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PLUS

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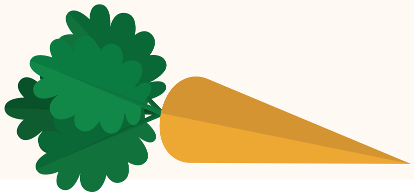
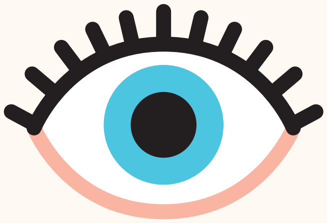
FROM THE EDITOR

We find ourselves in challenging times. Politically, socially and culturally we are still learning how to adapt to the changing world in which we live. For many people this can be a frightening and difficult experience, and NHS mental health services must respond by helping them to deal with the emotional and psychological challenges. Different people will require different approaches to this. As part of our series on the range of therapies offered within IAPT services, the lead article in this issue looks at dynamic interpersonal therapy (DIT), exploring the contribution of short-term psychodynamic work to NHS mental health services. We saw in the last issue that the take-up of non-CBT therapies within IAPT is very low indeed. Deborah Abrahams highlights that DIT represents less than one per cent of the overall number of referrals seen for treatment within IAPT services. It seems to me that we are missing out on the potential contribution that DIT and the other non-CBT offerings can make, alongside cognitive behavioural therapy itself.

DIT formulates depression as a threat to the patient's attachment system. Attachment is also the theme of Graham Music's article, which explores why NHS mental health staff and patients need more compassionate, emotionally secure settings. Graham draws parallels between the attachment experiences of early childhood and the way in which our working environment influences our ability to provide care and support to our clients. He questions whether the fast-paced, pressurised environment that characterises many IAPT services can really be conducive to our ability to provide a secure base for those who so desperately need it. The article challenges all of us to consider how we can contribute to the development of organisations that provide a secure base for staff and clients alike.

One of the biggest challenges facing NHS services today is an ageing society and the impact that this has on the provision of both physical and mental health services. According to Kelly Birtwell and Linda Dubrow-Marshall, more than 850,000 people in the UK are currently living with dementia, a number which is expected to double in the next 30 years. Kelly and Linda report on a BACP-funded study into the insights of people with mild dementia and their experiences of psychological support, skilfully highlighting their experience of loss, both of memory and of the ability to do the things that they used to do. Also emphasised is a changing sense of self, both in terms of how dementia sufferers experience themselves and how others experience them.





The researchers underline the importance of tailoring psychological support to the individual. This can only be achieved, they assert, by seeing the person first, rather than the condition. This, I think, is wise advice for all of us with our clients, no matter what their presenting issue.

The challenge of remaining client centred can be a difficult one in times when resources are scarce, and political and organisational pressures are great, as is currently the case across the UK. Jacqui Taylor reflects on the challenges currently facing third sector mental health providers in Scotland, including Brexit and a possible second referendum on Scottish independence, as well as the pressures of public sector funding cuts and austerity. While Jacqui highlights the significant impact of these external challenges, she is quick to point out that there are also new opportunities, if we are prepared to think differently, demonstrate flexibility and find new ways of working more efficiently. The lessons that Jacqui draws seem, to me, to be of relevance to third sector organisations across the whole of the UK.

The third sector perspective has been eloquently and thoughtfully represented in this journal by Michael Lilley for the past four years. We are very sorry to announce that Michael has decided to stand down from this role, as he has now retired from the counselling profession. We highly appreciate all the hard work he has put in over his time with us. While we are very sorry to lose him, we wish him all the best in his new role as a Green councillor on the Isle of Wight. We will be looking for someone to take over the third sector column from October, so if you work in a third sector counselling organisation and would like to contribute to this journal on a regular basis, then please do get in touch.

Joanna Benfield, *Editor*
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NEWS & RESEARCH

NICE consultation on depression

Over the past two years, the National Institute for Health and Care Excellence (NICE) has been undertaking an update to its guideline on 'Depression in adults: recognition and management'. The guideline is aimed at professionals in primary care and secondary care who are supporting adults with depression, as well as at NHS managers and clinical commissioning groups. The guideline covers adults over the age of 18, with mild, moderate or severe depression, and has a specific focus on older people, men, black and minority ethnic groups and people with co-existing mental health conditions.

The previous update of the guideline in 2009 recommended the removal of counselling and short-term psychodynamic psychotherapy as interventions for depression in adults. With the help of our members, BACP successfully fought NICE and ensured they were retained within the guideline.

Once again, BACP is concerned that there is a real risk that counselling and short-term psychodynamic psychotherapy will be recommended for removal from the guideline. We therefore have a campaign plan in place to fight these recommendations, should they be brought forward.

The final consultation on the guideline will be launched this summer. If you would like to find out more about our campaign, please visit BACP's campaign page: http://www.bacp.co.uk/policy/campaigns/

Source: BACP

REFERENCE

National Institute for Health and Care Excellence. Depression in adults: recognition and management. [Online.] NICE; 2017. https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0725 (accessed 9 June 2017).

COUNSELLING FOUND TO BE AS EFFECTIVE AS CBT IN TREATING DEPRESSION

A new study by BACP and the University of Sheffield has found that counselling is as effective as CBT in the treatment of depression. The research, which was published in *BMC Psychiatry*, analysed data on over 330,000 people suffering from depression, who presented in 103 IAPT services.

The research showed that the two therapies were comparable in terms of reliability and the production of clinically significant change. It also found that counselling received a higher number of referrals of clients with moderate to severe depression, and that counselling achieved comparable outcomes in fewer sessions than CBT. The study found that variability between sites had a greater impact on outcomes than the type of therapy did, with the most effective site having twice the recovery rate of the least successful site.

The study's authors concluded that there is no evidence to suggest that CBT is superior to counselling; in fact, counselling was shown to be more efficient than CBT, and this has potential cost implications for the NHS. The authors assert that this study shows that it is time to stop focusing on small differences in the outcomes of different therapy types, and to focus instead on other factors that might affect outcomes, such as the variability between services. Finally, the authors highlighted that it was concerning that half of all patients, irrespective of the type of therapy, did not experience reliable improvement.

Source: BACP

REFERENCE

Pybis J, Saxon D, Hill A, Barkham M. The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. [Online.] BMC Psychiatry 2017. http://rdcu.be/tmxM (accessed 12 June 2017).

Seven NHS trusts to pioneer digital mental health services

NHS England has selected seven mental health trusts to pioneer digital services for mental health patients. The seven trusts will develop their own technologies to allow patients access to tools to help them manage their conditions. All practitioners who are involved in the patients' care will have access to real-time records, which will cover all stages of the care process, from assessment to referrals and follow-up. The NHS is providing £35 million for this project, with the trusts matching this amount themselves. The trusts that have been designated as 'Global Digital Exemplars for Mental Health', are: Berkshire, Birmingham and Solihull, Mersey Care, Northumberland, Tyne and Wear, Oxford, South London and Maudsley, and Worcestershire. Each of these trusts is already working on developing innovative digital mental health services. For example, Oxford Health NHS Foundation is developing a platform which will allow people to access psychological therapies online, while Mersey Care Health and Care NHS Trust is developing an app for responding to suicide and self-harm risk. Worcestershire Health and Care NHS Trust is providing all mental healthcare staff with access to mobile patient healthcare records, while Northumberland, Tyne and Wear is developing online consultations. The aim of the Global Digital Examplars for Mental Health programme is to disseminate knowledge and expertise to the wider NHS, in order to improve the digital management and delivery of mental health services.

Source: NHS England

REFERENCE

NHS England. Mental health patients set to benefit from pioneering new digital services. [Online.] NHS England; 2017. https://www.england.nhs.uk/2017/04/mental-health-patients-set-to-benefit-from-pioneering-new-digital-services/ (accessed 5 May 2017).

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NHS ENGLAND ANNOUNCES ADDITIONAL FUNDING FOR CHILDREN'S MENTAL HEALTH SERVICES

NHS England has announced funding for 150–180 new beds for children and young people with mental health issues in previously underserved areas of the country. The aim is to cut down the need for young people to travel far from home for treatment. Over the last three years, the number of young people in treatment for mental health issues has increased by 20,000.

NHS England also aims to decrease hospital admissions by treating more young people in the community. With this in mind, 67 new community eating disorder services have been established and are currently being developed.

In addition, NHS England has announced that it will be opening four new mother and baby mental health units, increasing the total number in England to 19, while increasing the number of beds available in the existing units. The new units will be in East Anglia, north-west England, south-west England and on the south-east coast. The units will provide care for mothers with severe mental health disorders, such as schizophrenia and psychosis.

Source: NHS England

REFERENCE

NHS England. Next steps on the NHS Five-year Forward View: NHS acts to cut inappropriate out of area placements for children and young people in mental health crisis. [Online.] NHS England; 2017. https://www.england.nhs.uk/2017/03/nhs-acts-to-cut-inappropriate-out-of-area-placements-for-children-and-young-people-in-mental-health-crisis/ (accessed 5 May 2017).

The reasons why some of us cannot stop worrying

Although worry is a normal part of daily life for most of us, for some people worrying can become pathological, distressing and uncontrollable. A new study in *Biological Psychology* explores the emotional and cognitive factors that contribute to pathological levels of worry. The report also includes some advice for therapists working with clients who suffer from high levels of worry.

The authors, from the University of Sussex and the Institute for Psychiatry, Psychology and Neuroscience, found that people who worry uncontrollably tend to be very vigilant about sources of danger and threat, and are more likely to assess a situation as being threatening, even when that threat is not obvious. They found that these attentional biases play a causal role in worry and anxiety. The authors recommend that therapists use psychoeducation to help clients to identify their own patterns of worrying.

The study highlights that, when people are trained to pay attention to the positive aspects of a situation, rather than focusing on what might be wrong, they tend to report fewer intrusive thoughts than those who have not been trained. The study therefore recommends attentional training programmes for people suffering from excessive worrying.

The authors also examine the factors that perpetuate worry once it has been triggered. These include a belief that the worrying is a positive thing, keeping the person safe by helping them to avoid unpleasant occurrences, preparing them for negative outcomes and assisting them in solving problems. The study recommends that therapists address these beliefs with the client and help them to challenge them.

Worrying is also perpetuated by the fact that people who worry tend to feel as though they have to think a problem through to the end, in order to avoid all sources of potential danger or risk. The study suggests that it would be useful to teach people how to let go of their worries at an earlier stage, rather than ruminating upon every eventuality.

Finally, the study found that people with high levels of worry tend to experience more negative moods. They tend to interpret these low moods as indicating that they need to continue worrying in order to rid themselves of the threat or risk. The study provides some suggestions for combating these low moods, such as going for walks. Acceptance and mindfulness-based approaches are recommended by the study to help reduce clients' distress about their worry and to address the low mood.

Source: BPS

REFERENCE

Davey G, Meeten F. The perseverative worry bout: a review of cognitive, affective and motivational factors that contribute to worry perseveration. [Online.] Biological Psychology 2016; 121(B): 233–243. http://www.sciencedirect.com/science/article/pii/S0301051116300965 (accessed 16 May 2017).

BUILDING RELATIONSHIPS

SATINDER PANESAR

The issue of mental health has consistently been in the media recently; this has really highlighted to me the importance of building and maintaining relationships with key stakeholders, in order to ensure that we remain clearly in the public eye and that the voices of our members are heard. Here in Scotland, BACP has been working hard to ensure that it has the ear of decision-makers and is able to contribute to key discussions and decisions that will impact upon the delivery of mental health services. This is particularly important at this point in time, as the Scottish Government has recently published its 10-year mental health strategy.[1] You can read more about this in Judy Stafford's column on the next page and in Jacqui Taylor's article on page 24.

BACP's recent meeting with the Scottish Government's Minister for Mental Health, Maureen Watt MSP, provided an excellent opportunity to cement our relationship with the minister and to discuss how BACP can support the Scottish Government with implementation of the strategy. While BACP did not shy away from concerns around resources, the core focus was on providing practical solutions to help fill gaps within the strategy. The minister was keen to work collaboratively to further develop a number of policy areas which lack sufficient detail. This included, for example, BACP seeking an assurance that the Government's stated plans to increase the number of mental health NHS posts include sufficient numbers of counsellors and psychotherapists to achieve the wider objectives of the 10-year strategy.

> *…BACP has been working hard to ensure that it has the ear of decision-makers and is able to contribute to key discussions and decisions that will impact upon the delivery of mental health services*

BACP Healthcare was also recently represented at a BACP Private Practice meeting in Glasgow that looked at a four nations approach to mental healthcare. We were able to share some details of how BACP's work can influence policy and practice in Scotland. Steve Mulligan, BACP's Policy and Engagement Lead for the Four Nations, stated, 'This was a fantastic opportunity to talk through the work we are doing to strengthen relationships with decision-makers from across the political spectrum in Scotland. It also critically provided a forum to listen to our members, so BACP can adapt its approach to best serve their needs, as well as finding further opportunities to work together to secure positive change.'

I was able to meet with Steve recently to discuss some of the issues that I have been facing in healthcare counselling in Scotland. Our exchange centred on the deterioration of counsellors' roles within healthcare in Scotland, and upon how we can raise awareness of the importance of the role of counselling. We also discussed how the BACP Healthcare division links into each strand of BACP's strategy. Steve shared some of his expertise about what was happening nationally, and I found this extremely useful.

