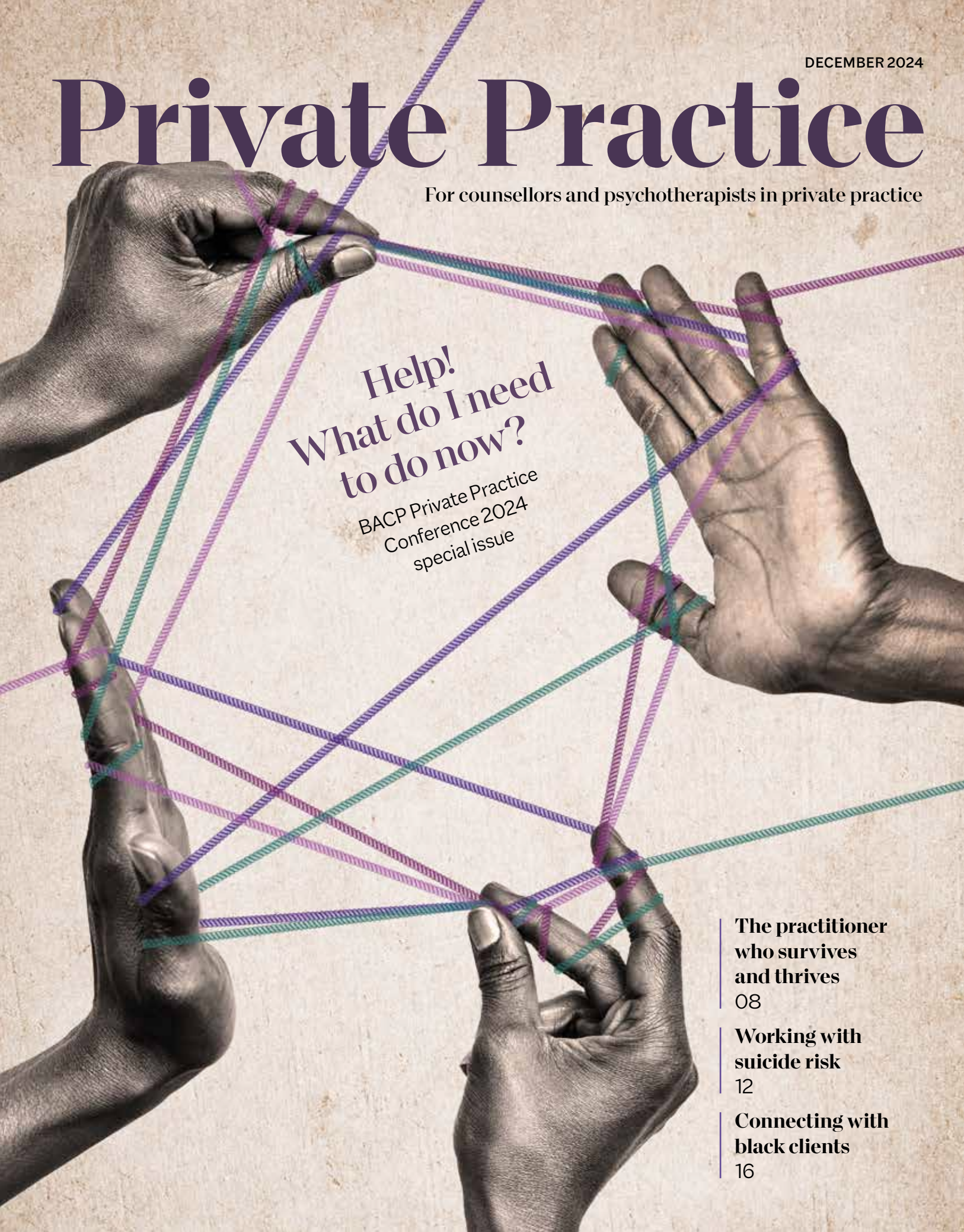
DECEMBER 2024

Private Practice

For counsellors and psychotherapists in private practice



Help! What do I need to do now?

BACP Private Practice Conference 2024 special issue

Private Practice is the quarterly journal of BACP Private Practice division, for counsellors and psychotherapists working independently, either in private practice or for EAPs or agencies, in paid or voluntary positions.

It is published by the British Association for Counselling and Psychotherapy, BACP House, 15 St John's Business Park, Lutterworth LE17 4HB. Tel: 01455 883300

The journal is distributed free to members of BACP Private Practice in March, June, September and December.

It is available online at **www.bacp.co.uk/bacp-journals/private-practice**

Membership of BACP Private Practice costs £20 a year for individuals, and £40 for organisations. For details, call BACP's Customer Services department on 01455 883300

EDITOR
John Daniel
Email: privatepractice.editorial@bacp.co.uk

CONTRIBUTIONS
Contributions are welcomed. Please contact the editor on the email above. For author guidelines, see **www.bacp.co.uk/bacp-journals/author-guidelines**

ADVERTISING
For rates, call 0203 771 7214 or email cara.termine@thinkpublishing.co.uk
Publication of advertisements in *Private Practice* and inclusion of advertising material do not constitute endorsement by BACP *Private Practice* or BACP.

DESIGN
Steers McGillan Eves Design 01225 465546

PRINTER
Hobbs the Printers Ltd

ISSN print 2049-2677 ISSN online 2398-3612

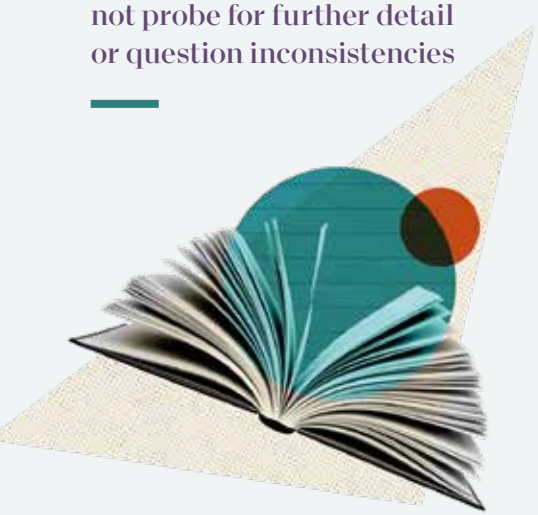
FEATURES

REGULARS

28
Pre-trial therapy

Jill Swindells on what we need to know about pre-trial therapy to avoid possible pitfalls

> Our clients can now talk about the crime(s) in therapy, but, as we're not investigators, we should... not probe for further detail or question inconsistencies



Welcome

Ours is a risky business. Perhaps more so for those of us in private practice than for our colleagues working within organisational settings, where there are systems of support, policies and procedures, and management structures in place. In private practice, we carry the risk of our work in isolation, with the support of a supervisor, of course, but the clinical responsibility for our clients is ours alone.

Risk is ever present in our work and comes in many forms. We sit relatively powerlessly with vulnerable clients who may be at risk of harm to themselves or others. With those considering taking their lives by suicide or living with suicidal ideation. With those in the grip of addiction, whose alcohol or substance use, disordered eating, chemsex dependency or other self-harming behaviours may be out of control and the cause of considerable risk to the emotional, physical and psychological wellbeing of both our clients and those close to them.

It's in the very nature of our work that we offer ourselves to be at the effect of clients' negative and positive transferences onto us, which makes us vulnerable to becoming the object of fantasy, paranoia, love and hate. We work with clients whose traumatic histories, adverse childhood experiences and psychopathologies will all play out in myriad ways, more often unconsciously than consciously, in our consulting rooms. This can result in us being dreamt up in clients' internal worlds as potential perpetrators of harm, as well as longed-for reparative parents. In extremis, these common projections can render us open to attack, in the form of complaints, and obsessions, which can result in boundary violations of various forms, including stalking.

It's also unavoidable, given that our stock-in-trade is the inexorable messiness of human relationship, that we will fail our clients, by saying the 'wrong' thing, risking challenging a defence before sufficient safety and trust in the therapeutic alliance has been built, 'forgetting' something of utmost importance, or taking a break at a time when a client can't tolerate being without us. Being the cause of rupture isn't only unavoidable in our work, but also essential therapeutically, so long as empathic breaches can be addressed and worked through well enough, which isn't always possible. Endings won't always prove satisfactory. Successful alliances can't always be forged.

We've also, whether we acknowledge it or not, all been drawn to this work because of our own wounding, and the extent to which we've attended to this in our own personal therapy, or other self-development activities, will influence our capacity to sit with the wounds of others, without rushing into rescue, or abusing the power of our position by thinking of ourselves as the 'well' ones in the 'service' of those we deem to be unwell.

Given all I've written above, it's a wonder any of us continue to pursue our peculiar vocation. I suspect, like me, that most of us didn't really know what we were getting ourselves into until well after we qualified. In my experience, the practise of therapy doesn't become any easier or more straightforward the more experienced we become, but rather the more we know, the more we realise we don't – and will never – know. Hopefully, it's this realisation that keeps us humble and prevents us from believing that we somehow have the answers or the godlike capacity to save anybody else's life but our own.

If what I write resonates with you, I hope you'll enjoy reading the features in this issue, all of which are written by therapists who presented at the 2024 BACP Private Practice conference, entitled 'Help! What do I need to do now? Tricky situations and ethical dilemmas in private practice (and how to handle them)'. There's still a brief period (until 18 December 2024) in which to access the on-demand conference broadcast online.

John Daniel, Editor
privatepractice.editorial@bacp.co.uk

BACP NEWS

Catch up with the latest BACP news and resources

Anxiety is the top reason why women in menopause are seeking therapy

Anxiety is the number one reason why women in menopause are seeking therapy, according to our Mindometer survey. The survey, which provides an in-depth look at what our members have experienced in their practice over the past year, showed that almost three in five (58%) therapists say their clients in menopause are seeking support for anxiety. And nearly two thirds (65%) stated that menopause-related issues are having a detrimental impact on their clients' mental health.

Mood changes and relationship issues, sex and intimacy were also among the top reasons why women in menopause are seeking therapy. Around half (53%) of the therapists who help clients in menopause saw women seek support for mood changes, and just under half (47%) for relationship issues, sex and intimacy.

The survey also revealed that, over the past year, over half (55%) of the therapists said their clients had not realised they were experiencing symptoms of menopause.

Find out more at: **https://tinyurl.com/yjyjehvh**

BACP member celebrates National Lottery funding for women's online self-esteem group

Our member, Natasha Page, is celebrating receiving National Lottery funding for an online support group to help women boost their self-esteem and build mental resilience. Natasha won funding for her 'The New Me' project, inspired by her own struggles with self-esteem, as well as her experience as a psychotherapist supporting hundreds of clients on their journey towards higher self-esteem.

The project invites all women (of any age, race or background) to attend eight free online fortnightly group therapy/coaching sessions designed by Natasha's professional and personal experience of shedding old, destructive thought patterns. The project was made possible by a National Lottery award from The National Lottery Community.

Find out more at: **https://tinyurl.com/4k8f5ksb**

Update on our Board of Trustees

Three members of our Board of Trustees have stepped down from their roles. Ian Jones, who was appointed to the Board as Senior Independent Trustee at our AGM in November last year, Dr Charlotte Venkatraman, who was voted in by members at the same time, and Marc Leppard.

Ian, who was also Chair of our Governance, Remuneration and Nominations (GRaN) Committee, has told BACP that due to disagreements about governance procedures and the Board's recent response to an external investigation carried out earlier this year, he feels no longer able to discharge his duties as a Trustee. Charlotte, who was also Chair of our Research Committee, has left due to personal reasons that have meant she can no longer commit the time and resource needed to the role. Marc, who was also Chair of our Public Protection Committee, has stepped down as he's taking on a new full-time role and no longer has the time available to be a BACP Trustee. He also expressed his hope that BACP will address the governance challenges facing the association as a priority.

The Board would like to thank all three for their contributions to BACP and wish them all the best for the future. The Charity Commission and Companies House have been informed about these departures. We'll be recruiting new Trustees and Chairs of our Research Committee, GRaN Committee and Public Protection Committee soon and will keep members updated.

Find out more at: **https://tinyurl.com/2b5d3pre**

Joint statement to mark World Mental Health Day

To mark World Mental Health Day, we worked with our partners to issue the following statement in support of the NHS and its workers:

'Lord Darzi's report into the state of the nation's health and wellbeing is a blue-flashing light. He has called for urgent support for our NHS. As professional organisations with members both working in the NHS, and supporting health and social care staff, we know that without the workforce, there is no NHS.

'At the heart of ensuring the health service thrives is making sure all staff have access to high quality, counselling and mental health and wellbeing services.

'On World Mental Health Day 2024, BACP, the British Association for Behavioural & Cognitive Psychotherapies (BABCP) and the British Psychological Society (BPS) are coming together as professional bodies dedicated to high standards in evidence-based practice and experience, to highlight the need for adequately resourced services, compassionate leadership, and essential time for reflective practice and clinical supervision, so that our members can deliver the best care to all our NHS patients, and the staff they depend on.

'We are committed to working together, in partnership with the NHS across the UK, to help shape improved practice for our members working in health and social care and for all NHS staff who undertake such vital work.'

Find out more at:
https://tinyurl.com/uhpxrw6u

Unmasking ADHD through therapy

To mark ADHD Awareness Month, we launched a campaign to highlight how therapy can help people to navigate the emotional challenges of a recent ADHD diagnosis and masking. 'Unmasking ADHD through therapy' highlights this struggle through a series of powerful portraits. Each photograph features individuals with ADHD holding masks they've created that symbolise the contrast between their public personas, and traits and feelings they tend to mask.

The imagery is complemented by a short film that captures the process of creating these masks in an art workshop, featuring four case studies and one of our members.

The campaign is part of our continuing PR work to help people find a BACP-registered therapist who can help them, and to highlight the skills and expertise of our members. By bringing personal stories of masking and unmasking to life, the campaign aims to foster greater understanding of ADHD and masking, and promote the importance of therapy as a supportive resource.

We've also released data from our annual Mindometer survey, which more than 2,600 of our members responded to this year. The survey found:

- More than three quarters (76%) of therapists reported a rise in clients seeking therapy for ADHD-related issues in the past year
- More than half of therapists (57%) reported they often see clients masking their ADHD traits to avoid stigma
- More than half (58%) of therapists have noticed a rise in clients seeking their services to adjust to a new ADHD diagnosis
- Almost three quarters (72%) of therapists say clients feel relieved after receiving a diagnosis
- Emotional regulation (82%), academic or work performance (67%) and relationships with friends and family (67%) are the top three areas of life where ADHD has the greatest impact, according to therapists.

Find out more at:
https://tinyurl.com/y6myf54u

Why people are seeking therapy in 2024

Our recent survey of over 2,600 members shows that almost two thirds (64%) of therapists have seen an increase in clients coming to therapy for support with stress, persistent worrying and overthinking over the past 12 months. The survey, which provides an in-depth look at what therapists are currently experiencing in their practice, also showed that therapists saw an increase in neurodivergence-related issues (61%), generalised anxiety (55%), low self-esteem (53%), and loneliness and isolation (49%) over the past year.

The top 10 list of issues therapists have seen an increase of in the past year include:

1. Stress/persistent worrying/ overthinking (64%)
2. Neurodivergence-related issues (61%)
3. Generalised anxiety (55%)
4. Low self-esteem (53%)
5. Loneliness and isolation (49%)
6. Social anxiety (48%)
7. Depression (45%)
8. Work stress (45%)
9. Trauma (44%)
10. Financial anxiety (42%).

The survey also revealed that three in five (60%) therapists say that the public's mental health has deteriorated since last year – with almost all therapists (94%) perceiving that financial concerns and the cost of living had an impact on this. Three quarters of therapists (76%) also said that war and conflict had impacted the nation's mental health, closely followed by 75% of therapists perceiving that negative news had contributed towards the public's mental health deterioration too.

Find out more at:
https://tinyurl.com/yu7ndudj

DIVISION NEWS

Catch up with the latest news from BACP Private Practice

BACP winners at Memcom awards

We're thrilled to have been named winners of the 'Best Member Newsletter' and been highly commended in 'Best Public Awareness Campaign' at this year's Memcom Excellence awards. The judges said our fortnightly eBulletin 'stood out' for '...asking the members what they want and producing exactly that by using the customer thermometer tool'. They also praised the constant testing to ensure the newsletter was fully accessible as well as being '...written in plain English, easy to navigate and visually looked amazing'.

