was commissioned by Prime Minister David Cameron in 2010 with the aim of exploring alternatives to Gross Domestic Product (GDP) as the sole measure of national prosperity. We have had one set of data already, in July this year, and are promised more next month.

The first set of data told us that machine operatives in Thurrock are unhappier with their lives than anyone else in Britain and that teachers, doctors and lawyers in Rutland and the Orkneys are among the happiest. We also learned that the average level of contentment with life in the UK is around seven out of 10, which isn't so bad; in Botswana the comparable figure is 3.6 (see, for example, the World Happiness Report at <http://www.earth.columbia.edu>).

The ONS survey asks four simple questions to gauge people's wellbeing: overall, how satisfied are you with your life nowadays; to what extent do you feel the things you do in your life are worthwhile; how happy did you feel yesterday, and how anxious did you feel yesterday? Only 10.9 per cent of people rated their levels of 'happiness yesterday' as less than five out of 10, and the UK average for 'anxious yesterday' was just 3.1 out of 10.

But there were marked differences between social groups. People in manual occupations and sales and customer services were less likely to rate their lives as satisfying and worthwhile in comparison with professionals, managers and directors. Black African, Caribbean and Black British people reported the lowest life satisfaction

ratings. People in poor health were more likely to have higher levels of anxiety, and nearly two fifths of people with disabilities gave a lower than average rating for life satisfaction (almost twice the proportion of non-disabled people). Some 45 per cent of unemployed people (more than twice the proportion of employed people) rated their life satisfaction as below average.

The inescapable fact is that poorer, marginalised and disenfranchised people find their lives less enriching and are, on average, less happy.

The impact of income and social inequalities have been extensively researched by Richard Wilkinson and Kate Pickett in their book *The Spirit Level: why equality is better for everyone*. The book, published in 2009, opens with the telling observation: 'It is a remarkable paradox that, at the pinnacle of human material and technical achievement, we find ourselves anxiety-ridden, prone to depression, worried about how others see us, unsure of our friendships, driven to consume and with little or no community life.'

It goes on to report hard evidence from statistical analyses to support the argument that the gap between the poorest and the richest in societies is a cause of major social ills.

Wilkinson and Pickett looked at data on national prosperity, relative incomes within nations, wellbeing, physical health, life satisfaction and more; their findings reveal a consistent trend. Inequality breeds unhappiness: countries with less income inequality generally do better on a whole range of health and social measures associated with a better quality of life, such as less crime, better mental and physical health and more

trust, social cohesion and social mobility.

The implications for governments are immense. They are immense also for those who work in what could be termed the 'happiness' industries – mental health, counselling, psychology, psychiatry and psychotherapy – practitioners who work on the frontline with human misery and distress.

Wilkinson and Pickett's statistical analyses have been challenged (see, for example, <http://spiritleveldelusion.blogspot.co.uk/>) but their conclusions are also widely accepted, certainly among those working in public mental health. And if their analysis is correct, this difference in life satisfaction and mental wellbeing is likely to worsen as the income gap between rich and poor grows ever larger in the current economic downturn.

Social solutions

Relative poverty is so much more damaging than absolute poverty because it 'undermines social justice and corrodes the soul,' says public mental health consultant Lynne Friedli. Friedli is the author of a report published by WHO Europe in 2009 titled *Mental Health, Resilience and Inequalities*. The report's subject is mental health in its broadest sense, not just mental ill health but also mental wellbeing – how we feel about and experience our lives.

Friedli gathered evidence from research on mental and physical health and what influences them, from neurobiology, and from epidemiology and epigenetics. 'Inequality exacerbates the stress of coping with poverty,' she says. It has clear physiological as well as psychological effects. 'People who are poor often refer to the pain of being



made to feel socially worthless, of no account. Inequality injures our universal human needs for status, control over our lives and sense of belonging. This may explain why even the most resilient poor children rarely do as well as those from more affluent backgrounds. Supportive families, high quality primary schools and interventions like parenting programmes can help to compensate. But these efforts are still generally trumped by material advantage.'

Moreover, she argues, the very factors that can strengthen resilience in the face of disadvantage are those that the current Government's economic and social policies appear hell-bent on destroying. 'To survive adversity, people need respect, dignity, opportunities to influence the decisions that affect their lives and connectedness. These are issues of fairness and social justice. Governments have to address both the material and social aspects of deprivation. To be resilient against adversity, individuals and communities need opportunities to retain or gain social recognition and to stay connected. But social recognition and collective action are frequent casualties of today's economic and cultural trends.'

Peter Morrall, senior lecturer in health sociology at Leeds University, makes a very similar argument in his book *The Trouble with Therapy*, published in 2009. Morrall's views haven't changed in the intervening years. Therapy is palliative care, Morrall says bluntly. 'Probably 90 out of 100 times, therapists' work is a sham. It is morally unjust to sit with a client with major illness, living in poverty, marginalised from society, and not recognise and seek to do something about the injustices in the world that are affecting that client. In a society like ours, where inequality is growing, it's the structural things that matter.'

Morrall acknowledges that the scale of the challenge is beyond the influence of the individual practitioner. He believes it is for their professional organisations, like BACP, to pick up the gauntlet and

tackle the fundamental causes of their clients' unhappiness – the social conditions in which they live and the government policies that create them. 'The "happiness" debate is blinding us to the reality that our world is in a mess. What right do we have to be happy when there is so much distress in the world and particularly when we, or our professional organisations, are doing nothing about it? It's time they took social responsibility, moral action and political action for social change,' he argues.

Existential psychotherapist Emmy van Deurzen has also explored the nature of happiness in relation to psychotherapy. In her book, *Psychotherapy and the Quest for Happiness*, published in 2009, van Deurzen, who is principal of the New School of Psychotherapy and Counselling (NSPC) in London, asks if it is the role of therapy to aim for 'normality and adjustment'. 'Should therapists try to eliminate unhappiness at all costs? Or should they make people think about their lives and how they live without trying to eliminate ordinary human misery? ...Do we want counselling and therapy to be a brief intervention that targets happiness?' she asks.

Her view is that philosophy has the answer: 'Psychotherapy has to be about helping people to think clearly about their lives and to find the freedom they need to come to their own conclusions about how to live and, hopefully, how to live well. Indications are that if you live well and in the right way there will be happiness along your path. There will also be suffering and misery, but you will be better equipped to deal with it and not fear it so much.'

She argues that psychotherapy isn't about teaching people to lead a happy life. 'It's about helping them live more courageously and take ownership of their life. We like to believe that for life to be pain-free and effortless is the best option. Instead we should be thinking, "What is it that would make me feel I have really accomplished

something not just for myself but in order to make the world a better place?"'

Ways to wellbeing

Celia Atherton is Director of Social Justice at Dartington Hall, the independent education and learning trust in south Devon. She is also founder of the Dartington Interrogate! festivals, which take place there every autumn. Last year's festival took as its theme income inequality; this year (13–14 October) the theme is happiness. The festivals provide a forum for people to explore the chosen theme from different perspectives and through different media, including the creative arts and social and community action.

'I think we have lost sight of what brings us true happiness and contentment,' Atherton says. 'We've been encouraged to focus on the acquisition of material goods and social status. We have become much less focused on what it is about self-esteem that comes from real achievement through hard work. There is very little real focus on encouraging people to understand that if you put hard work in, you will get results, and if you do that in the context of looking out for each other and doing a good turn every day, the evidence is you will feel really good about yourself, and you will be healthier.'

'We need to be more focused on each other's wellbeing and less materialistic and individualistic,' agrees Action for Happiness Director Mark Williamson. Action for Happiness is the brainchild of Sir Richard Layard, the economist whose work kick-started the national Improving Access to Psychological Therapies programme. In its own words, it's a 'movement for positive social change bringing together people from all walks of life who want to play a part in creating a happier society for everyone'. 'The idea that everyone is just out for themselves or that we should all be aiming to succeed at the expense of others runs counter to what we know about human nature and how

communities thrive,' Williamson argues. 'Western countries like the UK and US have got richer, but it hasn't made us any happier. The research shows that, after a certain point, greater economic prosperity doesn't necessarily improve people's quality of life. People's sense of wellbeing has flat-lined and if we and our governments aren't improving quality of life, something surely is wrong. We need to focus more on our human relationships and what we can contribute to society, not just the size of our houses or the growth of our GDP.'

It was to provide a means for ordinary people to do something collectively to make their lives happier that community activists Mike and Liz Zeidler set up the Bristol-based Happy City initiative. Happy City is trying to engage individuals, organisations and communities in Bristol in making the city a happier place, as defined and measured by the people of Bristol themselves. It is run entirely by volunteers. Says Mike: 'Happy City is all about bringing people together and helping them share what they know about increasing happiness. Marketeers have ruthlessly exploited our need for short-wave, instant gratification and pleasure, which some would call happiness. Our definition of happiness is what we call long-wave – fulfillment, having a sense of purpose, of place, of belonging and direction in life. That is where the public benefits are. The gains from happiness are at individual and community level, but it is the community elements that are really powerful.'

Zeidler says people feel powerless to make any real change. 'People talk about the pursuit of happiness as if it will bring you to a final destination when in fact it's a process. At the moment the environmental, social and economic crises give us a sense that we are travelling towards Armageddon. If you present people with the scale of the problem that they can't relate to, they do what any animal does: they flee, fight or freeze. So what we need to do is change the direction of travel

and make the problems feel more manageable. We set up this project to show people how they can play a part, in their own self-interest, in making a difference. It returns it to a more human scale. It creates a bridge over the chasm.'

In Kent, the arts organisation People United is attempting something very similar, but with a specific focus on 'kindness'. Chief Executive Tom Andrews says: 'People United is about how we live better together. Kindness links us with other people. It incorporates notions of compassion, social justice, neighbourliness and respect for others. We are interested in the conditions and factors that can help grow that.'

The arts are the perfect medium to communicate their message, he believes: 'Arts hit the head and the heart at the same time. They are a superconductor. They allow people to connect with the subject in lots of different ways. And it's fun.' But they are also keen to develop a solid evidence base for their work; they are collaborating with the University of Kent on a paper, to be published shortly, that explores the relationship between the arts and kindness and what makes the arts potentially transformative.

People United works in and with Kent's schools and communities and shares the results nationally, in the hope their successes will be replicated. They organised a three-year 'We all do good things' project that involved the whole of the town of Herne Bay in recording and celebrating in different art forms people's individual stories of acts of kindness, given and received. The project ended with a giant picnic for over 1,000 people, which continues as an annual community celebration. A range of new initiatives have developed from the project, including the acquisition of a beach hut, which People United painted blue, because this was the colour local people said they associated with goodness, and which is available to groups and individuals who want to take time out to reflect on how to make the world a better place. 'We all

do good things' has been trialled in other communities across the UK. 'Our work is intended to encourage reflection and action at individual, institutional, community and society level,' Andrews says. 'We're trying to communicate the message that everyone has the potential to do something through little acts of kindness. You don't have to be Nelson Mandela to make a difference.'

Action for Happiness has extended the Government's Five Ways to Wellbeing public mental health campaign (connect, be active, take notice, keep learning and give) into '10 keys to happier living'. The 10 keys include the aspirations to 'Find ways to bounce back', 'Take a positive approach' and 'Be comfortable with yourself'. Mark Williamson doesn't agree that a focus on individual resilience ignores the wider context of people's lives. He points to the DIY Happiness project, a series of eight-week workshops, based on the Five Ways to Wellbeing, for women in deprived communities in South London. The workshops were part of the Big Lottery funded Well London initiative aimed at encouraging individuals and communities to work together to improve their health and wellbeing.

'Many of the women said that, although they initially expected the project would be irrelevant to their lives, by the end it had been transformative,' Williamson reports. 'They told us that, although the conditions of their lives may not have improved, their ability to deal with them had.' He denies that this amounts to offering individual solutions to social problems. 'Yes of course we must work to improve the conditions of people's lives, but you can also help people deal more constructively with adversity. Someone with greater resilience and a more positive outlook is better able to do something about the conditions in which they are living. This isn't about telling people to accept their lot; it's about giving them greater self-efficacy and improving their ability to make change happen.' ■

Yogis have long practised yoga for mental transformation, above all to calm the mind. In fact, in the yoga sutras – one of the fundamental and oldest yogic texts – it is declared that ‘*Yoga citta vritti nirodhah*’ – ‘Yoga stills the mind’. That yoga might offer a way of treating psychological problems is in the West a recent notion. But it is one that is attracting great interest in the wake of new discoveries about the role of the autonomic nervous system and certain neuropeptides (small protein-like molecules in the brain that are used by neurons to communicate with each other) in promoting psychological wellbeing. Increasingly, the benefits of yoga are being explored by practitioners and psychology researchers. For some, yoga is even being seen as a treatment for mental illness.

Professor Sat Bir Khalsa, Director of the Kripalu Center for Yoga and Health, and Assistant Professor of Medicine at Harvard Medical School, has been involved in yoga practice and instruction for over 35 years and has been researching it for over 10 years. He is currently investigating the treatment of primary insomnia with yoga and meditation techniques. He is also interested in the potential effectiveness of these techniques to treat insomnia that is related to other conditions, such as depression, anxiety and fibromyalgia, and other sleep disorders. Yoga, he says, is increasingly being used alongside medical and psychiatric treatments for a range of mental health conditions, including chronic stress, anxiety and insomnia; there is a growing body of evidence to support its effectiveness in both treatment and prevention.

Increasingly, yoga is recognised as a holistic approach that works on several psycho-physiological levels. Next month, November 2012, international experts are gathering in London at a conference that will bring together yoga and mental health professionals to discuss the latest research findings into the neurobiology of yoga and how it can benefit our mental health and wellbeing.

Affect regulation

For practitioners of integrated medicine, the potential of yoga to promote our physical wellbeing and steady the mind is understood principally via the concept of affect regulation. The ability to manage one’s feelings, especially when under pressure, is part of healthy child development. However, the strains that are placed on individuals in societies where attachment relationships are frequently disrupted or insecure – where basic securities can rarely be taken for granted – mean that emotional disruption is increasingly endemic. Effective and accessible solutions for the resulting mild anxiety, depression and shame are needed and yoga may be an emerging prescription.

Specialists in the field of neurobiology emphasise the interpersonal nature of our capacity to self-regulate – that we learn to recognise and manage our feelings from a caring parent, who provides safety at times of turmoil. This, over time, becomes an internalised ability that enables us to self-soothe adaptively in response to the challenges of life. The biological mechanisms of this process are becoming increasingly well understood through advances in attachment theory and neuroscience,

which in particular demonstrate that the development of the emotionally sensitive right brain is dependent on the quality of interaction between the infant and their closest parent figure.

Most psychological practitioners are familiar with the workings of the autonomic nervous system and the negative impact of trauma or disturbed attachment relationships on that feedback loop. Trauma work now frequently focuses on establishing the client’s ability to stay within a ‘window of tolerance’^{1,2} between the two polar extremes of dissociation/withdrawal and the fight/flight response. The role of the caring other in maintaining this homeostasis is essential. Indeed, ‘affect regulation therapy’ is a new discipline. As one of its innovators, Dr Allan Schore of the UCLA David Geffen School of Medicine, says: ‘In an interpersonal neurobiological model of psychotherapeutic expertise for working with early-forming relational trauma, our conception of clinical expert is shifting from one who offers insight-oriented interpretations in order to make the unconscious conscious to one who optimally processes and regulates the patient’s unconsciously communicated bodily-based affective states, in order to facilitate development of the unconscious mind itself.’

Yoga for trauma

Interestingly, trauma psychiatrist and Director of The Trauma Center in Boston, Dr Bessel van der Kolk has so fully embraced yoga as a treatment for post-traumatic stress disorder (PTSD) that the centre now offers training in trauma-sensitive yoga

Next month an international conference in London will be discussing the latest research into the neurobiology of yoga, meditation and mental health.

Jane Ryan outlines the emerging evidence Illustration by Jacob Stead

Yoga for the mind



instruction. They have offered yoga classes to thousands of PTSD sufferers, from survivors of rape and childhood incest to Gulf war veterans. Their confidence in this approach is based on a ground-breaking two-year study, funded by the USA National Institute of Health and completed in 2011. This study showed that trauma-sensitive yoga was more effective than dialectical behaviour therapy in reducing PTSD symptomology. The randomised controlled trial compared the benefits of eight 75-minute sessions of gentle Hatha yoga with dialectical behaviour therapy (DBT) for a group of 16 female trauma survivors. After eight weeks, the eight yoga participants showed greater improvements in all dimensions of PTSD and in their physical vitality and body attunement than did the eight women in the comparison DBT group. Although the study sample was too small to produce statistically significant results, it does suggest that yoga can positively affect self-regulation and decrease hyperarousal, and that these effects are comparable, if not better than those achieved through DBT, which is commonly used to treat PTSD.³

How then might yoga work as a therapy for emotional dysregulation? Using an alternative paradigm, based on Eastern spiritual practices, it appears to achieve its effects through the yoga positions and focused breathing, which enable the person to divert their attention from an upsetting state to a point of inner emotional stability. As Mira Mehta, a leading teacher of yoga, explains on her website:⁴ 'Yoga is the control of the mind with the

goal of spiritual peace. It is founded on ethical conduct and calm-inducing mental habits. Physical practice begins with postures which train the body-mind complex. The next step is breath control, a direct means of controlling the mind. Linked with this is the control of the sense organs. Yoga philosophy underpins these practices, giving them perspective and depth. Meditative states, the culmination of yoga, are the fruit of practice arising from stilling the senses and concentrating the mind.' Here, the other 'regulating' person is replaced by the ability to self-induce nervous system stability through yoga techniques.