I am pleased that we have been able to highlight the current challenges facing counsellors and psychotherapists in the third sector in Scotland in this issue of the journal. Jacqui Taylor's article provides an excellent overview of the current situation, which, I believe, is of relevance to each of the four nations. Jacqui is one of the most dynamic individuals I know and her commitment to mental health is second to none. She is passionate about making a difference, inspiring people to reach their potential and empowering them to do more of what they care about – get things done, have fun, communicate and accomplish great things. I believe that this is a great philosophy for every single one of us. ■

REFERENCE

1 *Scottish Government. Mental health strategy 2017–27 – a 10 year vision. [Online.] Edinburgh: The Scottish Government; 2017. http://www.gov.scot/Publications/2017/03/1750/0 (accessed 25 April 2017).*

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ACCESSIBLE COMMUNICATION

JUDY STAFFORD

My hope in the run-up to the general election was that the candidates would focus on their manifestos rather than trying to discredit each other. However, it would seem that politics cannot raise its game, either here or in other countries. Unfortunately, its domination of the news headlines overshadowed the successful work that the likes of Princes Harry and William, Bryony Gordon and other celebrities were doing, chipping away at the stigma surrounding mental health.

Nevertheless, there's some positive political news from Scotland. At the beginning of May, BACP met with Maureen Watt MSP, Scotland's Mental Health Minister. We were delighted to be told that BACP was her first choice of organisation to meet with since the Scottish Government published its 10-year Mental Health Strategy in March.[1] Discussions focused on how BACP can support the Scottish Government with implementation of the strategy. Recognising significant concerns around resourcing the ambitions outlined in the plan, BACP offered practical solutions to help address these challenges, which were well received. The strategy identifies a welcomed ambition for dedicated counsellors to be employed in A&E departments, GP surgeries, prisons and police station custody suites, underpinned by a promise of 800 additional mental health workers in those key settings.

BACP also discussed the review of school counselling, which forms part of the strategy, and which BACP hopes will be a catalyst for the provision of counselling in every school in Scotland. The minister was particularly taken by BACP's argument that this could reduce the burden on CAMHS provision in Scotland. To support the review, BACP has offered to bring experts from Wales and Northern Ireland together with their Scottish counterparts, to share best practice.

BACP's endeavours to share best practice also continue with additions to our range of *Good Practice in Action* resources on: 'how to choose a supervisor for your service', 'monitoring the supervisory relationship (supervisor)' and 'what is supervision?' The latter is intended for the public. If you have any ideas for other topics you would like covered, please get in touch.

The launch of our eagerly awaited new website is also progressing and, if we make our deadline, it should be available soon. We hope that the public and practitioners will find it accessible, but – as ever – your feedback would be much appreciated. We do hope you like it! Accessibility has, naturally, been at the centre of our wrangles over language and tone for the webpages. Should we use social media language, basic language or academic/research language? It has been quite difficult to decide and gain consensus. It's a bit like meeting a client who has English as a second language, and having to weigh up if it is necessary to employ a translator or whether it is sufficient to rely on the counsellor's knowledge of body language and ability to 'hear the music behind the words' and to reflect and paraphrase. It is of paramount importance that the client knows they have the counsellor's full attention, they are understood and they can let the counsellor know if that's not the case. So, in that respect, the words are secondary to the emotion or feeling that the client is expressing. This is reflected in the latest issue of *BACP Children & Young People* journal, in which Henry Kronengold describes his work with an anxious child who loves rock music and how music can open up the channels of communication with clients and convey feelings when words seem impossible.[2]

I find the subject of communication quite fascinating, as do most counsellors. The communication styles of the contributors to the June issue of *Therapy Today*[3] were particularly interesting, as all four feature articles had very different methods of delivery. I wonder what you thought of them: was one style more accessible than the others, did you switch off part way through the 'heavier' academic style? We're keen at BACP to get it right and we can only do that if you communicate with us. So drop us a line by email, phone, or write to *Therapy Today*, this journal or any of the other BACP divisional journals – we would really appreciate hearing from you. ■

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1 *Scottish Government. Mental health strategy 2017–27 – a 10 year vision. [Online.] Edinburgh: The Scottish Government; 2017. http://www.gov.scot/Resource/0051/00516047.pdf (accessed 4 May 2017).*

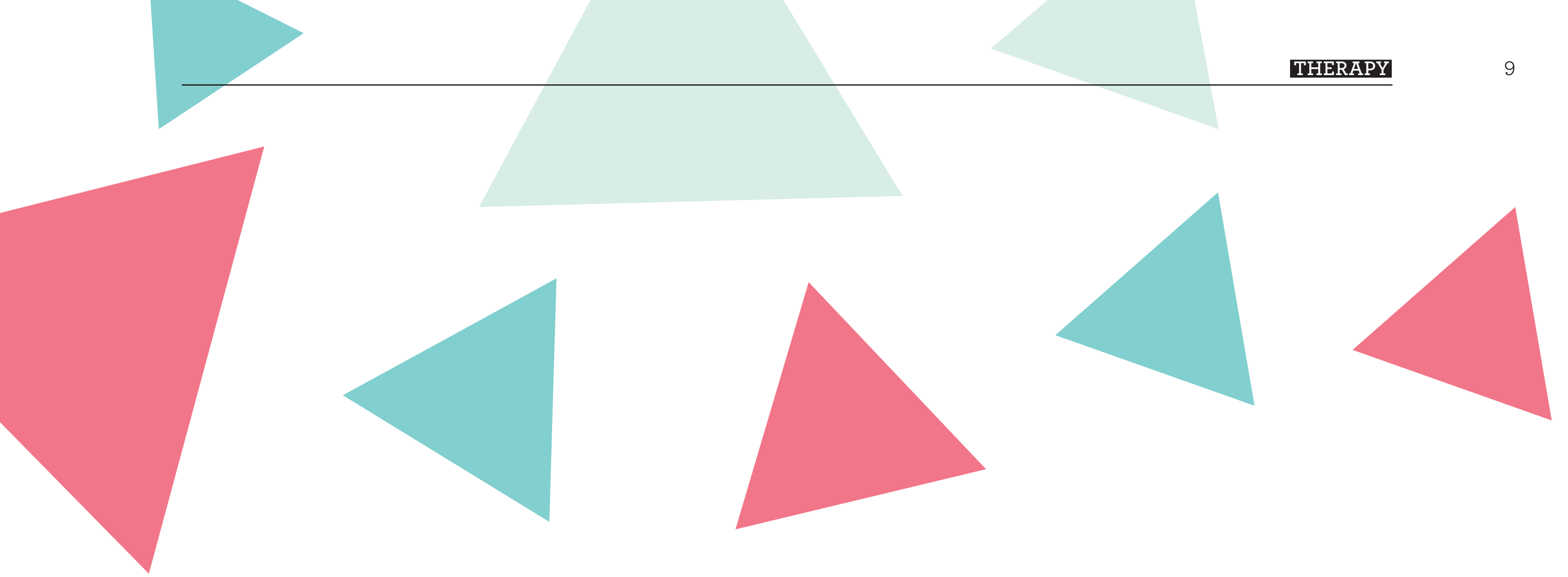
2 *Kronengold H. Ghosts in the playroom. BACP Children & Young People 2017; June: 4–8.*

3 *BACP. Therapy Today 2017; 28(5).*

*This is a regular column by **Judy Stafford**, who works in the Healthcare, Journals and Professional Standards departments of BACP. Judy is also a registered member of BACP and is a person-centred counsellor working in the third sector.*

DYNAMIC INTERPERSONAL THERAPY: WORKING WITH PERCEPTIONS OF THE SELF AND OTHER

DEBORAH ABRAHAMS OUTLINES THE CONTRIBUTION OF SHORT-TERM PSYCHODYNAMIC WORK TO IAPT SERVICES



WHAT IS DYNAMIC INTERPERSONAL THERAPY?

Dynamic interpersonal therapy (DIT) is a brief model of psychodynamic psychotherapy that was developed by Alessandra Lemma, Peter Fonagy and Mary Target in 2010.[1] It arose in response to the Improving Access to Psychological Therapies (IAPT) initiative, in order to ensure that a psychoanalytically informed model would be offered alongside CBT, as one of the non-CBT approved treatments for depression. However, IAPT's annual workforce surveys indicate acute gaps in the DIT workforce nationally, with DIT representing less than one per cent of the overall number of referrals seen for treatment.[2–5] The importance of patient choice in accessing psychological therapies is widely recognised: over 50 per cent of patients do not move into recovery with CBT, as shown by the annual IAPT reports.[3] Surveys of patients and IAPT leads have demonstrated strong demand for DIT in order to improve therapy uptake, completion and recovery rates through increased patient choice, as well as improved staff retention through opportunities for professional development and greater work satisfaction.[6] Research found that the way in which some local areas have interpreted and implemented IAPT has actually led to a reduction in both choice and access to psychological therapies.[5,7] A survey carried out by Mind showed that only eight per cent of patients were given a full choice of IAPT therapies. Those patients who had a choice were three times more likely to be happy with their treatment than those who did not get the choice they wanted. In addition, people who were offered a full choice of therapy were five times more likely to report that therapy helped them back to work than those who were not.[8]

The DIT model draws on a systematic review of clinical competencies in psychoanalytic and psychodynamic models of psychotherapy.[9] As such, DIT is underpinned by a strong evidence base. Those who attend the DIT training often find many familiar points of reference with the model; this is to be expected, since it is a distillation of best practice in brief psychotherapy approaches.

I have always had an interest in brief models of psychotherapy with children, families and adults, and was attracted to this new development while I was working as a clinical psychologist and psychotherapist in the Camden and Islington NHS Foundation Trust IAPT and psychodynamic psychotherapy services. I was part of the first DIT training cohort in 2010 and I continue to use DIT in both my NHS work and private practice. I find it a containing and meaningful structure within which to approach brief work, both for practitioners and patients. Although DIT was designed as a treatment for depression, it also has a strong effect size with anxiety symptoms.[10] This is understandable because DIT formulates depression as a threat to the patient's attachment system, which is accompanied by an increase in anxiety. DIT allows the practitioner to work trans-diagnostically and to consider the interpersonal implications of the difficulties the patient is facing.

STRUCTURED BRIEF WORK

DIT is informed by theories of object relations, attachment, mentalising and interpersonal psychoanalysis. It has three phases. During the initial phase, which lasts for around four sessions, the therapist maps the patient's interpersonal world and collaborates with the patient in trying to identify a repeated pattern of relating that is linked to the presenting difficulties. During the middle phase (sessions five to 12) the therapist works explicitly with the patient around this agreed focus, encouraging change and taking up inevitable resistance to change. The ending phase is heralded by a goodbye letter in session 13, and the last four sessions bring the work to an end.

THE INTERPERSONAL AND AFFECTIVE FOCUS

At the heart of DIT is the 'interpersonal and affective focus' (IPAF): how the patient perceives others in relation to a self-perception, and the affect that links these two experiences. For example, the patient may see themselves as unwanted and experience others as rejecting, which leaves him/her anxious, with less conscious feelings of rage. The pattern is ideographic to each patient and draws on the patient's imagery and experiences. The more powerful the descriptors, the more impactful the IPAF will be. A patient's imagery or significant catchphrases often capture a multifaceted experience of self or other in an evocative way that goes beyond our usual repertoire of descriptors. Self-descriptors such as 'on the shelf', 'slug' or 'street rat' are more affect-laden than 'out of sight' or 'unacceptable'.

Unlike other types of psychotherapy, in DIT we communicate this formulation directly to our patients and negotiate a shared focus for the work. This is part of the collaborative approach adopted in DIT, a stance that is more supportive than would be the case in longer-term work. We then invite our patients to consider how they want to work towards change over the course of the remaining sessions. This can be a novel approach for some longer-term psychotherapists, who are not used to agreeing goals with patients or helping patients to articulate explicit expectations for therapy.

At all times, DIT is informed by the clinician's psychoanalytic stance. This means that we are on the lookout for our patients' resistances and defence mechanisms that may get in the way of making changes, both consciously and unconsciously. We might also take up the way the patient has an investment in keeping these patterns going, despite their stated wish for change. Part of the work is understanding the patient's coping strategies and the cost to the patient of maintaining them. However, we remain respectful of the patient's defences: given this is brief work, we are not intending to dismantle these.

Often, therapists become intimidated by the process of identifying an IPAF and find it difficult to settle on one pattern among several. However, it is helpful to consider this as a starting point, rather than an end point, for therapy. We continue to refine and polish the formulation as the work progresses and as new material emerges. The focus of the work should reflect the presenting difficulties, as well as making sense of past relationship struggles. The IPAF should be generalisable to more than one relational and temporal domain for it to have credibility. By this, I mean that the focus of the work should have its origins in the patient's childhood and be repeated in the present, so that the pattern makes sense of several different areas of the patient's life and is emotionally meaningful.

The IPAF is also a means to an end. We know that in depression, patients are often unable to mentalise flexibly. Mentalising is the ability to keep mind in mind, to see ourselves from the outside and others from the inside. The IPAF usually represents a troublesome and fixed way of viewing self and other, one that has developed out of difficult, even traumatic life experiences. Although it is painful, it is familiar to reinstate this pattern in uncertain interpersonal situations. By having an awareness of this repetition and considering ways of stepping outside this pattern, we are facilitating our patient's capacity to mentalise more flexibly. This results in greater reflective capacity and enhanced emotional regulation.

So what does DIT and the formulation look like? Given how personal the IPAF usually is, it is difficult to protect patient confidentiality when providing examples. For the purposes of this article, I have therefore amalgamated several different patient details in the following case studies.