'Anxiety Is', our campaign raising awareness of symptoms around anxiety using AI-generated images, was highly commended in the 'Best Public Awareness Campaign' category. Using quotes from real people describing how anxiety manifests in their daily lives, we created and exhibited a collection of AI-generated art. We wanted people to recognise and address these feelings, so they don't suffer in silence and accept them as the norm. The images were exhibited near Waterloo Station in London to coincide with Mental Health Awareness Week and were popular with the public and the media. The campaign was widely reported by print and broadcast media, including *The Guardian* and *Metro*.

We were also nominated in the Best Lobbying Campaign category for our work to reverse the removal of funding for the pioneering Healthy Happy Minds primary school counselling programme, in Northern Ireland.

Find out more at:
https://tinyurl.com/3maktn2c

BACP Private Practice Conference 2024

There's still a brief period (until 18 December 2024) to access the on-demand Private Practice Conference 2024 online. The conference, titled 'Help! What do I need to do now? Tricky situations and ethical dilemmas in private practice (and how to handle them)', was a day full of interesting insights and chances for hundreds of therapists working in private practice to connect with each other. Speakers included Anne Power, Andrew Reeves, Jill Swindells, Susie Jamieson, Andrew Grimmer, Su Dunn and Matthew Johnston.

Find out more at: **https://tinyurl.com/2jtu6654**

Call for new Executive Committee members

We're looking for new members to join the Executive Committee, so please get in touch if you're interested in joining the team.

Email: **governance@bacp.co.uk**

Private Practice Toolkit

The *Private Practice Toolkit* supports members in private practice to set up and maintain a thriving practice. It combines business skills with ethical and therapeutic practice. We're continually adding a wide variety of new content to the *Toolkit* from our journals, blogs and *Good Practice in Action* (GPiA) resources.

Find out more at:
www.bacp.co.uk/pptoolkit

Networking

Network meetings offer unique opportunities for members to come together to share experiences, challenges, success stories and business ideas. Meetings are held across the UK, helping you to get to know other therapists in your area.

Our regular meetings focus on issues for our members living in all four nations. They give you the chance to network with other members and meet your elected and Executive members. The meetings are free for BACP members and are a great place to discuss issues of current, internal, external, national and local importance.

Find out more at:
https://tinyurl.com/3kcfusuf

INDU KHURANA

> The biggest takeaway for me was that no matter how long you've been a therapist, there's always more to learn and grow into

Indu Khurana is a transpersonal integrative psychotherapist, coach, supervisor, trainer, facilitator and croissant eater. She prides herself in being relational in her dealings with others. Occasionally, she is a writer too.
www.indukhurana.com

Greetings. I write as the Acting Chair of the Private Practice division. I'd like to start by thanking Jo Cook for her tenure as Chair from January to June 2024. Jo led the Executive Committee over the period of planning for the BACP Private Practice Conference, which took place on Saturday 14 September in London, alongside a simultaneous live online broadcast.

The conference, titled, 'Help! What do I need to do now? Tricky situations and ethical dilemmas in private practice (and how to handle them)', was a great success, attracting the largest number of delegates – both in-person (approximately 300) and online (approximately 1,000 to date). My personal takeaways (as someone who's been in full-time private practice for two years) included that it's possible to talk about a topic as serious as suicide in a light-hearted manner without being light-hearted about the topic. Suicidal feelings are handled very differently in organisations such as the NHS or MIND, where the response focuses on risk management and minimisation.

In private practice, we're in the privileged position of not only managing risk (because risk is ever-present) but being able to have conversations with our clients about the feelings behind potential actions. We can inwardly acknowledge our own feelings about risk and discuss them in supervision. And, with our clients, we can hold ongoing discussions around risk, and offer them choices through these explorations.

Personally, having made the move from working in the NHS into private practice, it was a great reminder of the multi-dimensional role we can hold with our clients, instead of the more dualistic expectations that previously governed my working life. It was also a good reminder to have a conversation around risk with my own supervisor – how they manage risk generally, and how they may manage it in my work with my clients.

The talk on pre-trial therapy was an eye-opener. I have always feared that I might end up in a position where a past or current client becomes involved in a legal trial. So, it was good to hear that although a client attending pre-trial therapy shouldn't talk about the incident itself, they can talk about their feelings in relation to it, and that this only applies once the justice process is in progress – not before. I heaved a sigh of relief on hearing this. It was also good to hear that the police can only request relevant information from the therapist about their work with the client.

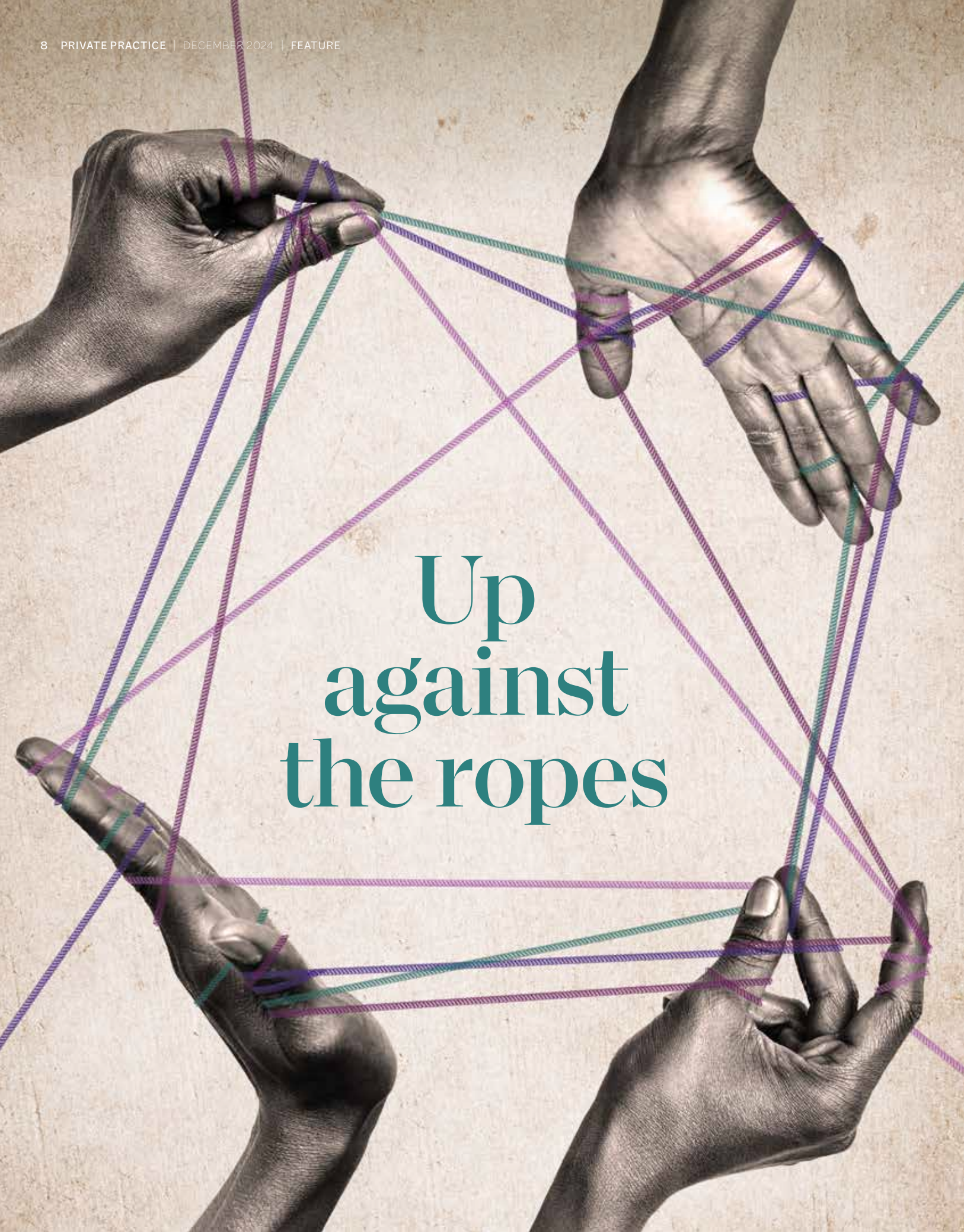
These were just two of the presentations I attended and just a few of the many points raised by the presenters that prodded my awareness. I realised that there are potentially far more points to raise with clients than I currently include in my working agreement, but also that I can be free to work fluidly with my clients and not get too bogged down in paperwork and administration. This is still an ongoing process for me and, I suspect, for others too. The biggest takeaway for me was that no matter how long you've been a therapist (I've been a counsellor and then a psychotherapist for about 25 years and a supervisor for nearly 20), there's always more to learn and grow into.

So, what do I hope for during my tenure in this role? I hope for an opening up once more of communication channels between BACP and the membership, and for continued appreciation from BACP of the value the divisions bring to the organisation. I bring a deep desire to raise awareness around minority groupings, and to affect lasting change to accessibility within our profession – if only by raising awareness.

On a personal level, I stand for minorities achieving big. With skin that's brown of hue, I have experience in this country of being in a minority category. More recently, I've moved into the realm of being differently abled and this has added another facet to my minority holdings. I hope to show that women don't have to adopt the alpha-masculine style of leadership to achieve things. I wish to demonstrate how a person who remains in her softer feminine energy can function as well as someone wielding the traditional masculine style of leadership.

Alongside these personal desires, I hope to support a growing Executive team so that we can update some of the existing resources, listen to the membership and their needs, and be guided by the universe to whatever needs my attention and presence within the remit of this role. We're seeking more Executive members and especially encourage people from diverse backgrounds to apply. So, if you've been considering it for a while, now may be the moment to take the leap.

There's still an opportunity to access the full conference content online until 18 December 2024. I would like to extend my appreciations to the BACP Events team for their hard work securing amazing speakers on topics that were extremely on-point and relevant to our work in private practice.



Up against the ropes

Whether we're facing a complaint, the suicide of a client, or some other deeply troubling or challenging situation, we'll be better placed if we have a secure attachment figure to whom we can turn, writes **Anne Power**

It's mid-afternoon on a Saturday. Somewhere in the country, there's a therapist trying to go about her weekend in a normal way. Her partner is working in their beautiful garden, and she's just left her child at a friend's house to stay over. She's got a precious free hour. Any sliver of free time would normally light up the joy part of her brain, but this isn't a normal time, she can think of only one thing – the complaint a former client is bringing against her. These days, she'd rather not have free time because it puts her more sharply in touch with the fear.

Attachment relationships as our anchor in a storm

I've said 'a' therapist, and I've indicated she's a woman, but if we want to know how she copes with fear, with the threat of losing her profession, and the shame of being found at fault, we need to know about her attachment history. Bowlby taught us that a secure attachment relationship can provide a safe haven (a place of shelter) and a secure base (a platform for growth).

Many of us in this profession didn't have that secure a childhood. Our fictional therapist may have 'earned security', but in a time of crisis, her residual insecurities will be reactivated. Whether we're facing a complaint, the suicide of a client, or some other deeply troubling or challenging situation, we'll be better placed if we have a secure attachment figure to whom we can turn. When we feel threatened, our attachment behaviour ramps up and our capacity to explore and learn is reduced. When our attachment needs are met, we'll be more able to cope and to come through the crisis stronger and wiser.

If we say this colleague has a residual avoidant pattern, then under stress she may be trying to appear more 'together' than she is, holding her partner and friends at bay because to connect with them is to connect to the fear and potentially collapse. If we say she has a residual anxious preoccupied pattern, then under stress she may be demanding closeness, desperate to have her feelings taken away from her, and tending to criticise and reproach others for not getting things right.

We hope she'll be able to make a warm connection with her partner, and while this can't take away the fear that comes with a clinical crisis, connection with our attachment figure helps us regulate and cope with the threat. This comforting and supportive connection will depend partly on her partner's attachment style. If these two were in a secure place, this will be an incredible blessing at this point. If things were already rocky, this will be very tough.

> "When we feel threatened, our attachment behaviour ramps up and our capacity to explore and learn is reduced

If the partner is the more anxious one, they may be showing their anxiety by asking many questions and trying to engage with her when she doesn't want to talk. If the partner is the more avoidant one, they may be resenting her increased demands and feel very unhappy that this is a problem they just can't fix – so they'd rather put it out of mind.

Care-seeking skills

As therapists, we're probably reasonably skilled in caregiving skills, but how do we do on care-seeking? This is an equally important relational skill. In a professional crisis, it would be good to get the help that's available, whether from a supervisor, colleague or partner. We'll do better at asking and receiving help if we are a secure care-seeker, which would mean we:

- start off with a belief that the other person will help if they can
- can signal this is important, and, if necessary, repeat our request
- can express our needs clearly
- can show our vulnerability so that the other gets an accurate picture
- have an ability to be comforted.

You can imagine how people with either avoidant or anxious attachment patterns would struggle on each of these points. I'd like to illustrate this with a piece of dialogue from a couple I interviewed for my book, *Contented Couples*.[1] This couple had been together over 20 years. In their early days, their contrasting attachment styles meant they had to cope with a distinct pursuer-withdrawer fit. Here they're looking back and remembering how difficult care-seeking and caregiving had been. Diana, who speaks first, is the more anxious partner.

Diana: *I used to wait to be asked, 'What's wrong?', and when I wasn't asked, I would get very upset and feel very neglected, but I've learned that it's OK if I just go to Kate and say, 'Can I talk to you?' and just spill it all, and she... will give me her attention and, you know, often offer to give me a hug, which is often what I need, or she'll hold my hand while I spill my story.*

REFERENCES

1 Power A. Contented couples: magic, logic or luck? London: Karnac Books; 2024.

> One of the ways we can prepare for crisis is to equip ourselves with a good support system

Kate: *Yeah, I'm trying to learn not to try to fix it. I'm trying to learn to just keep my mouth shut, to listen, to be a more empathic listener.*

At this stage in life, both are aware of how their patterns can drive behaviours that get in the way of successful care-seeking and caregiving. Diana found it hard to ask directly and acted out distress and resentment. Kate would wade in with solutions overlooking Diana's simple longing to know she was there.

One of the ways we can prepare for crisis is to equip ourselves with a good support system. We need reliable supervisors, colleagues and friends and/or a partner, and, crucially, we need to be able to approach them effectively. It's good to be familiar with our own patterns. What do we typically do when we're scared? Do we lean towards a more anxious or avoidant strategy? How well does that work for us?

Building our resilience

To show why this is so important, I'd like to quote from Marie Adams' book,[2] *The Myth of the Untroubled Therapist*. Adams is a therapist who lived through a complaint that was eventually not upheld, but nevertheless, she lived through months of intense fear. Years later, she researched how therapists cope when they're up against the ropes. Can we still be helpful to clients when coping with anxiety or depression? First, an encouraging finding: 'Like many of the therapists I spoke to, my capacity for empathy may even have been heightened. But I was also very tired from lack of sleep, and I was always on the lookout for unusual sounds in the house, in case there was an emergency. I couldn't possibly have been all there for my clients.'[2]

Her research showed that anxiety in the therapist is likely to be more disruptive to our work than depression. Anxiety brings distraction and pre-occupation. 'Experience [of personal struggle] may draw us closer to our clients, but anxiety prises us apart.'[2] So, then an additional anxiety rises: what if I'm so anxious that I can't work and can't earn? Supervision will be the place to take that dilemma, and, in my experience, practitioners know at some core level if they need a break. If we do feel compelled to take time off, we can imagine that rage is likely to rise – at the unfairness and our helplessness.

Crises sometimes simmer before they erupt, but often, they take us by surprise. Sometimes they hit at a time when our resources are already stretched – we could be recently bereaved, in the middle of menopause, responsible for a very sick parent, having a difficult relationship with a colleague or manager, teenage child or partner. For these reasons, we need to anticipate crisis and aim to build in some reserves of capacity.