Current understandings of the interaction between psychological processes and the various branches of the nervous system demonstrate how the body and the mind talk to each other through signalling pathways – a dynamic that can be controlled by yogic or meditative breathing exercises. Such practices are thought to have a direct neurobiological link into the immune and cardiovascular systems. It has been speculated that PTSD may be a primitive defence system;⁵ Stephen Porges of the Brain-Body Center University of Illinois at Chicago has found that meditative activities are associated with the down-regulation of defensive responses to threat.⁶

Neurophysiology

Unsurprisingly, psychologists, researchers and yoga experts have begun turning their attention specifically to the benefits of yoga for mental health and wellbeing. New and exciting research findings are being published on the

effectiveness of yoga to treat mental disorders such as schizophrenia, PTSD, insomnia, anxiety, ADHD and depression. A search on Google Scholar for academic articles published since January 2012 under the term 'yoga and mental health' throws up 2,720 results.

One leading figure in this development is yoga teacher and psychotherapist Heather Mason, who has set up a training institute called Yoga Therapy for the Mind. Her approach grew out of her own experience of working with people with depression and anxiety. After years of personal yoga and academic study in both Buddhist psychology and neuroscience, she has developed an approach that blends yoga practices with psychotherapy and neurobiology. A possible key to the effectiveness of yoga on the mind is the relatively recent discovery of neuroplasticity, which underpins sustained psychological transformation. 'Part of our work,' Mason explains, 'is to understand how to positively promote this plasticity. We want to see if we can isolate factors that give rise to brain change and to see how specific yoga practice may achieve this. Essentially, we need to understand how the practice of yoga through its various mechanisms, such as controlled breathing, stretching, coordinated physical movement, enhanced cardiac output and mindfulness, combine to enhance brain functioning and promote positive mental health.'

Heather Mason is not alone in the quest for evidence to substantiate the benefits of yoga for the mind. Research projects in several universities – for example, Harvard, Boston University and the University of Bangalore – are

'The yoga positions and focused breathing appear to enable the person to divert their attention from an upsetting state to a point of inner emotional stability'

now publicly funded, suggesting that yoga is being perceived by the medical research establishment as a potentially worthwhile treatment for a range of psychological issues. At the November conference, scientific researchers, including Dr Chris Streeter, Dr Sara Lazar and Professor Sat Bir Khalsa, and those with an interest in meditation and affect regulation, including Dr Pat Gerbarg, Dr Richard Brown and Dr Alan Watkins, will be presenting their findings alongside psychotherapists and psychologists who seek an integrated, mind-body approach to working with mental distress.

Dr Sara Lazar, a keynote speaker at the November conference and Instructor in Psychology at Harvard Medical School, has been practising yoga and mindfulness meditation since 1994. She is researching the neural mechanisms underlying the beneficial effects of yoga and meditation for people with a mental illness and for healthy individuals. One focus of her work is determining how yoga and meditation influence brain structure, and how these changes in turn influence behaviour. She explains: 'We use neuroimaging techniques to study neurological, cognitive and emotional changes associated with the practice of meditation and yoga. We also incorporate measures of peripheral physiology (breathing, heartbeat) in order to understand how meditation practice influences the brain-body interaction and we use MRI to study the neural underpinnings of yoga and meditation.' Lazar has produced data showing how yoga and meditation influence neural function and structure.

These changes, she argues, lead to long-term improvements in physical and psychological health and wellbeing.

Dr Pat Gerbarg and Dr Dick Brown, both from the US, are exploring how yoga breathing can correct a wide range of disorders: autonomic nervous system imbalances, over-activity of stress responses and dysfunctions in emotion regulatory systems and inhibitory neurotransmitters. They believe that, by changing breathing patterns, we can alter the interoceptive messages from the body to the brain where they can influence key neuro-anatomic regions involved in trauma processing, emotion regulation and recovery. 'Through these pathways,' Gerbarg says, 'we can see how specific breathing practices can alleviate symptoms of post-traumatic stress disorder such as anxiety, insomnia, intrusive memories, over-reactions, distorted body perceptions, disconnectedness and loss of meaning.'

Drilling down into the neurophysiology of the matter, Dr Chris Streeter, Associate Professor of Psychiatry and Neurology at Boston University School of Medicine, is researching the effects of yoga-based practices on brain gamma amino-butyric acid (GABA), the primary inhibitory neurotransmitter of mood and heart rate variability. Her studies use magnetic resonance spectroscopy to document increases in brain GABA levels and improved mood in association with yoga practice. 'Yoga practices correct decreased parasympathetic nervous system activity and also correct under-activity of the gamma amino-butyric acid (GABA) system – the primary inhibitory neurotransmitter system,' she argues.

These studies are attracting worldwide attention and reflect a new development that crosses psychology, psychotherapy and physiology disciplines – to offer a therapy that can combine a caring, interpersonal relationship with the teaching of self-regulating practices; one that purposefully enhances neuroplasticity and enables the individual to continue the work outside the therapy room. As the ancient wisdom of the yoga would describe it: we are rooted in the body when the mind focuses and settles. ■

'Yoga, the brain and mental health' takes place in London on 2–4 November 2012. For more information and to book a place, visit www.confer.uk.com

Jane Ryan is Director of Confer, an organisation specialising in conferences for mental health workers. She originally trained as an attachment-based psychotherapist and is the editor of two books: How Does Psychotherapy Work? (Karnac, 2006) and Tales of Psychotherapy (Karnac, 2007).

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'These studies reflect a new development to offer a therapy that can combine a caring, interpersonal relationship with the teaching of self-regulating practices'



The deceptions of the pharmaceutical industry

James Davies explains why we should always question scientific evidence, especially when it's funded by the pharmaceutical industry
Illustration by Jacob Stead



Psychotherapists and counsellors have always disagreed on the value of antidepressants. Some regard them as nothing more than anaesthetics that mask deeper problems and encourage clients to avoid making the personal changes that suffering often signals are long overdue. Others see them as useful aids to therapy that can stabilise the client's emotional state so that therapeutic work can proceed.

Where we are far more likely to find consensus is in our response to the deceptions the pharmaceutical industry has been revealed to have perpetrated in its claims about the healing powers of antidepressants. This article is about these deceptions, and how we should all make it a professional obligation to find out about them.

Early in my career as a psychotherapist in the NHS, I simply did not know about the facts I am going to describe here. When I heard senior psychiatrist colleagues claim that the efficacy of antidepressants had been 'scientifically proven beyond dispute', I did not question them. These psychiatrists, it now turns out, did not know the facts either. Had we all been better informed, our conversations (and, more importantly, our therapeutic work) would have taken a very different turn.

Misreported trials

In recent years we have been inundated with numerous studies showing that antidepressants work little or no better than placebo (dummy) pills.¹⁻³ Such research has been seminal in persuading the UK Government to revisit antidepressant prescribing in the NHS and increase provision of psychological therapies. What has received less attention, however, is the research revealing how lax regulatory oversight has allowed pharmaceutical companies to perpetrate a number of practices that are clearly against the public interest. A report by MPs on the House of Commons Health Committee in 2005 listed the practices brought to their attention:⁴

'...that clinical trials were not adequately designed – that they could be designed to show the new drug in the best light – and sometimes fail to indicate the true effects of a medicine on health outcomes relevant to the patient. We were informed of several high-profile cases of suppression of trial results. We also heard of selective publication strategies and ghostwriting. The suppression of negative clinical trial findings leads to a body of evidence that does not reflect the true risk-benefit profile of the medicine in question.'

‘When I heard senior psychiatrist colleagues claim that the efficacy of antidepressants had been “scientifically proven beyond dispute”, I did not question them’

The former editor of the *British Medical Journal*, Richard Smith, discussed the proliferation of these dubious practices in a paper titled ‘Medical journals are an extension of the marketing arm of pharmaceutical companies’.⁵ Smith described how pharmaceutical companies have manipulated drug trial data in ways so sophisticated that, as he admitted, it took him ‘almost a quarter of a century editing for the *BMJ* to wake up to what was happening’. This recent awakening has been due largely to the release of pharmaceutical industry internal documents revealing that its marketing strategies have deceived us into believing these drugs are far more effective than the science supports. These documents were unearthed through a number of lawsuits brought against pharmaceutical companies by government prosecutors.

The first major litigation was against the British pharmaceutical giant GlaxoSmithKline (GSK), which manufactures the antidepressant paroxetine (marketed as Seroxat in the UK and Paxil in the US). GSK conducted three trials to investigate whether this drug could reduce major depression in adolescents. But the trial results were highly inconclusive. One trial showed mixed results, another showed that

Paxil/Seroxat was no more effective than a placebo, while the third suggested that the placebo might be more effective with some children. GSK published only the most positive study as evidence that the drug is effective for major depression in children.

This would have gone unnoticed had not an internal company document been leaked to the Canadian Medical Association. This showed that GSK officials had actively suppressed negative results from one study because, as they said: ‘It would be commercially unacceptable to include a statement that the efficacy had not been demonstrated, as this would undermine the profile of paroxetine.’ Once this information came to light, a lawsuit was filed against GSK in 2004 for intentionally hiding negative findings. This was settled out of court two months later when the company paid \$2.5 million for charges of consumer fraud – a meagre sum considering that it made \$4.97 billion in worldwide sales from the drug in 2003 alone.⁶

A separate class action in 2010 revealed that the international pharmaceutical company AstraZeneca buried negative data from a study it commissioned on its antipsychotic Seroquel. This study investigated whether Seroquel worked better than an older drug when treating

schizophrenia. The results showed that Seroquel was only mildly better than the older drug in improving cognitive functions such as memory and attention. But in total it was far worse than the older drug. After a year patients on Seroquel had more relapses and worse ratings on some symptom scales. They also gained on average five kilograms in weight, which put them at increased risk of diabetes. But again, AstraZeneca simply buried these negative findings, and published only the positive results, leading to the drug’s approval for general use. But so many thousands of patients suffered such awful side-effects that in 2010 AstraZeneca was finally forced to pay up £125 million to settle a class action out of court.⁷

And again, in 2010 an article in the *British Medical Journal* revealed that the drug reboxetine, marketed as Edronax by the drug giant Pfizer, was no more effective in treating major depression than a placebo sugar pill.⁸ Data on 74 per cent of the patients in Pfizer’s studies of the drug were never published. If these data had been included, the evidence would have shown that the risks of taking the drug far exceeded the benefits.⁸ Yet reboxetine has been approved for marketing in many European countries (for example,

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'The plain truth is that the powerful hand of industry influence is still everywhere: paying doctors to promote their products, funding research that is often biased'

the UK and Germany) since 1997, and is still being taken by thousands of people in the UK today.

The widespread suppression of negative data by the pharmaceutical industry was dramatically revealed in an article published by *The New England Journal of Medicine* in 2008.⁹ This article reviewed over 70 major studies of antidepressant efficacy. Of these 70 studies, 38 showed positive results for the antidepressants tested and nearly all had been published. But of the remaining 36 studies, all of which showed negative results, 22 had never been published, 11 had been published in a way that suggested a positive outcome, and only three had been published accurately.

Financial ties

The disconcerting reality is clear: most of the major antidepressant manufacturers have concealed negative studies of their products.¹⁰ This raises serious questions as to why that arm of psychiatry that relies on pills as a first line of treatment has not renegotiated its practices. While of course such renegotiation is a complex matter and has been hampered by many factors, one that warrants serious attention is that psychiatry has become so dependent on pharmaceutical revenues

that if it were to snub the industry its powerbase would be threatened.

Consider, for example, that most clinical trials of antidepressants are funded and often also analysed and directed by pharmaceutical companies,¹¹ and that many university psychiatrists researching drugs have financial ties to the pharmaceutical industry. In addition, nearly 60 per cent of the taskforce who wrote the current *DSM-IV* received money from pharmaceutical companies,¹² as have most research centres in the US and the UK¹³ and many heads of psychiatry schools.^{12,14} Furthermore, of the 29 experts now writing the forthcoming *Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)*, to be published in May 2013), 21 have received honoraria, consultancy fees or funding from pharmaceutical companies, including the taskforce Chair and the Vice Chair.¹⁵

The potential corroding effects of pharmaceutical sponsorship were highlighted to me by the immediate past president of the American Psychiatric Association, Dr Carol Bernstein, when I interviewed her recently in New York. In her view, some people in the industry were in bed with the pharmaceutical industry and she suspects that they were just seduced by the money and perks and stopped thinking objectively.

The pharmaceutical industry is, she pointed out, also 'a business, so its primary purpose is to make money for shareholders'.

Bernstein believes the solution lies in stricter guidelines prohibiting mental health professionals from deriving personal income from these companies. But, despite her rallying cry, the plain truth is that the powerful hand of industry influence is still everywhere: paying doctors to promote their products, funding research that is often biased, financing the bodies who should be keeping these companies in check and, in the absence of being able to conduct direct-to-consumer advertising in the UK, finding ways to promote their products via the media and the internet.

The challenge for all of us, then, is not to take medical authority for granted and to avoid collusion with the pervasive belief the antidepressant industry is an entirely benevolent and unblemished presence in mental health provision. ■

James Davies is a senior lecturer at the University of Roehampton and author of the recent book The Importance of Suffering: the value and meaning of emotional discontent (Routledge, 2012) and the forthcoming book Cracked: the unhappy truth about psychiatry (Icon Books, 2013).

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As a Dutch national born to a naval officer father, I lived in both the UK and the Netherlands as a child. Later, while working in the UK as a journalist, a personal crisis brought me into contact with the helping professions and I decided to change career. I volunteered with the Samaritans for two years before training as a counsellor. In 1997, shortly after completing a diploma in counselling, I moved to Sweden with my husband, a Swedish national.

I quickly realised that the profession of counsellor did not exist in Sweden – at least not formally. You could work in private practice, which I did, but there were no jobs in schools or in the health sector, and there was no sense of belonging to a profession called counselling. This came as something of a shock.

The counselling sector in Sweden today is like that in the UK in the 1970s. Government regulation in Sweden covers only the professions of psychologist and psychotherapist. To become a psychologist it is necessary to have studied psychology at university and to complete a one-year practical training. To become a psychotherapist you need to have studied psychology, sociology, theology, nursing (psychiatric) or medicine. No other first degrees are

accepted. There are only four modalities that you can practise as a licensed psychologist and psychotherapist: behavioural, psychodynamic, family systems theory and psychoanalytical. In other words, both psychology and psychotherapy are very much part of the evidence-based medical sector; that both these professions still talk about treating ‘patients’ who are ‘unwell’ reflects the prevailing medical model.

Counselling, on the other hand, is seen as part of an unregulated, complementary health sector. The Swedish word for counsellor is *samtalsterapeut*, which translates as ‘conversation therapist’, and anyone can set up in practice using this title. The grey field of *samtalsterapeut* is often criticised by the regulated professions as unprofessional, dangerous and unreliable and, to some extent, it’s difficult to disagree, since there is no way for the end user to know how skilled or experienced a practitioner is.

There is also a profession called *kurator*, which combines practical advice-giving with a more therapeutic role and for which the basic training is that of a social worker. *Kurators* are found in schools and hospitals where in the UK you would normally find counsellors. There is no requirement

Counselling in Sweden is unregulated and has little status as a recognised health profession.

Lysanne Sizoo describes her efforts to drag her Swedish colleagues into the 21st century

Illustration by Jacob Stead

Counselling in a cold climate





for the *kurator* to undertake personal therapy or supervision.

A Swedish client's typical route to a talking therapy tends to be either through referral by a GP to a long waiting list to see a regulated psychotherapist or psychologist or a *kurator*, or self-referral to an unregulated *samtalsterapeut*.

Self-regulation

It was in response to this situation that I set up the Register for Accredited Counsellors in Sweden (RACS), based on BACP's model in the UK, with the aim of creating a more professional counselling sector. I wanted to establish an accreditation system for therapists who had completed a high level of training and were receiving supervision and personal therapy, in the best tradition of self-regulation, such as BACP has developed in the UK.

To join RACS, counsellors need to have been on one of the eight accredited training courses in Sweden and to be able to provide evidence that they have completed 850 hours of face-to-face taught theory covering eight subjects. They also need to be receiving supervision, to have received 150 hours of personal therapy, to commit to undertake three days of CPD per year, and to have insurance.

This is an alien culture to many Swedish counsellors. For example, outside RACS there is no requirement for counsellors – or, for that matter, for licensed psychotherapists – to undergo CPD. Having worked 'under the radar' for so long, there is a certain reticence among my Swedish colleagues

when it comes to providing proper credentials and back-up information for accreditation. Apart from RACS, there is no umbrella organisation representing the counselling sector as a profession in Sweden.

I also started Turning Point, a counselling service based near Stockholm. The service offers individual, couple and small group counselling, and also training workshops and short courses. I wanted Turning Point to be seen as a model of best practice and to create a place where the whole process of being in therapy was normalised, while maintaining a safe and secure holding space for our clients.

Cross-cultural counselling

The vision for Turning Point was initially local: an 'English-style' counselling centre that would cater for the local Swedish population in Stockholm. As the service became established, however, it began to attract other international counsellors working in Stockholm who were also 'lost' in terms of knowing where they fitted in. And, with an increase in international therapists, we also saw an increasing proportion of our client base coming from the international community.

We are now a multi-lingual counselling centre that offers different therapeutic modalities under one roof. At present we have therapists from the UK, Holland, Poland, Italy, the USA, Iran, Russia, France and, of course, Sweden. All our therapists have completed an officially recognised training, either in their home countries or in Sweden,

that is at least equal to accredited counsellor level in the UK. Currently we offer CBT, transpersonal, Gestalt, person-centred, body-centred and psychodynamic modalities.

Some 1.33 million people living in Sweden are foreign-born (2010 figures). Of these, 859,000 were born outside the EU and 477,000 were born in another EU member state. The people who seek the services of Turning Point include ex-pats on temporary contracts and their families, people who are married to Swedes, and international students and general globetrotters. We also work with the Global Expat Centre, which offers a first line of community support for people who are not indigenous Swedes.

Relocating to another country has its challenges and these are often underestimated. Issues that bring people into therapy, such as bereavement, lack of self-worth, eating disorders, infertility etc, don't go away just because you live abroad. Indeed, when you are away from family and friends it can be much harder to deal with these challenges. Our workshops and support groups tend to cover the kind of issues that are important to this particular group of people. In our international women's group, for example, what often comes up is a sense of shame that they are the 'plus one' to their partner whose work brought the couple here. These women often have good degrees and have held excellent jobs in their own countries but in Sweden, unless you have a very good command of the language, it is hard to find work of equal status. An unhappy family is one of the main reasons people

'Counselling is seen as part of an unregulated, complementary health sector. The Swedish word for counsellor is *samtalsterapeut*... anyone can set up in practice using this title'

on ex-pat contracts go back home, so finding a way to give meaning to the period spent as an ex-pat can be an important part of the settling process.

