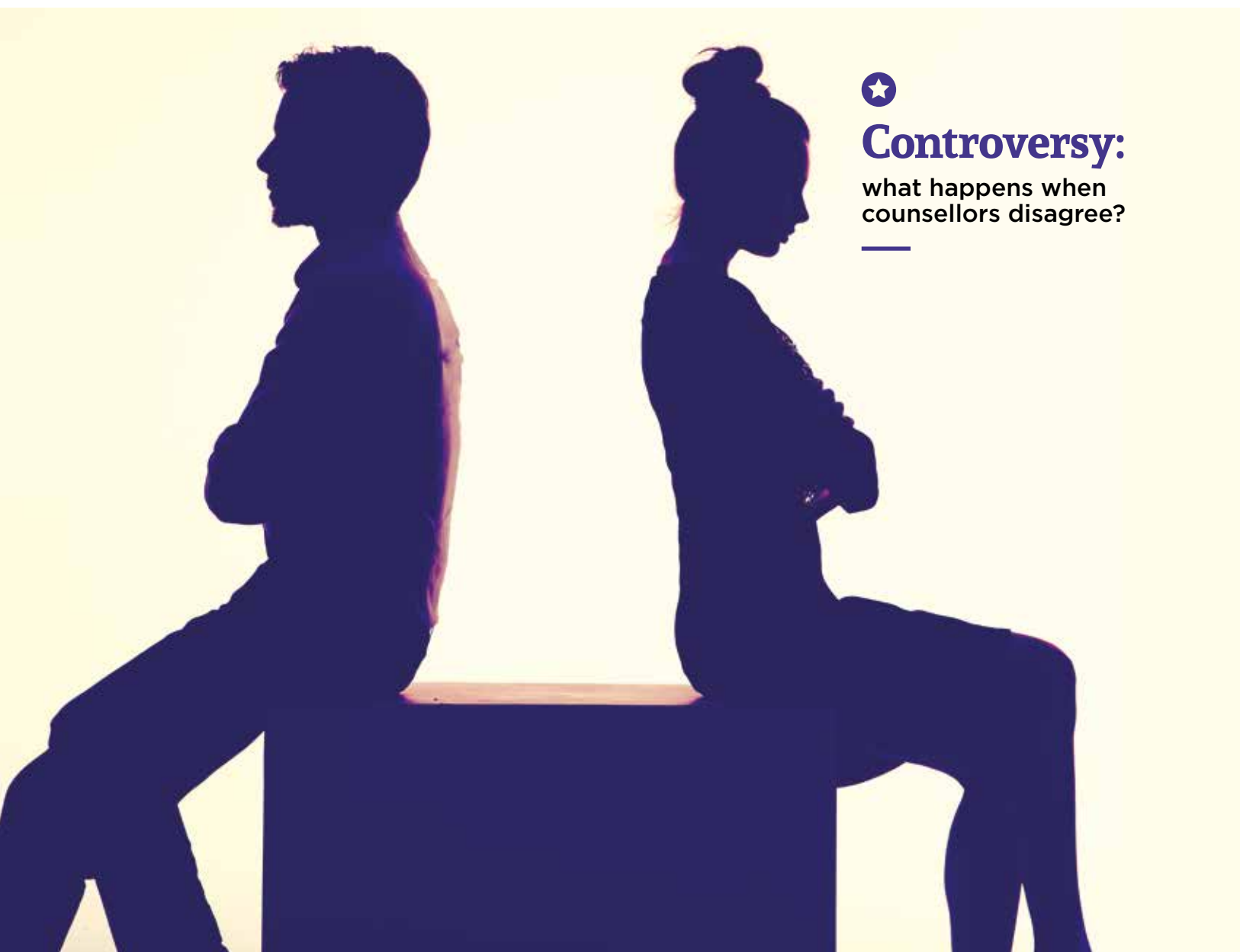# UNIVERSITY&COLLEGE
COUNSELLING

FOR COUNSELLORS AND PSYCHOTHERAPISTS IN FURTHER AND HIGHER EDUCATION

Controversy:
what happens when counsellors disagree?