We all need a first aid kit

It's worth identifying our top ways to regulate and to make sure we're practising them regularly when times are calm. Here are a number we might choose from, and probably you have others which have helped you survive challenges: breathing exercises, walking, self-talk, writing, doing something creative, talking to wise people, spending time in nature. There may be some ways we'd like to use but currently don't – we'll need to work on these in advance if they're to support us in rough times.

Breathing exercises

These are a potent way to calm ourselves, to lower our heart rate and support our parasympathetic nervous system. Without some way to soothe ourselves in a crisis, all our necessary maintenance systems – eating and digesting, sleeping and resting – could be disrupted. Online videos and apps are a great way to learn and practise different breathing patterns.

Walking

This is such a wonderful self-help strategy it really needs no guidance, but it can be inspiring to understand some of the ways it benefits us. Apart from taking us out into the sunlight and exercising our bodies, research is beginning to show how walking calms us through the eye movements we make as we move along. When we walk, our eyes naturally engage in lateral movements – scanning the environment from side to side. This process is known as optic flow and appears to suppress the amygdala's activity.[3]

Self-talk

We all conduct internal conversations and it's important to listen in and take a lead if some parts of us are acting out unhelpful ancient scripts. Making friends with our self, especially

with the less lovely parts of ourselves, is great preparation for a crisis. The more difficult the parts, the more important that we make time to listen. For example, if a part of us fears an angry client, we might:

- want to wish it away – we tell ourselves to 'man up'
- want to blame the client – 'they're too disturbed to be seen here'
- want to deny the fear entirely – 'I'm such an experienced therapist'.

Can we listen thoughtfully to those reactive parts which are trying to protect us in the ways they learnt way back then? Can we even thank them for doing their best, and reassure them that there's now a grown up, experienced part who can help? This way of bringing curiosity and compassion to our difficult parts is enabled by internal family systems (IFS), and is a way of fostering secure attachment within ourselves.

Journalling

There are four very good reasons to write down our thoughts on both the events and our responses:

1. We may be glad of the clear record of events if we must face legal proceedings
2. This processes the feelings and helps to contain them
3. This helps us learn from events and find some opportunity within the crisis
4. Our writing could be developed into a piece for publication, which would be helpful to others.

> "In cases of suicide, complaints and stalking, anger for our helplessness and what has been done to us are... likely to be present

I won't spell out the benefits of doing something creative, speaking to wise colleagues or spending time in nature, because we feel the benefit so immediately when we do these things. Thomas Skovholt is a psychologist who has researched the issue of practitioner resilience, and he has written about the strategies we can use to protect ourselves by building resilience:

- being curious and hungry to learn and grow in the work
- learning to offer 'boundaried generosity'
- embracing the ambiguity – tolerate the uncertainty about what we do
- enjoying small victories
- continuing to make our own small steps towards growth and maturity.[4]

Skovholt's *Resiliency and Self-Care Inventory* is a useful resource that measures personal and professional vitality and stress. This can be downloaded free.[5]

Loss and grief

Many therapists reading this will have faced the profound anxiety of a client who is at imminent risk of killing themselves. Some of you will have lived through the actual suicide of a client. This frightening loss could bring profound grief. The initial grief is likely to be for the client who has taken their own life and for the work you were doing together. Gradually, other losses may come into view, including a wished-for part of our self-concept: the therapist who can help her clients and keep them safe. If my client kills themself, I'm never again going to be a therapist whose client did not kill themselves – that version of me is no more.

In cases of suicide, complaints and stalking, anger for our helplessness and what has been done to us are also likely to be present. When acute grief has passed, we'll have more access to our curiosity, and that will be our best tool for learning from our loss. Whatever model of mourning you find helpful, keep it in mind now. Find permission, as well as support, to be sad, angry or lost.

Conclusion

There's a lot we can do to prepare for difficulties, and the investment we make will be valuable, even if we never have to face a major crisis. So, build up your resources in advance:

- within yourself – know your attachment style and develop a compassionate internal conversation
- if you're in a relationship, do the work that will make this a safe haven and secure base
- invest time in your network of friends and colleagues
- have a work-life balance that gives you something in reserve if you do hit an obstacle
- practise your first aid tools
- always have reliable supervision in place.

Measure your progress. What would you need to be doing now if you were to make measurable progress on one of these areas in one month or one year? If you're living through a clinical emergency now, I wish you strength as you draw on your earlier learning. If you've lived through a horrible crisis and been changed by it, I hope this article speaks to some of the struggle you have survived and the loss you now face. ●

ABOUT THE AUTHOR

Anne Power has been an attachment-based therapist for nearly 30 years and has written widely on attachment. Her new book, *Contented Couples: magic, logic or luck?*, published by Karnac Books, is based on interviews with 18 long-term couples from different traditions, including arranged marriage. It explains couple dynamics in an accessible way and describes how partners' complementary attachment patterns can work well together. Anne posts on Instagram: **@and_attachment**, with content for people who want to understand attachment in their relationships. Her TEDx talk, 'Attachment theory is the science of love', also addresses this theme and has been viewed over 500,000 times. **www.contentedcouples.com**

YOUR THOUGHTS, PLEASE

If you have a response to the issues raised in this article, please write a letter, or respond with an article of your own. Email: **privatepractice.editorial@bacp.co.uk**

2 Adams M. The myth of the untroubled therapist. London: Routledge; 2014.

3 de Voogd LD, Kanen JW, Neville DA, Roelofs K, Fernández G, Hermans EJ. Eye-movement intervention enhances extinction via amygdala deactivation. Journal of Neuroscience 2018; 38(40): 8694–8706.

4 Ronnestad MH, Skovholt TM. The developing practitioner: growth and stagnation of therapists and counselors. London: Routledge; 2013.

5 Skovholt T. Skovholt practitioner professional resiliency and self-care inventory. [Online.] https://tinyurl.com/57nvdtzm (accessed 17 October 2024).

Suicide risk isn't binary

When working with suicide risk, therapists in private practice have the freedom to define much of their own practice, writes **Andrew Reeves**

I remember early in my career, when working in statutory services, a consultant psychiatrist telling me that counsellors wouldn't routinely see clients at risk of suicide because, as she put it, they would immediately refer them on to specialist services who were best placed to do such work.

Across my career, I've worked in schools, universities, the third sector and statutory services as a counsellor, and have met many clients with thoughts of suicide. Likewise, as a private practitioner of over 25 years, suicide risk has been an ever-present profile in my work. The inaccuracy of the early advice given to me comes back often and, additionally, I'm reminded daily of the important – and life-saving – support counsellors offer in meeting their clients at a point of suicidal crisis.

It's my core assertion here that private practice counsellors offer something valuable and important to clients around suicide risk, and such exploration can often be a central component of therapeutic work; after all, risk isn't binary, is it? Clients aren't 'at risk', or 'not at risk': rather, risk in its broadest sense is woven into the fabric of our everyday lives for us to explore, consider and navigate as best as we're able, at any given point. Risk of suicide is, arguably, part of some people's existential engagement with the world and, as therapists, we're well-positioned to create an opportunity for such exploration, consideration and navigation.

Why private practice is so critical

Of course, counsellors in the broadest range of contexts work with clients at risk of suicide, but there's something about private practice that perhaps is unique in this respect. In almost all other settings, processes around working with risk are set by an organisation, which counsellors generally must follow. Sometimes, that will be consistent with a counsellor's own professional values, but at other times it might be at odds. In private practice, however, counsellors have the freedom to define much of their own practice and offer a space that's most consistent with their way of working, as well as the ethical, philosophical and existential position they take; only a few aspects of practice are defined by law, and ending your life through suicide is not one of them.

Clients will often access services at the point when they're most available to them: a student accessing school, college or university counselling, or someone with depression or anxiety being referred for talking therapy following a GP consultation. In private practice, however, clients can make an independent choice about their preferred counsellor – perhaps defined by gender, age or culture etc, and around who they feel most able to '...share the immediacy of their pull towards death'.[1]

As I've written much in the public domain about suicide and therapy, I often have potential clients contact me in private practice because they feel I'm best able to hear their thoughts about suicide. In short, the private practitioner sits outside of organisational demands and expectations, and crafts their own practice, consistent with their own values and the ethical requirements of practice. Importantly, in relation to that

latter point, the key ethical requirement around private practice with suicidal clients is that the client is clearly communicated with about the counsellor's approach to working with suicide, and where the boundaries of confidentiality sit, so that the client can make *informed consent* about who they work with and how that work will be framed.

Drawing on the latest evidence

Working in organisations has additionally typically required counsellors to make use of risk assessment tools – tick boxes and questionnaires – to determine levels of risk and make decisions about allocation and discharge. While such tools can offer a gateway into a more meaningful dialogue, they've often been the start – and end – of working with suicide risk. This has, for a long time, been inconsistent with many counsellors' belief systems about practice.

NICE[2] guidance about working with suicide and self-harm makes clear that, drawing on the latest evidence, mental health practitioners (including counsellors) shouldn't use such tools for that purpose, essentially because there's little evidence they have any reliable predictive value. For a fuller discussion of this, it's worth looking at BACP's latest guidance on working with suicide risk more generally.[3] Suffice to say, however, we're instead drawn back to working in a way I suspect many counsellors have always done anyway – to talk to the client about their suicidal thoughts.

Five core principles for the private practitioner

Before briefly exploring the 'tripping hazards' of talking about suicide risk, however, I offer here five key principles for the private practitioner to keep in mind for their work with suicidal clients, as these can help position practice – and the practitioner – well in their work:

1. In its varying forms, risk is an integral part of all relationships, including therapeutic relationships. All clients who present in private practice will do so with some degree of risk, which may include suicide risk.
2. Given that risk is integral, it's helpful for us to embrace that reality, and rather than viewing risk as something that should simply be identified and minimised, we should embrace it as a therapeutic opportunity: 'What does this risk mean for you?' 'What sense do you make of it in your life?'.
3. Risk is not binary and will bring with it different meanings for clients. Our therapeutic task around working with risk is about meaning making, so that the client can make their best sense of their own thoughts and experiences. We must remember that – assuming a client has capacity to make their own decisions – it's not us who will keep the client alive. Rather, our task is to equip the client with their own resources for keeping safe and help-seeking.
4. We must ask questions about suicide risk, clearly, transparently, directly and with empathy. 'I wonder if you have had thoughts about ending your life?' 'When you say that, I wonder if you're talking about acting on your thoughts about suicide?' Not through metaphor or alluding to risk, but directly and in plain language, to create a less-stigmatising space for an honest exploration.
5. It is, of course, not a one-off conversation. Discussions about suicide risk need to be woven through our therapeutic dialogue, when appropriate, so that it becomes a normalised area for exploration and thus, more accessible for the client to begin to think about self-care and self-support.

> "I'm reminded daily of the important – and life-saving – support counsellors offer in meeting their clients at a point of suicidal crisis

These principles not only support ethical practice, but they provide a mechanism for the private practitioner to check out the client's capacity for safety. The recommendations here clearly speak to a context within which the counsellor and client are willing and able to work collaboratively. In the event where the counsellor is concerned about the client's immediate safety, or the client is unwilling or unable to work with the counsellor to explore these issues, this might be a 'red flag' for referral.

Dangers of the unexplored

Talking about suicide is notoriously challenging, however, and the research around 'unacknowledged countertransference' or 'edge of awareness' anxieties can silence us, me included.[4] I offer below a summary of some of these aspects:

- Our own sense of feeling overwhelmed or helpless in our capacity to bring about change can impair our sense of 'being' in the relationship if we don't recognise it. However, it can be a powerful mechanism for helping clients to feel really understood, if named appropriately
- Projecting our own fears of how the client might experience our questions about suicide might lead to us fearing that questions about suicide will be experienced as clumsy or insensitive. Yet often, clients tentatively bring their suicidal thoughts into the room, in the hope their counsellor will take the lead in naming it
- Suicidal thinking can often be centred in feeling worthless or unimportant. We can pick that up too: what difference can we make? Naming suicide and taking the time to explore it can be hugely validating
- Clients will often bring their suicidal thinking – at the first mention – through metaphor or by alluding to it. It's very easy, therefore, to allow our anxiety to not pick it up. Naming thoughts of suicide can be one of the biggest steps in reducing risk
- Colluding with a sense of minimising risk, to help support our own sense of anxiety, can lead us into telling ourselves we're OK when we're not – minimising our own experience of crisis. As counsellors, we can collude with this by not gently challenging these internal dialogues

REFERENCES

1 Shea CA. The practical art of suicide assessment: a guide for mental health professionals and substance abuse counsellors. London: Mental Health Press; 2011.

2 National Institute for Health and Care Excellence. Self-harm: assessment, management and preventing recurrence: NG225. [Online.] https://tinyurl.com/2f52mnt9 (accessed 25 October 2024).

3 British Association for Counselling and Psychotherapy. Talking about suicide risk with clients in the counselling profession: good practice in action resource 042. Lutterworth: BACP; 2024.

4 Reeves A. Working with risk in counselling and psychotherapy. London: Sage; 2015.

- Hearing our client's narratives through an unconscious selective frame (not hearing implicit references to suicide) can make some things hard to hear. If we don't hold this in our awareness, we can select the positives and sidestep the more difficult areas, like suicide
- Fearing getting it wrong and being blamed for not doing enough, or doing too much, can mean that we're pulled into avoiding talking of it entirely. The important factor here is that naming suicide can support us – and particularly our clients – in navigating these concerns
- Fear, anger, a sense of incompetence and impotence when working with suicide are held by many counsellors; our terror can be immobilising.

Ten key tips for practice

In summary, private practitioners have much to offer clients at risk of suicide but must first see risk differently – rather than something to be avoided or overwhelmed by, it's a critical part of any therapeutic process. We must be willing to name it clearly and directly, often taking the lead in doing so, and then working with our clients to build their capacity and capability to keep themselves safe. This can be supported through referral to additional services, where available, with the client's consent, but we must be willing to act if we believe a client is at immediate risk or is no longer willing or able to work with us around their suicidal thinking.

In bringing this together, I offer 10 top tips for the private practitioner to support themselves in this work:

1. Risk tolerance

We need to reflect on our own tolerance to risk: how able do we feel we are to work with risk in our private work, using self-reflection and supervision to explore this? Keeping in mind that our tolerance to risk will be shaped by a variety of factors, including crises in our own lives, health, faith, a sense of overwhelm in our work generally, etc.

2. Crisis, or not crisis

Be clear what it is we're offering: some private practitioners offer out-of-hours crisis support, whereas others don't. If we do, do we have the training and capability to hold that risk, and are we sufficiently embedded in mental health systems for support? This shouldn't be offered in isolation. If we don't, this needs to be clearly communicated to the client. While I worked in a statutory mental health crisis team for many years, I personally choose not to offer out-of-hours crisis support.

3. Fitting in with the system

Make sure we're aware of service availability *before* we need them. How would we access crisis services, or other support? If working online with a client out of the area, we *must* have their GP contact details as part of the registration and contracting process. We don't want to find ourselves needing that information at a point of immediate crisis to realise we don't have it (and such details must be kept up to date too).

4. Contracting

Contracting is the first point where we can explore suicide risk (but not the last), as well as clearly communicating to the client our ways of working and any boundaries of confidentiality that sit around working with suicidal thoughts. We *must* obtain informed consent from the client before commencing therapy with them.

> "...only a few aspects of practice are defined by law, and ending your life through suicide is not one of them

5. Working practices

While organisations typically have policies around risk, as private practitioners, we can do the same. It can be hugely helpful to write out our own working practices around suicide risk, as this can help support equitable delivery of services, and can also inform our discussions with clients to help gain informed consent about our work.

6. Supervision

Supervision is critical at times of crisis, but it's equally critical to talk to our supervisors before a crisis comes along: what are our mutual expectations around risk and preferences around work? It's not a good time, when a crisis arrives, to find out we see practice differently.

7. Referral routes

If we need to make a referral for a client (with or without their consent), do we know how? It's important to find that information out before we need it.

8. Record keeping

We must always include in our record keeping specific details of discussions about suicide risk: what was said, by whom, what was agreed, and the outcome of any actions. This supports good practice, as well as allaying practitioner anxiety.