Internationals who marry Swedes make up another large client group. For cross-cultural couples, relationships can be affected when one partner feels they have sacrificed everything to live in the other's country and culture. This client group may also be confronted with their own sense of inadequacy when, for example, learning the language takes longer than they expected. I often see in my one-to-one work how the challenges that men and women experience in acclimatising to their new home can evoke unfinished issues from the past. There is nothing like standing in a supermarket feeling like a three year old who can't make herself understood to trigger any unfinished business from long ago. It can be wonderfully supportive to hear that others feel exactly the same way, and reframing the process can give it a positive and meaningful direction.

Childcare is different in Sweden too. Women here have an identity only when they work and, although mothers get a whole year of maternity leave, it is both financially and socially expected that the children will go into subsidised daycare when they are around a year old, and that the women will return to work. For international mothers who may want to stay at home and look after their children, there is very little peer support. I have experienced myself that the full-time mum is slightly frowned upon as self indulgent, and staying at

home is only possible if your husband supports you, which is frowned upon even more. Obviously, this can cause problems in a relationship where the couple's cultural expectations differ or where one partner's expectations are not those of the prevailing culture.

Living in Sweden can also involve adjusting to more than a different culture. One of our workshops is specific to the geographical latitude. At 60 degrees north, both the quantity of sunlight and the quality (a result of the very slanted angle) affects those who are not born here. Swedes have natural ways of adapting to this climate that can be misunderstood by foreigners. During the winter months they become more introverted, spend less time socialising, and conserve their energy in a way that non-nationals don't. The workshops provide participants with an insight into such cultural behaviours and advice on how they can adapt their own behaviour to get through the winter months.

At Turning Point we ask that our therapists only work in their mother tongue (or tongues, as many are bilingual). Research from the US and New Zealand^{1,2} suggests that a therapist who works in a language other than her native tongue might have a reduced ability to be fully present, affecting the depth of the therapeutic relationship. I used to work with Swedish clients and most would call me fluent in Swedish. However, I am not the same therapist when I work in Swedish as I am when I work in Dutch/English; there is always a part of me that is 'hung up' on the linguistic side of the

narrative. This affects both my ability to understand and, more importantly, my ability to accurately mirror and reflect in subtle detail what clients have said. So I no longer work with Swedish clients, especially since I have excellent colleagues who can do a better job.

Sadly, our client profile is self-selecting in terms of income, and so we tend not to work with internationals who are here as refugees or low income migrants. However, there is a strong culture of care in Swedish society that meets the needs of these groups in the best way possible. We have explored ways of offering our services to the Swedish social care network involved with immigrants but, as I have described, there is a real distrust of anyone working in the 'talking therapy' profession who is not trained in Sweden either as a psychologist or psychotherapist.

Slow process

Swedes have slowly changed their attitudes towards counselling; going to talk to someone about their problems is no longer seen as such a big deal. Partly due to the numbers of non-licensed talking therapists now practising, at least in the main cities such as Stockholm, Gothenburg and Malmö, consulting a therapist no longer carries a great stigma. There is a lively culture of self-help literature being translated from English and also being produced by Swedish psychotherapists and those in the unregulated sector.

For younger people in their 20s and 30s – and I am sure this is universal across Europe – therapy is seen as a

‘Research suggests that a therapist who works in a language other than her native tongue might have a reduced ability to be fully present, affecting the depth of the therapeutic relationship’

service that they can choose to buy. They are, in my experience, often very clear about what they need, and the idea of being able to change behaviours is very natural to them. The over-50s, on the other hand, may be less likely to take the initiative to seek individual counselling for a mental health problem. For them, the medical approach of GP and a referral to a psychologist or psychotherapist is still the most logical route.

As to the professional development of counselling in Sweden, however, I am more sombre than I might have been two years ago. Training courses have begun to appear in the last 10 to 20 years in modalities such as Gestalt, transactional analysis, psychosynthesis, expressive arts and existential therapy. These are often initiated by Swedes who invite representatives from training organisations abroad to teach workshops here and longer training courses have subsequently developed. However, since the Swedish Government only recognises behavioural, psychodynamic, family systems and psychoanalytical approaches because they have a greater evidence base (and have also been around the longest), therapists trained in these other traditions are not recognised or regulated in any way.

As in England, CBT has been favoured by the Government. However, there are now signs that this is being reviewed and in the future it seems that people will be given more choice in their treatment.

RACS has now been established for two years; three training organisations have been accredited and we have 15

accredited members. Needless to say, the process is slow and laborious; RACS took seven years to set up and, as a foreigner, I remain astounded that, despite their enthusiasm in principle, therapists are slow to sign up and sceptical about it.

Despite much complaining about the unfairness of this 'us' (unregulated) and 'them' (licensed psychologists and psychotherapists) situation, there seems to be a lack of drive to develop internal standards. The Swedes like to do things collectively, and are used to external authorities telling them what to do, so self-regulation is a difficult concept for them to grasp. Whether RACS will survive the next 10 years remains to be seen.

There has been a lot of interest in the European Certificate of Psychotherapy, which requires 3,200 hours of training and is issued by the European Association of Psychotherapists (EAP). There is also growing interest in the European Certificate for Counselling, which requires 450 training hours and 450 practice hours and is issued by the European Association of Counselling. But neither certificate is recognised by the Swedish Government.

Those who truly lose out, due both to the Government's lack of action and to therapists' own inertia, are the potential clients. There are long waiting lists for psychotherapy in Sweden and clients who choose to find a counsellor have no way of knowing what standard of treatment they are getting, because there are no ethical guidelines governing the profession.

This inertia stops Swedes from taking personal initiatives. Self-regulation of the profession would require people to stick their necks out and be part of something that is bigger than their own personal needs. I have seen much positive talk, yet little effective commitment. That means that, unless there is an initiative for Government regulation, which I doubt, counselling will remain part of the complementary medicine sector, vaguely abandoned and overlooked, to the detriment of the end users. ■

Lysanne Sizoo is a UKCP registered psychotherapist. She has an MA in psychosynthesis psychotherapy from the Psychosynthesis and Education Trust in London. She gained her counselling diploma in 1997 and was a member of BACP until 2010. In 2000 Lysanne wrote Small Sparks of Life, dealing with pregnancy loss. In 2008 she wrote and directed 'Aviva', a musical drama representing the therapeutic journey from a transpersonal perspective. Lysanne is married to a Swedish national and has one son. Visit www.eng.turning-point.se

Therapy Today.net

Visit www.therapytoday.net to read Colin Feltham 'In conversation' with Lysanne.

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'I often see in my one-to-one work how the challenges that men and women experience in acclimatising to their new home can evoke unfinished issues from the past'

Questionnaire

Andrew Powell

Life would be nothing without the heart that enables love, says *Andrew Powell*, psychiatrist and psychotherapist

When did you become interested in psychological therapies?

I knew by the time I was 13 that I wanted to study the mind.

What gives your life purpose?

Discovering who I am and finding the courage to be that person.

What is your earliest memory?

Lying in my pram staring into a blue sky framed by leaves.

What are you passionate about?

Making the most of my consciousness.

Do you always tell the truth?

Lying is abusive and best avoided. But 'the truth' can be thrown at someone like a brick, which is not kind either. We might also debate 'What is truth?', for it is notoriously subjective.

What has been the lowest point in your life?

Enduring the misery of boarding preparatory school.

How do you relax?

I am a pianist and I especially like playing Chopin. In my youth I was rather dismissive of the 'Romantic' composers. I just didn't understand then the full expression of the human soul.

What keeps you awake at night?

A bad conscience. Thankfully, I sleep better these days.

If you could change anything about society, what would it be?

I used to think that psychology pointed the way to human progress but the tail can't wag the dog. I wish that human society could grasp that we are all one family, one consciousness, one life. Then we will stop killing each other.

What makes you angry?

People hurting each other and disfiguring this beautiful world. We are in the



kindergarten of evolution and the future of our species is uncertain, at best. I hope very much that we will survive and flourish but if we don't, so be it. From the non-dual perspective, all is perfect, even the imperfect!

Which person has been the greatest influence on you professionally?

Probably my analyst Charles Rycroft, whose dislike of theocracy led him eventually to resign from the British Psychoanalytical Society.

How do you keep yourself grounded?

Gravity helps. I feel immensely supported by terra firma and I like gardening.

What are you reading for pleasure right now?

Joseph Conrad's *Heart of Darkness*, a chilling story about Africa under British colonial rule; Nisargadatta Maharaj's *I Am That*, a wonderful exposition of Advaita; and Rebecca Elson's *A Responsibility to Awe*, poetry by a young astrophysicist who lived with cancer for 10 years before dying aged 39.

Do you fear dying?

Concerning bodily death, not at all; I'm looking forward to the next chapter! But if adverse circumstances arise, I hope to be able to choose when to end this one.

What would you have written on your tombstone?

Let my family decide. I'll be equally happy to have my ashes scattered on the wind. It will be nice to be remembered with love.

What do you feel guilty about?

I have done some very selfish and thoughtless things, but I don't feel guilty about them now. We are all flawed, yet admitting to that is how we learn and grow. The important thing is to try not to make the same mistake again. Saying sorry also helps.

What makes you laugh?

Humour is inexplicable but wonderful. In that moment, we see the whole picture and can smile at our own folly.

Where will your next holiday be and why?

I have no idea. I don't plan ahead much these days.

What is your idea of perfect happiness?

Since emotions are transient, seeking happiness is like trying to hit a moving target. Being at peace is more important to me.

Do you believe in God?

Belief is a thought and I don't take my thoughts too seriously, for the mind can tell itself just about anything. Rather, I have awareness of God (to give a name to the experience).

What's your most treasured possession?

I need the brain to service my mind, but life would be nothing without the heart that enables me to love.

What do you consider your greatest achievement?

It's the inner journey that counts most and I have a long way to go yet. We are known by the fruits of our labours. That's enough for me. ■

Andrew Powell has held consultant and academic posts in London and Oxford and is founding Chair of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists (www.rcpsych.ac.uk/spirit).

Standing up for counsellors

Is it the role of the supervisor to challenge employers who put pressure on counsellors to work with high client caseloads? *By Davy Hutton*

I am a BACP senior accredited supervisor and counsellor working in private practice and in the voluntary/community sector in Northern Ireland. I have been motivated to write this by some worrying trends that I have noticed in relation to counsellor caseloads that I think need serious consideration.

BACP describes supervision as: '... a formal arrangement for therapists to discuss their work regularly with someone who is experienced in both therapy and supervision.'

Beinart² proposes various models of supervision, ranging from those based on psychotherapy theories to those developed specifically for supervision: ie developmental models, social role models and systems approaches. Essentially these are all model-specific or trans-theoretical models of supervision.

McCann³ describes supervision as having four dimensions: clinical, managerial, educational and formal evaluation of the work. He expands this to include the training institution and agency within which supervision occurs. This article refers to clinical supervision involving counsellors or therapists.

Dryden writes: 'The clinical supervisor has a privileged, responsible position as mentor, guide and, often, assessor; it is quite different from regulatory managerial supervision.'⁴ Hawkins and Shohet⁵ describe a supervision matrix consisting of three client and three process aspects or modes of supervision and a seventh element, the wider context or environment in which the supervision takes place, that has an influence on these six modes. It is this environment, or 'work context', I would like to discuss further.

Workload trends

The current and likely future trend in counselling requires organisations to tender for work, which does not seem

to have helped counsellors. In Northern Ireland, organisations that win the tendering process tend to be those who offer the lowest tender. They then find they cannot financially sustain or deliver the service for the price quoted. Organisations can be tempted to ask counsellors to maintain unsustainable and possibly unethical client caseloads to compensate for this. The solution from a purely organisational, financial perspective is relatively simple: get the counsellors to work more client contact hours for the same remuneration.

For every standard 50-minute counselling hour delivered, some organisations are saying the counsellors 'owe' them the missing 10 minutes. This is then aggregated on a weekly/monthly basis and the counsellor is expected to work the cumulative shortfall. So, for example, for every six clients, the counsellor will accumulate an extra client hour (six 10-minute periods) to be worked. When clients do not attend (DNA), the organisation may also aggregate these hours and add them to the counsellor's workload for the next week. So, if a counsellor is required to see 20 clients per week and six of them do not attend, the next week the counsellor will have to see 26 clients.

This, however, does not recognise the dramatically increased risk of either burnout or compassion fatigue for the counsellors involved.

One of the acknowledged roles of a clinical supervisor is to ensure that counsellors are competent, ethical and professional in their work with clients (a safeguarding role). A possibly unforeseen consequence of the above trend may be that supervisors have to safeguard counsellors from the organisations for which they work.

BACP guidelines for client caseloads (information sheet G4,⁶ to be read in

association with the BACP *Ethical Framework*) suggest 20 clients for a full-time post (ie 37 hours per week). This ratio of client contact roughly equates to 60 per cent of the weekly workload. Organisations in Northern Ireland are apparently expecting counsellors on a 12-hour contract to see 12 clients. Similarly, counsellors on a 24-hour contract are expected to see either 20 or 22 clients. The BACP information sheet says the 20-client/37-hour ratio needs also to take into account a number of variables, such as client cohort complexity, vulnerability and risk, and the amount and quality of support available, including peer support and supervision. The information sheet also states that, in less supportive circumstances, the client contact hours may need to be reduced to 15 or 16 hours per full-time post. This is because therapists are working with highly emotionally-charged material.

Anyone would be hard pressed to describe client contacts in Northern Ireland as 'straightforward' or 'ideal', given our 40-year history of internecine civil conflict. Over those 40 years, terrible atrocities were committed by both sides and the intergenerational/transgenerational and vicarious trauma experienced by a large proportion of our population is severe.

I feel that some organisations are in danger of playing fast and loose with BACP's *Ethical Framework* and guidance, for purely financial reasons. They appear to be cherry-picking the sections of these documents that they like and ignoring the elements they dislike. This, I think, is a mistake; the *Ethical Framework* should be adhered to in its entirety.

How should supervisors respond?

Given this appears to be the current/future landscape of counselling in

Northern Ireland, what should be the response of clinical supervisors?

First, if supervisors try to challenge this there can be a financial penalty; organisations may remove supervisors from their 'approved' list. Also, the lack of supervisor training and accredited supervisors in Northern Ireland does not help, although recently this situation has improved. Currently, on BACP's 'Find a therapist' website, there are nine accredited supervisors listed for Northern Ireland. Some colleagues have said they don't see the need for supervisor accreditation or training when they can supervise without the financial outlay that training and accreditation entails. BACP does not, I feel, proactively advocate the benefits of accreditation enough.

Supervisors can be left in an ethical conundrum as to whether to try to 'hold the line' on behalf of their supervisees or acquiesce to the considerable financial pressure exerted by employing organisations. This can include emotional blackmail/bullying: 'You're not being seen as a team player,' 'Other supervisors seem happy with our protocols and procedures,' 'Remember, there are not many counselling jobs and a lot of counsellors would be happy with this job' and so forth. In the current economic climate, this is a powerful, implicit threat, which has reportedly been used with counsellors who complain about the client caseloads.

Organisations can see the benefits of employing accredited counsellors because BACP has helped communicate these benefits and now funders are asking for this as a pre-requisite of awarding tenders. There is a financial incentive for organisations, which drives change. But the benefits of employing accredited supervisors have not been promoted in the same way. Organisations can

have supervisors who have no formal training in clinical supervision and in some a counsellor does not even have to be accredited to become a supervisor.

This, I feel, is a serious mistake and counsellors are suffering today as a result. Without the experience implicit in supervisor status and formal training in models of clinical supervision, the supervisor may, through inexperience or ignorance, overlook the risk of burnout/stress and compassion fatigue in counsellors. It is to be hoped that experienced supervisors who have sufficient counselling experience themselves will have studied/worked with compassion fatigue/stress/burnout and will be aware of the real dangers and their impact. They may also be more secure in voicing their concerns about this implicit bullying by organisations who appear to think that, by bringing supervision in house, they can control any dissent/disquiet.

The counter argument is that there are not enough accredited supervisors, but this can be easily remedied. When the IAPT programme was rolled out in mainland UK, there was a shortage of trained CBT therapists. Training institutions were asked to design one-year intensive courses to remedy this and, within two years, hundreds of CBT counsellors were trained to fill the shortfall. A similar programme could be organised to train more supervisors or to encourage more supervisors to become accredited. I feel that, unless this trend of ever-increasing client caseloads is addressed, the detrimental impact on the psychological wellbeing of counsellors may be considerable.

I wonder whether this issue is unique to Northern Ireland or if it applies to parts of the UK? Could this trend possibly infringe or compromise an organisation's duty of care, or increase

rates of counsellor work-related stress? My question is, are supervisors ethical guardians or submissive observers? The answer may seem simple, but perhaps only in theory. Both have repercussions: ethical guardians may face financial penalties, implicit bullying and vilification; submissive observers may tacitly contribute to increased counsellor burnout and compassion fatigue.

BACP could help mitigate this trend by firming up their guidance on counsellor/client caseloads and possibly including it in the BACP *Ethical Framework* in a more definitive, explicit manner. This could help educate organisations to adopt a fairer and more compassionate approach towards their biggest asset – their employees. ■

Davy Hutton is a BACP senior accredited supervisor and EMDR Europe accredited consultant. He currently works with a community agency dealing with 'Troubles'-related trauma and is a clinical supervisor for Queen's and Ulster universities and in private practice.

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Dilemmas

Transference in couples therapy

This month's dilemma

Lloyd, an experienced counsellor, has been working with a couple, Julie and Tom, for around six weeks. The impetus for the counselling came from Julie, and Lloyd is aware that Tom only comes to please Julie. Lloyd has not found the work easy, and has sometimes struggled to contain their aggression, some of which is towards him, particularly from Tom.