CASE STUDY ONE: PETER

Peter came to see me for long-standing depression at his GP's request. He was the youngest son of a family of four and felt that his birth was an afterthought. His mother was often exhausted and unable to attend to his needs. Not only was she juggling two or three part-time jobs at any one time to make ends meet, but she was also consumed with worry about his sister, who had a life-threatening medical condition. Peter learned to keep himself in the background. He was afraid of overloading his mother's already stretched resources. He spoke painfully about times when he was left out of family trips. Despite feeling a deep sense of unfairness, he was unable to directly voice his complaints, becoming increasingly withdrawn and quiet. He drifted into a marriage but never felt that his wife truly wanted to be with him. When she announced that she was leaving him for someone she had met through the Internet, he felt a familiar sense of unfairness and resentment. He came forward for help when his mother developed dementia and he took on the role of being her full-time carer, moving back into the family home. He felt trapped and unable to have a life of his own. His siblings were not pulling their weight, happy to leave the lion's share of the care to him.

The focus for the work that we settled on was a sense of himself as 'an unimportant afterthought' and of others treating him in a dismissive manner that could even feel exploitative. This left him with feelings of hopelessness and resentment. It was more difficult to get hold of the resentment because, in many ways, this pattern protected him from the knowledge of his own aggression by locating it firmly in others.

Part of the reason for sharing the formulation with the patient is to help them to understand the defensive function of the IPAF and how it serves to protect them from parts of the self that are difficult to know about and are often projected into others. When identifying the affect that links the self and other representations, we are aware that the patient is more conscious of some affects than others. In sharing the pattern, we titrate how much we feel the patient can manage to hear. In brief work, we are largely working with conscious and pre-conscious levels of awareness. However, in the course of the work, deeper layers of understanding often emerge.

> *A patient's imagery or significant catchphrases often capture a multifaceted experience of self or other in an evocative way that goes beyond our usual repertoire of descriptors*

Peter found it useful to have this pattern made explicit to him and together we identified that he would like to work on the goals of being more visible and less of a 'wallflower'. We saw that there were ways in which he contributed to maintaining this pattern by retreating into the background and being avoidant. We could link this to his fearful avoidant attachment style. This is actively addressed in DIT when we ask patients to rate themselves on the Bartholomew and Horowitz relationship scale, which measures adult attachment styles.[11]

I am often surprised at the level of change that patients are able to manage in the course of the 16 weeks of DIT. Peter began to question his certainty about feeling solely responsible for his mother. It was transforming for him to be able to step outside this pattern and mentalise more flexibly about himself in relation to others. It freed him up to put his needs forward more clearly to his siblings and, to his surprise, they were able to step forward and cover for him. This allowed him to return to aspects of his life that he had put on hold. Indeed, the impetus for change was the realisation that he was waiting for his mother to die before he felt he had a right to resume his own life.

MIDDLE PHASE OF DIT

In the middle phase of DIT, the clinician adopts a more open approach to the sessions, listening to the narratives the patient brings and to what emerges in the dynamics between patient and therapist, so an idea of who is doing what to whom can be explored and clarified. I find the middle sessions of DIT to be the most similar to 'therapy as usual'. However, there is also a danger that we slide back into our familiar ways of being. The IPAF is the spine of the middle phase of the work. By repeatedly referring to it and continuing to refine it, we are more likely to remain on model. We are also able to work with our patient's unconscious processes in the middle phase. We will take up the defences the patient uses more actively, pointing out the cost of these defences in the hope of mobilising some change, while still respecting the need for those defences. After all, this is brief work and we are not expecting to radically change our patients' defence systems in 16 weeks.

We will also address the way the transference is activated in relation to the IPAF. In the case of Peter, I often found myself pulled into being controlling, even pushy, in response to his elusiveness in therapy and his hopelessness that anything could be different. It was useful to name this in the room and understand both how this might happen and his contribution to keeping others engaged with him in this way. The therapeutic relationship can become a very powerful part of the mutative experience in DIT. I have found this way of working in the transference is often experienced as less persecutory by patients, perhaps because we already have agreement about the focus of the work and because the transference is used judiciously to illuminate that focus.

ENDINGS IN BRIEF WORK

In brief work, the ending is present from the beginning of therapy and we work actively with this throughout the 16 weeks. When we get to session 12, we prepare our patients for a 'goodbye letter', summarising the work. The therapist drafts this letter for the 13th session.

Patients have a range of fantasies about the meaning of both the letter and the ending. We work very actively with those fantasies and try to put words around the particular sense our patients make of the ending. How does the ending tie in with their childhood experiences? Do they feel replaced by another, more worthy, patient? Do they feel we have grown bored of them and are discarding them?

Sharing the goodbye letter is often an evocative and charged experience. My first DIT patient burst into tears as I was about to read the letter to her. What emerged when we explored her reaction was her fear that I would whitewash her struggles. Her relief at reading the letter was palpable, as she realised that I acknowledged her struggles and the areas she still needed to work on.

The letter does several things: it is a summary of the patient's background and referral, which informed the IPAF; it sets out the IPAF, the pattern we have worked on throughout the therapy, as well as detailing the various coping strategies the patient has employed in the face of it; and it points out what happened over the course of therapy, the changes the patient was able to achieve, and the remaining unfinished business. With 12 sessions behind us, we may be able to anticipate the effect of the upcoming ending or events in our patient's life that may be worrying for them. The letter also addresses the impact of this pattern on the therapeutic relationship. The letter is presented as a draft so we can continue to collaborate around its content as we conclude therapy. It is important that patients feel they can contribute towards it, so that it functions as a record of their experience and a transitional object to consolidate the work and assist with relapse prevention.

we are on the lookout for our patients' resistances and defence mechanisms that may get in the way of making changes, both consciously and unconsciously

CASE STUDY TWO: ALIYA

Aliya came to see me for DIT because she was depressed after being diagnosed with breast cancer in her early 50s. She grew up in Pakistan as the youngest and only daughter in a family of five. She said that being female was never valued in her family; her brothers received preferential treatment. She came to the UK through an arranged marriage and although she hoped her partner would have more progressive views, she was disillusioned at finding herself in a similar situation to her family of origin. She was unable to have children and felt distanced from other women in her community, feeling she had failed as a wife. She found refuge in her work as a bookkeeper; however, since becoming unwell, she had had to take time off work and no longer felt validated there. She was aware of a growing sense of anger, particularly towards her husband and, on one occasion, she admitted that she had lashed out at him physically.

We identified the focus of our work together as the way Aliya experienced herself as 'second best' and expected others to be critical of her, resulting in feelings of anger and shame. We also saw how the pattern could reverse itself: Aliya would be the critical one, judgmental of others and furious at the way they were treating her. At its most extreme, this happened when she became violent towards her husband and it resulted in her feeling even more worthless. Taking up this reversal is part of the dynamic focus of DIT; it involves taking back the aspects of the self that are disowned and projected onto others. Some patients cycle through the IPAF, repeatedly switching from the self to other experience. Since this is an object relationship, we can also expect to find an internalised IPAF at play, and occasionally we may explore the way the patient can, in the example of Aliya, treat a vulnerable, second-best part of themselves with criticism and derision. Ultimately, DIT is an interpersonal therapy and we work in the domain of here-and-now relationships; the patient's early experiences are embedded in the IPAF. In this brief approach, we do not routinely make interpretations linking to the past.

With Aliya, we recognised the way she expected to find in me a critical, belittling therapist. She thought I would tell her it was all her fault and that she was getting things wrong in her marriage and her life. This critical voice chimed with both her parents during her childhood, as well as her husband, mother-in-law and one of her employers in the present. It was a real struggle for Aliya to concede that change was possible and for us to agree a goal for our work together. Over time, she was able to find some relief in identifying and exploring these patterns and the sense of being a waste of time. During therapy, Aliya's sense of being always 'second-best' began to fade. We were also able to consider the way her difficulties interacted with her husband, and she began to have a different appreciation of his point of view. As the work came to an end, there was a brief resurgence in her low mood and anxiety, something we often find because the ending reactivates attachment anxieties. Yet, with the help of the IPAF, we were able to make sense of this and her fears about being left behind.

WHO MIGHT BENEFIT FROM DIT?

I find it useful to have DIT as one of the approaches to consider when seeing new patients. Not everyone can make use of longer-term psychotherapy. Some patients benefit from the more active, circumscribed and supportive stance that DIT offers, as well as the focus on mentalising. Therapists, too, may find it useful to work in short-term treatments alongside open-ended cases, particularly those therapists who are moving towards retirement and have a time-limit in their minds. I have always found brief work a refreshing reminder of the resilience and creative capacities of patients. Sometimes, we can join patients on their journey for a short while and help them identify a core, repeated interpersonal pattern that is holding them back. This can allow them to move forward in a more constructive way. Occasionally, people require more help, and in those cases, I feel more confident that, after completing DIT, they can make good use of psychodynamic work.

WHO CAN TRAIN IN DIT?

The current DIT training is designed for those people who have already demonstrated the psychodynamic/analytic competencies, as evidenced by a minimum of a year of personal therapy, 150 hours of supervised practice of psychodynamic therapy and a course in psychoanalytic theory. It is a five-day training programme that leads to supervised practice of two cases. There is a new proposal to make DIT accessible to a wider audience, including counsellors, psychological therapists and third-year psychology trainees, and to open up the entry criteria that have served as a barrier to eligibility for DIT training. We anticipate that Health Education England will adopt this extended DIT training, which will teach and develop core DIT competences, so that DIT is better represented in IAPT services and patients have a greater choice of therapy. IAPT services are facing ever-increasing pressure to meet performance targets, leading to a privileging of numbers over quality and treatment choice. It is clear that DIT's 16-session model poses certain challenges in this environment. However, the current approach of restricting IAPT services to even shorter-term work represents a false economy, often resulting in a 'revolving door' service. I believe that a more substantial one-off investment in 16 sessions of DIT represents a more cost-efficient and effective treatment over the longer term. ■

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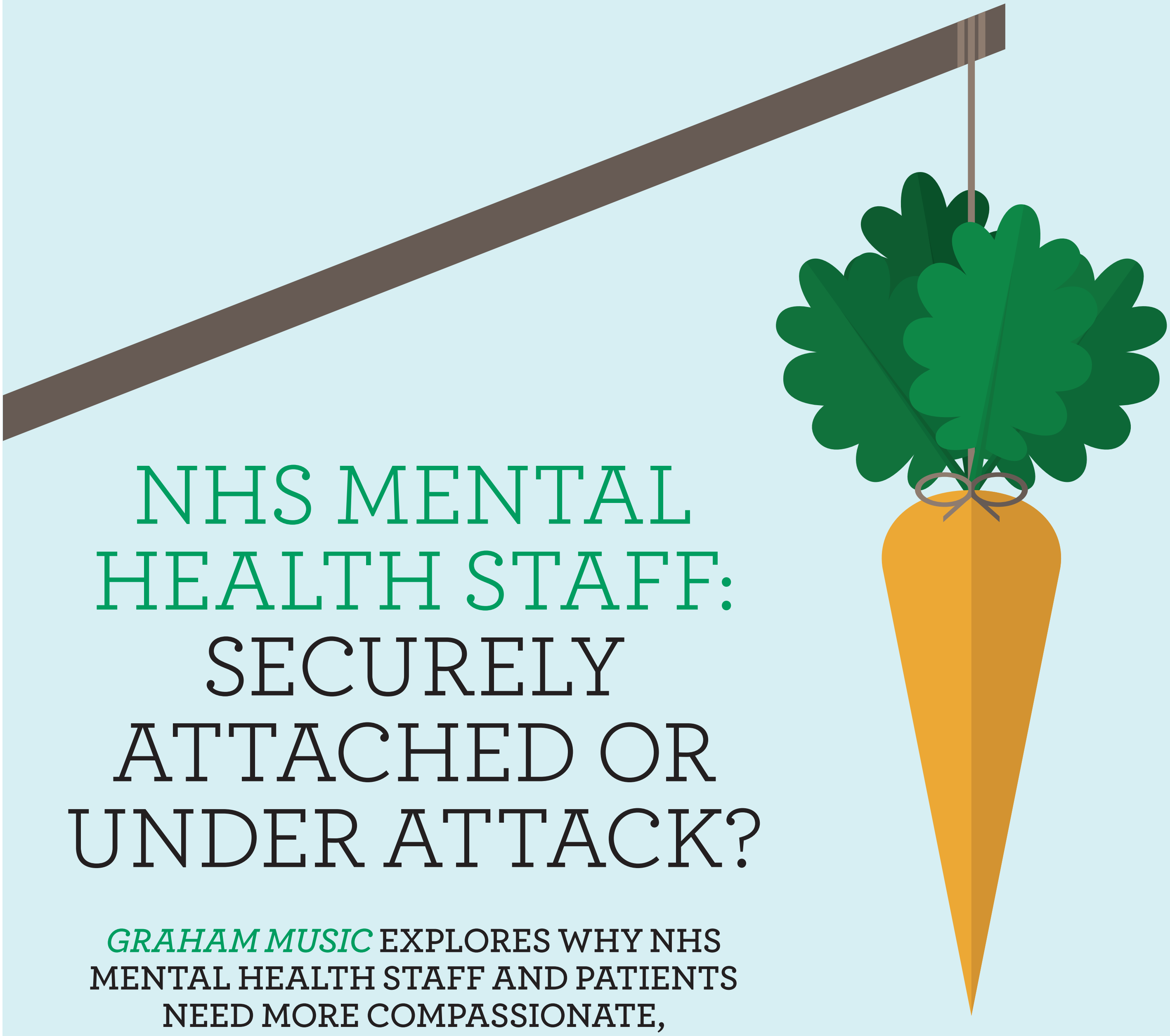
READER RESPONSE

The author would welcome feedback on this article. To contact her, please email deborah.abrahams@icloud.com or DAbrahams@tavi-port.nhs.uk

Details of DIT training dates can be found on the Anna Freud National Centre website (www.annafreud.org), as well as the DIT website (www.d-i-t.org).