SEX ADDICTION:
does it really exist?

PSYCHODYNAMIC THEORY:
how useful is it in our work?

TRIGGER WARNINGS:
do they have a place in education?

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bacp | counselling changes lives

David Mair
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FROM THE EDITOR

Counsellors are such lovely people – so kind, so gentle, so understanding, so full of the milk of human kindness... While this may – in part – be the popular perception of counsellors, as 'insiders' I'm sure that this description is likely to elicit a cynical raising of the eyebrows, at least. Counsellors are – first and foremost – human beings. Despite our training and our therapy, we are individuals and, in my experience, strong-minded people who are not afraid to express our opinions and beliefs.

As in any profession, counsellors come in all shapes and sizes and from all types of backgrounds. Our political views cover the whole spectrum of opinion. Some voted for Brexit; others see this as madness. Our experiences of spirituality vary enormously. Some have a strong spiritual belief system to guide them; others are atheists, eschewing any notion of religion or the supernatural. Our counselling trainings and theoretical models can be very different. Some are invested in non-directive, humanistic models of therapy; others passionately believe that clients need directing and challenging, especially in short-term work. Put counsellors together in a team, and you are as likely to find tension, conflict and disagreement as in any other professional group. How do we deal with and respond to our differences? In my experience, differing theoretical and spiritual frameworks are often the catalysts for discontent in counselling teams, especially if those teams are operating – as we all do – within institutions which may have little time for, or understanding of, the features of our work which we believe to be pivotal.

In this issue, our contributors explore issues which are likely to raise the hackles of some, and elicit cheers of support from others.

Dominic Davies challenges the concept of sex addiction, arguing that it is an unsubstantiated, values-driven diagnosis of behaviour which can be understood in other, non-pathologising ways. Colin Feltham questions psychodynamic theory (and by extension, other therapeutic theories), and asks us to reconsider what some may hold to be sacrosanct in their understanding of how therapy works. And, perhaps swimming against the cultural tide among many educators, Amy Beddows argues in favour of trigger warnings in universities, seeing them as a respectful way of fostering independence and self-empowerment, especially for students who have experienced trauma.

As you read these articles – which may present views diametrically opposed to your own – the invitation is simply to be aware of any tendency to dismiss or devalue the strongly held and sincere beliefs of someone who does not see eye to eye with you. Our clients come in all shapes and sizes too, and with some there will be a more natural fit than with others. Yet our training helps us to 'bracket' or 'hold' our differences with clients, and, hopefully, to work supportively with those who are very different from us. Perhaps this is something we can all emulate in our relations with colleagues who may also be very different.

At the start of a busy, demanding year, I hope these articles stimulate and challenge: if you feel strongly enough to write a response, do get in touch. Our journal exists to give voice to the whole range of opinion without advocating any particular bias: tin hats may be needed at times – respectful acknowledgement of difference is key to thriving in our work. ●

THE DEATH OF ONLINE THERAPY

MAKING SENSE OF HOW TECHNOLOGY AND THERAPY MEET

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Given the ubiquity of computers, tablets, smartphones, and their infiltration into virtually every area of life, can we make more flexible use of this technology in our work? **Terry Hanley** explores

Ten years ago it may have been customary to start an article about the place that online counselling has within further and higher education settings by flagging up the absence of evidence about this emerging practice. This is no longer the case. Pretty much all university counselling services now have an online presence in some form or other. This includes services that provide information through this means, offer access to self-help facilities (including relaxation audio recordings and computerised cognitive behavioural therapy (cCBT)), and those that offer person-to-person therapy. Times have certainly changed.

There is a similar trend when it comes to researching online therapeutic work. This is most demonstrable when it comes to looking at the research examining cCBT. Software developers have been amazingly strategic in developing a body of research that demonstrates the efficacy of such technologically mediated practices. So much so that cCBT is recommended by the National Institute for Health and Care Excellence (NICE) as a major resource for common difficulties such as depression and anxiety.[1] Further, there have been substantial inroads into understanding why individuals use online counselling services, what they do within them and how effective they can be for those seeking support. It is this area I consider in more depth here, before moving to consider what this means for the work of counsellors and psychotherapists (or at least how I have made sense of it all). To end, I then change tack and, maybe somewhat surprisingly, predict the demise of online therapy.