One day, when Lloyd is idly scanning the internet, he comes across a blog written by Tom entitled 'Couples counselling – a true story'. Lloyd is very tempted but decides not to read further. However he wonders whether he should tell Tom that he has seen it or wait for Tom to bring it up first.

What are the ethical dilemmas involved in this scenario, and what should Lloyd do?

Tim Branson

**Psychological therapist/
specialist counsellor
and senior accredited
supervisor of groups**

From a supervisor's perspective, it seems clear that Lloyd needs help with working with the anger in the room and with any negative transference from Tom. I wonder if he might role-play in supervision different ways of openly addressing Tom's aggression?

Is Tom's aggression 'communication', in the same way that the blog is a communication? Perhaps part of the therapy is to encourage him to find more straightforward ways to communicate his feelings. Indeed, it seems both parties are holding anger and clearly Tom has feelings about being in therapy and about the therapy itself that he cannot express in the moment. I wonder if challenge and encouragement to bring his feelings to the session could be key?

As to Lloyd's ethical dilemma about disclosing that he has discovered the blog, he does not know if Julie is aware of it (this, perhaps, representing a very 'non-verbal' communication from Tom), so raising the issue directly could be unhelpful for them.

That Tom hasn't talked about the blog suggests it is negative about the therapy, although this is not necessarily the case. It may state that the therapy is helpful but Tom is unable to express this in session.

It might also be better for Lloyd if he doesn't read the blog at this stage as it may negatively influence his ability to sit with Tom and Julie's issues. However, knowing that there is a

'Knowing that there is a public statement about his work with Tom and Julie may in itself prevent Lloyd developing a stronger therapeutic alliance'

public statement about his work with Tom and Julie may in itself prevent Lloyd developing a stronger therapeutic alliance.

Perhaps a task of supervision might be to work with Lloyd's fantasies about what the blog might say, so that he becomes more comfortable sitting with this unknown element of what is, ostensibly, simply client material.

Lloyd might benefit from reading the blog when the therapy has finished, however. How often do we get an opportunity for uncensored and honest feedback – even if it is from an angry client's perspective? And, after all, the blog is in the public domain for all to see. That said, if the outcomes of therapy are positive the blog may totally diminish in importance. From a cautionary perspective, if Tom wrote it when angry, it might include inaccurate or inappropriate material and, however painful, it would perhaps be better if Lloyd knows what it says and can bring it to supervision.

William Johnston

**Person-centred counsellor
in private practice**

Experienced as Lloyd might be, it seems to me that the issue here is to do with boundaries.

I was struck by the phrase 'idly scanning the internet'. Presumably this is Lloyd's

phrase. It would, I think, be difficult to come across such a blog, written by a client, unless Lloyd were in some way looking for it, or at least looking for something about Tom, as a way to help him out of the difficulties he is experiencing with this couple.

As a point of speculation, I have a suspicion that Tom may either be working beyond his competence – a difficult admission for an experienced counsellor to make – or may be reluctant to challenge the dynamic of the sessions for fear of Julie and/or Tom terminating therapy and leaving Lloyd feeling a failure.

As described, there is a serious inequality here. If Tom really is only there to please Julie, then that needs to be confronted head on. I can see no point in continuing the sessions unless this is done. If Tom is venting his aggression against Lloyd, then that would suggest that this issue has not been confronted and Tom may well feel in some way ganged up against. Lloyd's contract is with the two of them and their relationship, not with Julie at the expense of Tom.

It might well be that, once this imbalance is acknowledged, Tom will be far more willing to continue with the sessions and to engage as an equal partner.

All credit to Lloyd for not reading Tom's blog. Regardless of whether he does or not, however, I suspect that inviting Tom to own his feelings about being at the sessions at all is likely to bring up all the issues that he may have confided to the 'private' setting of an online blog. At that point, the issue of the blog becomes somewhat irrelevant.

If Lloyd cannot establish an equality of engagement between Julie and Tom, then I think he might in any case have to consider terminating the sessions.

Margaret Akmakjian-Pitz
Psychotherapist and supervisor in private practice

When I was in therapy, I found the impersonal 'blank screen' and rational approach so chilling that I was totally unable to be open and vulnerable. Reading Lloyd's dilemma re-evoked those feelings of being pushed away, along with an unwelcome and uncomfortable feeling that, from a purist's point of view, he might be doing 'the right thing' in not reading Tom's blog.

It may be 'right' but is it in the client's best interests? *Everything* is grist for the mill, so it could be quite useful to discuss with Tom what he writes in his blog that he isn't able to bring to the sessions – and why that might be. Perhaps putting things in a written form is a way for Tom to get feelings out. Maybe Lloyd needs to use what is in the blog and move forward to Tom actually talking directly to him? In his shoes I'd be grateful to Tom for helping me find a way into the things that he is not able to tell me directly.

Tom is telling his story in the only way he knows how, through his blog. Perhaps Lloyd needs to explore with Tom how and why this is his chosen safe way to communicate, and demonstrate that both he and Julie can deal with what Tom says without retaliating. It will only be when Lloyd shows true empathy and understanding that Tom will be able to speak directly

about his feelings. Possibly, in Tom's case, it would be about his (and Julie's) aggressiveness.

I hope Lloyd can be courageous enough to read Tom's blog. Whatever its content, it's wonderful grist. As his therapist, I would want to work with the feeling in order to understand the aggressiveness.

Mandy Pitts
Trainee counsellor

Lloyd needs to think very carefully about what steps to take if he wants to avoid any major damage to the relationship he has built up with Tom and Julie.

First, I am assuming from the information provided that Lloyd did not go looking online for information on Tom, which would of course raise concerns in itself. However, having discovered the blog, he now has to decide whether to look at it or not.

Although Tom puts his own name on the blog, a bigger concern is whether he has given details that would make Lloyd recognisable, such as his full name and the address of his workplace.

Unless Lloyd looks at the blog, he cannot know what is written, but once he has read it, he can't unread it. My suggestion would be that Lloyd asks a colleague, or his supervisor, to read the blog, primarily to check that it maintains Lloyd's

confidentiality, but also to check that nothing has been written that would cause concern to the therapeutic process, such as threats of aggression towards Lloyd. If there is nothing like this, I think that Lloyd should avoid reading the blog. It is something personal by Tom, and he is entitled to post his thoughts on the therapy, although the fact that he has included his full name suggests he might have actually wanted Lloyd to find it, possibly as a way to intimidate him outside of sessions.

Whether to mention the blog in a counselling session is another consideration. Julie may not know about the blog and may not agree with its contents. By bringing it up in front of her, Lloyd could be seen to be breaking Tom's confidentiality – perhaps the blog is his way of expressing what he does not want or feel able to share with his wife. Instead, Lloyd could ask the couple how they think their counselling is going, so that they have an opportunity to discuss any issues about it that they are willing to share.

I would suggest that Lloyd does not disclose that he is aware of Tom's blog, unless he feels that he has no choice. Tom is already sceptical about the counselling; if the blog was intended as a way of expressing his thoughts on the process, which could be therapeutic in itself, knowing that Lloyd has found it is likely to cause anger, and even a feeling that Lloyd has been interfering in their life beyond the limits of the counselling. This is likely to make it impossible to maintain any sort of relationship in the therapy room and also risks affecting Tom's relationship with Julie.

Next month's dilemma

Deidre works as a therapist in a local voluntary counselling service, where she also has a managerial role and is expected to attend outreach and networking meetings.

However, at a recent event she notices that a client of hers is also present. Deidre leaves the event and tells her manager, who is not very pleased that she left the meeting. The manager is now considering appointing only non-practitioners as managers of the counsellors and counselling service.

What ethical issues are involved and what should Deidre and/or her manager do in this situation?

Please email your responses (500 words maximum) by 31 October to Heather Dale at hjdale@gmail.com. Outline how you would manage the dilemma and make your thinking as transparent as possible. Readers are also welcome to send in their dilemmas for consideration for publication, but these will not be answered personally.

'Perhaps putting things in a written form is a way for Tom to get feelings out. Maybe Lloyd needs to use what is in the blog and move forward'

Learning to live with myself

Comedian and writer
Rhona Cameron talks
to *John Daniel* about
adoption, therapy,
healing and the life
hereafter *Photograph by*
Studio 1B Photography

I'm a storyteller. Whether I tell stories on stage as a comedian, in a book or any other format, storytelling is intrinsic to my being; it's my vocation and tied up with the complexities of my character and life experiences. However, I've not been one 16th as productive as I could have been, had my emotional baggage not eclipsed my creativity. When I write I lock myself away and live like a hermit. I have to live something until it's coming out of my pores. I used to be very open and honest about everything but I'm learning to fictionalise more.

When I presented *Gaytime* TV in the 90s, it was the first programme of its type. I was just being me, which was a mixture of masculine and feminine. I still do countless things where I'm 'Rhona Cameron, the out lesbian'. But that's not how I define myself now, although I have my major relationships with women. People now don't need to explain what they are – it's not a big deal. I don't want to be pigeonholed in just the gay place, because my life is about so much more than that. I've always felt sexuality is more complex and that most of us are bisexual anyway.

This summer I re-read *1979: A Big Year in a Small Town* for the first time since writing it in 2003. I'm in a very different place now. I grieved for the first time for my father while writing it; he died in 1979. I'd sometimes have to go and lie down and sob. At the moment, I'm trying to write the screenplay. I don't have a problem with starting ideas but have difficulty seeing them through. I do beginnings and endings but find middles very difficult.

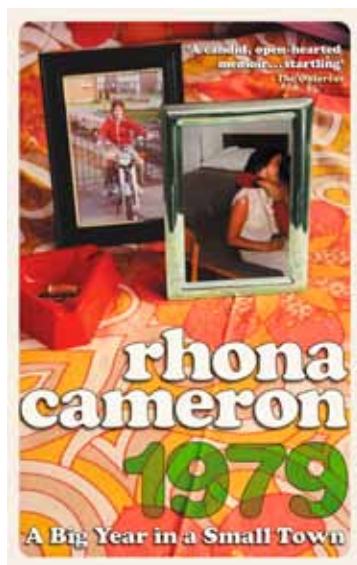
My mum, who's 82 now, had a very hard life. She had a baby die and she adopted me. I feel the burden of my

age and generation, and of being an only child. People always say, 'The war generation, they were real stalwarts,' but my generation – people in their 40s and 50s – we're the first generation who had to go to therapy to sort all that shit out: the children of parents who really shouldn't have been married to one another. I'm not saying that about my parents but I would question why most people of my parents' and grandparents' generation got married in the first place. Indeed, why anyone does without a period of self-examination.

I've done a lot of therapy about being adopted and I've read a lot of books. I'm always recommending *The Primal Wound* by Nancy Verrier to other adoptees. In my day, when you found out you were adopted, there was no help, no social workers, no counselling. For people wanting to adopt at that time, all you had to do was wear a collar and tie if you were the father, and have a decent home with running water. They certainly weren't told that the baby they adopted might have a whole list of problems because her mother left her.

When I was very young and asked where babies come from, my mum said, 'You came from a home with lots of babies.' I asked her why she chose me and she said, 'Because you had beautiful eyes.' Later, when I was nine, she spoke to me properly for the first time about it. She said my biological mother had a temper and that she was happy I was going to a good home and to a family who had a caravan so I would go on nice holidays. She asked me if I had any questions – which was quite unlike my mum – and I said, 'I don't care about her.' I was very angry. My world collapsed at about that time.





I'm not as angry as I used to be. I understand my mother's pain and I understand mine. I try to be grateful for all the things that have happened to me'

I met my birth mother in a pub when I was 22. Despite how articulate I am and how connected to my emotions, it's something that's very hard to convey to those who haven't gone through it. But that feeling you have when you are in love with someone, or when you are excited by early romance, it's sort of like that. This is the person who made you and you're seeing the image of yourself for the first time in your life. That very thing that everybody takes for granted, it's the strangest thing to you if you're adopted.

I took antidepressants when I was younger but feel strongly that far too many people are being medicated. I lose count of the people I meet in their mid-40s who are popping antidepressants. I didn't want to, so I sought out a more esoteric path that drew me into a mix of astrology, spiritual healing, and core process psychotherapy with a therapist who is a Buddhist. We're all depressed sometimes; we're all sad. Some people can fall further down but I honestly feel that about 70 per cent of people who are on medication don't need to be.

I was in analysis for seven years until a few years ago. I'm naturally an analytical person. Librarians suffer terribly from over-analysing and I am the worst case. Looking back, it was helpful but it didn't help me put into place on a practical level a way of dealing with my character and the wounds I carry and how they manifest. I absolutely needed it, and sometimes I really miss my analyst, but I left because I no longer found it helpful.

Currently I'm in core process psychotherapy, which originates from the Buddhist way of thinking. It's about helping you put the mind back in the body; the changes come from a developing sense

of connection with your core. It's helped me feel more grounded as a person, which has helped me dissolve some of my fears. At the end of the day, we can understand why we become who we are but we then need to be able to stay with who we are without wanting to run away from ourselves. The thing I love about the Buddhist way is there's no bullshit: you learn to sit with yourself and be with your feelings – the fear, the sadness and the joy.

I believe there's another dimension to our existence and that the soul goes on. I've been involved in the spiritualist church and have had evidence that those who leave this world are still around us. I feel life is spiritual and you can choose to tap into that and live by that or not. I think the whole world is moving towards a more holistic slant. I think artists and healers will lead the way, as will others whose work is about connecting with people, like teachers and therapists.

Middle age is very much about shedding and loss. I've gone through this process of change and I'm not entirely sure where it's going yet because I'm a work-in-progress. I'm in a better place now than I have ever been in my life, but it doesn't end; you don't arrive at anything. The big life struggle is about the connections we make while we're here and the attempts we make to connect with our authenticity.

I'm not as angry as I used to be. I understand my mother's pain and I understand mine. I try not to be self-pitying, because it's not helpful. I try to be grateful for all the things that have happened to me, even though some of them are painful. ■

Rhona Cameron is an award-winning comedian and writer.

How I became a therapist

Jon Treanor

Jon Treanor
changed direction
from a successful
career in corporate
business to train as
a psychotherapist
Photograph by
Stefanie Langenhoven

My first degree is a BA in marketing. I finally managed to do this in my 30s, while working for Sony. My boss saw promise in me and persuaded me to do it. I had no academic qualifications whatsoever. I spent most of my teenage years in institutions, where I became an expert and persistent absconder. My mother and I were physically abused on a regular basis by my late alcoholic stepfather and, as a result, my education was virtually nonexistent.

Armed with my degree and a new self-belief, I embarked on what turned into a very successful career. I held positions right up to senior vice president level in large corporations, with global responsibility for marketing operations.

Yet, despite my business success, I felt there was always something missing in my life. I had nice cars and holidays, travelled the globe, but still I was not happy deep inside.

Then, in the late 90s, I read a book that was to change my life. It sparked my spiritual curiosity to such an extent that I booked a flight to the US to visit the author. Neale Donald Walshe is a charming man who has received great acclaim globally with his *Conversation with God* (CWG) books. Could he really have spoken with God? Why him, why was he so special? Why was this God not talking to me? Either he was a con man, a charlatan, or he had seen or heard something that I felt keen to see and hear myself. We met and as a result I hosted a small UK speaking tour for Neale and set up CWG UK.

Doing this made me realise that the part that was missing in me was spiritual



and that I was unfulfilled as a human being. I was, in fact, pretending, and I had been for most of my life.

I struggled with this for a few years when my professional career was at its peak and finally relented when a girlfriend told me that I was socially void of empathy and that work was my mistress and it would probably kill me. I realised that she was right and that I had completely lost who I really am. I wept.

She recommended I go on the Hoffman programme, an eight-day intensive therapeutic approach for people seeking change in their lives. She herself had attended and felt that it might give me the incentive to change the way I was. Perhaps she saw something in me I was missing myself. During the eight days I experienced every emotion possible; I surrendered to the process. There I met a number of psychotherapists; one in particular impressed and inspired me. During a small group therapy session (my first experience of any sort of therapy), it was

'In my first year of training, typically competitive, I asked our tutor, "How do I become the best therapist in the world?"'

suggested that my true vocation might be as a therapist. For some reason this resonated deep inside and I researched what sort of therapist might suit my beliefs and values. I was then invited by the BBC to take part in a television series called *The Big Silence*, where I spent eight days in silence. This had a profound effect and effectively sealed my decision to become a psychotherapist.

I chose the Centre for Counselling and Psychotherapy Education (CCPE) and the transpersonal model because of its integrative and non-limiting qualities. The ability to draw on numerous approaches and modalities allowed me the freedom I wanted as a therapist. The non-religious spiritual aspect had also become increasingly important to me.

I knew that others like me were trapped in an ego constructed out of surviving and succeeding in the commercial world; that others had had poor starts in life and had seen their mothers abused and had been unable to protect them as children. These are my four reasons for becoming a therapist.

In my first year of training, typically competitive, I asked our tutor, 'How do I become the best therapist in the world?' His answer really woke me up to the change in life I had chosen. 'Being a good enough therapist is all one can hope for.' It is all I hope for. ■

Jon can be contacted via his website at www.jontreanor.com

The Big Silence is available on DVD and on YouTube at www.youtube.com/watch?v=L_zDtdYu3mA

Outmoded notions of science

I have to congratulate Martin Seager on his excellent article, 'Bad science and good mental health' (*Therapy Today*, September 2012). I think he encapsulates perfectly many of the problems surrounding the attempt to make counselling and psychotherapy more 'scientific', which, of course, relates directly to the whole debate around evidence-based practice and its incarnation in IAPT.

The problem, as Seager points out – and especially in his 'In conversation' piece with Colin Feltham on *TherapyToday.net* – is not so much that talking therapists are trying too hard to be 'scientific'. Rather, they are not being scientific enough. Or, to be more precise, they are working with a particular and rather outdated notion of 'science'. Ironically, the idea of 'science' that many proponents of evidence-based practice are still using was rejected many years ago by the 'leading edge' sciences, such as particle physics.