NHS MENTAL HEALTH STAFF: SECURELY ATTACHED OR UNDER ATTACK?

GRAHAM MUSIC EXPLORES WHY NHS MENTAL HEALTH STAFF AND PATIENTS NEED MORE COMPASSIONATE, EMOTIONALLY SECURE SETTINGS

Although attachment theory developed as a body of research to study children's development, some of its insights are extremely pertinent, if not crucial, to organisational life. This article recaps key concepts in attachment theory and suggests helpful areas of applicability to work contexts, particularly mental health work in the current NHS. It suggests that there are serious costs to current workplace cultures, such as carrot and stick management, high pressure workloads and increasingly competitive environments. The risks include a diminished sense of safety and security, increased burnout, higher levels of staff turnover and, most importantly, a poorer service to our clients, as we as therapists risk shifting out of more empathic and reflective ways of approaching our work.

A fundamental tenet of attachment theory is that we are an adaptive species, adjusting to survive and fit into our environments, whether they are calm and caring, or competitive and aggressive. Each kind of environment will affect and sculpt our brains, bodies, minds and even how our genes are expressed. The child raised in chaotic, violent surroundings will often become watchful, vigilant and untrusting, all of which are appropriate responses to help manage in such an environment. Such a child might then develop an ambivalent or disorganised attachment style, finding it hard to relax or trust. If that same child had been born into a family very dismissive of emotions, they would tend to become avoidant of emotional contact or of their own emotions. On the other hand, a child raised in a loving, attuned and emotionally sensitive environment usually develops a secure style, being more trusting and playful, relating well to peers and having a good capacity to emotionally self-regulate. Each adaptation aids survival initially, even if it can cause problems later.

We use very different parts of our brains when in different moods, or in different contexts, such as when in a loving environment or under threat, whether at work or elsewhere. When threatened, we tend to become aroused, tense up and resort to primitive survival responses, such as fight or flight, or even freeze.[1] Our physiology becomes geared to surviving the threat in front of us. Other capacities, such as compassion, empathy or higher order thought processes, go into abeyance when we feel stressed, fearful or endangered.

While early experiences can have a long-term and profound effect, as all counsellors know, we are constantly affected and influenced by our current environments. This, of course, includes friends, family, counsellors and our work environments. If we are subjected to constant top-down management pressures, for example, we are likely to become anxious and vigilant, and not feel as valued as we would do if our skills and competencies were seen as worthwhile and encouraged. When, under the work cosh, we feel more stressed, fearful and less valued, this breeds a whole constellation of emotional, bodily and mental states.

Current mental health work contexts increasingly feel pressurised and overly fast paced, with huge waiting lists demanding a speedy turnover of clients. IAPT services are perhaps typical of this. Burnout is not uncommon, and top-down management, inspection cultures and the accompanying back-watching are par for the course. NHS services are increasingly tendered out, often to the public sector. In such environments, the deep-seated values and hard-earned skills of therapists have little space to flourish.

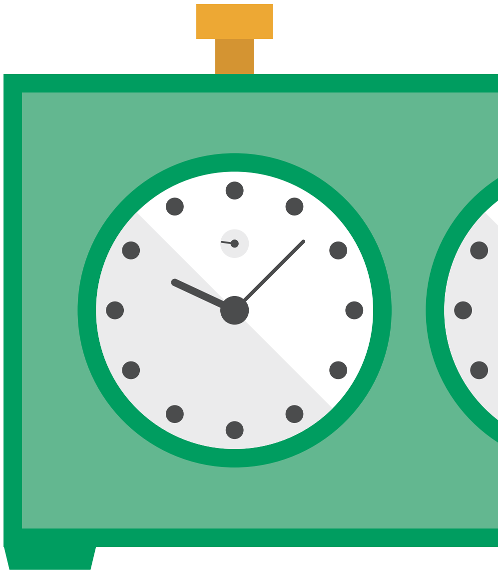
Most of us entered the work we do from a sense of vocation, the desire to contribute and a belief that we can make a difference. Increasingly, we are seeing management cultures that assume a carrot and stick model, based on a belief in the need to control or cajole, and on distrusting people's intrinsic motivations to do a good job. Constant pushes to increase 'productivity' and get people to do more for less have led to more controlling cultures, which can backfire as people feel less inclined to go the extra mile. Employees become resentful, distrusted and reactive. When time becomes equated with money, then the ability to be in the moment and be satisfied with what we are doing diminishes, as does the wish to volunteer or act altruistically.[2] Ariely[3] asked people to do a boring task, such as dragging as many circles as they could from one side of a computer screen to the other. Some were given a reasonable sum of money for this (five dollars), others were offered only 50 cents, and still others were asked to do this 'as a favour'. Maybe surprisingly, the people who scored highest were those asked to do it as a favour. The public sector runs on goodwill, with people going the extra mile out of a sense of duty, or care, or love of the work. Such states of mind are under increased threat in the current climate, as goodwill declines in the face of increased demands and less trust or autonomy.

Just like the child who develops a secure attachment relationship with an attuned, thoughtful and caring parent, when working in an environment that feels safe, supportive and mutually caring, a range of brain areas central to empathy and understanding become more active, and reward circuits linked to co-operation are activated. When people in experiments play a financial reward game, those who co-operate have more activity in brain areas central to empathy. We have evolved so that working together is its own reward.[4]

Competitive environments give rise to very different motivational systems. Often, the stress responses of the sympathetic nervous system, such as fight-flight, kicks in,[5] and we experience symptoms such as an increased heartrate, sweating, quicker breathing, tension in the body and more. When either this or our more primitive freeze responses are active, we are not predisposed to feel relaxed, co-operative or empathic. We all need this arousal system at times, but it is not conducive to compassionate public sector work. In the long term, it leads to disaffection, burnout and poorer work. It is no surprise that a British Psychological Society (BPS) report last year suggested that almost 50 per cent of NHS psychological therapists felt like failures, and similar numbers were depressed.[6]

The aspect of our autonomic nervous system that is central to secure attachment and to both feeling good and being open to others depends on a sophisticated (ventral) branch of our vagus nerve, sometimes called the 'smart vagus', which connects our brainstem, heart, stomach and our facial muscles.[1] This will be firing when we get that warm glow in our chests when with someone we like, or when we feel safe and at ease or appreciated. Physiologically, it leads to a lower heartrate and blood pressure, better digestion, more relaxed states, deeper breathing and enhanced digestive and immune systems. This system stops working when we feel anxious or threatened but needs to be cultivated if we are to ensure workforces that experience wellbeing and satisfaction, and are committed to their jobs for the right motives. When in our threat system, we cannot be present to our clients in the way they need us to be.

Even low levels of anxiety can lead to this system being turned off, and most of us will admit that we are not very nice when we are in a rush or anxious. Another classic experiment showed this.[7] Theology students were instructed that they had to give a talk in a nearby hall. Some were then told that they had to hurry as the talk was very soon, while others were told that they had plenty of time. Some students were instructed to give their talk about the parable of the Good Samaritan, while others talked about a non-helping topic. An actor was told to look as though he was in trouble and was positioned en route to the talk. Usually, being primed with the Good Samaritan story would increase the likelihood of any of us offering help to someone in distress, and presumably even more so for theology students. Interestingly though, of those in a hurry, only 10 per cent stopped, as opposed to 63 per cent who had more time, irrespective of the talk they were to give. Stress, pressure, busyness and anxiety, even in small doses, make us less caring and other minded. Chronic levels have an even worse effect.



In another famous experiment[8] from the 1970s, a dime was sometimes left in a phone booth and at other times no money was left. Random people were observed using these phone booths, and as they came out, an actress pretended to drop a sheaf of paper. Fascinatingly, 84 per cent of the people who had unexpectedly found a dime helped the person who supposedly had dropped the papers, while only four per cent of those who did not find a dime offered to help. Of course, a dime was a very insignificant amount of money, even in 1972, but when the world feels like a more beneficent place, we tend to respond more kindly. Both adults and children generally are more generous when they are in better moods. Even toddlers become more helpful after they have been shown pictures of people who are nice, such as dolls cuddling.[9] Care for others tends to increase when we feel good.[10] Feeling good and being altruistic seem to constitute a virtuous circle, good acts fuelling good feelings, which, in turn, fuel good acts.[11]

Having one's feelings understood and empathised with, as in a secure attachment relationship or with a benign boss or work colleagues, makes us feel safe, leads to higher vagal tone, more emotional flexibility, a better functioning oxytocin system and more openness. It increases the likelihood of being empathic oneself and of wanting to help others, as well as of a healthier workforce. A critical, intrusive and unpredictable boss will lead to a scared or disaffected workforce, showing the kind of vigilance seen in ambivalent attachment relationships. On the other hand, a withdrawn, distant manager will lead to us being cut off and unmotivated, as in avoidant attachment. Of course, some of us are more likely to accept such conditions than others, I imagine linked to our own values and attachment styles.

A task of mental health professionals, managers and policymakers is to enable the conditions for the development of the sophisticated social, biological and psychological systems linked to feeling more at ease, happy, healthy and more caring. Ultimately, feeling safe and cared for, and not too threatened, opens up all kinds of possibilities for empathic atmospheres. This happens both inside secure attachment relationships and in safe social situations, in caring work environments, families or communities.

Kasser[12] analysed the impact of materialistic values on individuals and society. He calls these 'extrinsic' values, denoting being motivated particularly by how one is perceived by others. The opposite of extrinsic values, both he and others call 'intrinsic', meaning valuing a cluster of attributes like being community- and family-minded, being kind to others and living by deeply held beliefs. All too frequently, such materialistic values come with emotional insecurity and unhappiness. More materialistic desires are often an attempt to compensate for not feeling very good inside, acting as defences or ways of coping with inner distress.

The current public sector, including mental health services, is increasingly marketised and monetarised, as well as more competitive. Such an environment can turn off intrinsic motivation and make us more self-interested and less at ease. In another fascinating experiment, subjects were given words to re-arrange into sentences. Some had in front of them a random selection of words, whereas others had similar ones but also some words linked with finance, such as 'profit' or 'high salary'. After this task, they had a more complex puzzle to do, and they could both ask for help and offer help. Those who compiled sentences using the financial words took about five minutes longer to ask for help and were also less likely to offer help.[13] This is a small, short experiment but it is clear that, over time, working in increasingly market-led cultures will have a profound effect.

In another simple study,[14] people were asked to imagine there was a water shortage, and the available water should be shared with several other people. The water users were either described as consumers or as individuals. Those described as consumers were less trusting of the others, less helpful and less likely to work in partnership than those designated as individuals. The only difference between the groups was the label, and personality differences between the participants did not affect the result. This is very similar to another study[15] in which two groups played exactly the same game. For one group, it was called the 'Wall Street Game', and the other 'The Co-operation Game'; 70 per cent of those playing the 'Co-operation Game' did indeed co-operate, as opposed to only 33 per cent of those playing the 'Wall Street Game'. There are lessons here about how more market-based messages and values might diminish co-operative and helpful behaviour.

Such research can be linked to the effects of creeping monetisation and marketisation, which has been widely documented. Sandel[16] has, for example, described how it is now possible to buy and sell what used to have no price, whether a traffic-free lane in a motorway, priority access to flights, access to politicians, medical care and much more. Market values encourage a more extrinsic and less relationship-oriented approach to many areas of life. Indeed, one recent study showed that, while people mostly don't approve of practices such as child labour, land grabs or cruelty to animals, when induced into a market mentality, they are far more likely to override their principles.[17] Our values shift, depending on context. In this study, people induced into a non-market state of mind would not accept money if doing so led to harm to an animal, whereas in a market-based state, they went along with less moral behaviour if it enhanced their success.

Rather than money, it is the pursuit of intrinsic motivations, the motivations that took most of us into mental health work, which increases wellbeing. These might include committing to a career to which one is dedicated, valuing intimacy and the capacity to be vulnerable, or a belief in a greater good than our individual ambitions. Research by Henrich and colleagues[18] showed that social and work contexts where there is more equality, mutual respect and social cohesion are the ones where people tend to feel more trusting, believe that each has responsibility for others, and also experience greater emotional wellbeing.[19]

Recent psychology research[20] has differentiated between two very different kinds of happiness and, interestingly, each seemingly has different effects on our health and wellbeing. Some researchers[21] recently divided a relatively large sample in terms of whether their happiness was of a more hedonic kind, such as that derived from buying consumer goods or having an exciting time, or of a more eudemonic kind, that is happiness derived from engaging in meaningful activity based on personal values, such as a passionate interest or a cause. The two kinds of happiness had surprisingly very different effects, right down to a genetic and cellular level. Those whose sense of happiness and wellbeing derived from being motivated by a strong sense of meaning and purpose had lower levels of inflammation and higher levels of immune response and antibodies than those whose version of happiness was more hedonic. In other words, the good life, as the Greeks might have defined it, gives rise to emotional and physical health, a win-win situation. On the other hand, if we are motivated by a more hedonic buzz of immediate desire or a wish to achieve or consume, then physiologically this is not so good for us. It leads to more inflammation of our cells and worse health.