9. Keep-safe plans

NICE talk about 'keep-safe plans', and these can be the cornerstone of good practice in supporting clients to keep themselves safe. These are discussed in more detail in the BACP resource,[5] as well as the online resource, listed below.

10. Regular review

Remember, this is not a one-off process. Review keep-safe plans and broader discussions around risk regularly, so that such discussions become a normalised aspect of our therapeutic explorations. ●

ABOUT THE AUTHOR

Andrew Reeves is Professor in Counselling Professions and Mental Health at the University of Chester, a BACP (Snr Accred) counsellor and psychotherapist, an EMCC senior accredited coach and coach supervisor, and a registered social worker.

YOUR THOUGHTS, PLEASE

If you have a response to the issues raised in this article, please write a letter, or respond with an article of your own. Email: **privatepractice.editorial@bacp.co.uk**

5 British Association for Counselling and Psychotherapy. Exploring suicidal risk with clients resource. [Online.] https://tinyurl.com/555cvuaj (accessed 25 October 2024).

NICKY MARSHALL

> I've been reflecting on the impact on the therapeutic relationship when there's a literal baby in the room

Nicky Marshall is in private practice and a trainer at the Re-Vision Centre for Integrative Transpersonal Counselling and Psychotherapy. She is a contributor to *Transformation in Troubled Times* (Kaminn Media Ltd).

It's interesting to notice a pattern emerging in one's practice. Recently, I've been working with three pregnant supervisees, and over the past few years, I've usually had a pregnant student in the final year of the training on which I teach. So, I've been reflecting on the impact on the therapeutic relationship when there's a literal baby in the room, not only the inner child of the client (and therapist), and what this means for all three – therapist/mother-to-be, client and unborn baby.

Given how much mothers have traditionally been the focus of therapeutic work, and the way that the mother/child relationship often receives so much attention in the work with clients, it's curious how little professional literature there is on this subject. In writing this column, and talking with my supervisees, it's also emerged that this invisibility is mirrored in our professional bodies – neither UKCP nor BACP have the flexibility to recognise the specific status of registrants taking maternity/parental leave in pausing their registration for the duration.

Sporadically, over the years, I've worked with the occasional pregnant supervisee, but the extent to which the issue is asking for attention in the supervisory space has prompted me to ponder what might be behind this. One thought that occurs to me is that there are well-documented statistics that people, including therapists, are waiting longer before having a child.[1] There is thus an increased likelihood that a therapist may well have an established practice before choosing to conceive.

Conversations in supervision have had to address numerous facets of the situation – from the practicalities of how and when to tell clients about the impending break; concerns for the wellbeing of the baby, especially if the therapist is experiencing a lot of stress in the workplace;[2] to all the individual meanings that the pregnancy will have for each and every client, and how this will play out in the work.

The post-pandemic increase in working online has added further complications. When working in the room, there comes a point when the client's going to start to notice something. Online, when the client can only see the top half of the therapist's body, there is, theoretically, more choice about when to make the disclosure, but even then, the presence of the foetus, energetically and within the psyche of the therapist, will have some influence on the field of the work.

In one instance, a client seen online for support around difficulties in conceiving, spent several weeks reporting her distress when yet another colleague or friend announced they were expecting. Shortly before it reached the point where disclosure of the pregnancy was becoming imperative, and after much reflection in supervision about how best to hold the conversation, she elected to stop the work and seek counselling with her partner – although she couldn't have consciously known, her unconscious had clearly intuited the presence of the 'third being' in the relationship.

When disclosure becomes necessary, whether in the room or online, there's the uncertainty of when the work will end. While a finish date can be set considering the baby's due date, maternal health may dictate an earlier end than planned. This needs to be talked about, in fairness to the client, so that they can be involved in planning the end and engage with the decision whether to end for good, or to plan on a return when the therapist comes back to work.

Therapeutic themes attended to have included clients who have a history of a troubled experience when a younger sibling came along; clients who've made conscious choices about not having a child, often for environmental reasons, and who are in counselling for support with environmental and climate anxiety; a client with a child with a disability from birth; clients working with the legacies of childhood trauma and abandonment, and those whose survival depended on being 'nice' and who struggled to give a place to their own feelings of sadness and anger that their therapy was coming to a close.

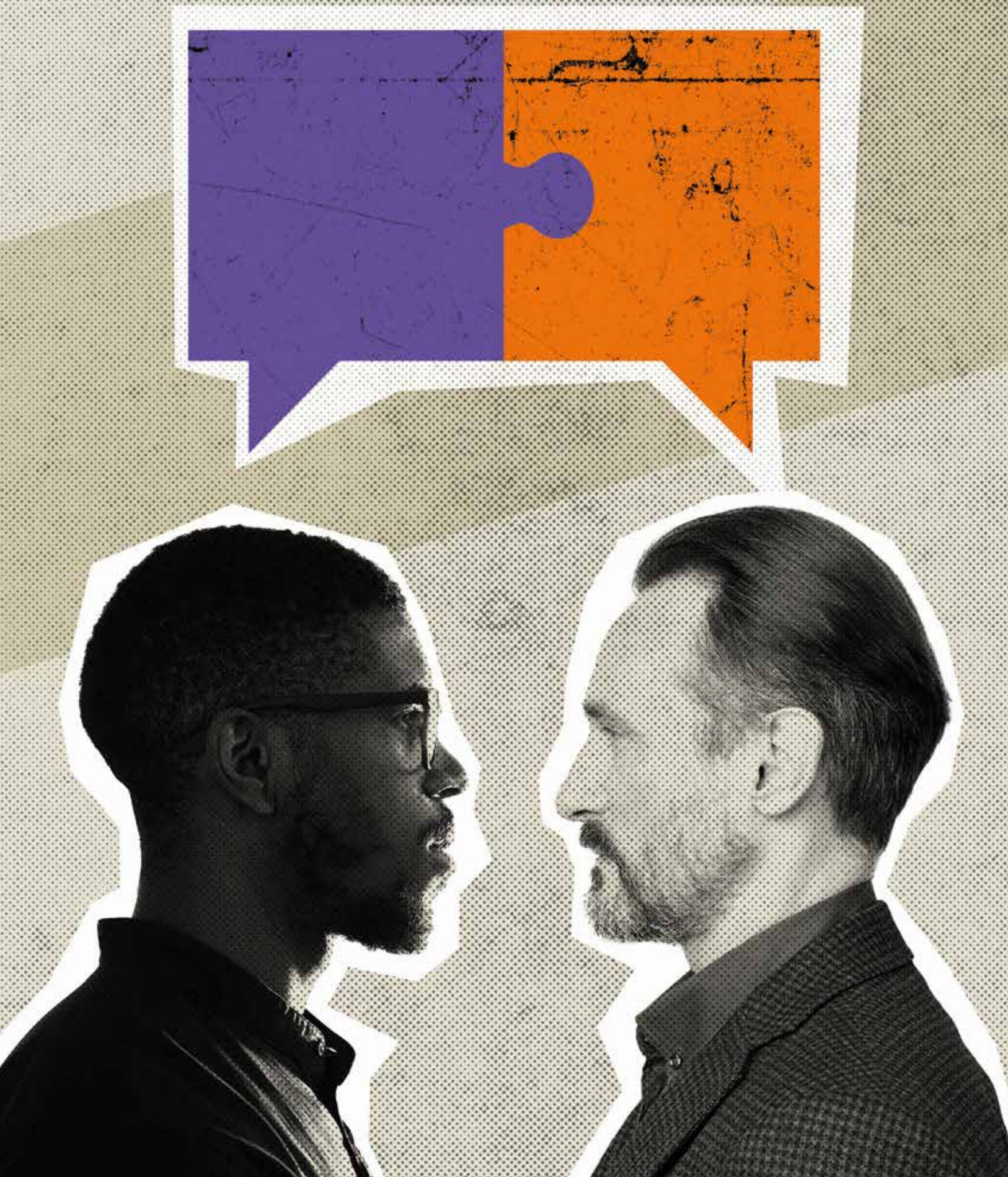
We've also thought about the various fantasies that clients might entertain about the nature of the therapists' private lives, the conception of their babies, and all that this may evoke. In all these reflections, we've held that the new life the therapist is bringing into the world is a tangible and embodied manifestation of the possibility of change, and new life in symbolic form.

And finally, I've been conscious of what I've felt for the supervisees and the babies they're carrying. Not all my supervisees have had an easy time conceiving, and this has evoked deep maternal feelings in me, as someone whose own daughter required assistance to conceive. As a grandmother, I've also felt a grandmotherly tenderness towards the unborn children who've been in the supervision meetings. The meaning and deep soul significance of all these threads, for supervisees, their clients and for me, has been a rich focus of reflection.

REFERENCES

1 Office for National Statistics. Census 2021. Birth characteristics in England and Wales: 2021. [Online.] https://tinyurl.com/542r4bwy (accessed 14 October 2024).

2 Coussons-Read ME. Effects of prenatal stress on pregnancy and human development: mechanisms and pathways. Obstetric Medicine 2013; 3(6): 52-57. https://tinyurl.com/yc67dxe6 (accessed 14 October 2024).



Bridging the gap of difference

Matthew Johnston on the essential need for cultural competency when working with black clients

The premise of my presentation at the recent BACP Private Practice Conference in September was to directly address white practitioners who, due to a lack of exposure and/or experience, struggle to connect with black clients, or simply wish to strengthen their practice with black clients. As I did during the presentation, when referring to white counsellors and whiteness, I'll be doing so only in reference to those who struggle with a lack of understanding, experience or connection with black individuals. This article isn't intended to address or make claims about all white practitioners, merely those who can admit (or not) to having gaps in their cultural awareness.

> "...a large proportion of white counsellors come from white worlds which can, despite the practitioner's best and most genuine efforts, create a distance between client and counsellor

I make this distinction and raise this discussion because the truth of the matter remains that a large proportion of white counsellors come from white worlds which can, despite the practitioner's best and most genuine efforts, create a distance between client and counsellor. I seek to offer some insight into what I've found to be useful in reducing this sense of distance and connecting with black clients.

'That must be so hard for you'

My work with black clients has come about in two ways. As a counsellor and team lead within university counselling services, my work with black clients has been a response to the increased demand for culturally competent provision in the aftermath of the murder of George Floyd and the emergence of the Black Lives Matter movement. Black students were hurt, scared and angry, and needed to feel secure in exploring these emotions with somebody they felt safe and comfortable with.

To address the issue of the lack of black representation in counselling service staff, I put together a black students' support group to offer wider access to a black psychotherapist (me) and a safe therapeutic space. In my private practice, my work with black clients comes from a more implicit preference or need for cultural familiarity and acceptance. Much less is said initially about cultural proximity, however an unspoken understanding is always clear, usually through the ease with which culturally specific details are brought up and explored.

In both cases, what I bring to my role, and perhaps what's desired, if not expected of me as a black psychotherapist, aside from my professional ability, is the value of having looked at life through a similar lens; having a shared vocabulary with which to describe and interpret reality; and the experience of having to work out how I too must live and survive as a black individual in this world. In my experience, this sense of a shared

> What, or who, does the maintenance of the distance between a white practitioner and the black individual's experience of racism serve?

perspective is often accompanied with a sense of security and relief at the likely prospect of being accepted and understood.

In both settings, I often work with black clients who've previously worked with white counsellors and, unfortunately, all too often, the experience is reported of having to explain the mechanics of racism or some other culturally specific aspect of their life while getting very little useful support in return. The sin is amplified if, after learning about racism for the first time, your white counsellor says, 'That must be so hard for you'. As well-meaning as the sentiment is intended, like a righteous admission of ignorance and a highlighting of the client's expertise in a certain brand of trauma all at once, to the black individual on the other end, it emphasises that, as far as the counsellor is concerned, this is *your* problem, and not a problem that will ever affect them. A unique moment in which the mental health expert in the room readily jumps up to admit having zero experience of a central issue, as if that's in some way helpful or good.

You wouldn't give a client suffering with anxiety the impression that you know nothing about the experience of anxiety and expect that to help. On the contrary, you may be tempted to offer a sense that you understand how anxiety works, through professional or even, heaven forbid, personal experience. So why are some issues solely within the client's range of expertise and others not? What, or who, does the maintenance of the distance between a white practitioner and the black individual's experience of racism serve?

My sense is that, perhaps, the urge to distance yourself from the traumatic experiences of another is a subconscious attempt at self-preservation. A stand against the notion that such horrors could possibly befall you, as if your whiteness serves as a shield against having to consider the possibility of experiencing the level of suffering and stress associated with racism and the black experience.

Not understanding an issue is one thing, but not feeling the *need* to understand it, further than being able to give the appropriate impression of empathy, is another.

If this wilful disconnection from the experience of the black client is clear, or if the possibility to form a real connection is unclear, then there's an unavoidable separation, which leaves the client to process their trauma in isolation.

Difference, otherness or variation?

Part of my work with black students within university counselling services has involved writing reports with detailed feedback and suggestions offered by me and my black clients. This feedback includes the students' experience of feeling limited, muted or disconnected from white practitioners, and an inevitable call for and recognition of the value of black therapists. For some therapists, and indeed some of my colleagues, however, there's an argument that their therapeutic modality and expertise offer substantial enough therapeutic value that to question the quality of their cross-cultural work based solely on their whiteness is unfair. In response, I would question the basis on which there can be any certainty that the modality you adhere to was designed with the black experience in mind? And who takes most risk in believing in the universal utility of the classic modalities?

Time and again, I've spoken with black clients who've had alienating experiences with white counsellors who just didn't seem to care about or understand what they brought to therapy. Some clients would report having to repeatedly explain cultural nuances and watch as their counsellor feigned an understanding. Others would respond to the first instance of disconnection by omitting any further reference to culturally specific experience, to make their therapist's life easier. Others would try in vain to overlook the fact of being misunderstood and hope to at least gain something out of hearing themselves engage in their own process, amidst the nods and knowing noises coming from their well-meaning yet otherwise inconsequential counsellor.

When we decide that the safety in the room and the quality of the work is *never* threatened by our being white or person-centred or of a different generation, are we simultaneously saying that it's the blackness, culture, trauma or perspective of the client that compromises the success of therapy? Is it the otherness in the room? Or the very *perception* of otherness, an insistence on the existence of an objective 'other' that causes a disconnection? An insistence that difference *is* otherness.

In my work, while being, in some way, of African descent seems to at least reduce a sense of obstructive 'otherness' with black clients, it isn't the mere colour of our skin nor superficial cultural similarity that drives the substantial content of our discussions. It's the sheer amount of time we've spent, and are willing to continue to spend, thinking about and processing our emotional responses to the same or similar enough problems.

I don't have to be a black woman to understand and have an interest in wanting to solve, at least in some personal way, the issue of the 'angry black woman' stereotype or the appropriation and whitewashing of African feminine beauty. I have a black mother, sister and daughters – being male doesn't preclude me from having a relationship with their suffering. Furthermore, my being male doesn't preclude me from experiencing versions of the *same* experience. I too struggle against an 'angry black man' stereotype. I too am affected by a fetishisation of African masculinity in the white gaze.

I understand, as do my black clients, that any difference between us doesn't automatically create a sense of otherness but a degree of *variation* of the same human experiences. In this regard, there's always

> Time and again, I've spoken with black clients who've had alienating experiences with white counsellors who just didn't seem to care about or understand what they brought to therapy

something clear on offer to both black client and counsellor in the therapeutic space in being able to share and explore some of the most difficult and complicated issues. What variation of a so-called black or culturally specific issue might you, as a white therapist, be able to relate to? And what might be on offer to you if you had the opportunity to explore such an issue?

What does the work have to offer?

If there's anything a white practitioner should address to improve their work with black clients, it's their ability to identify the points at which they share the fundamental problems of the black individual. Learn to see yourself in others, despite superficial difference. Realise that an insistence on the restrictive significance of difference, even if meant as an attempt at achieving some sense of equality, only strengthens the boundaries between us.

We want our anorexic clients to find health, our anxious clients to feel safe, our depressed clients to feel joy, our suicidal clients to survive and thrive, because on some level, we can relate to their response to the trials and tribulations of life. If there's a way forward for them in their journey, there's a way forward for us, as feeble individuals who happen to be counsellors and psychotherapists.