For illustration purposes only; posed by models

This might seem counter to much of what I am saying, but, for me, this seems to be the natural end point of the current direction of travel.

Where technology and therapy meet: reviewing the research

In recent years I have been involved in a number of projects looking into therapeutic practices online. For instance, I have published two systematic reviews that pull together the empirical research around such work. Here, I'll provide some edited highlights.

The outcomes and alliance in online text-based therapy: when starting to look into online therapy, I was very interested in whether online relationships could be of sufficient quality to create therapeutic change. The dynamics of such work contradicted much of my training and thinking about therapy. To explore this further, one project I completed collated the literature looking at therapeutic outcomes and alliance in text-based therapy.[2,3] This took a slice of Barak et al's review of the effectiveness of internet-mediated therapeutic interventions to focus solely upon the findings related to text-based therapy.[4] It complemented this with a summary of the five studies that explicitly look at the quality of the online therapeutic alliance. In conclusion, it outlined that clients commonly reported outcomes and the online alliance to be of a similar quality to face-to-face counterparts.

Text-based online counselling for 11 to 25 year olds: another project brought together the literature looking at text-based therapy with younger client groups.[5]

This project primarily aimed to examine what the literature tells us about why and how young people/adults use online therapeutic resources. In doing so it provides a descriptive account of 19 relevant papers (papers looking at *service development*, *online client characteristics*, *in-session processes* and *therapeutic alliance and outcomes*) and highlights that (i) there is much potential in developing online services, particularly with a view to making services more accessible, but those commissioning them need to learn from others and develop them in an informed manner so as to avoid common pitfalls, (ii) the client demographic make-up is not very different to face-to-face services; however, people with high levels of distress do appear to gravitate to such services, (iii) online therapeutic work has numerous benefits, such as a heightened sense of anonymity, and specific challenges, such as the potential for miscommunication, and (iv) as with the review mentioned above, reports of outcomes and alliance in online therapy are similar to those reported in other media.

The findings of these reviews, alongside my own work exploring young people's perceptions of the online therapeutic alliance and reflecting upon the goals that individuals work on in this medium, have slowly turned me from a sceptic of online therapy into an advocate.[6–8] The research indicates that online therapy not only acts as a means to improve the accessibility of therapeutic services, thus providing support to individuals who would not ordinarily access it, but that the quality of such work and the aligned outcomes also appear to be as effective as face-to-face equivalents. With this in mind, I no longer challenge the idea that therapy can be successfully offered online, but I have still been tussling with how to make sense of this shift in thinking. The sections below attempt to outline where my thinking has taken me.

Making sense of the technological turn in therapy

Today's culture is often described as going through a *therapeutic turn*.[9] This term reflects the increasingly prevalent therapeutic discourse that has entered general culture (for example, therapists seem to be commonplace within cultural products such as films or dramas on TV these days). As is noted above, however, therapy has not remained the same either. Technological developments have meant that there has been what might be described as a *technological turn* in the practice of therapists. Here we can see that these technological developments have become unavoidable, given their pervasive nature within society.[10] Clients might bring in pictures of loved ones on their phones or ask to meet in a virtual world. Further, fresh developments, such as the growth of virtual reality headsets, will inevitably lead to new developments.

In trying to make sense of the way that technology is impacting upon the work of therapists, I have found myself considering another area of my work. As a trainer and therapist I have been involved in writing articles and chapters related to the pluralistic framework for counselling and psychotherapy that

THERE HAVE BEEN SUBSTANTIAL INROADS INTO UNDERSTANDING WHY INDIVIDUALS USE ONLINE COUNSELLING SERVICES, WHAT THEY DO WITHIN THEM AND HOW EFFECTIVE THEY CAN BE FOR THOSE SEEKING SUPPORT