The kinds of states of mind that we see in secure attachment are exactly those that are dominant in atmospheres of mutual trust, co-operation, empathy and compassion, those in which our ventral vagus system is firing away, in which we feel at ease and open, and look forward to the next moment. This, I think, might be under threat in current mental health work settings, mirroring the increase in narcissism in contemporary Western market societies.[22] It is no coincidence that the decline in empathy found in American studies[23] parallels an increase in dismissive adult attachment styles.[24] It is possible to develop work cultures based on more compassionate leadership styles, styles which enhance trust, mutual support, genuine dialogue, and working without constant fear of reprisals, all of which lead to more security and increased empathy.[25] In fact, higher levels of dispositional empathy have recently been linked with lower levels of burnout, and the development of more empathic, safe and caring cultures is likely to benefit the workforce and our clients.[26] Similarly, we know that, in cultures where empathy is higher, we also see higher levels of collectivism, agreeableness, conscientiousness, self-esteem, emotionality, subjective wellbeing, and prosocial behaviour.[27] This must be worth fighting for.

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READER RESPONSE

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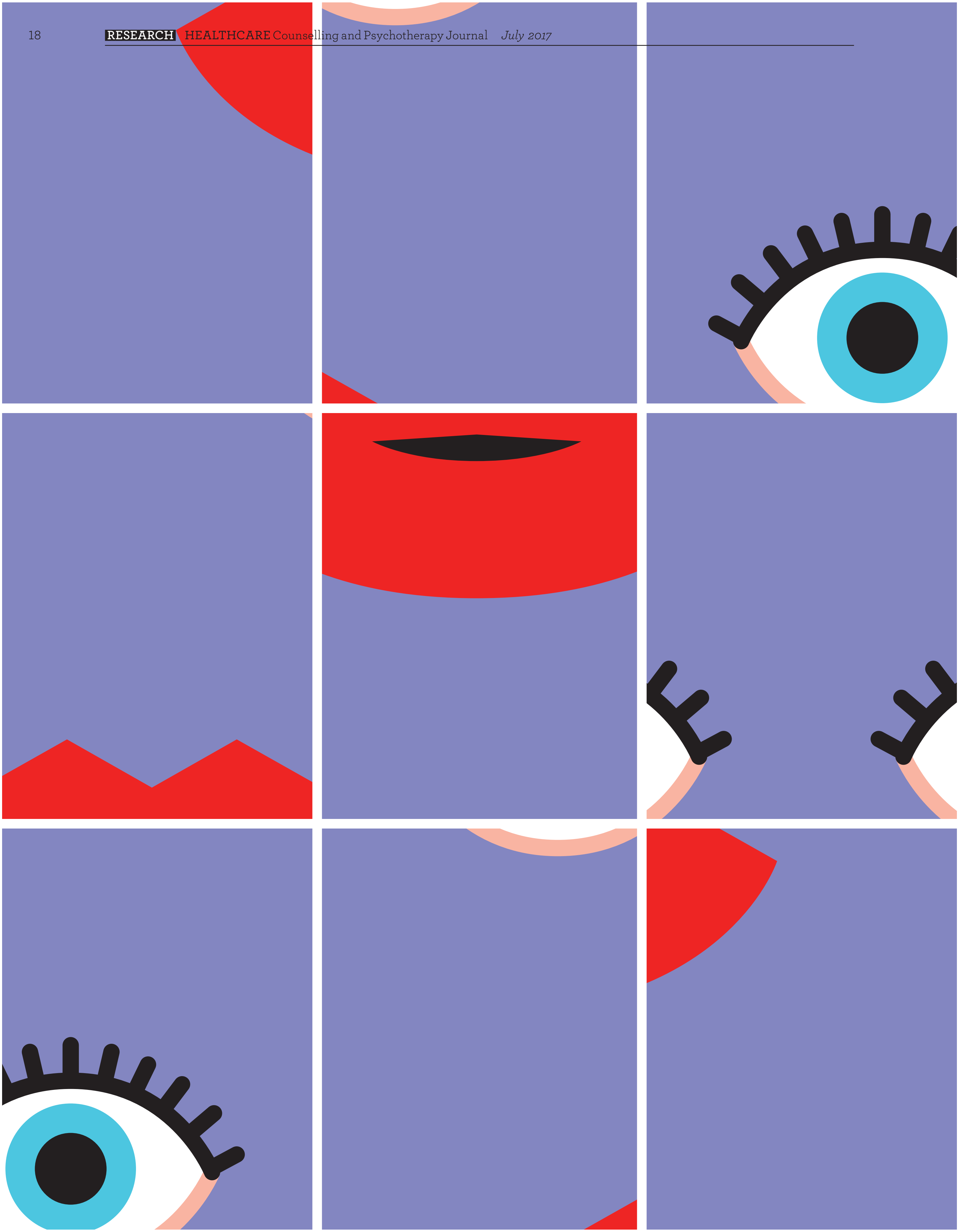


AFFIRMING IDENTITY AND CONTROL FOR PEOPLE WITH DEMENTIA THROUGH PERSON-CENTRED APPROACHES TO SUPPORT

KELLY BIRTWELL AND *LINDA DUBROW-MARSHALL* REPORT ON A BACP-FUNDED STUDY INTO THE INSIGHTS OF PEOPLE WITH MILD DEMENTIA AND THEIR EXPERIENCES OF PSYCHOLOGICAL SUPPORT

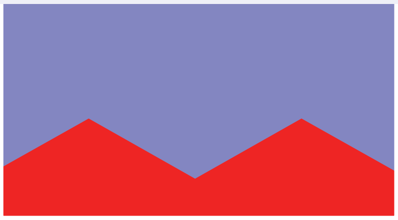
Carol lives with her family in the leafy suburbs of Manchester. Sat in the living room, sunlight streaming through the bay window, she spoke about the time she gave up working: 'I was a teacher. And I knew that I couldn't do things anymore. You know, I had a computer and, erm, I looked at… I looked at a PowerPoint and I just couldn't work it out at all. And I knew then that I couldn't continue.'

Carol is 59 years old and has Alzheimer's disease, the most common type of dementia. Over time, Carol had begun to notice changes in herself and found she was struggling to carry out some of her usual day-to-day activities. As Carol's quote above illustrates, well-developed skills such as using a computer were no longer readily available to her. Dementia, often mistakenly thought of as forgetfulness and a part of growing old, is actually caused by disease of the brain, with symptoms that are far more wide-ranging. People under 65 can be affected, as well as older adults.

Dementia is, without doubt, one of the biggest challenges facing our society. More than 850,000 people in the UK are living with dementia, supported by over half a million unpaid carers, who are very often the family and friends of the person with dementia.[1,2] The number of people suffering from dementia is expected to double in the next 30 years[3] and for people over the age of 55, dementia is the most feared disease.[4]

Carol's mother had been diagnosed with Alzheimer's disease before she died, so Carol had some knowledge of the condition. Although Carol suspected something was wrong, she put off going for the assessments: 'I didn't go ahead with it because I just couldn't bear to hear it.' Carol said she was also concerned about the implications for her family.

Being diagnosed with dementia can have a devastating impact on the person receiving the diagnosis, as well as their friends and family.



When we meet or work with people with dementia, we must remember that a person with dementia is first and foremost a person. We must see the whole person rather than the person defined in terms of their illness

It can affect self-esteem and the sense of ‘personhood’.[5] According to Kitwood, ‘personhood’ refers to ‘a standing or status that is bestowed on one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust…’[6]

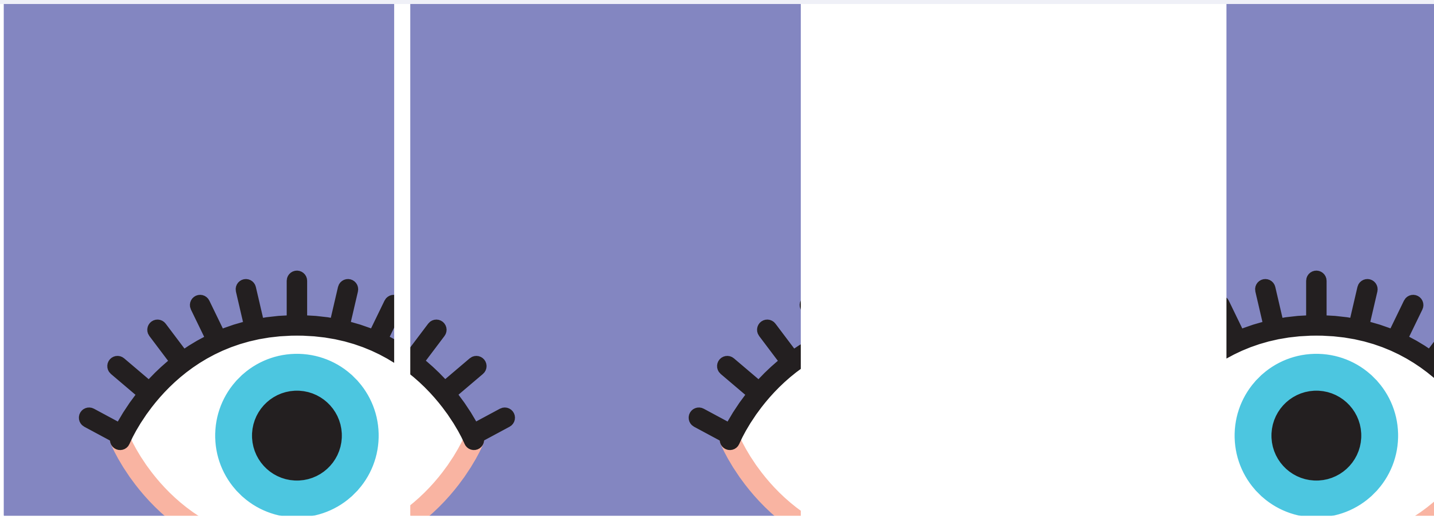
It is, therefore, vital that people with dementia are supported to make sense of the diagnosis and to make positive adjustments to their lives,[7] which allow them to maintain a sense of personhood and integrity. There may be a lack of understanding from others about the condition, and this, coupled with the stigma of dementia, can have a negative effect on quality of life.[8] Following a diagnosis, people often report losing friends and feeling lonely,[8,9] and, of those who took part in a survey by the Alzheimer’s Society, more than half said they had felt anxious or depressed recently.[10] Carers of people with dementia experience higher levels of stress than other caregivers,[11] and spouses of people with dementia are four times more likely to become depressed than spouses of people without dementia.[12]

In 2012, the Prime Minister launched a national ‘challenge on dementia’[2] in order to improve dementia care and research. A second challenge was launched in 2015,[13] which stressed the importance of support to improve quality of life after a diagnosis. The fact there have now been two Prime Minister’s challenges on dementia shows how important the Government views tackling the condition and supporting those affected. It also highlights the increased awareness of the issue.

According to the National Institute for Health and Care Excellence (2013),[14] people with dementia should have choice and control in the decisions that affect their care and support. With this in mind, we wanted to know what people with dementia thought about the different types of psychological support they might have experienced or could be offered. With small grant funding from BACP, we conducted a qualitative study to explore the attitudes to, and acceptability of, psychological support for people with mild dementia, from their own perspective. Five people with mild

WHAT IS DEMENTIA?[16]

Dementia is not a natural result of ageing, it is a neurodegenerative syndrome. Although the majority of people with dementia are over 65, in the UK more than 40,000 people aged 65 or under have ‘young-onset’ dementia.[10] Dementia is caused by a number of diseases that share similar characteristics. Alzheimer’s disease is the most common, and other types of dementia include vascular dementia, dementia with Lewy bodies, Parkinson’s disease dementia, frontotemporal dementia and semantic dementia. Symptoms can include memory loss, mood changes, loss of motivation, depression, and problems with concentration, communication and reasoning. As dementia progresses, the symptoms become more severe and people may experience problems carrying out day-to-day activities, as well as behavioural and psychological symptoms of dementia (BPSD), such as wandering, agitation, disinhibition, hallucinations, delusions and aggression. Symptoms differ according to the type of dementia, and it is important to note that symptoms will vary from person to person. Each person with dementia will have their own unique needs, and treatment should be tailored accordingly. At present, there is no cure for dementia but some medications may help to control the symptoms for a time, and psychosocial interventions can support people with dementia and their carers to live well.



dementia were interviewed, including Carol, quoted above. The age of participants ranged from 58 to 79 years old; one participant was male and four were female. All were accessing support from local Memory Assessment Services or the Young Onset Dementia Service. While each person's story had its own unique quality, themes of loss, coping and support consistently appeared in all of the interviews.

Being diagnosed with dementia constitutes a major life change and the people who took part in our study all acknowledged a sense of loss, including the loss of abilities and loss of identity. The loss of abilities included memory problems, and the accompanying frustration of not being able to remember: 'I know I've only just said something about it and then I just can't remember and it's frustrating' (Barry). As mentioned earlier, Carol spoke about the problems she encountered using a computer, which led to her giving up work and losing her role as a teacher. Another participant spoke about losing her friends and place in the community: 'You be rejected by your friends. You be rejected by many people [cries]' (Clara). So, as well as the symptoms of dementia, people also had to cope with their changing sense of self and the way they were treated by others, and issues of personhood.

The participants coped with these changes and losses in a range of ways. Some participants described feelings of denial soon after diagnosis: 'I suppose I put my head in the sand' (Carol). There was also a tendency to assess their abilities, problems and level of coping against others as benchmarks: 'I don't want to be one of them people that goes out and starts wandering about… that worries me a bit. But other than that, I'm not bad' (Beryl).