A lot of this seems to go back to the desire by those in the social and human sciences, and especially in psychology, to prove they are 'real' (macho) scientists, without bothering to ask what 'real science' actually is. So they blindly emulate what they think is the 'benchmark' for 'real' science – ie empiricism. In other words, they hold on to the 19th century idea that science consists of making careful observations – ie collecting data – and then looking for patterns in that data. This, in essence, is what 'evidence-based practice' is. As any philosopher or historian of science will tell you, this notion of science was discredited in the 1930s by

Karl Popper and his idea of falsification. In other words, science is not about collecting mountains of data for the sake of it, or even about trying to prove hypotheses. Rather, it is about *falsifying* hypotheses – the famous 'black swan' argument. Since then, of course, there have also been many other philosophies of science – for example, the work of Roy Bhaskar and his idea of critical realism – and a whole host of 'new paradigm' theories. In other words, science has moved on a long way from the rather quaint idea of the 'scientist' as someone who simply collects data and then analyses them. Ultimately, science is about theory building, and techniques such as falsification are simply ways to test such theories.

Now, the strange thing is, anyone who has done a degree in psychology or in a related social science in the last 30 years will (or, dare I say it, should) know all this. I suspect many of the readers of *Therapy Today*, and those 'experts' who advise the policy makers, including those who set up IAPT and who advise NICE, know all this too. Certainly, when I did my degree, I did a whole course on the philosophy of science. So my question is: why do so many in the world of talking therapies continue to adhere to a completely outmoded notion of science? After all, policy makers do not make policy in a vacuum: they rely on experts in the field, and when it comes to talking therapies, the experts are ultimately those with a background in psychology and counselling and psychotherapy.

Of course, I am well aware that, when it comes to policy and advisory meetings, the

topic of conversation is unlikely to be the finer points of Popperian theory or a comparison of different paradigms. Rather, it's about *realpolitik* and what will get ministerial approval. But let's not forget, the views of academics such as Richard Layard were highly influential in the establishment of the IAPT programme, so ideas do matter. If our representatives from the world of talking therapies are going to advise policy makers on the development of therapy services, at least they could base their advice on *real* science rather than *pseudoscience*.

So, to all those macho would-be scientists (and policy advisors) out there: wake up – it's the 21st century, not the 19th!
Leslie Chapman
MBACP; BA (Hons); MSc;
psychoanalytic therapist

Insights of middle age

Natalie Marshall-Shore (Letters, *Therapy Today*, September 2012), with reference to a recent *Sunday Times* article, asks why there are so many middle-aged women training to be counsellors. As a (slightly) post-middle-aged woman, who first trained in counselling in her late 20s and subsequently re-trained in mid-life, I'd like to offer a few thoughts.

To me, the counselling field could be compared to journeying through the whole countryside of life. Trauma aside, we could say that, developmentally, the landscape of the late teenage years and through the 20s

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and 30s has its own particular vistas and characteristics, which training enables us to identify in ourselves and support in others.

And then there comes that shift, which is like a recognised mutual perspective from the inside, outwards. Generalising, but not too greatly, the land of the over-40s is a new country, revealing meaning (welcome or unwelcome) behind and within our outward living. The mid-life landscape is ultimately capable of showing and sustaining 'shadow' (as in Jung), and acquiescence with paradox – such as gain through loss, or the acknowledging of one's own unique, wonderful identity, even in brokenness, warts and all.

In my own experience, this has meant therapeutically evaluating half a lifetime of choices and non-choices in the light of values then and life-values now. Inevitably I was drawn to consolidate process with professional practice and so, at the age of 53, I went on to four years plus of further counselling training. Although primarily an integrative, person-centred and psychodynamic counsellor (with lots of CPD hours behind me), I chose to attend to what meshed with my inner life; hence much Jungian work, but also CBT and holistic stress management.

So, in answer to the original question about middle-aged counsellors, I suspect that it is this 'from the inside out' experience of growing through transitions (with all that implies of incorporation and transformation into new freedoms) that draws other middle-aged students to train or re-train as counsellors. Perhaps it is the outcome

of struggling for familiarity with one's own depths until we can humbly, and more knowingly than previously, settle with the ultimate simplicity of our very own way 'to be' and 'to be with'.

Counselling is so much more than a career or a career path. To me, now in my sixth decade, it is a mystery; you could almost say a ministry, and as such I would hope that the widest demographic would find accommodation within the profession. Younger counsellors bring fresh eyes, ears and insight to the work, and older counsellors bring another insight, perhaps with something of the quality that poet Gerard Manley Hopkins called 'inscape' – that is, neither better nor worse, but both and.

Yet, since the question was raised, who gets the clients? Well, there seems to be a lot of people out there, and the old adage 'You gets the clients you deserve' still holds true. Taken positively, and from the experience both of counsellor-glutted cities and also less populated areas, I have found that clients, like streams, brooks and rivers, find their own water level in this land. Thus I believe we get the client who surprisingly 'finds' us, younger or older, as a welcomed match and I trust in that for all of us.

Anne Alcock

Age is no barrier

I am writing in response to Natalie Marshall-Shore's letter regarding Cosmo Landesman's article in the *Sunday Times* (*Therapy Today*, September 2012). Natalie

writes that the most disappointing bit was the quote from me saying that 'patients don't want to discuss their problems with a 20 year old who has little life experience'. I just wanted to concur, and say that this was the most disappointing bit for me too.

I talked with Cosmo for over 40 minutes, essentially contesting his view that the counselling profession is a haven for middle-aged, middle-class women who fancy a change. In the context of the more positive view that age is not a barrier to older people coming into the counselling profession, I did say that some older clients found it difficult to talk to someone much younger than them. It can be equally true that some younger people are put off by the idea of talking to someone a great deal older than them. And sometimes, of course, age is not a factor at all.

Clearly I did not succeed in changing Cosmo's opinion. I'm glad to have the opportunity to say that I didn't share it either.

Nicola Barden

It's the real thing

With reference to Kevin Ryan's letter (*Therapy Today*, September 2012) about being paid in cash – and the analogy with prostitution 'paying someone to love you for 50 minutes'. I just wanted to point out that the difference is that in counselling the love is not faked.

Annie Tumnicliffe
MBACP

No shame in taking cash

I have recently completed an MA in counselling and psychotherapy and wrote my dissertation on counsellors' attitudes towards money, so I simply had to respond to Kevin Ryan's letter 'Cash in the hand' (*Therapy Today*, September 2012).

Kevin asks if others share his feelings about money: namely, that the exchange of cash in the counselling room leaves him feeling unsettled and uncomfortable. To cut a long dissertation short, the answer seems to be that Kevin is not alone in his discomfort in accepting cash, and the question is, why is there such tension between creating a caring therapeutic relationship and managing the financial contract?

As therapists we know that counselling is ideally an open, honest and transparent experience and yet within the therapeutic relationship money is rarely openly and honestly discussed. To find out more I interviewed both newly qualified and experienced therapists and the results were interesting in that there was little difference in attitudes between the two groups. Both groups spoke about self-worth, the intimacy of paying for therapy (which only the female participants likened to prostitution), keeping the transaction hidden, perhaps as a result of tension between what is perceived as the 'loving' relationship (the therapy) and the business transaction (the payment), and the feelings that taking payment, in particular cash, can evoke, whether difficult, such as embarrassment, or more

positive, such as increased feelings of confidence.

More significant than experience was the personal meaning that money held for the participants. Any unresolved issues concerning money, as with any other unresolved issue, can impact on the therapeutic relationship and so the implication is that more discussion about money is needed, whether on training courses or in supervision, personal therapy or correspondence such as this.

Zoe Scholar

MBACP; PG Dip; MA (Dist)

In praise of melancholia

I found *From Melancholia to Prozac* by Clark Lawler (reviewed in *Therapy Today*, September 2012) an absorbing and coherent read. It's a narration and also a consideration of how human societies have responded to and tried to get to grips with sadness and loss through the ages. Surely Catherine Jackson, in requiring 'a clear definition of depression' misses the point that every culture and era has different definitions. However, we may seek a clearer understanding of these matters.

We may make something worthwhile out of this challenge, perhaps the most enduring that human beings face. Isn't that why many clients arrive at our doors, and also what drew many of us into our profession in the first place?

I thought the book got off to a slow start by dwelling too long on Samuel Johnson, but after that Lawler's breadth of scope comes across very

clearly. I particularly enjoy what he writes about the influence of the *DSM* in the last 30 years, bringing an emphasis on symptoms rather than causes. It is likely that in the next 30 there will be new emphases and perhaps new terminology too, although in my opinion 'melancholy' has stood the test of time and is as good as we've managed so far.

Chris Payne

Morality and money

I write in response to the letter from Kevin Ryan in September's *Therapy Today*.

When I began practising as a counsellor, I too experienced uncomfortable feelings around the acceptance of the donation for the charity, where I was in placement. Resonating with the comment he quotes that likened counselling to prostitution, taking a fee in payment for my humanity felt somehow 'wrong' and, after some wrestling with this subject in many a journal entry at the time, I found that I was indeed undervaluing myself ('I'm just a trainee; they [clients] shouldn't be paying me,' to quote my journal).

I personally organise my sessions to receive any payment at the start. This, I feel, leaves the remainder of the time for the client to work on the issues that are important to them. The idea of discussing fees at the end of the session is, for me, an invasion of the client's 'space', which has an air of abruptness to it.

On the subject of cash as a means of payment, I feel that any other form

of payment offers a potential breach of the client's confidentiality. All electronic transfers (via online banking or debit card) and cheques contain information that could expose the client's use of counselling services to third parties to whom they may not wish to disclose this. For example, a client in an abusive relationship may have a very real need to be discreet as he/she begins to explore their life in a safe environment and any record of his/her therapy may be detrimental to their safety.

Concerns over such possibilities may lead to people avoiding accessing the counselling that they may desperately need. As counsellors, I feel that it is our responsibility to offer a confidential space where clients can explore all that they need to, safe in the knowledge that none of the information they share will place them in a situation where other people may discover something that the client may not wish to 'make public'; this includes the disclosure of an individual accessing the service.

Finally, with reference to Kevin Ryan's feelings of criminality, I feel that there is nothing 'morally wrong' with taking cash payments; it is what we do with the money afterwards that defines our moral standing. If Mr Gaukes or any other member of parliament feels that it is morally wrong to use a legitimate form of currency in this country then that is their issue. Personally speaking, I find that the less I look towards the external moralities directed (enforced?) by such people, the stronger my own internal moral compass becomes.

Darran Tolley

MBACP; volunteer counsellor

Because we're worth it

I was pleased to read in 'From the Chair' (*Therapy Today*, September 2012) that BACP is discussing the standardising of pay for counsellors. I feel that this is a long time coming and I fully support BACP every step of the way with this venture.

When jobs are advertised wanting counsellors to work for no money in some very demanding positions with potentially extremely vulnerable clients, it makes me angry. One never sees teachers, nurses or social workers expected to work for free under the guise of 'gaining experience'.

To become a fully qualified counsellor can take up to four years in training, and it is possibly one of the hardest, most demanding trainings out there, emotionally, academically and financially. Many people aren't aware of the hidden cost of counselling training, with approximately 50 hours of personal therapy to pay for and fortnightly supervision. These two components are likely to stay part of the working life of a counsellor and pay should reflect this, along with the quality of the training, not to mention their life experience, dedication to the field and the fact the counselling becomes a 'way of life'.

I'd really like to see the BACP job bulletin give BACP members the choice whether they receive paid or unpaid vacancies (or both) via email, opening up 'student posts' and 'qualified posts'. I love the variety of posts that are emailed to

me almost daily. However, each time an unpaid position comes up I'm infuriated. Even though this may reduce advertising income for BACP, I strongly feel organisations should be aware that some (or, hopefully, many) counsellors just won't tolerate unpaid work.

I would not like to see recently trained counsellors lose their chance to work towards accreditation and gain experience. However, I feel that taking a stand against organisations who think that it is OK to recruit someone's time and expertise for nothing will mean more paid counselling jobs make their way onto the market in the long run.

Kate Williams
MBACP

Bernard Ratigan

Bernard was one of my first supervisors. The three years (1983–86) I worked with him were some of the finest sessions I've had. He was a brilliant supervisor, mentor and friend.

Despite our obvious theoretical differences (my training had just begun in the person-centred approach), he entranced me with his rigorous intellect and commitment to psychoanalysis. When he left Loughborough University Counselling Service (which he founded), he was thrilled to be given the entire *Collected Works of Sigmund Freud*.

He was unstinting in his personal and professional support. Bernard contributed a chapter to *Pink Therapy* on working with older gay men. It was insightful, concise, delivered on time and needed no corrections. It's rare as an editor to get a perfect manuscript. Bernard delivered keynote papers at three Pink Therapy conferences. He always spoke with wit and humility. I was surprised by how anxious he got before speaking as it seemed incongruous with his fierce intellect and confidence.

As a gay man, he was declined by the psychoanalytic establishment for training as an analyst, and so it was gratifying to see his extensive contribution

being recognised by the British Psychoanalytic Council when they gave him their Outstanding Personal Leadership award in 2010.

Bernard was too unwell to attend the presentation but I sat with him at the BPC's first conference on homosexuality last January and I think he was both bemused by the 'Truth and Reconciliation' speeches and gratified to see his colleagues starting to grapple with the complexities of human sexualities and genders.

Dominic Davies
FBACP; Director, *Pink Therapy*

Bernard Ratigan (25 January 1945–29 September 2012), psychoanalytic psychotherapist and BACP Fellow

UKCP Faculty for the Psychological Health of Children
Sex, lies and social networking
growing up in a technological age



Saturday 10 November 2012

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Why the right brain matters

The science of the art of psychotherapy

Allan N Schore

WW Norton & Co 2012, £35

ISBN 978-0393706642

Reviewed by Sue Gerhardt



Allan Schore burst onto the international psychotherapy scene in 1994 with a powerful message that remains the same today: early relational trauma underlies many mental health problems. This is because it deeply affects the developing right brain – the side of the brain that encodes ‘procedural’ knowledge about how to relate to others, and so regulates our ability to form secure emotional attachments.

The papers in this book, which date from 2007 onwards, show that Schore continues to stress the importance of the right brain. In fact, he wants to see a paradigm shift away from the dominant theories of behaviourism and cognitivism towards a right brain emphasis on ‘body-based emotion’.

The implications for clinicians are the main focus of this collection of papers, which range from detailed work on the neuroscience of borderline personality disorder through to chapters on family law, and even on the development of African elephants. Above all, Schore highlights the need for right brain expertise in the practice of psychotherapy (and in the training of psychotherapists). What this means in practice is a focus on the early parenting processes: sensitively attuning to and empathising with the client’s emotional state, helping to regulate his/her emotions, as well as providing an authentic, personal response to the client, using humour, playfulness and other right brain qualities. Schore stresses the importance of the ‘bonding’ aspect of early parenting rather than the

more cognitive ‘mentalising’ processes of later childhood – a distinction that isn’t given enough space here to be argued, I feel, in a wholly convincing way.

In this volume Schore ventures further than before in alerting us to the wider implications of his work. Clinical repair of early relational trauma is not his only concern. He sees an entire culture that defensively denies, represses and dissociates from the consequences of a growing neglect of the mother-baby bond. American mothers are increasingly separated from their babies – a quarter of mothers are now back at work three months after the birth of their baby, and 52 per cent by six months. Instead of enjoying ‘body to body psychobiological transactions’, most babies experience the stress of low quality day care. Schore suggests it is no accident that right brain deficit disorders (such as ADHD, autism and bipolar illness) are on the rise: in fact one in five American children now has a diagnosable psychiatric disorder. Adult insecure attachment is also at a very high level (42 per cent).

The irony is that, despite Schore’s passionate engagement with these important issues, this is such a left brained book. I found myself longing for some of the right brain qualities that Schore advocates, as well as for more specific examples drawn from his clinical practice. However, Schore’s contribution continues to be invaluable. He voraciously digests the hard science on our behalf, and shows

us over and over again that the evidence is there, and that this really matters.

Sue Gerhardt is a practising psychotherapist and author of Why Love Matters and The Selfish Society

Hooked online

iDisorder: understanding our obsession with technology and overcoming its hold on us

Larry Rosen

Palgrave Macmillan

2012, £15.99 (hardback)

ISBN 978-0230117570

Reviewed by Phil Topham



This book proposes that the use of communication technology (phones, smartphones, laptops, internet) has, for some people, become extensive and psychologically harmful to the extent that it constitutes what the author, a US research psychologist and self-confessed technology addict, calls an ‘iDisorder’. Rosen argues that we are ‘using technology and media in ways that either produce symptoms that match those of a variety of psychological disorders or exacerbate already existing signs of a disorder’ (p218). Here he produces the evidence to support his contention.

The disorders range from narcissism and personality disorder to schizophrenia and voyeurism.

Rosen draws on a range of research to evidence the effects of excessive

use of online devices, and on surveys of the online generations, from baby boomers to the iGeneration (born in the 1990s), on the use and impact of text messaging, voicemail and social media etc.

Rosen tells us that 51 per cent of the iGeneration get anxious if they do not check their text messages every 15 minutes. Few 70 year olds have a FaceBook obsession and baby boomers also feature less across all fields.

Rosen presents research on the impact of persistent use on psychological attributes such as attention span, emotion regulation and the ability to empathise; this transdiagnostic perspective may usefully inform practitioners' thinking about their clients' experience.

And he identifies some of the benefits: people with ADHD play computer games because it helps to focus and calm their shifting attention; people with social anxiety are more comfortable communicating online.

For each 'iDisorder' chapter, Rosen provides self-assessment checklists and suggestions for remedial action by self and others, including parents. Eco-therapists will be pleased to learn that these suggestions include taking 'nature breaks' (ie switching off, and doing something totally different outdoors).

He also makes the important observation that these technologies have entered our cultures very quickly, giving us little time to make social and psychological adjustments.