Find what's on offer to you, as a white practitioner, in the journeys of your black clients. Would it not be inspiring if, at the very least, what was on offer to you was the opportunity to bear witness to triumph over inequality? To see that injustice doesn't always prevail? Would that not help spur the struggler in you forward in your own life? Or offer a sense of hope and renewed faith in people's (and therefore your) ability to cope with reality? And in coming to such realisations, in beginning to see yourself in another, there lies the possibility for true collaboration, connection and mutual benefit. This and, in my experience, only this is what dissolves a sense of otherness – not aesthetic similarity or even a shared culture, but when I can see and admit that what threatens you also threatens me, and that your survival increases the likelihood of my own.

A cultural education

A critical part of strengthening your work with black clients is addressing the extent to which you find yourself in meaningful relationship with black people. In some cases, an ability to tap into a shared journey with black clients may come a lot easier to black practitioners, but this is by no means a guarantee. Whether or not there's a shared cultural perspective, there also needs to be the readiness, willingness and capability to be exposed, vulnerable, emotionally connected and congruent. Shared blackness doesn't immediately equate to shared process or understanding.

Generational, religious, cultural, geographical and political differences, and difference in general life experience, are all factors that can result in a reduced sense of cultural proximity between black client and counsellor. A comprehensive cultural education is therefore necessary, no matter what group you come from.

As far as a black cultural education is concerned, there's no better source to draw from than the various windows into the lives of others that are gained through listening to, communicating with and investing in diverse black perspectives. This is no simple task and not something I expect everyone to have the capacity to do.

For instance, the only reason I feel as confident as I do working with white clients as a black psychotherapist, is off the back of

years of being in active relationship with white people. With white friends, colleagues and family members; white media and cultural norms; English and British identity and history; the political concerns and fears of white people. I'm well-studied in white society and can quite comfortably communicate, understand and appreciate a range of white experiences. This is the reality of being minority: you become fluent in the language of the majority. This is true cultural competency.

Replicating this sort of education requires time, dedication and access to the black experience. Outside of personal or professional relationships, there's a wealth of media available online in the form of film and documentary. Non-fiction stories told by black authors offer a source of nuanced black perspectives. Don't, however, expect to learn something about black British reality from African American media. Don't watch *Top Boy* and expect to learn something broad or concrete about black British reality. Don't expect to learn anything broadly applicable from your individual black clients.

The problem with words like 'black' or 'white' is that they are entirely useless in conveying any sense of meaning beyond what's noticeable at the lowest resolution. How 'black' can be a category to describe people from the Americas, through the Caribbean, across the Atlantic Ocean to West Africa, all the way through to East Africa, can only be a result of ignorance, if not sheer contempt for the value, beauty and diversity of peoples of African descent. Given how flimsy our definitions can be, there's no one film, book, cultural competency course or client you can rely on to educate you in the reality of the 'black' experience. When you imagine a black client, what do you imagine? What has your experience with black people thus far led you to believe about what constitutes being black?

Not for everybody

Of course, when suggesting such an expansive and immersive undertaking, such an enterprise can't and shouldn't be taken on by all. I believe it to be entirely reasonable for the white (or any) practitioner to look at themselves and assess the degree to which they're appropriately suited to cross-cultural work. It's not realistic or responsible to attempt to be all things to all people. My wife wouldn't visit the gynaecologist if their experience in the field was limited to the odd book or documentary. We don't accredit counsellors without the required amount of clinical experience. We make the distinction between trainee and qualified. We demand professional qualification and experience before we put faith in those we trust (or pay) to support us. This too is the demand of black clients. If you don't have the experience in the field, don't practise.

> "You wouldn't give a client suffering with anxiety the impression that you know nothing about the experience of anxiety and expect that to help

If diversity in the field of psychotherapy remains scant, and it can be the case that black clients aren't necessarily better off with black counsellors, then there is, depending on where you practise and what you offer, a real chance that a black client will walk through your door, in pain and crisis, having already had to overcome a multitude of barriers and stigma to see you. This is a person seeking another person to help find a foothold in the treacherous terrain of life. What they seek is the part of you that can help, hear, understand and be invested in their recovery.

For the black client there is nothing more reassuring than walking into a therapeutic space and, after having gone through whatever it took to be there in the first place, feeling assurance that they'll be understood. That, for instance, the professional in the room *already* knew how to pronounce their name; that they don't need extensive teaching about the impact of being a minority, a Muslim, a first or third generation child, or having English as a second or third language; that they have not only imagined themselves in those positions but can see enough of themselves in those positions that in their eyes is a warm, familiar look, as if, in some way, they've already met you and are happy to see you again. ●

ABOUT THE AUTHOR

Matthew Johnston is a psychotherapist currently practising at the University of Nottingham as Counselling Team Lead as well as in private practice. He's been in practice over 10 years and has a background in youth work. He currently works with young people, adults, couples and families. Matthew enjoys and feels privileged to work with a diverse range of people and most keenly enjoys working with those who thought therapy wouldn't be for them.
www.mjtherapy.co.uk

YOUR THOUGHTS, PLEASE

If you have a response to the issues raised in this article, please write a letter, or respond with an article of your own. Email:
privatepractice.editorial@bacp.co.uk

SIMONE LEE

> Monumental and trivial, your choices constitute your temporality

Simone Lee is an integrative existential therapist and supervisor in private practice in North London. Prior to COVID-19, she taught on counselling and psychotherapy trainings for 20 years.
tinyurl.com/3cfpa6vv

Thank you for deciding to read this. As a gesture of thanks, here's your biography: You were thrown into the world at birth without being asked about your preferences regarding parents, family, era, status, health, wealth, location, physical attributes, language etc. Since that affront, you've had to live your life in a world fraught with uncertainty, populated with other people and in a global environment, while all the time being propelled towards your ultimate breath.

If that's not bad enough, your burden – my fellow temporal being – is that you've had to make choices continuously. What to watch on Netflix? Quinoa? Change your sheets? Put your fees up? Floss your teeth? Climb Kilimanjaro? Swat a fly? Admit you were wrong? Throw yourself under a train? Monumental and trivial, your choices constitute your temporality.

Heidegger designates us humans as '*Dasein*'[1] (the 'There of Being') and thought we *all* exist within a shared, encompassing, greater realm of Being. This is why your biography is also true for reality TV celebrity Molly Mae-Hague, the *Big Issue* seller outside Waitrose, Tommy Robinson, Queen Camilla, Judith Butler, Marcus Rashford, the 263 bus driver, and everyone else who's ever been and ever will be.

Paradoxically, the commonality of your human situation sits alongside the fact that your life is uniquely an issue for you; it matters to you in a way that couldn't possibly matter to somebody else, because you're the one who lives it. Sartre states: 'Man is condemned to be free.'[2] Once born, only *you* can live your life, and die your own death. No one else can do it for you: you're autonomous and responsible for your choices.

Sartre goes one step further. Not only do we make choices, we *are* our choices, and through these we create ourselves. 'Existence precedes essence.'[3] We're not born as fundamentally predetermined, fixed selves, but are in a state of becoming. So, while on one hand our interests are vitally at stake, literally, when we make decisions, the upside is we are disburdened from being immutable human objects and are instead beings brimming with possibility. We can, therefore, disgorge the belief that we're sentenced to be the good one, the bad one, or the ugly one. This might even spur us to be creative and excited about being human, and more yielding and receptive to the contingency upon which our lives are predicated: a pivot of active and passive.

We're all, clients included, invested in trying to influence the trajectory of our lives. We all face dilemmas and life's conundrums. Our naivety might tempt us into believing that happy outcomes can somehow be guaranteed if only we look in the right places. But we're hurtling into uncertainty, into the unknown yet unlived future, over which we have no ultimate control. 'Life can only be understood backwards, but it must be lived forwards,' says Kierkegaard.[4] Decisions are therefore not clear-cut. Kierkegaard writes ironically: 'There are two possible situations — you can either do this or that. My honest opinion and my friendly advice are this: do it or do not do it – you will regret both.'[5]

When we choose, we're at risk of irrevocably losing all the possibilities we've just eschewed. Notwithstanding, the best we can do is to be guided by what feels true and right for us at the time, underpinned by our values and meanings, within the specificity of the situation and knowledge we have. Pinning all value on a decision is missing the point that it's more important to own and engage with your choice, whatever it is and *however it plays out*. That doesn't mean we have to stick to a chosen path no matter what, for that would be betrayal of our freedom. For, as we've established, choices are constantly present.

The spirit of Nietzsche's '*amor fati*'[6] ('love your fate') exhorts us to be continuously open and responsive to fate as it unfolds: you have one life and this is it, square up to it. At all junctures, we're plunging into the unknown. Of course, we don't want a life beset with bad things, but we can't avert them by averting our gaze. If we don't take courage to live committedly, we're in danger of disengaging from the present lived experience of the here and now, whatever its quality. If we refuse to take responsibility for our lives, we might be mired in the past, tormented by regret, or desperately projecting into the unknown, unresponsive future. Beware, despair has many guises.

And my client who tussles with a dilemma? Of course, I listen with empathy and explore with phenomenological openness. But I don't get drawn into helping to find a 'right answer'. I try to tune into the core human concerns that underlie the conundrum in focus; they may be veiled, but they're always there. And I listen out for whether my client feels agentic, alive and courageous. We take the conversation from there, human to human, mindful of the poignancy of Eliot's words: 'Humankind cannot bear very much reality.'[7] Quinoa? No thanks, I'll stick to freekeh.

REFERENCES

1 Heidegger M. Being and time. London: London: SCM Press; 1962.
2 Sartre J-P. Being and nothingness: an essay on phenomenological ontology. London: Routledge; 2003.
3 Sartre J-P. Existentialism is a humanism. New Haven, CT: Yale University Press; 2007.
4 Kierkegaard S. Kierkegaard's writing, III, part I: either/or. Princeton, NJ: Princeton University Press; 1987.
5 Kierkegaard S. Papers and journals. London: Penguin Classics; 1996.
6 Nietzsche F. The gay science. Cambridge: Cambridge University Press; 2001.
7 Eliot TS. Four quartets. London: Faber and Faber; 2001.

CHRISTINE SCHNEIDER

> Within the therapeutic relationship, the dynamics of gift-giving can become complicated

Christine Schneider HCPC (Reg) clinical psychologist and BACP (Snr Accred) counsellor and supervisor, offers online therapy, supervision and training worldwide. You can hear Christine talk about mental wellbeing topics every week on *Metal Therapy* and *The Friday Morning Show* on Cambridge Radio.
www.cambridgetherapycentreseminars.co.uk

My mother was very much a gift giver, something I'm reminded of as the festive season approaches. Whether we like to admit it or not, Christmas is synonymous with gifts – tokens of appreciation, love and sometimes gratitude for help and support received throughout the year. Within the therapeutic relationship, the dynamics of gift-giving can become complicated. This is particularly relevant towards the end of the year, when Christmas and other cultural celebrations that centre around the giving of gifts take place, and our clients may feel a heightened urge to express their gratitude in a tangible way.

While it's natural for clients to want to show appreciation, it puts us in a difficult position. Our professional guidelines are clear: accepting gifts from clients can impact the therapeutic relationship, potentially blurring the boundaries that protect both parties. But there's also the other side of the coin – the perspective of the gift giver – and since my mother was a gift giver, I often became a gift giver by proxy.

Reflecting on my own childhood, I remember the tension and embarrassment I felt because of my mother's insistence on giving often extravagant gifts to my teachers. She was always keen to express her appreciation with something tangible and often expensive. When I was 10, she made me give a luxury perfume to my favourite PE teacher. I still remember vividly the sinking feeling followed by excruciating humiliation when the teacher took me aside to explain that she couldn't accept such a lavish gift, not because she wasn't grateful, but because she felt it was inappropriate. And although I hadn't done anything wrong, I was left feeling reprimanded and deeply shamed.

A few years later, when I was 15, the experience repeated itself in a different form. This time, my mother insisted that I give a bottle of Champagne to a teacher who had mentioned that he'd never had the opportunity to try it. I didn't want to, but, once again, she made me. I did my best to hide the massive bottle from my peers throughout the morning, hoping to give it discreetly and unnoticed. But, despite my efforts, a classmate saw me, and the situation quickly became food for gossip. Again, I was mortified, and again, I was the one who had to suffer humiliation and embarrassment, despite not actually having done anything wrong. Thankfully, this time round, the teacher accepted the gift graciously and with thanks, but the act of giving the gift had made me feel exposed, awkward and unsure of my standing with both the teacher and my peers.

These personal experiences taught me to be mindful of how I respond to unexpected gifts. Clients might give a gift as a way of showing appreciation or marking the end of the therapeutic journey. But the act of giving a gift can hold different meanings, some of which we might not be immediately aware of. For some clients, it could be an attempt to deepen the relationship. While for others, it might simply be a genuine gesture of thanks.

Rejecting a gift outright may come across as dismissive or hurtful, particularly if it's given with pure intentions. At the same time, accepting a gift without consideration for its potential impact on the therapeutic relationship can lead to boundary issues. One approach that works for me is to consider the context. If a client brings a small token to their final session, I might choose to simply accept the gift with a straightforward, 'Thank you very much', instead of exploring the act of giving a gift to their therapist any further.

The key here is to consider the client's feelings, and the timing and nature of the gift. At this time of year, the issue can become complicated, given the cultural emphasis on gift-giving. I've found it helpful to address this early with clients, sometimes even discussing the topic during the weeks leading up to the festive season. December is probably the only time where I try and cover specific topics in my sessions. I usually make a point of asking clients about the festive season, what it means to them, and how they feel about Christmas or other holidays they may be celebrating, depending on their culture. As part of this, it can be easy to slip into the conversation that therapists don't typically accept gifts due to professional boundaries, thus preventing an awkward situation from arising in the first place. That said, every situation is unique, and, unfortunately, there's no one-size-fits-all answer.

Our reaction to gift-giving needs to be mindful of the dynamics of the therapeutic relationship and sensitive to the client's perspective. As we head into the festive season, it's worth reflecting on how we might handle these situations, ensuring we communicate ethical boundaries with empathy and care. And please spare a thought for 10-year-old me, since the gift giver's perspective could already be more complicated than you may have realised.

Rupture and repair

Andrew Grimmer proposes an 'opportunity-threat' model of rupture and repair that applies both to personal and therapeutic relationships

The concept of rupture and repair is relevant across diverse therapeutic orientations. Muran et al state that a rupture is a '...marker for the messiness in the patient-therapist relationship' and repair a 'critical change process'.[1] Wile[2] emphasised that while couple conflict is inevitable in intimate partner relationships, a well-managed repair can deepen connection. Gottman and Gottman[3] identified the ability to avoid escalating conflict as one of the strongest predictors of relationship longevity.

This article aims to formulate a description of rupture and repair that applies both to personal relationships and to the therapeutic alliance, highlighting the shared processes that strain relationships and the relational techniques that promote repair. Given that ruptures can lead to either positive or negative outcomes, depending in part on how they're handled, I propose an 'opportunity-threat' model of rupture and repair that applies both to personal and therapeutic relationships.

Rupture and repair in personal relationships

The opportunity-threat model in personal relationships describes a cyclical relationship between relationship satisfaction, violated expectations, rupture and repair. There are two versions: a virtuous cycle of effective repair (Figure 1) and a vicious cycle (Figure 2).

How stress is handled plays a big part in relationship satisfaction. Many of a couple's daily tasks of living involve managing stresses brought about by external events, state factors (such as mood) and enduring personality characteristics. Bodenmann[4] found that chronic minor stresses erode relationship quality and predispose a couple to increased frequency and severity of ruptures. When couples are unable to develop effective shared strategies for managing stress, it contributes to reduced satisfaction, alienation, and ultimately separation. Wile[2] pointed out that even in satisfied couples, there are points where the sensitivities of one partner grate against the sensitivities of the other. These manifest as aversive behaviour that violates expectations of what should happen in a relationship or come as an unwelcome surprise.[5]

A rupture response is a reaction to aversive behaviour. Rusbult et al[6] describe four responses:

1. *Exit* by leaving a relationship
2. *Voice* by articulating your discontent
3. *Loyalty* by willingness to persevere
4. *Neglect* by allowing a poor situation to deteriorate.