Staying engaged in daily life and keeping busy were important aspects of positive coping: 'I mean, you have to get on with your life, don't you? And that's what I'll do' (Carol). 'You need a bit of company and you also need something to occupy you, like I knit and I read' (Beryl). Taking part in activities and learning new skills were important. Two of the participants described their experiences at a local gardening group. Carol said how much she enjoyed it and that she had been learning about seed drills: 'the man who does it – I can't remember his name, but, erm, he's very … thoughtful and, erm, he shows you how to do it.' Barry liked to water the plants and viewed this as a valuable role: 'to me, I'm giving them life.' The engagement in activities, learning new skills and even finding new roles (including ones that were nurturing), appeared to offset some of the losses mentioned above, enhancing the sense of self. The individuals could perceive themselves and be seen as functioning people, able to take part in activities with others and to make positive contributions.

In relation to support, the participants told us that knowledge was valuable – knowledge about their diagnosis as well as about available support. People were concerned about a lack of support, not knowing where to go to access support, and the impact of financial cuts on service provision. The most important factor for engagement with support services appeared to be consideration of the person's individual needs and preferences. A person-centred approach is key, and should take account of whether a person is ready to access services: 'I think everyone has to do it in their own time' (Carol).

All of the participants viewed group-based activities positively, such as walking, gardening and support groups. The social aspects of support appeared important in helping to reduce loneliness, fostering a sense of belonging and community, and instilling hope: 'coming here, meeting with all the people, has given me the hope' (Clara). People found it helpful to talk about how they were feeling, either through support groups or counselling: 'you can talk, you know, let things out that you have inside, you know… It was, very helpful' (Joan). The participants were open to trying mindfulness and counselling; in fact, Carol had learned to practise mindfulness while working as a teacher and continued to practise after she was diagnosed with dementia: 'I like mindfulness. Erm, I can sit on the floor and just, you know, be still.'

Although this was a small study involving only five people, it has provided an insight into and a feel for some of the issues that affect people with dementia, their methods of coping and their attitudes to and experiences of psychological support. Personal and social factors are just as important as the biological factors in our understanding and treatment of people with illnesses. The way a person reacts to and experiences the symptoms of dementia, as well as their treatment by 'healthy others' and their reaction to this treatment, are all important factors in the experience of living with dementia.[15]

When we meet or work with people with dementia, we must remember that they are first and foremost a person. We must see the whole person rather than the person defined in terms of their illness. Each person has their own unique personality, ways of coping, preferences and support needs. When we reflected on the research interviews, it was clear that some people were more talkative than others and this made for a more comfortable interview. We can imagine how it might be daunting for counsellors working with clients with dementia for the first time. We encourage counsellors to be patient and tolerant of their own possible discomfort and to use supervision accordingly, just as they would with any other client population, and to give themselves a chance to get accustomed to a potentially very rewarding client group. With person-centred care and support, involving the person in decisions, people with dementia can be supported to live well. Tailored support, a choice of interventions, and involving people with dementia in activities with family, friends and the wider community, can all help to enhance the individual's self-esteem and sense of personhood.

In the words of Ann Johnson, a former nursing lecturer who is living with dementia: 'Dementia is not an identity, it is a label… I have dementia: I also have a life.'[15] ■

HOW CAN WE SUPPORT PEOPLE LIVING WITH DEMENTIA?

A person with dementia is first and foremost a person. It is important not to pathologise and dismiss aspects of the person's mood or behaviour by seeing the disease first. This could result in missing opportunities to provide valuable support. Taking the time to understand the world from the individual's perspective will help to ensure that appropriate support can be offered, and that the support is tailored to meet the needs of the individual. There are some aspects of dementia, however, of which it might be helpful for those working with people with dementia to be aware. For example, problems with memory could mean that people with dementia need reminders or support to attend appointments. Therapists should be aware that people may not accurately remember recent events or the content of some sessions. However, this need not be a barrier to engaging in psychotherapy, and there is evidence that people with mild dementia can engage in and benefit from brief psychotherapy.[17] Some people may experience problems concentrating for long periods, so the duration of activities needs to be considered. For example, there has been research looking at mindfulness courses for people with dementia, where the duration of meditation periods has been shortened.[18] The people interviewed for our study were open to trying different types of psychological support, and particularly favoured group-based activities, counselling and mindfulness.

The British Psychological Society has produced a much-needed guide to psychosocial interventions for people in the early stages of dementia.[19] The guide outlines the different needs that people with dementia might have, and explores the types of intervention that may be helpful for those needs. The guide also provides information about the relevant research evidence and is clearly an important resource for those working with people with dementia.

Personal and social factors are just as important as the biological factors in our understanding and treatment of people with illnesses. The way a person reacts to and experiences the symptoms of dementia, as well as their treatment by 'healthy others' and their reaction to this treatment, are all important factors in the experience of living with dementia

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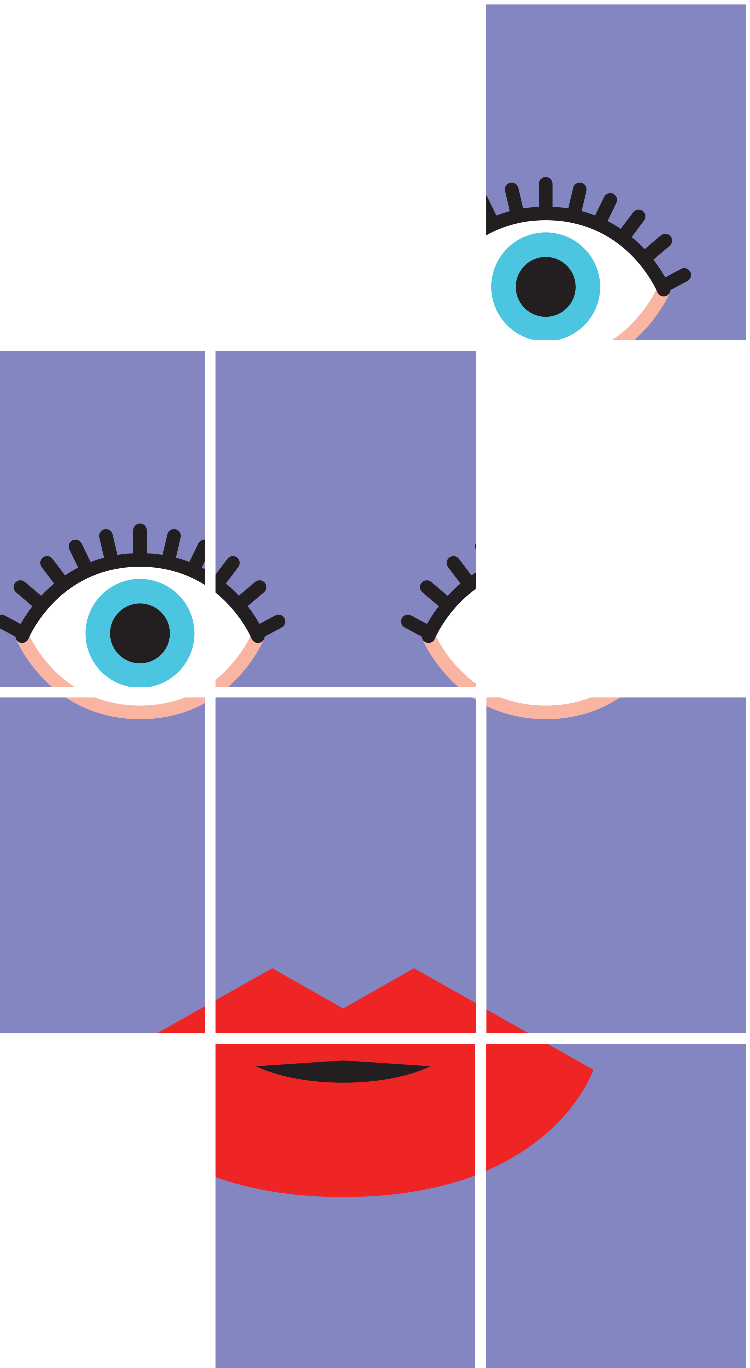

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READER RESPONSE

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THE THIRD SECTOR'S ROLE IN DESIGNING AND DELIVERING NHS-COMMISSIONED COUNSELLING SERVICES: A SCOTTISH PERSPECTIVE

JACQUI TAYLOR REFLECTS ON THE CHALLENGES AND OPPORTUNITIES FACING THIRD SECTOR MENTAL HEALTH PROVIDERS IN SCOTLAND

INTRODUCTION

The Scottish Government's 10-year mental health strategy[1] was launched on 30 March 2017. The vision for the strategy, derived from work by the Scottish Mental Health Partnership, is one 'where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma'.[1] The strategy focuses on achieving parity between mental and physical health, and on ensuring equal access to care, equal efforts to improve the quality of care and equal status in the measurement of health outcomes, as well as raising aspirations of service users and recognising service users as equal partners. While the strategy document itself is welcomed, there is a general feeling across the third sector that the strategy lacks detail and that information about the investment needed to deliver it is vague.

Public sector services across the UK are facing significant cuts and are in the throes of transformational change and service redesign. This article aims to highlight some of the very real challenges currently facing mental health service providers in the third sector and the public sector in Scotland. Utilising the example of Lifelink – a Glasgow-based mental health service provider – the article seeks to explore the role that the third sector plays in delivering commissioned services in an era of public sector cuts and economic uncertainty. It suggests that there are still opportunities to be harnessed, if we really think about how we can deliver services differently, ensuring that we are fit for the future.

THE CHALLENGES AHEAD

The current and future challenges facing Scotland, and the UK in general, are significant across all sectors. On the political front – and perhaps at the forefront of our minds – are the negotiations for the UK to withdraw from the EU, the implications, or benefits, of which are still very much unknown as we work through the negotiation period. We need to be mindful that this has the potential to have a significant financial impact on the third sector, and of course the public sector. Many organisations in these two sectors currently access European Social Funding (ESF) and match this against other funds to deliver services. There are understandably concerns in the third sector about the consequences of Brexit for ESF funding. Funding opportunities have already been diminishing in recent years for the third sector, with grant funders, such as the Big Lottery Fund, moving to a collaborative and partnership approach to delivering services; this comes at a time when many third sector organisations are operating right at the edge of financial stability.

Meanwhile, people need services and they need help and support at the right time. Stress is on the increase, as people face the daily challenges of balancing work, families, health and finances. Our services are seeing more clients with complex needs, and statutory services are bursting at the seams, with the demand for counselling, health and wellbeing services on the increase. Delivering more for less is a real challenge for all of us, made more complex by the current and future challenges facing our political landscape.

In order to address these challenges, third sector organisations need to think differently, demonstrate flexibility and find new ways of working more efficiently. If they are able to do that, then there will be more scope and opportunity to tender for commissioned services, reducing the need for grant funding. The landscape for commissioned services in Scotland has been changing over the last few years, most recently following the Royal Assent of the Public Bodies (joint working) (Scotland) Act 2014[2] and the integration of health and social care, for which the legislation came into force on 1 April 2016.[3] Integration is enabling services to radically transform, shifting the balance of care to improve health and wellbeing, and to achieve better service outcomes.

Austerity means that times are tough; the key challenges for many third sector organisations will be in their ability to transform their own services and to be creative and innovative with the resources that they have. Leading a third sector organisation, in a time of diminishing – if not practically non-existent – grant-funding opportunities and a shifting landscape of commissioned services, is not without its challenges. However, I do believe that, where there are challenges, there are also opportunities. I would, therefore, like to share a little about how Lifelink has addressed these challenges and created new opportunities in its journey through the world of commissioned services.

LIFELINK: AN OVERVIEW

Lifelink has operated across Glasgow for the past 25 years, designing and operating services to support people with stress-related, mild to moderate mental health issues and complex needs. As a social enterprise with charitable status, Lifelink exists to provide early and crisis interventions specifically in relation to stress management and mental health improvement. We do this through evidence-based, time-limited interventions, including counselling and personal development. We seek to build emotional resilience within a supportive and accessible therapeutic environment, in particular – but not exclusively – in areas of high deprivation. Our passion is for empowering and engaging people, including clients, staff, partners and stakeholders. Our focus is twofold: firstly, to provide high quality, client-centred services for young people and adults, to support them to be healthier and happier, wherever they live, work or learn; and secondly, to provide a great place to work where staff are valued, respected and developed to reach their full potential.

Lifelink supports individuals who are experiencing one or more of the following: difficulties coping with everyday stress; anxiety and/or depression; personal problems that are causing high stress and negatively affecting them physically, mentally and/or emotionally, such as debt, relationship difficulties, bereavement, unemployment and addictions; trauma; and self-harm or suicidal thoughts. We currently provide the following services:

Where the external environment brings challenges, it also provides opportunities. It brings possibilities to harness innovation and do things differently, to engage the third sector, to build capacity within communities and to increase resilience in those individuals most at risk community-based stress-related services for adults across Glasgow City; school-based counselling services in 42 secondary schools across Glasgow, Renfrewshire and West Dunbartonshire; community-based mental health improvement services for young people in south Glasgow, aged 10–18; youth health service provision in north-west Glasgow; employee counselling services for C-Change and Neighbourhood Networks; and crisis intervention services at HMP Barlinnie, commissioned by the Scottish Prison Service. Our services are mainly commissioned through a competitive tendering process by the health and social care partnerships in Glasgow, Renfrewshire and West Dunbartonshire. Our service commissioners require providers to be open, transparent and mutually respectful to support partnership and co-production, in line with Royal Society for Public Health (RSPH) guidelines.