This is an interesting book to dip into and to remind ourselves of the strong, emotional and not

necessarily beneficial relationships we can develop with technology. No one is immune but for practitioners working with adolescents and young adults in particular it is useful to be informed about the downsides to online involvement and the signs of incipient iDisorders, as clearly identified here.

Phil Topham is a counselling psychologist at UWE Bristol

The beauty of brevity

The art and science of brief psychotherapies: an illustrated guide

Mantosh J Dewan, Brett N Steenbarger and Roger P Greenberg (eds)
American Psychiatric Publishing 2012, £52.00
ISBN 978-1585623969

Reviewed by Angela Cooper



The aim of this book, according to its editors, is to 'give readers a taste of different brief therapies and their underlying strengths and similarities'. It does this more than competently, and the use of empirical evidence to support each model is impressive.

This is a revised and expanded second edition of the publication, first published in 2004, and includes a new part one on 'Building a foundation for successful therapies', and a DVD that shows master clinicians demonstrating the techniques described.

I would recommend viewing the DVD as you

read the individual chapters, in order to get a real feel for and understanding of the approaches described.

The book features six brief therapies and explores their core concepts and the skills required of the practitioner. Some chapters stand out. 'Cognitive therapy' is an excellent introduction for those new to this approach. In 'Solution-focused brief therapy', I liked the section on pre-session change and found the discussion on the dangers of distraction (rather than learning to be with the strong emotion) very useful. 'Interpersonal psychotherapy' acknowledges the possibility (indeed the probability) of relapse, and also the use of transference as an indirect way of informing treatment. The DVD demonstration of 'Time-limited dynamic psychotherapy' shows a highly empathic therapist working effectively and movingly with a complex case in 12 sessions. I would challenge any sceptic of this approach to remain unconvinced. The other two therapies featured are behaviour therapy and brief couples therapy. The final chapter provides a useful overview and summing up of the book's contents.

Counsellors already practising brief therapy who want to develop and update their knowledge will find this book useful. It would be a good introduction to those exploring brief therapy for the first time. It would also be helpful for therapists using longer-term models who want to understand more about short-term interventions with a view, perhaps, to adding them to their repertoire.

Angela Cooper is a BACP senior accredited counsellor and supervisor

Freedom to choose

Existential perspectives on coaching

Emmy van Deurzen and Monica Hanaway (eds)
Palgrave Macmillan 2012, £24.99
ISBN 978-0230293861
Reviewed by Adrian Pepper



This book collects together writings by 14 leading figures in the existential coaching field who each explore how a coach can use the concepts of existential philosophy in their work.

The contributions are arranged in three parts. Part one describes the parameters of existential coaching and offers a clear, philosophical framework for the work, basic definitions of existential terms and many practical guidelines. This approach can be used to help clients live more effectively by reflecting on their actions, attitudes, experiences and values, defining their sense of purpose and creating meaning in their lives. The key existential issues considered are freedom, responsibility, authenticity, purpose, meaning, paradox and dilemma.

Part two illustrates how existential coaching can be offered to clients in a wide range of settings: from life decisions and career development to leadership and conflict management, as well as in the workplace. In each context, the chapters demonstrate how clients are

enabled to take stock of the ways in which they make things more difficult and less satisfactory for themselves and to reconsider how they want to live their lives.

Part three demonstrates how coaches can integrate existential ways of working with other coaching approaches: embodied focusing, neuro-linguistic programming, attachment theory, psychometric testing, cognitive-behavioural therapy and mindfulness.

In its 232 pages, the book explains well how to apply existential concepts to the practice of coaching. In my view it could be a foundation text for trainee coaches, mentors and supervisors of coaches and mentors. I would also recommend this book to experienced coaches and counsellors; it would be helpful in reviewing and extending their current skill sets and practice.

Adrian Pepper is a business and executive coach and a supervisor of coaches

Sorrows every day

Still practicing: the heartaches and joys of a clinical career

Sandra Buechler
Routledge 2012, £22.99
ISBN 978-0415879132
Reviewed by Els van Ooijen



Despite its title, this book does not discuss the ageing practitioner but the difficulties inherent in therapeutic work. Buechler

sees anxiety about performance as inevitable: 'Did I handle that session well enough?' 'Why am I not getting more referrals?' 'Why did that client leave prematurely?' 'Am I a lousy therapist?' Failure and shame are seen always to be lurking just around the corner, as clients can sack their clinicians at any time (pxi). Buechler wonders about the cumulative effect of being emotionally available to people in distress hour after hour and day after day, as well as the numerous losses experienced throughout a practitioner's career. She compares therapists to foster parents who become deeply involved with a child for a while and may then never see or hear from them again.

The book is in four parts. Parts one and two explain how infantilisation and shaming during training can leave lasting scars on the therapist. In addition, the requirement for students to work in placements may mean that the least experienced practitioners see the most disturbed clients. Unless adequate support is available, this can lead to students losing confidence and enthusiasm.

In part three Buechler discusses effects of insecurity and loss. She relates how practitioners may take their insecurity out on each other in supervision, or at professional gatherings, and how all terminations involve a loss of some kind, resulting in a state of chronic mourning. To end, in part four she discusses how resilience may be sustained through sufficient support, a balanced life, deep empathic connection with clients, continuing curiosity and what she calls an 'internal chorus' of helpful theorists.

Although the author is a psychoanalyst, the issues raised are equally applicable to counselling and psychotherapy. The book is well written and contains useful examples and stories. However, it is somewhat repetitive and would, I think, have benefited from more diligent editing.

This is a useful book for all practitioners, and particularly those involved in training. The author's wisdom is summed up for me in the following sentence (pxvii): 'I hope that my clinical encounters with shame and sorrow will strengthen me to bear the personal and professional losses my future holds'.

Els van Ooijen is a relational-integrative psychotherapist and supervisor

Big book of trauma support

The international handbook of workplace trauma support

Rick Hughes, Andrew Kinder and Cary Cooper (eds)
Wiley-Blackwell 2012, £110
ISBN 978-0470974131
Reviewed by Mary Parker



Following on from a previous joint publication, *Employee Well-being Support: a workplace resource*, Hughes, Kinder and Cooper have brought together a huge collection of international contributors to provide a comprehensive and current review of the subject.

The book is divided into five sections: 'The evolution and development of workplace trauma support', 'The legal and business imperatives to manage trauma effectively', 'New understandings in models of trauma support', 'The theory and practice of post-trauma support' and 'The organisational response to trauma'. Each chapter provides a different perspective and approach on how to work with trauma, including trauma risk management (TRiM), support post-trauma (SPoT), eye movement desensitisation and reprocessing (EMDR), mindfulness, and psychological first aid (PFA).

By including international contributions, the editors are able to demonstrate how professionals across a swathe of different cultural or social environments and different disciplines are responding to and managing traumatic events. This helpfully demonstrates the influence of social, political and cultural factors on responses to workplace trauma and support. The book demonstrates quite clearly that one size does not fit all.

Naturally, these international experts in the field of trauma do not necessarily agree with each other and, although the chapters sometimes overlap, overall there is a fascinating breadth of perspectives.

Overall the book provides something for everyone who is or may be involved in working with trauma in the workplace. This book is both a reference tool of biblical dimensions and an invaluable workplace tool for practitioners and for organisations that contract their services.

Mary Parker is a workplace counsellor

Couples as parents

How couple relationships shape our world

Andrew Balfour, Mary Morgan and Christopher Vincent (eds)
Karnac 2012, £27.99
ISBN 978-1855758377
Reviewed by Anne Power



This is a scholarly but readable anthology of work by therapists and researchers connected with the Tavistock Centre for Couple Relationships (TCCR). Naturally, coming from this source, the prevailing theoretical base is psychoanalytic.

From the title, I had expected an exploration of the role of coupledom in our culture and how this central relationship impacts on society. In this respect I was disappointed. The book is, in fact, a resumé of current and recent couples work at the TCCR with a primary preoccupation with the parenting role.

The book's great strength is its structure, which twins each chapter with a commentary by a fellow professional from a slightly

different stable. Most of the commenting chapters are focused and engaging; some are very meaty themselves, and only a few seem to be rubber stamping the chapter they accompany.

The 10 chapters offer, as promised, a mix of clinical practice, research and policy. Surprisingly, the clinical work is given least space – this is not a book for people who want to build up their clinical skills. I also felt too little consideration was given to cultural variations in couple relationships across different ethnic groups. The chapters on research are particularly strong and would be valuable to anyone involved in researching therapy. The chapters on policy are also enlightening and address the court system as well as more general family policy issues.

Where the book would score particularly strongly is with those responsible for providing psychotherapy services for parents. A key theme is the value of couple psychotherapy as an effective intervention where parents are struggling. Several chapters explore the research finding that couple therapy out-performs parenting classes as a way to improve parenting skills. It is perhaps a pity that this valuable material on parenting is not reflected in the book's title.

Anne Power is a psychoanalytic psychotherapist and supervisor

No place for neutrality

Gender and power in families

Rosine Josef Perelberg and Ann C Miller (eds)
Karnac 2012, £22.99
ISBN 978-1780490656
Reviewed by Yvonne Farley



This book is as fresh and vibrant today as it was in 1990, when it was first published – which does raise some questions about developments in diversity awareness in therapeutic process over the last 20 years.

The contention of the editors is that a systems approach to the family assumes an 'equality of power between men and women' (p8). As Perelberg says: 'It may be that the idea that families are systems, which started as a metaphor, gradually became a straitjacket for family therapy' (p54) for, 'if the therapist does not recognise the inequality... within families, he or she ends up reinforcing stereotyped roles' (p37).

The contributors seek to explore, therefore, the 'variety of intrapsychic, interpersonal

and institutional forces interacting to control the lives and minds of women' (p157), looking at issues such as the complexity of the mother-daughter relationship and societal perceptions of intelligence and achievement in women.

There are sections on intervention strategies, on specific clinical issues and on applications in 'wider systems', such as clinical psychology in an urban, multi-racial housing estate. There is also a section about men and 'gender-sensitive therapy', which acknowledges that 'in order fully to comprehend gender and power in families, the experiences of superordinate as well as subordinate groups and individuals have to be studied' (p197).

Although the main context of the book is family therapy, its arguments are, in my view, equally relevant to other therapeutic models.

On reading this scholarly work 20 years on, you realise how easy it is to fall back into positions of complacency, to make simplistic assumptions about our neutrality. This book makes us think again about the balances of power and influence in our culture and in our work; it is refreshing, challenging, compelling and invigorating. *Yvonne Farley is a BACP and COSRT accredited relationship and psychosexual therapist*

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From the Chair



My dream came true

How do you prepare for a meeting with Irvin Yalom? By
Amanda Hawkins

Just occasionally life throws you an opportunity you never in a million years expect. Back in May I got the chance to meet Irvin Yalom, one to one. You may remember, I wrote in a previous column about seeing him give a talk in San Francisco back in March, and was very moved and taken by his continuing contribution to our profession. Around the same time the BACP Events team were planning a major BACP conference to be held in London in February next year. I thought I would be bold and write to Irvin to ask if he would consider giving a talk to counsellors and psychotherapists in the UK.

‘Nothing ventured, nothing gained’ has always been one of my mottos. And so it proved. To my great surprise, not only did he reply (by return), he also invited me to meet him, as he was by chance in London.

How do you prepare for a meeting with Irvin Yalom? The night before I didn’t sleep. I thumbed through my dog-eared copy of *Love’s Executioner*. I considered asking him to sign it, and rejected and accepted the idea all night through.

I got there on time, full of nerves, only to discover that he had double-booked. He took me to one side and apologised profusely and I then waited while he did an interview with Sky News.

The reality is, of course, that Irvin Yalom is just a man, a husband, a father and grandfather. He is softly spoken and still incredibly enthusiastic about the therapy profession. I am not sure what I expected, but I instantly felt at ease. There was a sense of sharing something that was precious to both of us: a shared love of what we do and a shared

‘There was a sense of sharing something that was precious to both of us: a shared sense of the honour conferred on us when people invite us into their lives’

sense of the honour conferred on us when people invite us into their lives.

We talked about the training of counsellors and psychotherapists in the UK. He was excited about the use of encounter groups that is still found in some training. We also talked about the future of therapy and the ‘industrialisation’ of talking therapies and the risks and benefits this brings. But it came to the point when I had to ask him if he would talk to us at our conference. I plucked up the courage – and he said yes.

So, via the amazing technology of video link (he explained that long haul travel is too much for him these days), Irvin Yalom will be our guest speaker at a special event in the evening of 4 February 2013 to mark BACP’s first international summit, which takes place the following day... and you are invited.

Irvin will be interviewed with his son Victor, who is also a therapist, and they have agreed to share their thoughts about the profession, past and present. They have also agreed to answer questions. The BACP Events team is taking bookings now, so be sure to book your place early. You can also suggest a question you would like to ask Irvin. Full details can be found on the BACP ‘Ask Yalom’ website at www.askyalom.bacp.co.uk.

(Oh, and I didn’t ask him to sign my book – but only because my husband had already done so when he first gave it to me, and it didn’t seem right somehow.)

Coming back to the present, in early September BACP hosted a breakfast meeting in London for key stakeholders in school-based counselling. The theme was ‘Attainment vs Wellbeing’ – should schools focus solely on educational attainment or should they also be concerned with nurturing and protecting children and young people’s emotional and mental wellbeing?

The answer, from all our panellists – whether they were from the realms of education or counselling – was a resounding yes to the latter. Sylvia Jones, who co-ordinated the roll-out of the national school-based counselling strategy in Wales, spoke movingly of the need to consult and involve young people in shaping and introducing school-based counselling. She told us: ‘They know what they need and if we listen to them, we’ll be on the right track.’ And Hannah Essex, of the education charity Teach First, powerfully reminded us that wellbeing is the ‘wrap around’ attainment – children can’t learn when they are upset and depressed and their lives are in turmoil. The two are inseparable.

All in all, it was thought-provoking and fruitful to have education and counselling in the same room, agreeing on these issues and, sadly, agreeing that we face the same barrier to moving forward – the lack of cash to make our ideal a reality. The BACP campaign for a counsellor in every school, UK-wide, continues! ■

Divisional journals



A distinct identity

In the third article in a series about BACP's portfolio of divisional journals, *John Daniel* introduces the BACP Private Practice journal

BACP Private Practice

BACP Private Practice is a specialist division of BACP. It works to help reduce the isolation often felt by many in private practice and to foster a greater sense of professional community and belonging. For further details about joining the division, email Julie Camfield at julie.camfield@bacp.co.uk

Could you describe yourself and your professional background?

I am a psychosynthesis counsellor in private practice in London, and I also work as an editor and writer. I've worked for BACP for four years, first as commissioning editor then as a contributing editor for *Therapy Today*, and now editor of *Private Practice*, which was previously called *The Independent Practitioner*. Before retraining as a counsellor, I worked in the arts in a variety of roles, including writer and editor for a number of performing arts publications.

Who is the journal for?

Private Practice is for practitioners who work independently as counsellors or psychotherapists in private practice or in organisations, including voluntary agencies, employee assistance programmes or in the NHS.

What is in the journal?

Each issue includes articles in which therapists share personal stories about major turning points in their lives and how these have impacted on the way they think about themselves and their work. For example, in the current issue (autumn 2012) a therapist reflects on the approach of old age and when it will be the right time for him to retire. Articles in previous issues have included the emotional and psychological impact of breast cancer and a piece by a therapist who has an alternative career as a stand-up comic. A typical issue might also include articles by practitioners about the people or activities that have inspired or supported them along their paths as therapists, and articles in

which contributors share practice issues with readers. Each issue also includes book reviews, news and research, a regular column by the Chair of the division, and sector-specific news and information from BACP.

As editor, what have been your priorities?

I wanted to create a vibrant, friendly, accessible journal that reflects the rich diversity of experience of therapists who work independently. I felt there was a gap in the market for a more personal, less academic journal that readers could feel a part of, and I have tried to develop a forum where therapists feel supported to explore some of the more difficult, less written about aspects of our lives and work: our own mental, emotional and spiritual health, for example, and how we take care of ourselves in a job that can easily become isolating and where uncertainty, insecurity and financial instability are ever-present realities. Over the first four issues I think *Private Practice* has developed a distinct identity that speaks directly to its readers and reflects the diversity of the division's membership.

The recent redesign of *Private Practice* has been a central part of redefining and repositioning the journal. People have told me that it looks inviting enough for them to want to sit down

'I have tried to develop a forum where therapists feel supported to explore some of the more difficult, less written about aspects of our lives and work'

with a cup of coffee and read it cover to cover. That's great to hear because it's exactly what I was aiming for: to create an attractive, colourful, professional journal written in plain English, which is free from jargon and reader-friendly and which covers a range of important issues in depth in a way that is accessible for all readers, including clients, potentially.

Are you actively looking for readers to contribute articles?

Yes – the journal relies on the active participation of readers and I am always open to ideas and suggestions for content and, of course, to readers submitting articles for publication.

What has given you greatest satisfaction in this role?

I enjoy working with contributors to present their writing in the best possible way and I feel privileged to be providing a forum that encourages and supports counsellors/psychotherapists to communicate with each other about aspects of our work that can all too easily get swept under the carpet.

Could you sum up in three words what you hope the journal provides for readers?

Inspiration. Community. Challenge. ■

John Daniel is editor of Private Practice, the quarterly journal of BACP Private Practice. He became editor in 2011. Please email John at privatepractice.editorial@bacp.co.uk

Private Practice is published four times a year and is mailed out free of charge to members of BACP Private Practice. It is also available on subscription. To enquire about either, contact the BACP Customer Services department on 01455 883300.

Open Forum responses

BACP members put the following questions to the Board of Governors in the Open Forum at the 2011 Annual General Meeting

Marcus Nolan asked if the Board of Governors would consider using designated funds for a special project to externalise and maximise the BACP brand, possibly through TV advertising, drawing attention to the *It's Good to Talk* website, and promote a national emotional wellbeing week that would benefit the profession as a whole.