Professors Mick Cooper and John McLeod first put forward in 2007.[11,12] As readers are probably aware, this is a philosophically minded framework for considering how therapists make use of/integrate different therapeutic approaches. It is a *research-informed* approach and thus, although valuing the utility of experimental research examining the efficacy of ways of working (such as that which is often prized in guidelines devised by organisations such as NICE), it acknowledges the complexity inherent in therapeutic decision making and the broader array of research that reflects that many approaches appear to be of benefit to individuals in need.[13–15]

At the core of the pluralistic framework is the need to develop a strong therapeutic relationship with the client. This involves working collaboratively with the client to decide how therapy might proceed. The therapist therefore works *with* the client to identify the *goals* of the therapy, the *tasks* that might be engaged in to address these goals (eg to work in a more cathartic way or to learn relaxation methods) and the specific *methods* to make the tasks come to fruition (such as engaging in conversation, role plays etc).[16]

It is this latter area of *methods* that I would argue the need to consider further when it comes to the bridge between technology and therapy. Here, it is not uncommon for us to consider whether the therapeutic task might be best served by a particular therapeutic approach – providing a facilitative explorative space or undertaking a more problem-focused activity. It is, however, not commonplace for therapists to consider whether the medium in which therapy takes place is important. Typically, we revert to a default setting of 'face to face'. However, as we become increasingly accustomed to incorporating technology into our work, another factor might be to consider the place that mediated relationships could have within this discussion. Below, I outline some of the ways that therapists might engage with the internet during the lifespan of a therapeutic relationship.

Online or face to face only – many therapeutic relationships appear to conform to this format, with clients and therapists choosing to only work in one medium. Given the availability of useable technology, and the growth of online therapy, this approach might now be viewed as a proactive decision not to utilise technology.

Face to face, leading to online – some individuals prefer to meet face to face when initiating a therapeutic connection. For some people this can help build up a rapport. Once a relationship has become more established, they then feel more comfortable to move their work to an online format. Some individuals

For illustration purposes only: posed by models

might use this as a sequential means of carrying on with therapy to better meet the needs of either party, while others might use this format as a means of sensitively phasing out a therapeutic contact.

Online, leading to face to face – in contrast to the previous way of working, some therapeutic relationships will begin online and then move to a face-to-face format. This is often a process that is guided by the clients themselves, as they may initially contact the therapist through the internet. In this instance, the client may feel that, as the relationship develops with the therapist, they wish to meet face to face with them. For some, this is viewed as a means of escalating the depth of therapy. However, this is by no means always the case in therapeutic relationships, with many online relationships being viewed as escalating at a much faster pace than face-to-face comparisons.

Blended therapy – this relates to therapeutic work that proactively harnesses both an online component and a face-to-face one concurrently. For instance, a client might decide they want to meet once every month face to face and then meet via a videoconferencing software such as Skype, telephone or email during the weeks in between. Such an approach can be very helpful when people are travelling, or on breaks from studies.

An example in practice

Soloman (a fictional individual) is an undergraduate student who has been struggling with very low moods since he left home for university. He is an international student and the combination of getting used to a new academic environment has caused lots of stress, and acclimatising to a new country has left him feeling isolated and alone. A lecturer suggested that meeting a counsellor at the university might be helpful. Solomon looked up the service on the university's website, read a lot of the material that was available and emailed to make an initial appointment.

Solomon met Abigail (the counsellor) face to face at the university counselling centre to discuss whether counselling might be a useful way forward. Solomon agreed that he wanted to 'give it a go and see if it helped'. Abigail then went through the assessment documentation and they discussed Solomon's goals for therapy. He specifically noted that he felt he wanted to 'get his head around all the new stuff happening in his life' (his initial goal). Despite this being very open as a goal, Solomon didn't want to make this more specific at this point in time. Abigail then described and discussed several

potential ways forward that she could offer; these included being directive, and specifically focusing upon particular things that were going on in his life, or being more non-directive in her approach, and primarily adopting more of a listening role. As Solomon was unsure where the process would lead him, such services not being very commonplace in his home country, he wanted to start the relationship in a more open fashion (thus identifying the initial therapeutic task).