A relationship rupture can therefore be defined as withdrawal (exit, neglect, loyalty) or confrontation (voice) in response to a violated expectation or aversive behaviour. While neglect is almost always destructive, the other responses depend on circumstances and how they're handled. An exit from an unsatisfying relationship might be advantageous; loyalty helps couples pick

REFERENCES

1 Muran JC, Eubanks CF, Samstag LW. Introduction: rupture in a wicked and wonderful world. In: Eubanks CF, Samstag LW, Muran JC (eds) Rupture and repair in psychotherapy: a critical process for change. Worcester MA: American Psychological Association; 2023 (pp 3–20).

2 Wile D. After the honeymoon: how conflict can improve your relationships (revised edition). Collaborative Couple Therapy Books; 2008.

3 Gottman JM, Gottman JS. Gottman method couple therapy. In: Gurman AS (ed) Clinical handbook of couple therapy (4th edition). New York, NY: The Guilford Press; 2008 (pp 138–164).

4 Bodenmann G, Ledermann T, Bradbury TN. Stress, sex, and satisfaction in marriage. Personal Relationships 2007; 14(4): 551–569.

5 Miller RS. We always hurt the ones we love: aversive interactions in close relationships. In: Kowalski RM (ed) Aversive interpersonal behaviors. New York, NY: Plenum Press; 1997 (pp 11–29).

6 Rusbult CE, Zembrodt M, Gun LK. Exit, voice, loyalty, and neglect: responses to dissatisfaction in romantic involvements. Journal of Personality and Social Psychology 1982; 43(6): 1230–1242.

Figure 1: A virtuous cycle of rupture and repair in personal relationships

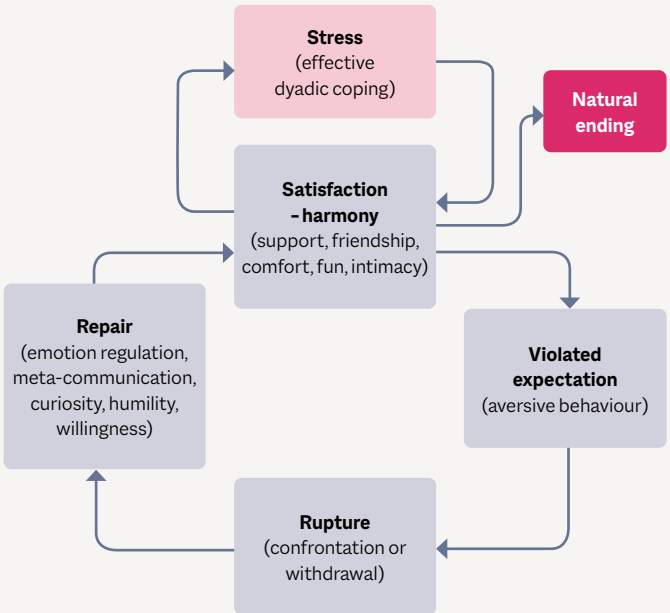
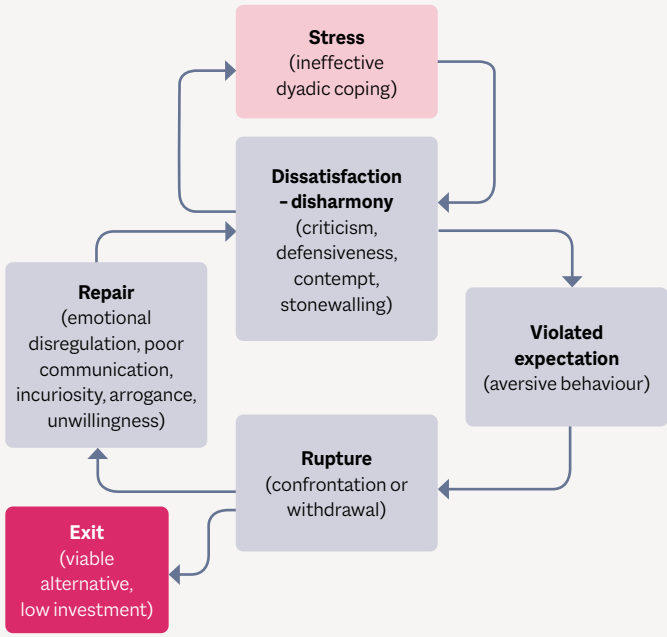


Figure 2: A vicious cycle of rupture and repair in personal relationships



> A competently handled rupture is an opportunity to uncover issues that need addressing and to get to know each other at a deeper level

their battles; and voice depends on the way concerns are raised. On the other hand, a premature exit, misplaced loyalty, or raising a complaint in a harsh manner,[7] could all be inadvertently destructive.

A couple who engage effectively in rupture repair can quickly move back to a state of satisfaction. Repair can take diverse forms. Gottman and Silver[8] developed a repair checklist of suggested phrases to help couples remain focused on prioritising the relationship over the specific topic of disagreement. Fruzetti's[9] dialectical behaviour therapy (DBT) approach to high-conflict couples focuses on the importance of validation. Integrative behavioural couple therapy (IBCT) invites couples to reflect on ruptures to deepen empathy and increase acceptance of difference.[10] Case's[11] model for treating the profound rupture caused by infidelity focuses on the transgressor's sincere apology through empathic attunement to the hurts caused by betrayal, while the wounded partner commits to forgiveness, that is, to stop punishing the transgressor. A competently handled rupture is an opportunity to uncover issues that need addressing and to get to know each other at a deeper level.[2]

A rupture can also lead to a 'final straw' irreparable breakdown and exit; a temporary truce that leaves the couple bond still strained; or avoidance combined with hope that the rupture repairs itself. Unhappy couples might find themselves trapped in a cycle of painful ruptures and ineffective repairs, such that dissatisfaction becomes more entrenched, and satisfaction is fleeting and unstable.

Understanding rupture responses that do not involve exit in unhappy relationships appears paradoxical. Rusbult et al's[12] investment model of commitment processes suggests that it's not a consequence of individual pathology but three interacting factors:

1. Satisfaction (positive qualities that attract partners to each other)
2. Investment (ties that bind each other)
3. Alternatives (the lack of a better option).

Even if satisfaction is low, the lack of viable alternatives or a strong investment in the relationship might prevent an exit response.

The opportunity-threat model describes how couples cycle through a process of rupture repair that either strengthens (opportunity) or weakens (threat) their satisfaction and security. The two illustrated versions represent ideal states for the purposes of describing the cycle; many couples are neither wholly satisfied or dissatisfied, that is neither relationship 'masters' or 'disasters'.[8] When couples learn they can manage ruptures without doing damage to the feelings they have for each other, it increases their confidence in speaking their mind or raising complaints, making them better able to manage life stresses and support each other. When ruptures are feared or avoided, couples are unable to resolve problems or maintain a constructive dialogue about points of difference, which can make the possibility of a rupture seem more significant, less controllable and more aversive.

Rupture and repair in therapy

Bordin[13] described psychotherapy as a purposeful collaboration between client

Figure 3: A virtuous cycle of rupture and repair in psychotherapy

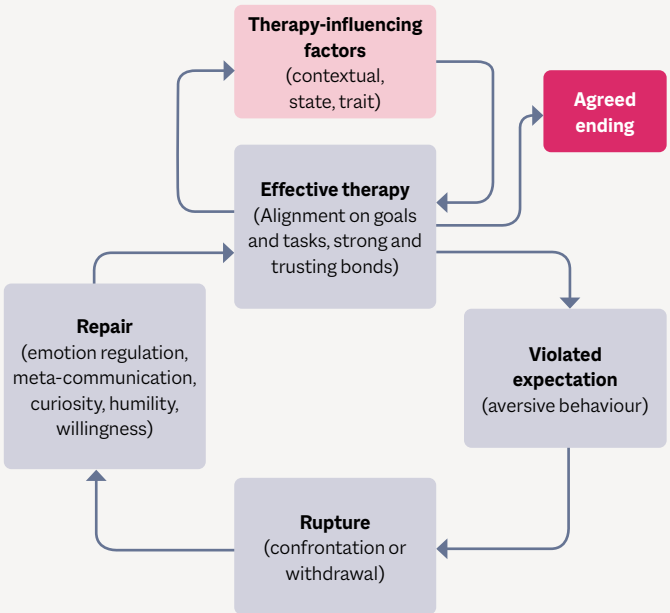
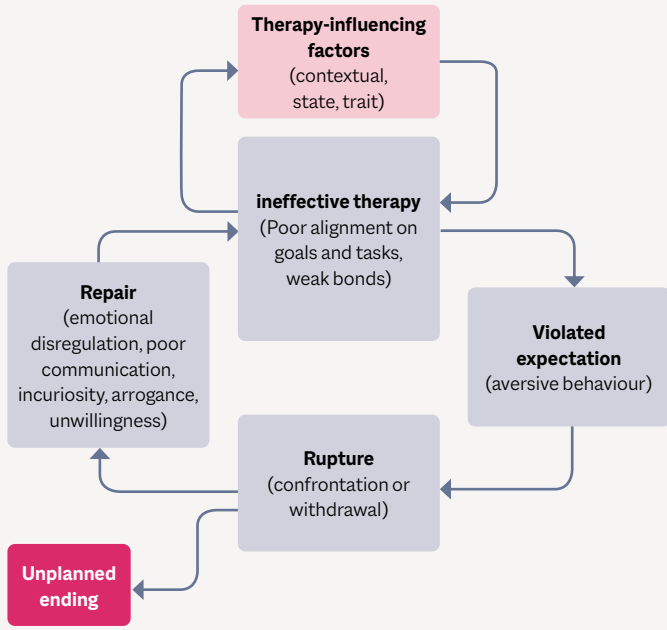


Figure 4: A vicious cycle of rupture and repair in psychotherapy



('the person who seeks change') and therapist ('the one who offers to be a change agent') that requires a working alliance consisting of '...an agreement on goals, an assignment of task or series of tasks, and the development of bonds'.[13] Barton,[14] from a CBT perspective, condenses it into two components: a trusting bond and a change process. For a trusting bond, the therapist must be supportive, consistent, empathic and compassionate, while the client must be disclosing, emotional, vulnerable and trusting. For an effective change process, the therapist must be curious, hopeful, provide a rationale for change, and facilitate learning, while the client must be reflective, set goals, be open to new learning, and prepared to experiment. Treatment complications arise when one of the participants in the therapeutic dyad is either unwilling or unable to provide these conditions for therapeutic change.

> A couple who engage effectively in rupture repair can quickly move back to a state of satisfaction

If therapy is in essence a learning experience,[15,16,17] cognitive constructivism can help us understand the therapeutic process. Therapy provides people with new experiences that expose them to new information that needs either to be assimilated into existing schemas (content change) or the schema needs to change to accommodate discrepant information (structural change). New information creates disequilibrium that the client needs to manage, so that they can move around a reflective cycle from lived experience, to reflection on experience, to active experimentation with new behaviours.[18] The therapeutic relationship is the frame or container that allows learning to take place in the relative safety of a trusting, confiding relationship that's separate from the vicissitudes of the client's day-to-day life. One venue for this collaborative reflective inquiry is the

7 Gottman JM. The marriage clinic: a scientifically based marital therapy. New York, NY: WW Norton & Co; 1999.

8 Gottman JM, Silver N. The seven principles for making marriage work. New York, NY: Harmony Books; 2015.

9 Fruzzetti A. The high-conflict couple: a dialectical behavior therapy guide to finding peace, intimacy, and validation. Oakland, CA: New Harbinger Publications; 2006.

10 Jacobson NS, Christensen A. Integrative couple therapy: promoting acceptance and change. New York, NY: WW Norton & Co; 1996.

11 Case B. Healing the wounds of infidelity through the healing power of apology and forgiveness. Journal of Couple & Relationship Therapy 2005; 4(2–3): 41–54.

12 Rusbult CE, Agnew CR, Arriaga XB. The investment model of commitment processes. In: Van Lange PAM, Kruglanski AW, Higgins ET (eds) Handbook of theories of social psychology. Thousand Oaks, CA: Sage Publications Ltd: 2012 (pp 218–231).

13 Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research & Practice 1979; 16(3): 252–260.

14 Barton S. Is complexity in the eye of the beholder? [Conference presentation.] BABCP Annual Conference & Workshops 2024 – Catalysing change: ideas to impact. Manchester, England.

15 Beck AT. Cognitive therapy and the emotional disorders. New York, NY: New American Library; 1976.

16 LeDoux J. Psychotherapy as a learning experience. [Online.] https://tinyurl.com/3z7h45wv (accessed 19 October 2024).

17 Piaget J. The theory of stages in cognitive development. In: Green D, Ford MP, Flamer GB (eds) Measurement and Piaget. New York, NY: McGraw-Hill; 1971 (pp 1–11).

18 Grimmer A. The cloverleaf model of cognitive behaviour therapy as experiential learning: implications for case formulation, therapeutic practice and practitioner development. The Cognitive Behaviour Therapist 2022. [Online.] https://tinyurl.com/2h4mk972 (accessed 20 October 2024).

client's life outside therapy, another is the therapeutic relationship itself. Therefore, repairing a rupture can be a '...useful, if not necessary, part of successful therapy'.[19]

A typology of therapeutic ruptures

Eubanks et al[20] define a therapeutic rupture as '...a disagreement between patient and therapist on the goals, a lack of collaboration on tasks, or a strain in the emotional bond'. Safran et al[21] state that ruptures vary from relatively minor tensions to major breakdowns in collaboration, understanding or communication. I define a therapeutic rupture in terms of its positive or negative impact on the ability to work constructively in therapy. Drawing on the model of rupture and repair in personal relationships, two similar diagrams can be constructed for therapeutic ruptures: a virtuous cycle where rupture repair enhances therapy (Figure 3), and a vicious cycle where it undermines it (Figure 4).

Contextual, state, or trait factors are also relevant in therapy and can influence its course as either facilitators of effective therapy (eg supportive context, mild and acute symptoms, agreeable personality traits) or predispositions to rupture (eg unsupportive context, chronic and severe conditions, prominent early maladaptive schemas). In the context of intercultural therapy, there's a risk of cultural misattunement that can manifest as either microaggressions or 'racial enactments' that embody racial stereotypes.[22] Areas of potential intercultural threat might concern:

1. Therapist empathy (understanding)
2. Cultural mistrust (liking and respect)
3. Communication expectations (forms of address and body language)
4. Professional authority (expertise)
5. Conceptualisations of mental health (illness and wellness)
6. Appropriate therapy goals (individual versus collectivist)
7. Culturally sensitive therapeutic tasks (relative to social roles, religious practices etc).

Ruptures might occur even before therapy begins if a therapist's stereotypes or unconscious bias mean they choose not to work with a client from a certain demographic or with a particular social identity they find unsettling. I describe these as 'pre-emptive ruptures'.

From a state perspective, both client and therapist can have a bad day that affects their capacity for patience and tolerance. It's important not to attribute a client's behaviour to enduring personality traits when they reflect a transient state of mind, or symptoms of their presenting problem. Likewise, either therapist or client might bring enduring personality traits, interpersonal problems, or sensitivities that disrupt therapy. Leahy[23] describes the impact of schema conflict between client and therapist that can result in unhelpful interactions that can be misinterpreted as 'resistance'. Nonetheless, when clients bring enduring interpersonal sensitivities and vulnerabilities with them, and enact those relational difficulties in therapy, they provide an opportunity for a corrective emotional experience.

Using Rusbult et al's[6] exit, voice, loyalty, neglect (EVLN) model produces four overarching categories of therapeutic rupture. Exit, loyalty, and neglect ruptures are versions of Safran et al's [21] withdrawal markers. A loyalty rupture might indicate a subjugated or people-pleasing client who's superficially compliant. We might assume therapy is going well but be unaware that the client isn't finding it helpful but is too anxious or unassertive to articulate a concern and so loyally perseveres. A neglect rupture might involve an unwilling attender who's been 'sent' by someone to be 'fixed'. An inexperienced or unconfident therapist might question their competence and try technique after technique only to be met with a passive resistance intended to protect autonomy.