BACP has recently invested heavily in its media relations and public relations team to improve the profile of the Association, its members and counselling/psychotherapy. It is early days but there is already evidence of significant growth in the published output. Further innovative ways to raise BACP's profile and to build potential initiatives and campaigns to support greater publicity continue to be explored.

Margaret Williams referred to a St Mungo report, *Battered, Broken and Bereft*, on homelessness and highlighting the impact of mental health services and counselling services, particularly for women. Was there a role for BACP in challenging services and keeping mental health and counselling services going?

BACP maintains a position that early provision of talking therapies has an essential impact on wellbeing. BACP continues to challenge potential closure or reduction in provision of psychological therapy services.

Cathy Bell challenged BACP in the way it has sought to engage with members and also to be more transparent. For example, how were accreditation assessors recruited and how were vacancies advertised?

The need for a Lead Advisor for Wales was proposed, and the lack of a Vice President from Northern Ireland was noted. Cashel Riordan also referred to the shortage of accreditation assessors and a five-month delay in assessing applications and asked if more assessors were being recruited.

BACP communicates with members through *Therapy Today*, various email bulletins and websites, coupled with a strong series of Making Connections events. Ways of improving communications are under constant review and suggestions from members are always welcome.

BACP's accreditation assessor team currently consists of staff either directly employed by BACP or who work on a self-employed, contract-for-service basis. All staff vacancies are managed through BACP's human resources team and in line with the Association's recruitment and selection policy and procedure to ensure equality of opportunity, transparency and consistency. Contract-for-service appointments are managed by the commercial contracts manager, in BACP's finance team, following the Association's contracting protocols. Vacancies are advertised through a variety of communication channels that may include, where appropriate, national external media, BACP publications and the website to ensure a diverse audience is reached. Employed positions are advertised internally within the existing staff cohort. The accreditation assessor team is currently at full complement, the last recruitment campaign being November 2011.

The current Divisional Review will incorporate an

assessment of the range and scope of the Lead Advisor role in the future.

Vice Presidents are appointed by the Board of Governors. These appointments are made in line with the Association's strategic aims and objectives in terms of harnessing particular skills and expertise that will facilitate and support the successful achievement of those objectives. Vice Presidents, like Governors, are not intended to be representative of any particular geographical location or focus and work for the benefit of the full membership and profession.

Roslyn Byfield commented that she hadn't read of any of the initiatives previously mentioned today in *Therapy Today*. Of particular concern was the apparent lack of awareness of the counselling for depression (CfD) training in Improving Access to Psychological Therapies (IAPT) services. Further information and an update on progress would be welcome.

Counselling for depression is a manualised form of psychological therapy as recommended by the National Institute for Health and Clinical Excellence (NICE) for the treatment of depression. It is based on a person-centred, experiential model and is particularly appropriate for people with persistent sub-threshold depressive symptoms or mild to moderate depression.

This form of counselling has been developed particularly for the IAPT programme in order to increase the choice of therapies available. A framework of competences describes the therapy, its

underpinning knowledge and how it should be implemented.

Based on this framework, a training programme has been rolled out from January 2011 to train IAPT counsellors in this type of therapy. This is a CPD programme for qualified and experienced counsellors, consisting of a five-day taught programme followed by 80 hours of supervised and assessed practice. Courses are endorsed by BACP and there is now provision to cover most parts of England. Current providers are Metanoia, University of Keele, University of York St John, University of Nottingham and Colchester Institute.

Over 100 counsellors have to date gone through the training, with training places funded by the Department of Health. More funded places on the courses are planned over the coming year.

An article describing the project in more detail appeared in the February 2012 issue of *Therapy Today* and can also be found on the *Therapy Today* website at www.therapytoday.net.

A final query was raised in the context of membership not being renewed and whether there was any research into the reasons for that decision.

BACP's membership and customer service teams regularly engage with those who have made the decision to leave BACP. For some it is about leaving the profession and retiring; for others there are specific reasons. The feedback received is used to help improve the service offered to members.

For further information on any of the above responses, please contact jan.watson@bacp.co.uk

Newly accredited counsellors/psychotherapists

Leonie Adamson
Irena Adelman
Luminita Alexa
Patricia Allen
Sara-Beth Allen
Sarah Amatt
Rohan Barua
Gillian Bishop
Janene Buckley
Vanessa Farrell
Sarah Heward
Nyah Malcolm
Lorraine Montgomery
Karen O'Rourke
Leigh Riley
Clea Stanley
Glenda Taylor
Sophie Thorne
Christa Welsh
Linda White
Stephen Wilson

Newly senior accredited counsellors/psychotherapists

Sue Daniels
Fiona Detrey
Joanna Devereaux
Peter Eldridge
Michael Fox
Deborah Green
Paul Hill
Kaye Hunt
Anne Kelly
Jennifer Leeder
Dawn Lilburn
Julie May
Ruth McIlroy
Pauline O'Keefe

Neil Percival
Pamela Savic-Jabrow
David Smith
Alison Thorne

Newly senior accredited counsellor/psychotherapist for children and young people

Diane Kane

Newly senior accredited supervisor of individuals

Hilary Kean

Newly accredited counselling/psychotherapy services

Six Milton Keynes City
Counselling Centre
additional services:
● CCC Counselling Service
● Counselling for Carers
● H4 Counselling Service
● MK-NHS PCT Counselling Service
● Post-Trauma Counselling Service
● SASS Rape & Sexual Assault Counselling Service

Newly accredited counselling/psychotherapy course

Iron Mill Institute (Exeter): the BACP accredited Advanced Diploma in Counselling (Integrative) is also now available as a BACP accredited course at Wimborne, Dorset

Members not renewing accreditation

Elaine Almond
Jocelyn Berger
Angela Beveridge
Gabrielle Brown
Clare Flinn
Jacqueline Gray
Mary Gunn
Barbara Jeffries
Anne Lagnado
Helen Priddle
Gill Pryce Jones
Edith Quilter
Ann Shelford
Penny Silverman
Diana Simpson-Hinds
Helen Slack
Sandra Summerfield
Maggie Thomas
Ann Waddell
Anne Yeardley
Louise Young

Correction

A small number of BACP members were previously incorrectly listed in *Therapy Today* as receiving their initial accreditation as a counsellor/psychotherapist rather than senior accreditation in a variety of categories. These members are now listed in the relevant senior accredited categories and we apologise for this error.

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

Accreditation of Training Courses

BACP has made the following amendments to the 2009 Accreditation of Training Courses 'Gold Book'

The changes to Part A: eligibility criteria are as follows and apply as of 13 July 2012:

● A2 suspended – courses will no longer be required to have graduated a cohort prior to application for course accreditation

● A3 amended – courses will still be required to have 400 staff-student contact hours but not 450 guided learning hours overall

● A4 suspended – courses will not need to have 50 hours of student work-based learning in addition to the placement hours

● A5 amended – 100 hours of supervised client work rather than 150.

The corresponding Part B course delivery criteria will be amended in accordance with the changes. Procedures for courses wishing to apply before graduating a cohort will be introduced as soon as possible.

The changes will be published as an addendum to the Gold Book until an amended version can be published.

Making the future yours

The 2013 BACP student event promises to be the best yet, with a new exhibition area and a packed programme of workshops *Catherine Jackson reports*



Participants at the first ever BACP student event in Salford in 2010

'First, you get exposure – to the largest professional body for counsellors and psychotherapists in the UK. Second, you get to meet a cross-pollination of fellow students from other courses and to meet the profession close up. Third, you get to hear a range of speakers offering a depth and breadth of knowledge beyond your course content.

'It's a taste of the profession they've signed up to, a networking opportunity and a chance to learn from each other.'

These, says Elspeth Schwenk, member of the BACP Board of Governors, and Acting Deputy Chair, are all reasons why student counsellors should come to the BACP student event, 'Making the future yours', in London early next spring.

The first BACP student event was in 2010. The next (the fifth) is on 23rd February 2013 in London, and promises to be the biggest and best yet. It will, for the first time,

include an exhibition area for businesses and organisations offering training and placement opportunities and other products.

Unlike most professions, counselling doesn't have a structured career pathway, Elspeth Schwenk points out. 'Students roll off counselling courses with no idea about the professional world around them and no sense of career or where to find it. The BACP student event is a must for students if they want to understand the landscape of their profession.'

The February 2013 event will offer a huge choice of workshops throughout the day from which delegates can 'pick and mix', as well as 'taster talks' by exhibitors. Workshop topics cover the key issues confronting the newly-qualified practitioner: setting up in independent practice, marketing your service, navigating a counselling career, accreditation, working in specialist fields, finding placements, handling

interviews, supervision and why research matters.

Richard Kershaw has just set up in independent practice in the north east of England, having qualified from a diploma course in transactional analysis in July. He attended the BACP student event in York in February. 'I went because I thought it would be helpful in mapping out my career pathway to accreditation. But it was helpful in many other ways as well – specifically, the business side of making the transition from student to practitioner. It was really useful to get the information and advice firsthand from experienced practitioners.'

For Richard, another huge benefit was the chance to meet BACP staff and talk to them about professional and ethical issues and concerns. 'For me, the title of the student event says it all. It's about taking responsibility for working out what I need to progress my career and how I'm going to make it happen.'

Patti Wallace, BACP Lead Advisor for University and College Counselling, has led workshops at several BACP student events and will be co-facilitating, with Elspeth Schwenk, a session on career development opportunities in February. She says the event is not just useful; it's also quite simply good fun. 'These people are early on in their career, there's a lot of energy and they are so interested in everything. And it's not expensive,' she points out.

The February BACP student event is co-sponsored by Towergate, which provides indemnity insurance for counsellors/psychotherapists, and Metanoia Institute, the national counselling training organisation. Says Mark Dowden, Director of Sales and Marketing in Towergate's Caring Professions division. 'The BACP student event is a really useful interface opportunity. It gives us direct access to counselling students to explain about the importance of insurance and how easy it is to arrange. It's also a chance for us to learn from them about the issues that matter to them.'

For Kate Fromant, Head of Central Services at Metanoia Institute, the event is a unique opportunity to communicate directly with students. 'We attended the York event and this one is promising to be even better,' she says. For students, there are no other events like it: 'It isn't only the training and CPD content; it's the opportunity to update on important issues, such as regulatory requirements and insurance. The event ensures that participants are informed about developments in the field and the range of career opportunities available.'

'Making the future yours' is on 23 February, at Imperial College, London. Tickets are £30 for BACP student members; £50 for non-members. Visit www.bacp.co.uk/studentevent to book or call 01455 883300.

Registration changes move forward

BACP has renamed its register and updated the register website as it moves towards formal application for accreditation

The UK Register of Counsellors and Psychotherapists (UKRCP) is now named the BACP Register of Counsellors and Psychotherapists. All BACP accredited members are automatically eligible to remain on the Register, and will receive a letter this month inviting them to do so if they wish, by signing the terms and conditions for registration. Non-accredited members will need to have successfully completed a

BACP accredited course or the Certificate of Proficiency before being eligible for registration. Information on how and where to take the certificate will be available in the next few weeks.

The Register will be governed by an independent advisory board chaired by Professor Ed Sallis OBE. Sally Aldridge is the Registrar and Director of BACP Registers, Hadyn Williams is Deputy Registrar and Deputy Director of BACP Registers, and Christina Docchar is the Assistant Registrar. The Register team will move to separate premises, to underline the separation between BACP's regulatory

and other leadership, standards and professional development functions.

The Register website carries information on the Register and on BACP registered members. Members of the public and employers will be able to access the Register directly. BACP members will be able to use it to check their eligibility. There is also a Q&A section with frequently asked questions.

BACP has been invited by the Council for Healthcare Regulatory Excellence (CHRE) to be one of a small number of professional bodies to pilot the new process to accredit voluntary registers across the range of health

and social care occupations. The voluntary register accreditation scheme reflects the Coalition Government's policy on professional regulation. BACP will pilot the application process this month and hopes to be able to submit its formal application in early December.

'BACP believes the Register will strengthen the counselling and psychotherapy profession and provide greater confidence to clients and employers of our members' commitment to the highest professional standards,' Sally Aldridge said.

Visit www.bacpregister.org.uk

Making Connections

The next BACP Making Connections event is in Yeovil on 6 November

Making Connections is an opportunity for BACP members to meet BACP officers, discuss issues of professional interest, and network with each other.

Guest speaker at the Yeovil event is Andy Reid, former corporal in the 3rd Battalion the Yorkshire Regiment. Andy was wounded in Afghanistan in 2009 and now works as a motivational speaker, fundraiser and Ambassador for ABF The Soldiers' Charity.

Making Connections events are free for BACP members and £50 for non-members. To book, call 01455 883300. Full details are online at www.bacp.co.uk

National Work-Life Week

Workplace counselling is a key factor in helping people cope with personal and work-related difficulties, says BACP

In a statement to mark National Work-Life Week, 24-28 September, BACP said psychological problems can affect both productivity at work and home life. BACP supports the Working Families campaign to improve the work-life balance of workers in the UK.

In a recent national Quality of Working Life survey by the Chartered Management Institute, 46 per cent of managers said they are now working up to two hours longer than their contracted hours each day, up from 38 per cent in 2007. Nearly two thirds (63 per cent) said the long hours are adversely

affecting their relationship with their children and 49 per cent said their relationship with their spouse was adversely affected. The 2010 BACP Attitudes to Counselling and Psychotherapy survey found that more than half (54 per cent) of employees wanted their employer to provide a confidential counselling service to cope with the effects of the recession.

Rick Hughes, BACP Lead Advisor (Workplace), said: 'We all experience life-crisis issues from time to time, such as loss, bereavement or family relationship difficulties. Even though these don't occur in the workplace, their effects can seep through into our work. Evidence shows that counselling is a cost-effective way of providing timely support for employees.'

Coaching division news

BACP Coaching is consulting members about what they want from its local network groups

BACP Coaching has network groups in Edinburgh, Elgin and Perth, Manchester, Brighton, Central London, Oxford, Norfolk and East London. There is also a LinkedIn group. Details of network co-ordinators and dates of meetings are on the BACP Coaching website at www.bacpcoaching.co.uk. New members are welcome.

Barry McInnes has stepped down as Executive Specialist for Research, due to pressure of work. He remains an active member of the division. Jo Birch, Chair of BACP Coaching, said: 'We shall miss him immensely.'

Wellbeing ‘essential’ to academic performance

Wellbeing and educational attainment go hand in hand; unhappy children won’t thrive and can’t learn

This was the conclusion from the panel and participants at a BACP breakfast summit in London on 20 September to discuss ‘Attainment vs Wellbeing’ and how to achieve both in a cash-strapped schools system.

Speakers included Sylvia Jones, former co-ordinator of the Welsh Government’s school-based counselling strategy, Siôn Humphreys, policy advisor with the National Association of Head Teachers, and Hannah Essex, Associate Director of Communications with the charity Teach First. The event was chaired by Michael White, Assistant Editor of *The Guardian*.

Sylvia Jones opened the debate by describing the genesis of the Welsh Government strategy and its development into statutory provision of counselling in all secondary schools in Wales. ‘Children tell us they can’t learn if they don’t feel emotionally well.

It is so obvious,’ she said. The evaluation of the strategy has produced hard evidence that access to school-based counselling improves children’s mental health and wellbeing, their relationships with teachers, peers and parents, their behaviour in class and their concentration and attainment, she said.

Speaking from a teaching perspective, Siôn Humphreys argued that schools can’t compensate for what happens in the rest of a child’s life, and they can’t do it all on their own. ‘Wellbeing is becoming embedded in schools. Every child continues to matter. But education, health and social care need to work together. Schools can only be effective if they are getting support from outside and a lot of the sources of that support are affected by austerity measures,’ he pointed out.

Teachers also need training and support. ‘Teachers are dealing with complex behaviours, but they get no supervision as such and that concerns me. If their wellbeing isn’t catered for, the wellbeing of young children will not be catered for either.’

Teach First works in schools in areas of high deprivation. Hannah Essex underlined the importance of wellbeing in enabling children from disadvantaged homes to achieve their aspirations: ‘Children from deprived homes do have very high aspirations, as do their parents, but they face much higher barriers,’ she argued. She pointed to studies that show that resilience, self-esteem and self-worth ‘all contribute to whether [disadvantaged children] will get where they want to go’.

Mick Atkinson, from the Place2Be primary school-based counselling charity, asked if academic attainment should be regarded as an adequate measure of the success of counselling interventions.

‘If you have a plant and just measure it, it won’t grow. It isn’t just about getting A-star grades, it’s about enabling the young person to feel proud and confident in what they achieve and to love learning. We need to fight for young people to enjoy school,’ Sylvia Jones said.

‘Ask Yalom’ BACP event

Irvin Yalom, famed US psychotherapist and writer, has agreed to speak at a BACP evening event in February next year, ahead of a BACP national stakeholder conference on counselling in the 21st century

Yalom will address the event in London via video link from his home in California, and will then be interviewed by his son Victor, who is also a psychotherapist. The event, which starts at 6.30pm on 4 February at the QEII Conference Centre in Westminster, will end with a Q&A session with father and son. Members can submit questions ahead of the event at www.askyalom.bacp.co.uk.

The Q&A session will be followed by the BACP 2013 excellence in practice and research awards presentation.

The one-day conference, on Tuesday 5 February, is also at the QEII Conference Centre.

Tickets to ‘Ask Yalom’ cost £25 for members and £50 for non-members. Visit www.askyalom.bacp.co.uk. For information about the BACP awards, visit www.bacp.co.uk/news/index.php?newsId=2969

TherapyToday.net praised in online reader survey

TherapyToday.net has been given an overwhelming thumbs-up by visitors

In an online survey of visitors, nearly two thirds (60 per cent) rated the site as good for access and navigation, 50 per cent rated the content

as useful and only nine per cent said it was difficult to find what they wanted.

Half the respondents were non-members (although 30 per cent of respondents didn’t identify whether they were a member or not). The majority (74 per cent)

said they visited the site most months. The main reason for visiting TherapyToday.net (43 per cent) was to read the latest issue, although 56 per cent said they visited just to browse. Carole O’Neill won £25 Amazon vouchers in the free prize draw.