With the direction of therapy agreed upon, Abigail then asked about the way Solomon would like to work together. Although Abigail was limited to contracts of eight sessions or fewer in the first instance, she was open to working in a variety of ways. Abigail mentioned how some people prefer talking, while others might want to express themselves and explore issues through different means, such as through artwork. She also mentioned that some people prefer communicating online. As Solomon was very technologically minded, he liked the idea of communicating using his computer. He didn't want to rely solely on it, however, and felt that getting out of the house would actually be useful. Through the brief conversation, they agreed to work in a blended way, with the first, third, fifth and eighth session being arranged face to face. The other sessions would all be online, using videoconferencing software, unless Solomon decided to change his mind. Abigail discussed some of the practicalities around this process, including providing some information about communicating safely online, before ending the meeting.

Bringing it all together

The aim of this article was never to convert people to a specific way of thinking – I am aware that people will have strong views about both the use of technology in therapy and the pluralistic framework. What I do hope, however, is that it acts as a useful provocation for considering what it means to integrate technology into therapy. In training sessions around technology and therapy, I often quote the words of Douglas Adams on the issue. He states:

'Another problem with the net is that it is still technology, and technology, as the computer scientist Bran Ferren memorably defined it, is "stuff that doesn't work yet?".... "Before long, computers will be as trivial and plentiful as chairs (and a couple of decades or so after that, as sheets of paper or grains of sand) and we will cease to be aware of the things."'[17]

For me, this has clear resonance with the work of therapists. In the years that I have talked about this work, it is very possible to see that people have shifted their perspective on it. It has grown in abundance and responded to the different ways in which the general public now seek out support. Universities and colleges have not shirked the topic either. It is recognised that this population is primarily made up of *digital natives*, those who have grown up in a world always knowing the internet, and that services need to be responsive to this changing familiarity with technology.[18] As such, maybe we are teetering on the verge of the death of *online therapy*. After all, why do we truly need the *online* in that phrase? As the technology now commonly 'works', is there any need to draw attention to it? I am sure that for some this is presently a step too far, and that the technology being used remains intrusive, but my sense is that the ethical frameworks we adhere to as therapists, along with the legal perspectives of how we manage information about people (eg the Data Protection Act), prove sufficient support to underpin the work that therapists undertake in this realm. Without doubt, such a position takes some realignment, and I hope that my thinking is in some small way helpful on that front.

Finally, for those who attend the funeral of online therapy, maybe we can also celebrate the birth of the next new therapeutic method together – commonplace virtual reality therapy anybody? ●

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SOME CHALLENGES FOR PSYCHODYNAMIC COUNSELLING IN FURTHER AND HIGHER EDUCATION