Neglect ruptures are forms of therapy-interfering behaviour that represent a lack of understanding or investment in therapy. These might include repeatedly cancelling or missing sessions, or a failure or unwillingness to complete between-session tasks, although these behaviours need to be understood in context. Loyalty and neglect ruptures are covert: they could be due to the 'sunk costs' fallacy ('I've already put so much in, I can't give up now'); a dread of an undesirable alternative (eg starting over with a new therapist); or if therapy is occasionally helpful, an intermittent reward schedule. Covert ruptures give the lie to the idea that a client 'must be getting something out of it or they wouldn't keep coming.'

An exit rupture or unplanned ending is often ambiguous. Clients don't always communicate their reasons for discontinuing, so we might never know if it was something we did or said and must live with the uncertainty. A voice rupture, which Safran et al[21] call a 'confrontation marker', is one where the client verbalises their discontent. If it's perceived as an attack or criticism that threatens the therapist's self-esteem, it might elicit a defensive response that worsens the rupture. If met with non-defensive curiosity and humility, there's a possibility of a repair.

Managing a therapeutic rupture

Each therapeutic orientation formulates a rupture using its own theoretical framework, many of which are described in the edited volume by Eubanks et al.[24] Muran's[25] intersubjective perspective describes ruptures as a tension between needs to belong and for autonomy. A rupture represents a struggle between therapist and client for whose subjective understanding will predominate. Where there is disagreement over the meaning of an act, it can lead to power plays over desired accommodations and refusals to accommodate, especially regarding appropriate boundaries. For example, is it fair to ask someone to pay for a missed session

> Unhappy couples might find themselves trapped in a cycle of painful ruptures and ineffective repairs

because their child was unwell, or is that an unreasonable and punishing stance? Is it reasonable to refuse to give a client the hug they request, or is that to reject and humiliate them? A repair in therapy can help convey to clients that while others may see the world differently, the world is still negotiable.[25]

Gelso and Kline[26] state that effective repair involves recognising, valuing and navigating difference while remembering that a rupture is fundamentally the responsibility of the therapist. The practitioner should acknowledge their part in the rupture and not simply attribute it to the client and his or her conflicts. To remain grounded, therapists need to manage countertransference reactions when feeling criticised, using reflection-in-action[27] based on self-awareness, metacommunication (mindfulness-in-interaction or immediacy) and emotion regulation skills. To process or better understand a rupture after the event, we can use reflection-on-action[28] strategies in supervision or a reflective journal.

Muran et al[1] describe three pathways to repair a rupture:

1. Using brief 'immediate' strategies to correct a misunderstanding
2. Renegotiating tasks or goals where they are unacceptable to the client
3. Using 'expressive' strategies that treat the rupture as an entry point into the client's assumptive world.

The key to using expressive rupture repair is exploring and formulating the rupture in terms of an unmet need (eg for belonging, autonomy or capability). Understanding the origins of this sensitivity through exploring formative experiences can reveal client assumptions about 'how a person like me gets treated in a world like this'.

To develop greater confidence in managing ruptures, Muran and Eubanks[29] describe a process of educating therapists using alliance-focused training with didactic and experiential components.[30] It includes providing information about rupture definitions and repair pathways while also using mindfulness as an emotion regulation strategy, and deliberate practice using role play or two-chair work to increase emotional self-awareness and to practise the skills of managing a rupture.

Conclusion

This article has reviewed the literature about rupture and repair in personal and therapeutic relationships to find commonalities between the two. Of course, a therapeutic relationship is a contracted helping relationship rather than a relationship focused on mutuality. However, in both cases, a rupture highlights something about each person's expectations and beliefs, or the state of the relationship and the ways in which it's not meeting the needs or expectations of one or both partners. Because the outcome of a rupture is uncertain, it can be a threat or an opportunity.

Key practice points are:

1. Preventing ruptures is, in general, better than repairing them – getting regular feedback can help prevent ruptures and improve outcomes
2. Some ruptures are probably necessary to bring important issues to the surface but are best attended to promptly with humility and curiosity
3. The way a rupture is handled depends on how we understand it, and our formulation plays an important part in determining whether we see it as an opportunity or a threat
4. It's important to balance treating a rupture as a reflection of the client's difficulties with validating its reality basis
5. There are skills we can develop to handle ruptures more effectively – interpersonal perceptual skills, relational skills, self-awareness and emotion regulation skills – we could usefully take offline opportunities to practise (eg in supervision) so that we are better prepared for them when we feel under pressure.

I'm grateful to the BACP Private Practice division for the invitation to present at the Private Practice Conference 2024 and the opportunity this gave me to develop this model. ●

ABOUT THE AUTHOR

Andrew Grimmer is an HCPC registered counselling psychologist, BABCP accredited CBT psychotherapist, and couple and relationship therapist. He is an independent practitioner, supervisor, lecturer and writer, and is currently conducting qualitative research on the meaning of competence to CBT practitioners as part of a PhD at Middlesex University.

YOUR THOUGHTS, PLEASE

If you have a response to the issues raised in this article, please write a letter, or respond with an article of your own. Email: **privatepractice.editorial@bacp.co.uk**

19 Gelso C. A tripartite model of the therapeutic relationship: theory, research, and practice. Psychotherapy Research 2014; 24(2): 117–131.

20 Eubanks CF, Muran JC, Safran JD. Repairing alliance ruptures. In: Norcross JC, Lambert MJ (eds) Psychotherapy relationships that work: evidence-based therapist contributions (3rd edition.) Oxford: Oxford University Press; 2019 (pp 549–579).

21 Safran JD, Muran JC, Eubanks-Carter C. Repairing alliance ruptures. Psychotherapy 2011; 48(1): 80–87.

22 Chang DF, Omidi M, Dunn JJ. Anti-oppressive approaches to alliance rupture and repair: a critical–cultural–relational model of rupture resolution. In: Eubanks CF, Samstag LW, Muran JC (ed) Rupture and repair in psychotherapy: a critical process for change. American Psychological Association; 2023 (pp 21–52).

23 Leahy RL. Overcoming resistance: a practical guide to the assessment and treatment of therapeutic impasses. Guilford Press; 2003.

24 Eubanks CF, Samstag LW, Muran JC (eds). Rupture and repair in psychotherapy: a critical process for change. Worcester MA: American Psychological Association; 2023.

25 Muran JC. Confessions of a New York rupture researcher: an insider's guide and critique. Psychotherapy Research 2019; 29(1): 1–14.

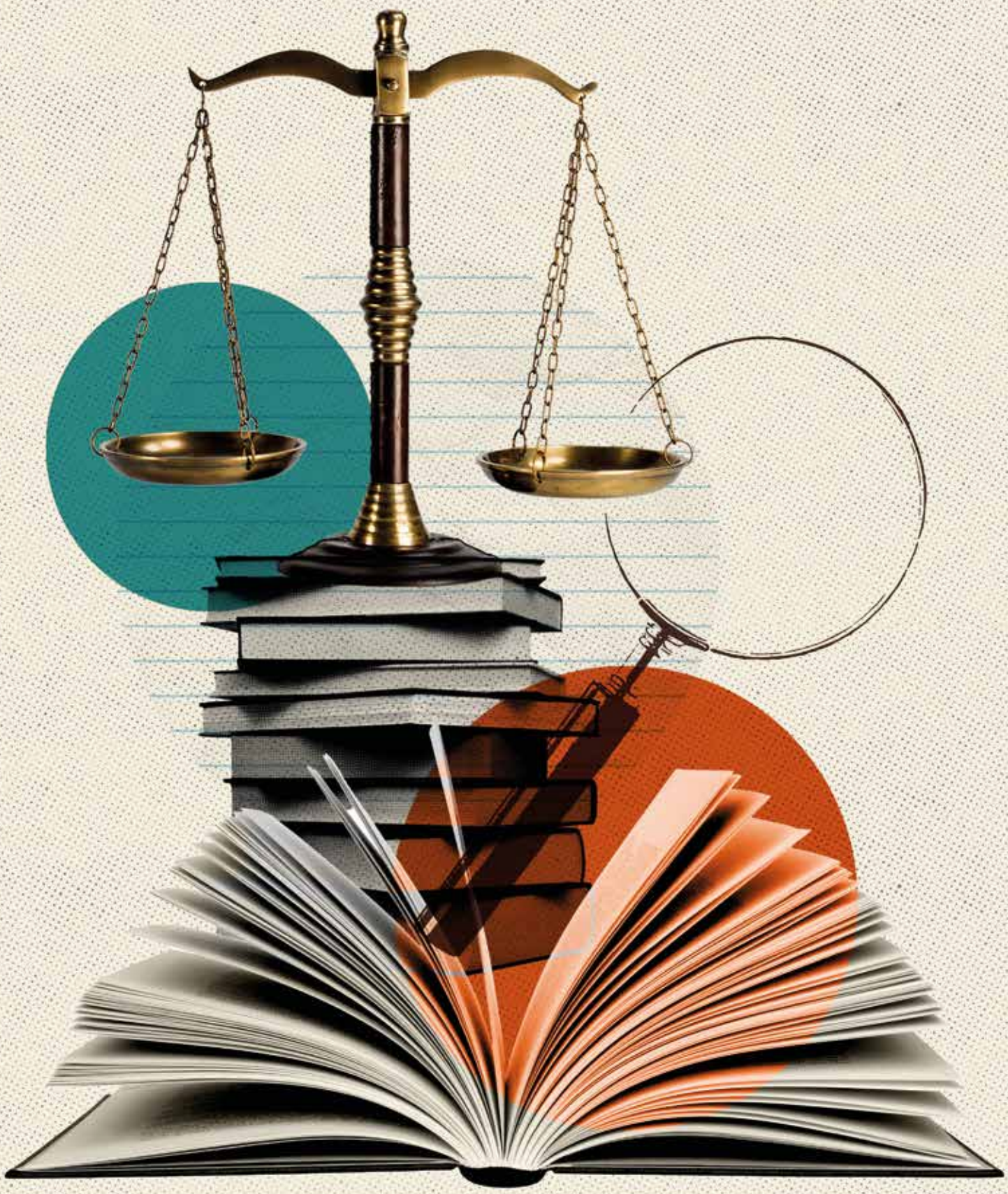
26 Gelso CJ, Kline KV. The sister concepts of the working alliance and the real relationship: on their development, rupture, and repair. Research in Psychotherapy: Psychopathology, Process and Outcome 2019; 22(2): 142–149.

27 Schön D. The reflective practitioner: how professionals think in action. Temple Smith; 1983.

28 Hewson MG. Reflection in clinical teaching: an analysis of reflection-on-action and its implications for staffing residents. Medical Teacher 1991; 13(3): 227–231.

29 Muran JC, Eubanks CF. Therapist performance under pressure: negotiating emotion, difference, and rupture. Worcester, MA: American Psychological Association; 2020.

30 Center for Alliance-Focused Training. [Online.] https://tinyurl.com/bdznhwz2 (accessed 19 October 2024).



Pre-trial therapy

Jill Swindells on what we need to know about pre-trial therapy to avoid possible pitfalls

I was delighted to be invited to talk about pre-trial therapy (PTT) at the BACP Private Practice Conference in September. I'm passionate about victims getting appropriate therapeutic support when facing the harrowing prospect of revisiting recent or historic crime(s) committed against them at a criminal trial – weathering the drawn-out process and balancing recovery with getting justice, which can itself be therapeutic when good support is in place.

Frustratingly, PTT has remained in the shadows until recent media controversies about victims avoiding, being discouraged or denied therapy pre-trial, and the call to make therapy notes private, which is unlikely to ever happen, as suspects' rights to fair trial trump victims' rights to privacy.

Unfortunately, PTT has suffered from being seen as niche, irrelevant to everyday therapeutic practice, and commonly misunderstood by both therapists and criminal justice practitioners. This is despite the first guidance being issued for England and Wales in 2001, nearly a quarter of a century ago. Some victims lucky enough to obtain PTT were overly silenced in therapy – barred from discussing their feelings about, or the impact of, the crime. Others inappropriately had generic counselling – risking breaking confidentiality if notes were subsequently requested, thereby endangering a possible trial.

PTT guidance

The long-awaited 2022 guidance[1,2] is designed specifically for clients who might appear in court as a victim of crime in England or Wales, after alleging a crime has been committed against them; so, after reporting to the police, who are investigating. It unhelpfully focuses on sexual crimes but applies to all crime victims. (Incidentally, I believe many aspects of PTT guidance can help inform good practice when working with crime witnesses, possible/alleged offenders and others whose notes might be requested.) Our clients can now talk about the crime(s) in therapy, but, as we're not investigators, we should only ask questions for clarity, not probe for further detail or question inconsistencies. Scotland has its own guidance,[3] but it states that discussions about the incident(s) should still be avoided in therapy.

> "Our clients can now talk about the crime(s) in therapy, but, as we're not investigators, we should... not probe for further detail or question inconsistencies

Note-keeping

As all our clients can request to see their notes, these should be accurate, brief and factual, and include dates and times. PTT notes are no different. We should never attempt to define the crime(s) ourselves, but use clients' language, acknowledge uncertainties, and take care to avoid writing anything that could be misinterpreted, such as misplaced guilt/blame. Also, we should avoid jargon, opinions, interpretation, self-disclosure, etc. However, the initial and any subsequent disclosures about the crime-specific incident(s) need to be documented verbatim. If we make no notes or they're deemed inadequate, we're more likely to be called to court as a witness.

All requests for notes from the police should be in writing to the private practitioner (or agency) after they have obtained permission from the client. Clients have the right to refuse, but notes could be subpoenaed, victims summonsed, or their cases dropped as a result. Requests need to be clear about what's required and why, in line with our data processing obligations and the 'data minimisation principle',[4] so limited to what's necessary, not speculative/blanket requests. We can redact irrelevant information and invite clients to review our proposed disclosure(s). Copies should be sent to the police securely or viewed in situ. We can refuse to share notes if we're unable to comply with our data processing obligations, if requests are not specific enough, or if they have no rationale.

We must be proactive and ready to work in our clients' best interests as soon as the need arises. Following the PTT guidance as best we can, and justifying why we might not when in our client's best interests, will

REFERENCES

1 Crown Prosecution Service. Pre-trial therapy legal guidance (for judiciary and police). [Online.] https://tinyurl.com/y493h279 (accessed 2 October 2024).

2 Crown Prosecution Service. Pre-trial therapy: accompanying note for therapists. [Online.] https://tinyurl.com/2nx73jf5 (accessed 2 October 2024).

3 Crown Office and Procurator Fiscal Service. Pre-trial therapy provision for victims of sexual crime: guidance for those supporting victims of sexual crime who wish to seek therapeutic support or counselling prior to or during court proceedings. [Online.] https://tinyurl.com/4ujemrnb (accessed 20 October 2024).

4 Information Commissioner's Office. Principle (c): data minimisation. [Online.] https://tinyurl.com/3ntvndtj (accessed 20 October 2024).

> We can refuse to share notes if we're unable to comply with our data processing obligations, if requests are not specific enough, or if they have no rationale

reduce the risks for both our clients and us. Hence, I advocate for a PTT informed approach to our general practice.

Being PTT informed

Being PTT informed, before any client notes are written and possibly requested, means we will already:

- be familiar with the main legal guidance for criminal justice practitioners, the accompanying note for therapists, and BACP's *Good Practice in Action* information[1,2,5,6,7]
- understand the criminal justice practitioners' guidelines, so we can challenge bad practice to protect our clients' rights when required[5]
- be aware of clients possibly being pre-trial earlier than the guidance defines officially (post-reporting), so we can inform clients from the outset that confidentiality cannot be guaranteed as any relevant notes can be requested
- know what constitutes good PTT practice at all stages – assessments, fully informing clients, contracting, approaches/techniques to avoid, writing notes/disclosures and managing requests for notes
- have discussed PTT with our supervisors (and agency clinical supervisor/line manager), and ensured they are PTT informed and able to provide support when required
- have our private practice PPT policies, procedures and paperwork in place (and our agency's if relevant).