There is still time to complete the *Therapy Today* reader survey. One reader who completes the survey before 30 November 2012 will win £100 in Amazon vouchers in our free prize draw. Visit www.bacp.co.uk/Questionnaires/index.php?id=136

Suicide prevention action call

The Department of Health has launched a new suicide prevent strategy, the first for over 10 years. BACP says this is a missed opportunity to roll out universal access to counselling for young people in secondary schools and colleges

The strategy was launched on 10 September, World Suicide Prevention Day, by newly appointed Care and Support Minister Norman Lamb.

Speaking at the launch, the Minister outlined the strategy's six key areas for action to prevent suicide by:

- establishing a better understanding of the reasons why people take their own life and how it can be prevented – which will be supported by £1.5 million in new suicide prevention research funding
- developing closer working relationships with the media and the internet industry through members of the UK

Council for Child Internet Safety (UKCCIS) to help parents ensure their children are not accessing harmful, suicide-related websites

- reducing opportunities for suicide by making sure prisons and mental health facilities keep people safer
- providing better support for high-risk groups, including people with mental health problems and people who self-harm, by making sure the health service addresses their mental health needs as well as any physical injuries
- improving services for vulnerable groups like children and young people and ensuring the mental health needs of people with long-term health conditions are met through the Government's mental health strategy
- providing better information and support for people bereaved or affected by suicide.

BACP is a member of the national Call to Action suicide prevention coalition, which is funded by the Department of Health and led by the Samaritans. Call to Action includes over 50 voluntary, independent and public sector organisations who will work together to put the strategy into action.

BACP has welcomed the Government's strategy but says there should be more recognition of the preventive role of counselling and psychotherapy for people with depression and those who have suicidal thoughts.

In particular, BACP says early intervention is crucial for adolescents with mental health problems and that all children and young people in secondary schools and universities should have access to professional, qualified counselling services within their educational establishment.

Around the Parliaments

At the beginning of September, the Prime Minister began a reshuffle of the Government, leading to big changes at the Department of Health, with just one of the previous Ministers remaining in post.

Secretary of State for Health Andrew Lansley has been replaced by his Conservative colleague Jeremy Hunt (previously Secretary of State for Culture, Media and Sport). Social Care Minister Paul Burstow has been replaced by fellow Liberal Democrat Norman Lamb MP, who has taken over the brief for mental health policy in the newly-named post of Minister of State for Care and Support. Dr Daniel Poulter (Conservative) has responsibility for professional regulation, having been given Conservative colleague Anne Milton's ministerial brief.

The Scottish Government also had a shake-up of personnel. Alex Neil replaced Nicola Sturgeon as Cabinet Secretary for Health and Wellbeing.

The Scottish Government has unveiled its legislative programme for the next 12 months. It includes a Children and Young People Bill, which aims to 'make Scotland the best place for children and young people to grow up, from giving them the best start in life to ensuring they... develop into healthy, confident individuals, ready to succeed.'

For more details about BACP's Parliamentary work, contact Martin Bell, Parliamentary and Public Affairs Advisor, at martin.bell@bacp.co.uk

Completed and active consultations

Completed consultations

A Scotland for Children: the Children and Young People Bill

Consulting body: Scottish Government

Subject benchmark statements for Counselling and Psychotherapy

Consulting body: Quality Assurance Agency for Higher Education

Guidance for substance misuse education

Consulting body: Welsh Government

The PSA's role in advising the Privy Council about appointments to regulator's councils

Consulting body: Council for Healthcare Regulatory Excellence (CHRE)

Shared decision-making and choice for patients

Consulting body: Department of Health

Active consultations UK Vision Strategy

Consulting body: RNIB
Nation scope: UK
Deadline for comments: 11 November 2012

Safeguarding Choice: a draft Assisted Dying Bill

Consulting body: Choice at the End of Life APPG
Nation scope: UK
Deadline for comments: 13 November 2012

BACP welcomes contributions from members to its responses to consultations. If you would like to contribute your views to any of the above active consultations, please email policy@bacp.co.uk, stating in the subject line the name of the consultation. To view BACP's full responses to these and other consultations, visit www.bacp.co.uk/policy

Lib Dems seek to prolong IAPT

Mental health once again enjoyed increased prominence at the Liberal Democrat, Labour and Conservative parties' autumn conferences, where BACP was represented by its Policy Unit

Topics discussed across all three political party conferences included the place of psychological therapies in the NHS, children and young people's mental health, mental health in the criminal justice system and the impact of mental ill health in the workplace.

The Liberal Democrat conference in Brighton debated a new policy motion to address the

under-provision of mental health services. During the course of the debate, speakers paid tribute to the work of the recently reshuffled Care Services Minister Paul Burstow, as well as speaking about their own personal experiences of mental illness.

The motion, which was voted through and is now formal Liberal Democrat policy, calls for IAPT to be continued beyond its current end date of 2014, and for IAPT targets to be included in the NHS Outcomes Framework and IAPT to be a priority project for the NHS Commissioning Board and Health Education England. It also says GPs should be required to

undertake placements in IAPT or CAMHS services as a part of their training.

To address concerns about poor provision of mental health services, the motion calls on central government to ensure its mental health policies are being implemented on the ground; for clinical commissioning groups to work with local authorities through Health and Wellbeing Boards to ensure that services are joined up to support people with complex needs; for a government review of funding for outreach mental health services such as assertive outreach and supported living services, and for a new government

strategy to improve access to mental health services for BME communities.

Stop press

The Early Intervention Grant, which currently funds many school and pre-school early intervention programmes for vulnerable children and young people, is losing its ring-fenced funding and will be cut, BACP Policy Unit has learned. The Early Intervention Foundation Consortium, led by Labour MP Graham Allen, has raised the issue with the Prime Minister. BACP is a member of the consortium and has also written to the Prime Minister to emphasise its very great concerns about the cuts.

Outstanding research award

Applications are invited for the BACP Outstanding Research Award 2012

The award is open to research projects completed or written up within the last 36 months. The aims of this award are to reward excellence in counselling and psychotherapy research and encourage counsellors and psychotherapists to engage in research. The deadline for applications is Friday 16 November 2012. The winner will be announced in February 2013 at the BACP Ask Yalom evening event in London.

Visit www.bacp.co.uk/research/resources/awards.php

School-based counselling trial begins

BACP has launched a joint randomised controlled trial to evaluate the benefits of school-based counselling in two London secondary schools

BACP is working with Metanoia Institute and the University of Strathclyde

on the trial. Their aim is to replicate a trial that was first piloted at Strathclyde University by Katie McArthur and subsequently rolled out in a second study, the RELY trial, in Birmingham, in partnership with Relate. 'Our aim with this important stream of

research is to establish the effectiveness of school-based counselling with a view to promoting it as a form of easily-accessible and non-stigmatising early intervention for children and young people,' said Andy Hill, BACP Head of Research.

Research into carers of people with dementia

BACP has commissioned new research to find out how counselling has helped carers of people with dementia cope with their caring role

This research, undertaken by Ruth Elvish, Rosanne Cawley and John Keady, consists of two separate projects:

a systematic review and a qualitative piece of original research. The systematic review, *Psychological interventions for carers of people with dementia: a systematic review of quantitative and qualitative evidence*, is completed and available to download for free from the BACP website. The qualitative

research, *The experiences of counselling and psychotherapy from the perspective of carers of people with dementia*, will be available to download free in the next few months.

Download the review at www.bacp.co.uk/research/Systematic_Reviews_and_Publications/dementia_carers.php

CfD manual commissioned

BACP has commissioned a trainee-friendly practitioner textbook to complement the CPD training for counselling for depression (CfD)

Since the launch of the new CfD modality in 2011, 186 qualified counsellors have undergone the training in the UK. The new publication is specifically intended for the trainee. It will complement the course manual (which includes training material/handouts and DVD) and describes the therapy and its implementation. The textbook will be written by Pete Sanders and published by Sage in 2014.

BJGC focuses on counselling in schools

The November issue of the *British Journal of Guidance and Counselling* will focus on school-based counselling

The special issue is guest-edited by Jo Pybis, BACP Research Facilitator, and Katie McArthur, PhD student at the University of Strathclyde.

Ten papers cover issues including perceptions of school-based counselling and the impact of school-based counselling on pupils' ability to study and learn. The issue is available online and will be published in hard copy in November.

Visit www.tandfonline.com/toc/cbjg20/current

Final call for BACP Research Conference papers

Deadline for submissions to the BACP 2013 Annual Research Conference is 16 November 2012

BACP is inviting submissions of abstracts for papers, workshops, symposia and posters for the event, which takes place on 10–11 May 2013 near Birmingham.

The 2013 conference will be co-hosted with the Irish Association for Counselling and Psychotherapy. The conference theme is 'Synergy in counselling and psychotherapy research'.

The keynote speakers will be Michael Lambert, Professor of Psychology at Brigham Young University, and Roz Shafran, Professor of Clinical Psychology, University of Reading.

BACP has created a new research award for the 2013

conference, to promote counselling and psychotherapy research with an equality and diversity perspective.

All papers submitted to the conference peer review group on any topic that relates to the nine 'protected characteristics' of the 2010 Equalities Act will be selected automatically for consideration for the £500 award. The winning paper will be presented at the Research Conference in May 2013.

The template for submitting papers for the conference can be found at www.bacp.co.uk/research/events/conf2013.php. For further information, please contact Angela Couchman at angela.couchman@bacp.co.uk. To register interest as a delegate, please email Katy Hobday at katy.hobday@bacp.co.uk

BACP links with CAMHS research consortium

The BACP Research team has joined the CAMHS Outcomes Research Consortium (CORC)

CORC is a grassroots collaboration of mental health specialists from over 70 child and adolescent mental health services across the UK and beyond.

The BACP Research department is exploring the use of the CORC CODE database for members of SCoPreNet, the BACP-led schools counselling practice research network. This would enable SCoPreNet members

to collect data using the same collection methods, so making analysis simpler.

SCoPreNet was launched by BACP to bring together practitioners, researchers and trainers engaged in research and evaluation in order to develop the evidence base for school-based counselling. The network now has 250 members. The BACP Research team is currently surveying all SCoPreNet members to gauge the use and activity of the network.

To join the SCoPreNet network, visit www.bacp.co.uk/schools

Research news in brief

● Upcoming dates for the BACP Research department research surgery are 24 October 2012, 27 November 2012 and 18 December 2012. The research surgery telephone advice sessions are intended for BACP members who do not have access to research supervision and have a research dilemma, question or problem. Members can book a 30-minute session with BACP Research department advisers between 2pm and 4pm on those days. To book a session for the research surgery, please contact stella.nichols@bacp.co.uk

● The deadline for applications for BACP seedcorn funding for new and innovative research is 9 November 2012. Any BACP member is eligible to apply for the £5,000 funding to support new research projects. Research proposals from practitioners are particularly welcome. For more information, call Jo Pybis on 01455 206359, email jo.pybis@bacp.co.uk or visit www.bacp.co.uk/research/seed_corn.php

● The BACP Research team keeps an updated record of funding opportunities for research into counselling and psychotherapy (visit www.bacp.co.uk/research). The British Academy for the Humanities and Social Sciences is awarding research grants of £500–£10,000 for research, workshops or conferences in all areas of the humanities and social sciences. The deadline for applications is 7 November 2012. Visit www.britac.ac.uk/funding/guide/srg.cfm

Professional conduct

BACP Professional Conduct Hearing

Findings, decision and sanction

Darren Simpson

Reference No 521894
Leicestershire LE10

The complaint against the above individual member was heard under BACP's Professional Conduct Procedure 2010 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 it was unanimous in its decision that those findings amounted to professional malpractice in that Mr Simpson's practice fell below the standards expected of a practitioner exercising reasonable care and skill. In particular, he provided the complainant with an inadequate professional service.

Sanction

Within one month from the date of imposition of this sanction, which will run from the expiration of the Appeal deadline, Mr Simpson is required to provide a written submission that evidences his immediate reflection on, learning from and understanding of the issues raised in this complaint.

In addition, Mr Simpson is required to have monthly supervision for at least one year with a BACP psychodynamic supervisor, other than and in addition to his usual supervisor, to address the specific issues raised in this complaint. In particular, Mr Simpson, in the light of the *Ethical Framework for Good Practice in Counselling and Psychotherapy*, is required to address the issues of:

- transference and countertransference in psychotherapeutic relationships and especially the issue of erotic transference
- the responsibilities of working in private practice
- contracting
- the use of supervision.

Mr Simpson is required to begin this monthly supervision within three months from the date of imposition of this sanction, and both inform BACP when this starts and provide details of this supervisor.

Within three months of completion of this year's supervision, Mr Simpson is to provide a comprehensive written submission that demonstrates and evidences his detailed learning from the complaint. This report should include evidence of having addressed the bullet pointed issues as above. The report should also include all the dates of the monthly supervision sessions and should be countersigned by the supervisor.

Mr Simpson is also required to provide evidence of formal training, which must be no less than a minimum of six hours and which addresses the responsibilities and requirements of a lone practitioner working in private practice. This evidence should be submitted to BACP and should include confirmation of Mr Simpson's attendance from the training provider, within 18 months from the date of imposition of this sanction.

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

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

BACP Professional Conduct Hearing

Findings, decision and sanction

Michael Parkes

Reference No 602138
Telford TF2

The complaint against the above individual member was heard under BACP's Professional Conduct Procedure 2010 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 it was unanimous in its decision that those findings amounted to professional malpractice in that Mr Parkes' relationship with client C fell below the standards expected of a practitioner exercising reasonable care and skill, and constituted an inadequate professional service.

Sanction

The Panel imposed the following sanction.

Within six months from the date of the imposition of this sanction, which will run from the expiration of the appeal deadline, Mr Parkes is required to provide a written submission of between 1500 and 2500 words in which he demonstrates his learning and understanding of the issues raised in this complaint. In particular, he should show his understanding of how the issues raised in this complaint impacted on his client. He should address what changes he would make in his practice and what procedures he

would put in place to ensure that the effects of his low blood sugar level relating to his diabetes did not have an adverse effect on his clients. He should address how he would work with any employer or agency to keep them fully aware of how he was managing his diabetes and any risks associated with this. He should also show how he has used supervision to discuss all the issues raised in this complaint and the different elements of this sanction, including his fitness to practise. This written submission must be signed off by Mr Parkes' supervisor who must be a member of BACP.

All reports must be sent to the Deputy Registrar and Deputy Director of BACP Registers and will be considered by an independently constituted Sanction Panel.

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

BACP Professional Conduct Hearing

Findings, decision and sanction

Maggie Noskeau

Reference No 517257
Nottingham NG9

The complaint against the above individual member was heard under BACP's Professional Conduct Procedure 2010 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 it was unanimous in its decision that those findings amounted

to professional malpractice on the grounds of incompetence and inadequate professional services.

Sanction

Within one month from the date of imposition of this sanction, which will run from the expiration of the appeal deadline, Ms Noskeau is required to provide a written report detailing her learning from this complaint, including particular learning about the importance of dealing with her own issues outside of client sessions.

In not less than three months but not more than six months from the date of the imposition of this sanction, Ms Noskeau should provide evidence that she has incorporated her learning above into her client work and provide evidence in the form of an extended case study to demonstrate that she has done so. The case study should also provide evidence of appropriate supervision that has incorporated an advanced understanding of transference and countertransference and that has been signed off by the supervisor who has supervised the material used in the case study. This supervisor should be someone outside of Ms Noskeau's current network who is BACP accredited or equivalent and has been so for at least five years.

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

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

Withdrawal of membership Maggie Noskeau Reference No 517257 Nottingham NG9 6FU

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

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

Withdrawal of membership Lesley Pilkington Reference No 526923 Hertfordshire WD3 5PE

A sanction was imposed on Mrs Pilkington following a Professional Conduct and Appeal Hearing.

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

Withdrawal of membership James Hennah Reference No 545652 Bristol BS5 8TN

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

The summary of the information was that Mr Hennah was charged with a number of sexual offences and that he admitted two offences of sexually touching a child and one of voyeurism

when he appeared before Exeter Crown Court on 18 May 2012. In the publicly available information relating to his reported behaviour, mention is made of him being an accredited counsellor. He subsequently informed BACP by letter dated 18 May 2012, received 21 May, that he admitted to pleading guilty to three of the four charges made against him and that he wished to terminate his membership.

The nature of the information raised questions about the suitability of his continuing membership of this Association and raised concerns about the following in particular:

- Mr Hennah's alleged actions have brought, or may yet bring, not only this Association but also the reputations of counselling/psychotherapy into disrepute
- Mr Hennah's alleged behaviour was incompatible with the values and principles of counselling and psychotherapy and was lacking in the personal moral qualities to which counsellors and psychotherapists are strongly encouraged to aspire. His alleged behaviour in this instance also suggested that his behaviour was incongruent with that expected of a BACP member
- the information further suggests that Mr Hennah's fitness to practise has been impaired
- by attempting to resign his membership, Mr Hennah allegedly wished to avoid accountability to BACP.

Panel's decision

The Article 12.6 Panel decided to implement

Article 12.6 of the Memorandum and Articles of Association and withdraw BACP membership from Mr James Hennah to take effect 28 days from notification of this decision. The reasons for its decision are as follows.

Mr Hennah's plea of guilty to the three serious charges referred to above, with the consequent requirement to sign the Sex Offenders Register, together with his declaration to BACP that 'I have failed and done untold damage', render him now quite unsuitable for continuing membership of the organisation.

In particular the Panel concluded that his actions:

- i) have brought, or could bring the reputation of BACP into disrepute
- ii) have brought or could bring the reputations of counselling and/or psychotherapy into disrepute
- iii) that if the public was accurately informed of all the circumstances of the case, the public's trust in the profession would be adversely affected
- iv) are evidence that his fitness to practise is seriously impaired.

The Panel found no mitigating circumstances.

Sanction compliance Iron Mill Institute Reference No 100657 Exeter EX4 6AP

BACP has received reports that verify that the requirements of the sanction have been met. As such, the sanction reported in the February 2012 edition of this journal has been lifted. The case is now closed.

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