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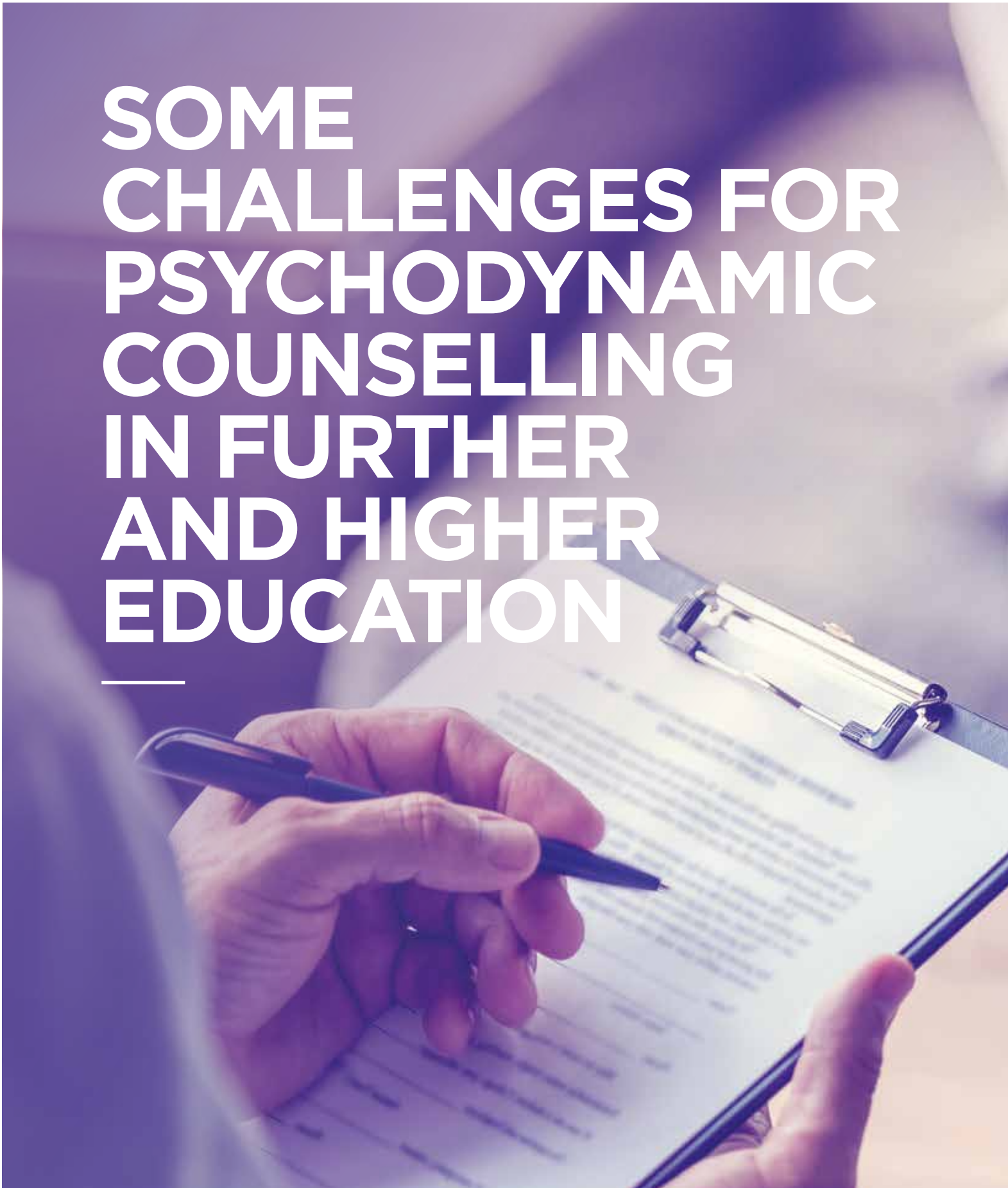
Although our various trainings may have helped us find our feet as therapists, the received wisdom of therapeutic traditions may also blind us to new truths and concepts. **Colin Feltham** encourages us to ask ourselves some hard but necessary questions about the nature of our therapeutic realities.

The psychoanalytic and psychodynamic tradition of counselling, psychotherapy and psychoanalysis now has a relatively long history in the private sector but also in health, education and other sectors. It has an element of respectability and durability about it, in spite of many serious criticisms over the past few decades. As with other traditions, many theoretical and institutional developments have taken place, some schisms remain sore points, and yet most practitioners probably feel secure in their clinical foundations and with mounting empirical research support. This article poses some well-known questions designed to review psychodynamic practice and theory as found in higher education institutions. Many of the points below also apply to non-psychodynamic therapy in these settings.

1. Durability of core theoretical principles
Central to psychodynamic practice has always been the concept of the unconscious, and with it the necessary concepts of defence mechanisms, transference and countertransference. Attachment, uncovering, interpretation, insight and other concepts are also central to the psychodynamic canon. Relatively new concepts of mirroring, mentalisation and so on are also influential.