After reading the guidance and discussions with our supervisor(s), decide if and how to work with it. Consider issues such as:

- including experience of crime/abuse and reporting history/intentions in all assessments
- following disclosures, checking for current risk of harm to clients/others and safeguard appropriately
- ensuring clients understand confidentiality boundaries, whether reported already or there's a possibility of reporting later
- contracting for PTT if a client is undecided or they/others may report later
- contracting/re-contracting for generic counselling if/when not reporting/proceeding to court
- clients reviewing notes/disclosures on a rolling basis when they can still remember the content of a session
- signposting clients to additional sources of support, such as Victim Support, Witness Service, etc
- attending PTT CPD to ensure we practice within our limits of competence
- if PTT is not for us, when and who to refer clients on to.

I'm grateful for this opportunity to put a positive spotlight on PTT. The time is ripe for us to step up to earn the trust and respect of criminal justice practitioners, so woefully lacking historically, while safeguarding and upholding pre-trial clients' rights. ●

ABOUT THE AUTHOR

Jill Swindells MBACP provides PTT training workshops, is person-centred by training and has counselling experience in both community and custodial settings with victims/witnesses of crime and offenders. She is a freelance qualitative social and market researcher specialising in sensitive issues, the vulnerable and hard to reach.
www.qualconsultancy.com

YOUR THOUGHTS, PLEASE

If you have a response to the issues raised in this article, please write a letter, or respond with an article of your own. Email:
privatepractice.editorial@bacp.co.uk

5 British Association for Counselling and Psychotherapy. Good practice in action 128: working with the Crown Prosecution Service pre-trial therapy guidance (2022) with adult and child witnesses in criminal courts in England and Wales. Lutterworth: BACP; 2024.

6 British Association for Counselling and Psychotherapy. Sharing records with clients, legal professionals and the courts in the context of the counselling professions GPiA 069: legal resource. [Online.] https://tinyurl.com/39k59yav (accessed 20 October 2024).

7 British Association for Counselling and Psychotherapy. Writing reports for the courts and giving evidence in court in the context of the counselling professions in England and Wales GPiA 083: legal resource. [Online.] https://tinyurl.com/45p3tuze (accessed 20 October 2024).

GRAHAM EASON

> Twenty clients a week is not realistic for most newly qualified counsellors

Graham Eason MBACP qualified as a counsellor in 2023, after working in business and running a classic car company. He volunteers for Cotswold Counselling and set up his private practice in January 2024. He also works as an automotive writer.
www.counsellingwithgraham.co.uk

Let's talk about money. When I was a student, I used to cycle past a black Alfa Romeo sports car on my way to learning yet more about European history. I love cars, especially Italian ones. That black Alfa became, in the years ahead, the sole reason I wanted a job – to buy one. Eventually I did.

Spool forward a few years – OK, a lot of years – and I'm nearing the end of my counselling training. Buying a black Alfa is not my motivation. Neither is money. If your peers were like mine, money was so far from the motivation for being a counsellor that nobody really talked about it. If it did come up, it was talked about in vague terms, a way to justify and enable doing something we would probably have done for free if we were able. My tutors and peers had far more esoteric stuff on their minds, like Winnicott's theory of attachment or Malan's triangles.

There might also have been other reasons. Money is a difficult subject. In a world focused on helping others, perhaps it feels grubby, selfish and inappropriate. And there isn't much of it to see. I wonder now, looking back, if tutors avoided it because the reality is not that encouraging.

Perhaps because courses don't really talk about it, 'What can I expect to earn?' is a common question online among students and the newly qualified. That's concerning. Why do we need to ask the question, and why isn't the answer resoundingly positive? There's huge demand for counselling. Mental health is the topic *de jour*. We've all trained for years. Why is the economic return in doubt?

And yet it is. Newly qualified counsellors do have choices. There are full- and part-time jobs out there. Generally, these come in at £25,000 per annum, with some scope to go a little higher. Or there is private practice.

Let's look at the economics of private practice. Most counsellors charge in the range of £40 to £60 an hour. BACP recommends working no more than 20 hours per week. That gives a gross potential income of between £41,600 and £62,400 a year. That assumes 100% uptake, 100% of the time. Then there are your costs – for room hire, supervision, travel, equipment etc. Quite quickly those numbers look very different. Namely, smaller.

Twenty clients a week is not realistic for most newly qualified counsellors. And many likely won't ever want that many. I faced this dilemma when I started my private practice. My solution is one that also seems to work for other counsellors. It might work for you. I 'portfolio' work. Twenty hours per week with clients is too much for me. But I also have bills to pay. I've found my private practice to be healthy but erratic – clients cancel sessions or just stop without warning, which can quickly knock my income. New enquiries are erratic. These are things I can influence but I cannot control.

I have sources of income I can rely on and other sources that I know will be less reliable. Private practice falls into the latter category. Accepting that, rather than trying to make it something it won't be, helped me considerably. I could focus on more fruitful areas I could – and wanted to – influence. This balance helps my stress levels – I'm not destabilised if several private clients leave or cancel – and informs the private clients I accept.

My portfolio currently has three components. I have a job as a writer that gives me a steady income – my financial 'secure base'. I really enjoy it. I can fit it around my clients, and it involves a change of mindset in my week. I also have a contract with a local agency to provide paid counselling. It makes my practice more varied, which I love, and is another source of steady, reliable income. Finally, I have my private practice. From that I can assume a base level of income that can fluctuate upwards.

Working across the different modes gives me variety in my week that I enjoy. It has flexibility built in – I can do more or less of different elements to balance each other out. I'm not heavily reliant on client work – I can choose what I do. That's important for my self-care. Other routes to portfolio working are to find a specialism that delivers a flow of clients. Or to work in a related role – such as in agency administration or client management. Or to run seminars or tutorials for other counsellors.

The financial rewards for our work are perhaps not what any of us would like. And the nature of our work contains in-built challenges too. Both point towards having to be creative when it comes to the economics. It feels important, as a newly qualified counsellor, to think about the balance that suits you – mentally and practically – and to keep your client work safe. Whether for the sake of variety, mental wellbeing or financial security, it's an issue we must continue to consider throughout our careers.

LIZZIE THOMPSON

> I thought therapists were supposed to rescue relationships, not pull them apart

Lizzie Thompson is a pseudonym

See Lizzie's blog at **www.theimperfect therapist.com**

'Right, we were going to have a review this week,' I say assertively, glad to be giving some structure to Amy's hour today. We've had a series of what I can only describe as moaning sessions. I know that certain clients need to moan, but, frankly, I'm a bit done with it. Mrs Danvers* gives me a sharp look. 'You're a bit tetchy today, my dear.' 'She is, isn't she,' says Boris.* 'Reign it in, Lizzie.'

'I'm tired,' I say, and feeling a bit jaded. I look at Amy. She's an attractive woman who wants the life of one or more of the celebrities she follows, and she wants more people to follow her – whatever that means. God help me. Maybe I'm too old to work with the under-40s. And something is clearly not going quite right in the therapy. We're stuck in a loop.

'Yes, we were,' Amy replies, energetically. In fact, this is the most lively I've seen her. She leans forward in her chair. I lean back. 'So, how did you find the process of thinking through the review?' I ask, somewhat defensively. 'Fine. I actually rather enjoyed it. Shall I start?'

Boris, usually dozing at this time of the afternoon, and Danny, customarily smoking and wistfully looking out of the window, both seem alert and focused. 'Bit scary,' Boris mutters, excitedly. 'Almost as if she's about to give you a b*****ing.' 'Language, Boris,' scolds Danny. 'Lizzie, you'll receive a sharp reprimand at the very least. This should be interesting.' I'm feeling unsupported by my companions. It's almost as if they're waiting for me to be shot down. My stomach feels uneasy.

'You suggested that I do a s**t sandwich,' Amy continues. (Did I really use that language?). 'So, here goes... One thing I appreciate is that you always have a glass of water ready for me.' Looking after her physical needs. Tick. 'Another is that you listen to me when I moan.' Good listener. Tick. 'One thing I really don't like is that you often look bored with my moaning, even though you listen.' Lordy. I inwardly cringe at this point. Boris puts his head in his hands. Danny is expressionless.

'But the thing that I'm really angry about is that you suggested that Ross and I reviewed our relationship. We did, and now it's over. It was a stupid, stupid suggestion of yours.' She looks hard at me. I can't tell whether she's near to tears or just furious. I feel apprehensive. 'I hear that you're angry,' I say. God, that sounds crass. Amy's eyes are sparkling with ire. She looks as if she might hit me. 'I've just said I'm angry.'

I look at her. I feel alert, interested and a teeny bit terrified. 'OK. Tell me a bit more about how it went?'

Amy reaches for her bag. For one ghastly moment I think she's going to get up and leave the session, but, instead, she takes out her phone. 'I wrote some notes on my phone... Yep, here they are. Well, the whole conversation lasted exactly nine minutes. I timed it. He basically said I had – hang on a minute – I've got the exact quote somewhere... Oh yes, I had "plundered his soul". He said he had nothing left to give, that I drained him of all energy, and he wanted out. So, thanks a bunch, Lizzie. I thought therapists were supposed to rescue relationships, not pull them apart.' Golly! I'm getting both barrels here. She's clearly livid with me. I'm wondering how to respond. At the same time, I'm thinking that nine minutes isn't much time for a full-blown discussion around the plundering of souls.

My mind is working overtime. Over the last few weeks, Amy's tiresome moaning has drained me of energy. And yet, here she is being seriously combative and I'm alert and energised. 'I'm sorry you've had such a difficult time,' I offer. 'Lame,' says Boris. 'Very lame.' Amy hasn't heard me. 'And...' she thumps her hand on the arm of her chair, 'he described me as tetchy!' Amy's tone has gone up a notch. Two more notches and she would be shrieking. 'I'm so easy going. I'm the least tetchy person I know.'

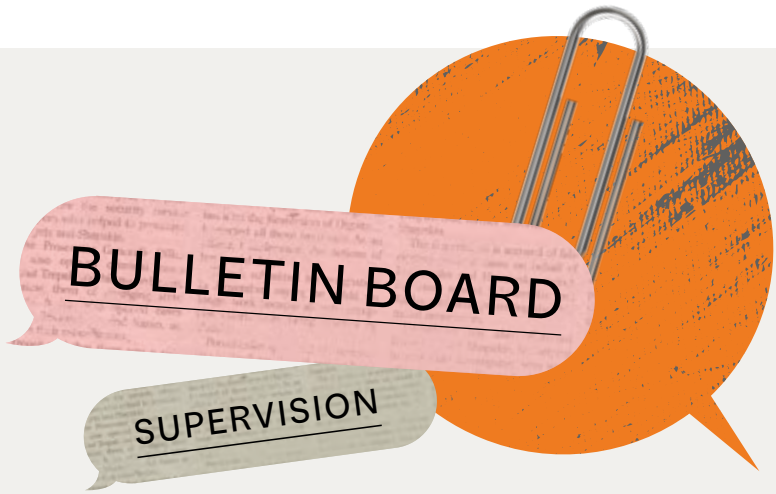
'Mirror, mirror,' drawls Danny. Boris giggles. He always seems to giggle rather than laugh. There's a pause... then, her sadness and confusion emerge. 'I tried so hard to be everything he wanted but he was always commenting on other women; how hot they were, how fashionable, how sexy, how stylish, how slim. I never felt as though I was number one in his eyes.' Amy's tone is quieter now. I begin to feel some compassion for this woman for whom celebrity culture has become a sort of religion.

'Is Ross stylish, slim and sexy?' 'He 's alright, yeah.' 'He doesn't sound very kind,' I add. 'He isn't.' She shrugs.

Should we do a brief grieving of this relationship? I decide against, on the principle that life's too short to grieve for jerks. 'I'd like someone kind, but he'd have to be, you know, hot stuff, obvs.' 'You'd like an attractive, kind partner.' I say, thinking of my attractive, kind partner. 'I want an attractive, hot, ripped guy who treats me like a princess.' Amy giggles. 'Surely everyone wants that.'

The next day, I speak to my supervisor. 'Can you run through parallel process with me again?' I ask. ●

*Boris and Mrs Danvers (aka Danny and Mrs D) are two of my inner critics.



Members of BACP Private Practice can post notices of up to 40 words free of charge on the Bulletin Board, promoting supervision services, networking opportunities and requests for research participants related to counselling and psychotherapy training. The editorial deadline for the March issue is 30 December 2024. Email: **privatepractice.editorial@bacp.co.uk**

REMOTE SUPERVISION FOR INDIVIDUALS AND GROUPS

Free supervision, online or in person, until the end of 2024 for trainee and recently qualified therapists while I complete my supervision training. I'm an experienced psychodynamic/relational therapist working with adults in South London.

CONTACT: Anna Lanninge MSc, BACP (Accred)
EMAIL: annalanningepsychotherapy@protonmail.com

BACP Private Practice mission statement

BACP Private Practice is the division of the British Association for Counselling and Psychotherapy(BACP) that supports members who are primarily in, or about to embark on, counselling or psychotherapy in private practice, including those who work in voluntary agencies.

The division has the following goals:

- to minimise the distortion of professional benchmarks arising from working in isolation
- to provide a supportive, encouraging and integrative network with opportunities to exchange ideas, work ethics, methods and styles
- to alleviate the loneliness of the private practitioner by disseminating relevant information, providing tips and techniques, and revitalisation
- to develop a comprehensive, appropriate and professional training programme primarily for those working independently
- to engage in and encourage constructive dialogue about the profession of counselling and psychotherapy, including explanation and discussion of BACP developments
- to offer therapists an opportunity to interact with the wider world of counselling and psychotherapy
- to protect clients by promoting BACP's standards and ethics.

The division provides a supportive network and training, with an emphasis on maintaining clear boundaries and having sufficient support and supervision. BACP Private Practice provides an interactive sense of professional belonging for all members of our multicultural therapeutic community. Equal opportunities are an integral part of this division's philosophy.

Visit the divisional website at **www.bacp.co.uk/bacp-divisions/bacp-private-practice**

BACP Executive contacts

Acting Chair: Indu Khurana
indu@indukhurana.com

Claire Djali
clairedjali@hotmail.com

Margaret Ward-Martin
mi.mindcoach@gmail.com

Leave the busy work to us

Practice management software that helps you make the most out of your day.

- **Plans start at £7.50/per month**
- In-platform insurance integration
- Scheduling & client waitlist
- Online forms & bookings
- Appointment reminders
- Progress notes
- Zoom® Telehealth
- Reports & analytics
- Plus so much more

Start a Free Trial

zanda
formerly Power Diary

★★★★½ 1000+ reviews

zandahealth.com

Marsh Commercial | oxygen™

Insurance for counsellors

We deliver specialist policies to over 15,000 talking therapists.

And that's not all – there's a professional body discount for British Association for Counselling and Psychotherapy (BACP) members.

SCAN ME

Get a quote online in under 5 minutes
www.marshcommercial.co.uk/probodies
or call **03301 739 534**

SCAN THE CODE TO SET UP AN APPOINTMENT.

SPEAK TO CIARA, GRACE, RACHEL, LAURA, TARA, YOMNA, DIRCE OR BRITNEY TODAY TO SEE HOW WE CAN HELP.

webhealer vs. DIY

SQUARESPACE / WIX

Discount for BACP members	Using a generic site builder, not therapist specific
1 Price - All you need	Takes longer to build
We build it for you!	Will you have to pay to remove ads, or access extra services?
Plain English, no jargon!	Is the site designed to be mobile-friendly? Is it ready for Google?
Built to attract customers	No option to speak to a human!
Call us for friendly support & chat!	

GET YOUR WEBSITE BUILT - FAST FIND NEW CLIENTS RANK ON SEARCH ENGINES
COMMUNICATE PROFESSIONALLY & SECURELY ENJOY FULL SUPPORT FROM WEBHEALER
JUST 1 CLIENT PER YEAR PAYS FOR YOUR SITE

All for ~~£249~~

★★★★★ Check out our 210+ Google reviews

CALL US ON 0345 557 0300 OR VISIT WWW.WEBHEALER.NET

WebHealer have been working with BACP members for 20 years. Speak to us about starting your new website, or moving your website from another provider.

* Offer price of £49+VAT one-time setup, then £20 monthly fee (incl. VAT).