Lifelink staff are accredited or working towards accreditation with BACP and Counselling and Psychotherapy in Scotland (COSCA), Scotland's professional body for counselling and psychotherapy.

> *Delivering more for less is a real challenge for all of us, made more complex by the current and future challenges facing our political landscape*

We operate all of our counselling services within BACP and COSCA guidelines, and to NHS Greater Glasgow and Clyde's counselling standards. In addition to our skills in therapeutic counselling, as a multidisciplinary team we are also highly skilled in delivering a variety of emotional resilience-building groupwork programmes. Our experienced staff are qualified in a range of other therapeutic practices, including life coaching, reiki, acupuncture, and family and relationship counselling. As we have an integrative approach, therapists work from a range of modalities.

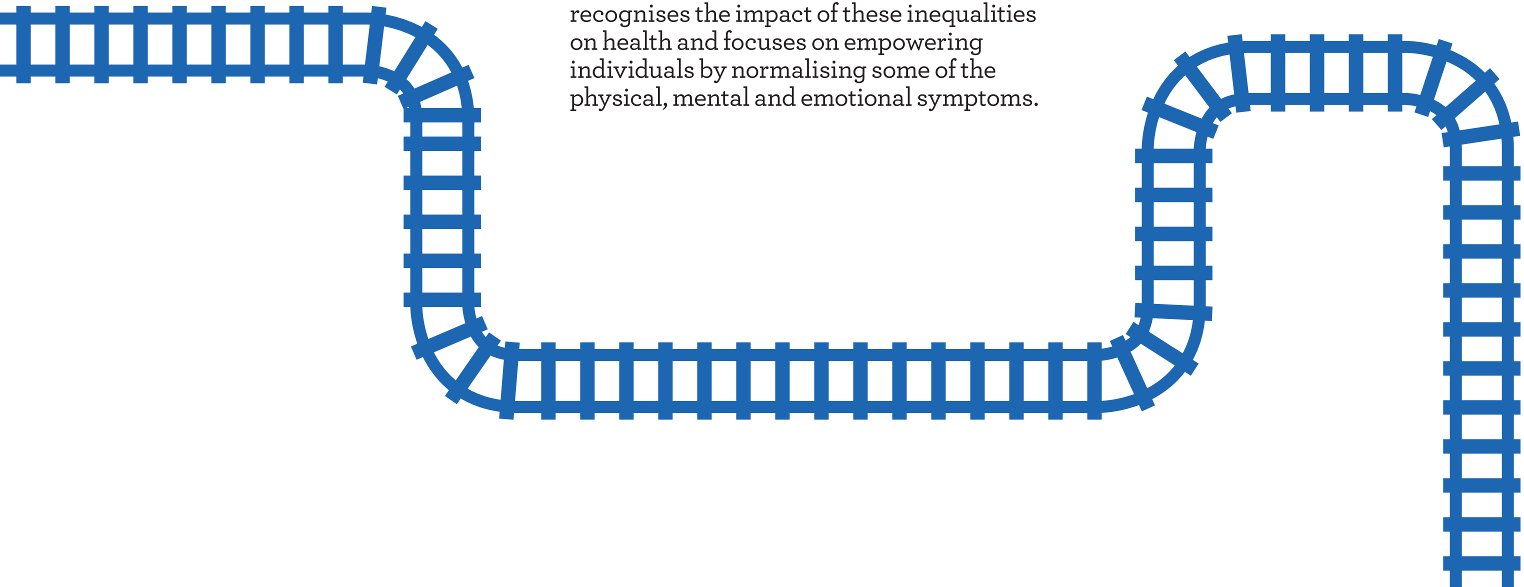
TACKLING INEQUALITY

Our philosophy is social, client centred, holistic and solution focused, viewing people in their entirety – in other words, from a perspective that recognises the relationship between the psychological, emotional and physical aspects and sets individuals and their difficulties within their personal and social circumstances. Improving community health capacity, capability and sustainability, and tackling health inequalities are at the heart of our commissioned services.

Sir Michael Marmot, Professor of Epidemiology and Public Health, has carried out extensive research and produced a report[4] that inextricably links the increased stress levels and reduced mental health created by personal and social inequalities to the onset and progression of physical disease. Life expectancy rates are lower in Glasgow than elsewhere in Scotland; for example, we know that life expectancy drops by two years for males and 1.2 years for females for each railway station on the railway line between Jordanhill (an affluent area of Glasgow) and Bridgeton (a deprived area).[5] Lifelink recognises the impact of these inequalities on health and focuses on empowering individuals by normalising some of the physical, mental and emotional symptoms.

In 2015, the suicide rate in Scotland for males was more than two-and-a-half times higher than that for females.[6] The same set of statistics also indicates that during the period 2011–15, the suicide rate for men was more than three times higher in the most deprived tenth of the Scottish population than in the least deprived decile. *The Men and Suicide report*,[7] which was commissioned by the Samaritans in 2012, indicated that men are less likely than women to seek help until they reach crisis point, and are wary of talking therapies. This research also indicated that misuse of alcohol was implicated in 65 per cent of male suicides. We know from our own service data that only 35 per cent of the clients attending our services are male. Clearly there is still work to be done to reduce suicide rates and tackle health inequalities in areas of deprivation, in order to reduce mortality rates.

Lifelink responds to these challenges by providing a continuum of services, ranging from prevention to early and crisis/suicide intervention (including self-harm), for young people from the age of 10 and for adults. We empower our clients to manage their stress more effectively and to reduce self-harm and suicidal ideation. We also help them recognise, affirm and increase their emotional resilience. We are careful to avoid stigmatising what people may be experiencing as a result of the stress, anxiety or extreme distress that arises from their circumstances. Our services ultimately aim to reduce people's need for medical services and to improve their general health, wellbeing and quality of life in a lasting way and thereby reduce inequalities in health.



WORKING IN PARTNERSHIP

A determination to build effective and real partnership drives Lifelink's multi-agency approach to delivery, recognising the strengths of partner agencies and the limitations of working in isolation. Over the last 25 years, Lifelink has worked extensively to build and maintain high quality partnerships with a wide range of strategic/delivery partners and networks. These relationships enable a community development approach to service delivery. Partnership working has been integral to the success of the organisation and the delivery of Lifelink's services to local people. It has provided a platform from which many successful collaborative projects and innovative developments have been established.

Our networks ensure improved access to services, they raise awareness of mental health issues and they prevent the duplication of services. Our close working relationships with a range of partners enable us to signpost service users to the most appropriate agency to provide support with the issues they currently face.

We have a wealth of experience and proven track records in working in partnership with the Health Improvement Team, Primary Care Mental Health Team (PCMHT) and GPs to deliver services in line with current policy, legislation and research, neighbourhood demographics and level of need within neighbourhoods and communities. This has strengthened the referral pathways and facilitated connections, which support individuals in building resilience. We continue to review and develop services in line with child protection and vulnerable adult policies, NHS counselling guidelines and Caldicott procedures, and we have robust protocols and monitoring arrangements in place for the delivery of services. A collaborative approach to service development is critical for success and is at the heart of our approach.

INVESTING FOR THE FUTURE

As a social enterprise, Lifelink invests any profits back into the business to support innovation and service delivery. Despite cuts in public sector-commissioned services over the last two years, we have been in a strong position to retain staff and deliver 'more for less', without the need to compromise on quality. We have invested in technology, in order to improve our services and to offer choices for our clients and our staff. We are currently developing our counselling services to support delivery via a secure videoconferencing platform at a time that suits the client, as well as our staff team, who may prefer to access clinical supervision this way, reducing travelling and ultimately lowering our carbon footprint.

I believe that we here at Lifelink have an exciting journey ahead, one that I am sure will benefit our clients, staff, partners and stakeholders. We continue to aspire to be the best that we can be; to be leaders in our field; to empower our clients and young people; and to inspire the communities near and far to reduce stigma around stress and poor mental health and wellbeing.

CONCLUSION

Where the external environment brings challenges, it also provides opportunities. It brings possibilities to harness innovation and do things differently, to engage the third sector, to build capacity within communities and to increase resilience in those individuals most at risk. Commissioning the third sector to deliver services brings added value, and the sector has much to offer. Third sector organisations are closer to service users and they help to bring service users to the table by supporting them in making an active contribution to the design and delivery of services. The third sector is well known for its agility, its entrepreneurial and innovative approaches and its ability to work across conventional services structures. Individuals who have a passion for making a difference often work in the third sector, and job satisfaction is their main driver, often resulting in a motivated workforce. At a time of public cuts, when we all need to deliver 'more for less', shifting the balance of services towards the third sector brings huge efficiencies and financial savings, often allowing organisations to access match-funding sources that are not available to public sector partners. We need to harness the experience, skills and resources that we have in organisations and use them collaboratively to deliver the best possible services that meet the needs of our clients. It is clear that third sector organisations offer a valuable and significant contribution to the delivery of counselling services commissioned by the NHS, in Scotland and right across the UK. ■

Jacqui Taylor, CEO of Lifelink, has 25 years' experience in the health, wellbeing and employability sectors in Scotland and has held senior management roles in a number of national and local organisations. A fellow of the Institute of Management, Jacqui has a passion for people and for making a difference.

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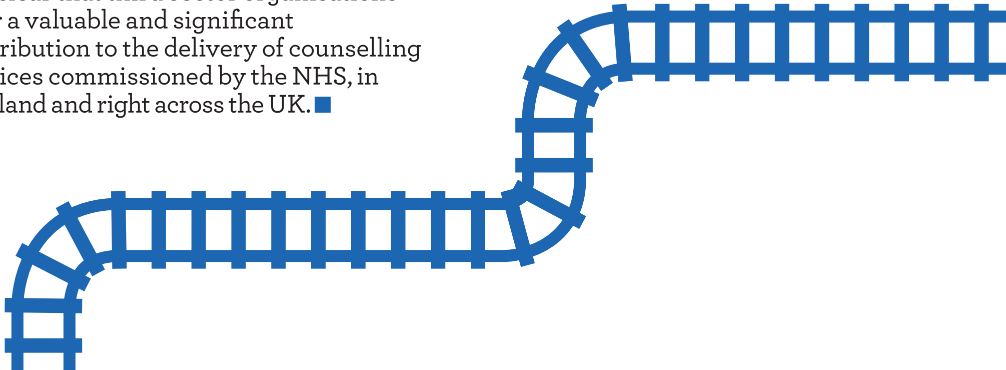
READER RESPONSE

The author would welcome feedback on this article. To contact her, please email JacquiTaylor@lifelink.org.uk



CHANGE AND CHOICE

ELAINE DAVIES

Do you ever feel a sense of being weighed down? Do you ever feel unhappy in the work you do? At some point during your role in primary care, it is quite likely that you will feel stuck, despondent and even restricted in what you can do. Maybe you are in a rut now, or even bored. It could be that there is no career pathway for you, or that you are aching for more responsibility. Perhaps you took the job because it was a lifelong dream but, because of organisational changes, you find yourself being underutilised. You could be under pressure to wear numerous different hats throughout the day. On some days you may feel out of your depth and your competencies stretched beyond your capabilities. Or maybe the context of your work has changed and you didn't see it coming. Perhaps you have feelings of not belonging, or a sense of a disconnect between what the service wants to achieve and what you believe is the right route to travel. Or perhaps you are noticing a mismatch between service expectation and your orientation.

> *Without change, nothing and no-one will grow. Put yourself first, and re-engage with what inspired you before or what gave you the incentive to work in primary care. With good support, we can all make choices that engender satisfaction and wellbeing*

If not explored, these experiences – and any others that limit you in your work – can have an effect on your wellbeing. They are likely to lessen your ability to perform at your best. If left, the feelings of discontentment could potentially show themselves in the work you do with clients. Sometimes, the restrictions or limitations can bring stress, anxiety and depression. How will you manage this and with whom will you discuss it?

It is important not to get embroiled in the feelings. As practitioners, supervisors, trainers and writers in talking therapies, we rely mainly on the internal supervisor for our barometer of feelings. Pay attention to yourself, reflect, write, or even go back to therapy. Individual supervision, team meetings and peers are other sources of support to guide us and help us understand the range of feelings that accompany limitations and restrictions. You will need someone to listen and help you come up with a plan, so seek out help from your supervisor or manager. If you are feeling underutilised or have skills that are stifled, ask to do more. If help from a supervisor or manager is restricted, find someone else in the same organisation to talk to. Most organisations these days have a duty to provide the possibility of 'confidential discussions', mentoring, coaching or even whistle-blowing. We can also turn to peers outside the organisation, such as those within our professional bodies. If you are unable to find satisfaction within work, find an outlet outside of work.

Change is, of course, inevitable. Services and people go through changes, some of which are expected, others forced, and some come unannounced. Change, however we approach it or however it comes towards us, will no doubt have an impact on our wellbeing. For some, change will stir up emotions from the past – perhaps uncertainty, fear and even sadness. For others, it will be a relief and bring excitement and new beginnings. Without change, nothing and no-one will grow. Put yourself first, and re-engage with what inspired you before or what gave you the incentive to work in primary care. With good support, we can all make choices that engender satisfaction and wellbeing. ■

Disclaimer: these are the views of Elaine Davies, not of 2gether NHS Foundation Trust

***Elaine Davies** is Clinical Team Manager at 2gether NHS Foundation Trust. She is a BACP accredited counsellor and supervisor and a BABCP accredited CBT practitioner, supervisor and trainer. To contact Elaine, please email hcpj.editorial@bacp.co.uk*

MOVING ON: FROM COUNSELLOR TO COUNCILLOR

MICHAEL LILLEY

FROM CAMPAIGNING COUNSELLOR TO GREEN COUNCILLOR

This is my last column in this journal as, this month – as I reach the age of 60 – I have decided to retire from the counselling room and enter the council chamber. I have just been voted in as a Green councillor on Isle of Wight Council. After years of lobbying politicians, I felt that I wanted to become one. In a small way, I wanted to continue as an advocate for change, but within a different arena. I am still an active listener, but now I support people by taking action with them and for them.