Views regarding differences between Freudian and Jungian schools can vary enormously or in some cases converge non-problematically. The most challenging critique has perhaps been to the concept of the unconscious and its components. Without unconscious conflict, defences against it, and the trained competency of the therapist to recognise and interpret these mechanisms, there is in effect no psychoanalytic tradition. Critics have of course for many years argued that unconscious processes – to which only an in-group of believer-practitioners are privy – are highly speculative and open to doubt. Insofar as psychodynamic work rests on the 'reality' of the unconscious, it would be an extremely fragile construct if it could be shown to be a shaky, unverifiable, or even non-existent entity.[1] Psychologists and philosophers have suggested that concepts of self-deception and non-conscious processes are better ways of understanding what psychoanalytic theorists have framed as the unconscious. While psychodynamic advocates warm to any sign of rapprochement between psychoanalysis and neuroscience, a majority of academic psychologists continue to spurn psychoanalysis as a valid 21st century subject, even if it is well received in many programmes of women's studies, queer theory, postmodernist studies, and critical theory.

At point five below, I look at some problems triggered by emerging knowledge from other disciplines. Freud may have been ahead of his time as far as his speculative neurology is concerned (this is the fond hope of his fans), or his theories may turn out to be increasingly superseded by scientific discoveries. At the very least we have to say that currently there is little consensus here.[2,3] Evolutionary psychology, cognitive neuroscience, and neuroparasitology, for example, offer some hypotheses and testable propositions that challenge psychoanalytic aetiologies and the ability of talking therapy to effect improvements. Ongoing research casts doubt on the competency of uncovering therapies to explain and address many specific disorders such as obsessive compulsive disorder (OCD) and attention deficit hyperactivity disorder (ADHD).

> WITHOUT UNCONSCIOUS CONFLICT, DEFENCES AGAINST IT, AND THE TRAINED COMPETENCY OF THE THERAPIST TO RECOGNISE AND INTERPRET THESE MECHANISMS, THERE IS IN EFFECT NO PSYCHOANALYTIC TRADITION

2. Changing practice components

Practice traditions have developed across decades and settings but began with Freud's own (often short-term and what would now be considered 'unorthodox' improvisational) methods. Psychoanalysis became time intensive (several times a week) and interminable (often lasting many years). For different reasons, including the pragmatic, economic and experimental, many practitioners began to work to a pattern of only twice a week for about two years (psychoanalytic psychotherapy). Psychoanalytic principles found their way into new forms of couple, family, group and organisational therapy. Under pressure from changing economic and accountability norms, new forms of time-limited psychodynamic therapies arose, including intensive brief dynamic therapy, short-term dynamic psychotherapy, and brief dynamic interpersonal therapy.

The more stringent requirements of some psychoanalytic theorists become impossible to observe in certain settings. In university counselling services, for example, therapists may find themselves uncomfortably rebranded as wellbeing practitioners; they may have less discretion than they would in private practice as to which clients they take on; they must usually be part of a team of practitioners who do not necessarily share their therapeutic beliefs; they cannot easily distance themselves from the institution and personnel that form part of the clients' world; and they often cannot control the physical environment. The chaise longue, free association, 'working through' and other methods used by the private practice analyst do not work in the busy university's salaried wellbeing practitioner's office. None of these changes should surprise us, since analysts have for decades disagreed between themselves about the aims of therapy.[4]

When counselling young students in university settings, practitioners can rarely think in terms of years of treatment, of lengthy dream interpretation, long silence during sessions, uncovering early childhood material and watching clients 'get worse before they get better'. Time and resource pressures mean that clients often need their egos strengthening (not dismantling), and coping mechanisms being taught to enable them to pass through crises as quickly as possible, in order to pass exams. The vexed question of 'pure' psychoanalysis being diluted into lesser intensity psychoanalytic psychotherapy, and even more diluted into psychodynamic counselling, is salient here. But since there is no realistic

possibility of long-term analysis being provided for the masses (nor even for thousands of students), the ethical and practical question of modified psychodynamic therapy must be faced.[5] Understandably, therapists want to do a good job and dislike corner-cutting compromises, but for most clients therapeutic interventions are a timely, modest form of help rather than a life-changing project of 'making the unconscious conscious'. I know of no evidence to support this, but I suspect that many therapists covertly compare themselves to shamanic healers of the psyche rather than to nurses on life's battlefield.