FROM PIONEERING DIVERSITY TO PIONEERING GREEN POLITICS

My column has been written in the context of working as a counsellor and a manager of a counselling practice within the voluntary sector. In 2007, a highlight for me occurred when the practice and organisation I founded (My Time) won the BACP award for innovation; later, we also won an award for research. My Time lives on within the Richmond Fellowship Group and continues to be driven by research and innovation. Now it is time for the next generation to take it further. I am proud that, throughout my career as a counsellor, I was able to pioneer new forms of engagement, improvements to service delivery and innovative approaches to counselling. My Time managed to bridge a wide range of services users, from asylum seekers to police officers, urban city (Birmingham) to rural coast (Isle of Wight), young to old, and English-speaking to 25 other languages.

> *There is no stability or normality within mental health services in the UK, and, as soon as I accepted this, the work became less stressful*

Having spent over 30 years in the third sector and mental health sector, I have learnt to become resilient in the face of continual change and adaption. There is no stability or normality within mental health services in the UK, and, as soon as I accepted this, the work became less stressful. I always believed that what we did at My Time was good and that, as long as we produced high quality work and there was a need, then somehow the funding would come, and strangely it did. For me, people come first and the rest follows.

POLITICAL TIMES ARE CHANGING

My grandmother always said, ‘When you think the ends meet, someone moves the ends.’ It seems that 2016 and 2017 are the years when the political landscape in the UK is moving so fast, as the ends are continually moved: from Brexit to Trump and from local to general elections. By the time you read this column, the political map of the UK will have changed again. Perhaps there needs to be future research into the political trauma of 2016–17.

Something drives all of us, and for me that driver is a deep sense of social injustice in the world. Throughout my working life as a community activist and a counsellor, I have seen and listened to a huge range of social injustices. I felt that, in retiring from counselling and from being a chief executive of a voluntary sector organisation, I had to find an outlet for my continued inner drive to help people. The experience of standing in an election, door-knocking and presenting myself as a candidate was terrifying and exciting at the same time; I have taken a personal step into the unknown.

HOPE FOR THE FUTURE

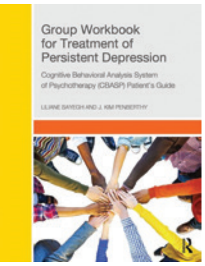
At the centre of counselling is a message of hope, even when at times you find it hard to connect with hope yourself. I have always believed that, as a counsellor, I should lead by example and, as a councillor, I believe the same. In a world of political uncertainty, holding on to the message of hope becomes more important.

A key component in my personal philosophy is that life is a journey and not a destination; at 60, I find myself entering a new phase in my life’s travelogue. We come to a time when we have to change direction and I have taken the step. I am sending you all my best wishes for the future on your own personal and professional journeys. ■

*This has been a regular column by **Michael Lilley**, Chief Executive of My Time, a division of the national mental health charity Richmond Fellowship. To contact Michael, please email hcpj.editorial@bacp.co.uk*

REVIEWS

BOOKS



GROUP WORKBOOK FOR TREATMENT OF PERSISTENT DEPRESSION: COGNITIVE BEHAVIORAL ANALYSIS SYSTEM OF PSYCHOTHERAPY (CBASP) PATIENT'S GUIDE

Liliane Sayegh and J Kim Penberthy

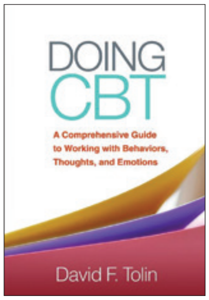
Routledge

ISBN 978-1-138-92602-8 £16.99 (paperback)

This workbook focuses on the use of the cognitive behavioural analysis system of psychotherapy (CBASP) for patients suffering from persistent depression. CBASP is a problem-solving approach to therapy that is best utilised within groupwork. The writers provide a logical path through this model for overcoming persistent depression. Chapters take the reader through the sessions, breaking down each into workable sections with session outlines and activities. It is suggested that CBASP be conducted over 20 group sessions. The workbook supports the transition from one session to the next. It guides the therapist through each session, offering a step-by-step approach to the therapy, activities and homework exercises. There are ideas for setting up the group and for consecutive sessions. At the end of the book, there is a very useful appendix which offers a range of handouts that can be photocopied and given to patients. These are also very useful for therapists. Although this type of therapy is best undertaken within a group with a trained therapist, the patient could conceivably use it by themselves.

All in all, this is an excellent addition for therapists working in the area of persistent depression. I found the exercises very useful, and the supporting information for each session is focused and logical.

Jo Sansby
MBACP (Snr Accred), BACP registered counsellor, psychotherapist and supervisor (neuroscience and major trauma), Central Manchester University Hospitals, and Lead Counselling Tutor, Oldham Lifelong Learning.



DOING CBT: A COMPREHENSIVE GUIDE TO WORKING WITH BEHAVIOURS, THOUGHTS AND EMOTIONS

David F Tolin

The Guilford Press

ISBN 978-1-4625-2707-6 £43.99 (hardback)

I am a great fan of David Tolin books; they are well written, comprehensive, easy to read, and display a sense of humour. It will, therefore, come as no surprise that I highly recommend this one. In this book, Tolin covers areas of CBT that are often lacking in other books on the subject, such as dialectical behaviour therapy (DBT), about which he provides a vast amount of information.

The book covers a wide range of topics, including how to manage the therapeutic relationship, how to make clinical decisions, how to deal with treatment-interfering behaviour and how to approach challenging cases. The book is broken down into three parts: 'Why do people suffer?' 'How do we help?' and 'Putting it all together'. Each part is then sub-divided in a useful way that allows the reader to dip in and out at any point. Throughout the book, there are 'try this' tips, notes on how an area 'might bug you', the science behind the concept or area of discussion, 'holding up a mirror' metaphors and advice on adapting the process. These are stand-alone sections that offer greater insight into the theory.

Tolin takes a direct approach to setting out what needs to be done in practice and presents it in an easy-to-read format. He takes us through the whole process, from the initial meeting with the client to the end of therapy. Case examples are offered in each chapter to support the concepts. This is a book packed full of useful information and examples of using CBT with a range of issues and clients. The overview of CBT principles, rationales and techniques is suitable not only for qualified practitioners but also for students and teaching staff.

Tolin appears to get better with each book that he writes and this one is no exception. I would say that this is a must for every therapist.

Jo Sansby
MBACP (Snr Accred), BACP registered counsellor, psychotherapist and supervisor (neuroscience and major trauma), Central Manchester University Hospitals, and Lead Counselling Tutor, Oldham Lifelong Learning.

BACP HEALTHCARE ROUND-UP

FORTHCOMING BACP EVENTS

Professional development days

BACP's series of professional development days (PDDs) are designed to deliver CPD opportunities that will develop practitioner skills in specified areas. The following may be of interest to those working in healthcare:

Supervision: relationship, authority and ethics
4 September – Edinburgh
Facilitator: Steve Page

Working with partners of trans-identified people
8 September – Southampton
Facilitator: Tina Clark

Working safely and therapeutically with domestic abuse
28 September – Bristol
Facilitator: Gary Williams

Integrating artwork into your therapeutic practice
11 October – Newcastle Upon Tyne
Facilitator: Pauline Andrew

Bridging the gap – working with unprepared clients
21 October – Manchester
Facilitators: Trish Blundell and Marcia Haley

Suicide and suicidal ideation
27 October – Cardiff
Facilitator: Kirsten Amis

Supervision: relationship, authority and ethics
7 November – York
Facilitator: Steve Page

Erotic transference and countertransference
16 November – Bristol
Facilitator: Sally Openshaw

Integrating artwork into your therapeutic practice
22 November – Belfast
Facilitator: Pauline Andrew

Societal rape myths and traumatic reactions
27 November – Norwich
Facilitator: Sally French

Erotic transference and countertransference
19 January – York
Facilitator: Sally Openshaw

Societal rape myths and traumatic reactions
23 January – Birmingham
Facilitator: Sally French

Suicide and suicidal ideation
26 January – London
Facilitator: Kirsten Amis

Additional dates for BACP events are always being added. For more information, please visit www.bacp.co.uk/events

Aims

We aim to provide a forum for the exchange of good practice and mutual support by:

- Sharing good practice – via the *HEALTHCARE Counselling and Psychotherapy Journal*, networks and interest groups/events.
- Providing information and resources.
- Representation at external meetings.
- Contributing to BACP responses on relevant policy consultations.
- Communicating with members (via enquiries and/or meetings).

About BACP Healthcare

BACP Healthcare is a division of BACP with nearly 1,200 members who work in services funded by the NHS, either in the public, private and/or third sector across the UK. Day-to-day running of the division and the delivery of long-term goals and projects are managed by the BACP Healthcare team, which consists of volunteers on the Executive Committee, and BACP staff.

Membership

Membership is open to individuals and organisations who are members of BACP, for an additional annual fee. As a BACP Healthcare member you will benefit from:

- Free subscription to the *HEALTHCARE Counselling and Psychotherapy Journal*, our quarterly journal, offering news, views and features relevant to healthcare practitioners.
- Access to the members' area of our website, containing useful information.
- Discounts on events.
- Networking opportunities.
- Our email enquiry service: healthcare@bacp.co.uk

Subscription fees

Individual membership:	£30*
Reduced individual fee:	£15*
Organisational membership:	£50*

* Please note these are the additional fees after BACP membership. For membership queries, please email healthcare@bacp.co.uk

MEMBERS' AREA
Visit the members' area of our website to download information sheets, guidance for best practice and full issues of the *HEALTHCARE Counselling and Psychotherapy Journal.*

bacp divisional journals

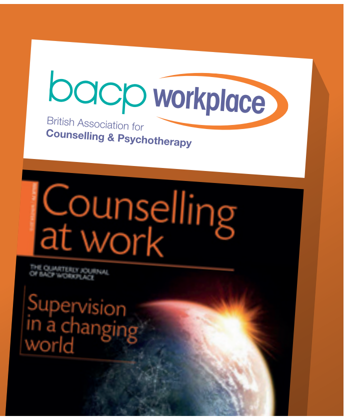
BACP publishes specialist journals within six other
sectors of counselling and psychotherapy practice.

Private Practice

This journal is dedicated to counsellors and psychotherapists working independently, in private practice, or for EAPs or agencies, in paid or voluntary positions.

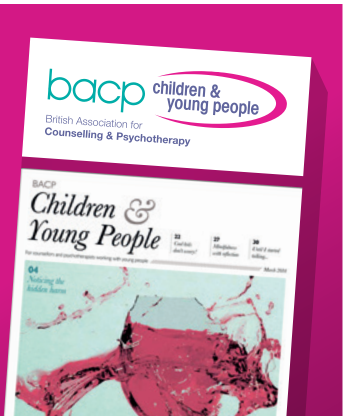
Counselling at Work

This journal is provided by BACP Workplace and is read widely by those concerned with the emotional and psychological health of people in organisations.



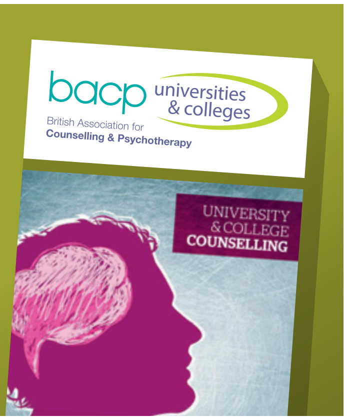
BACP Children & Young People

The journal of BACP Children & Young People is a useful resource for therapists and other professionals interested in the mental health of young people.



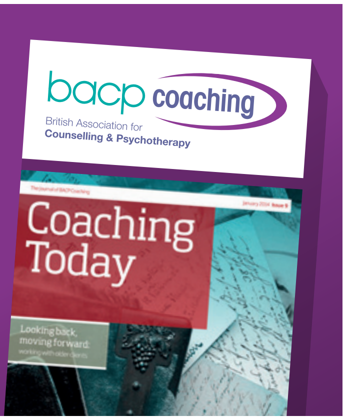
University & College Counselling

This is the journal of BACP Universities & Colleges, and is ideal for all therapists working within higher and further education settings.



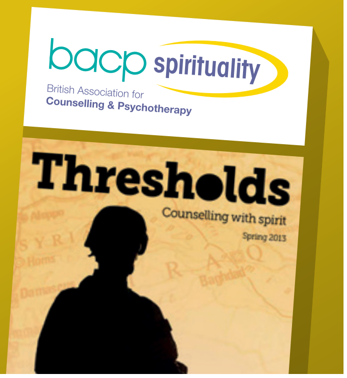
Coaching Today

The BACP Coaching journal is suitable for coaches from a range of backgrounds including counselling and psychotherapy, management or human resources.



Thresholds

This is the quarterly journal of BACP Spirituality, and is relevant to counsellors and psychotherapists involved or interested in spirituality, belief and pastoral care.



These journals are available as part of membership of BACP's divisions or by subscription.

To enquire about joining a BACP division, call 01455 883300.

For a free of charge consultation on advertising within these journals, contact Adam Lloyds on 020 3771 7203, or email adam@thinkpublishing.co.uk

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