3. Pressures to produce empirical evidence

Hans Eysenck made what remains one of the most challenging criticisms of psychoanalytic psychotherapy in 1952.[6] His paper suggested that psychoanalytic psychotherapy did not improve on results achieved by placebos or the passage of time. It challenged the tradition of peer-reinforced faith in psychoanalytic lore and case study justification, and eventually spurred generations of research. In the field of outcome research, however, CBT had stolen a march on other therapy models, its methods lending themselves to manualisation and standard practices that could be readily studied.

Psychodynamic therapy, like the humanistic approaches, has begun to catch up, and some newer (opportunistic?) brands are now designed with empirical research criteria built in.[7]

Quantitative outcome research is not the only valued form of evidence, however. From around the 1970s, when brief therapies were being investigated, the American experience of public therapy provision stimulated studies of brief therapy in different settings, of different theoretical kinds, and linked with clients' preferences. It was realised that, contrary to therapists' own assumptions and preferences, a majority of clients with access to free, open-ended therapy (such as much counselling in higher education in the 1970s to 1990s) commonly opted instead for quite short-term therapy.[8]

WHEN COUNSELLING YOUNG STUDENTS IN UNIVERSITY SETTINGS, PRACTITIONERS CAN RARELY THINK IN TERMS OF YEARS OF TREATMENT, OF LENGTHY DREAM INTERPRETATION, LONG SILENCE DURING SESSIONS, UNCOVERING EARLY CHILDHOOD MATERIAL AND WATCHING CLIENTS 'GET WORSE BEFORE THEY GET BETTER'

Among the many research interests in this field, consider the heavy emphasis placed by psychodynamic theorists, trainers and practitioners on the personal analysis or therapy of the practitioner. Among the arguments in favour of this costly element of training are these: the therapist must know what it is like sitting in the client's place; the therapist should make her own unconscious conscious to mirror or confirm the psychodynamic model; the therapist must experience transference in order later to grasp the significance of countertransference; the practitioner functions far better after having processed her own material. This last point is of particular interest. Anecdotal evidence suggests that psychodynamic therapists probably have no better mental health than others, and small organisations of psychodynamic practitioners with psychodynamically informed managers are hardly more efficient or conflict-free than others. Indeed some research confirms what should be obvious – that psychotherapists generally are not the paragons of mental health we might expect. Nor are they immune from the shocks of everyday life and the challenges of the later lifespan.[9] If nothing else, this should probably nudge us into accepting the modesty of therapeutic aims and results.

4. Competition from alternative models of therapy

Almost from the beginning, Freudian psychoanalysis came under attack and significant modification from once close allies of Freud and subsequent generations of innovative founders of new schools. Jung and Adler formulated their own approaches but remained linked with psychoanalysis. Others, such as Klein, Winnicott and Fairbairn, developed psychoanalytic therapy in an object relations direction. Yet others, often once closely linked with the Freudian tradition – such as Perls, Reich, Moreno, Berne, Assagioli, and Janov – broke away to create various models of distinctively humanistic therapy, placing more emphasis on accessing emotion, catharsis, sensory and bodily experience. Still others, notably Beck and Ellis, criticised and deserted psychoanalytic therapy in order to found early versions of CBT. This is all well-known history, but its underlying epistemology has never been satisfactorily resolved. Why exactly is psychotherapy such a pluralistic, contentious or malleable field?

If there is one clear improvement to have come out of the field in the past few decades, it is probably that of integration. Consensus on aetiologies and effective treatments may never be arrived at, but some

softening of attitudes across schools of therapy has occurred. Few would now disagree that significant common factors are in play in all therapies, and that these probably account for much of what success therapy has. Conscious efforts have been made in some cases to construct distinctive models, drawing from the best of different schools. For example, cognitive analytic therapy was designed with pressures of limited time in mind. Wachtel's 'cyclical psychodynamics' is one of very few models to attempt to combine not only disparate elements of psychodynamic and behavioural schools but also to add in clinical attention to known areas of social disadvantage.[10] In such ways, inter-school competition has proved fruitful. We might say that in the incessant struggle to adapt to the therapeutic marketplace, the most appealing models succeed.

> ...A MAJORITY OF ACADEMIC PSYCHOLOGISTS CONTINUE TO SPURN PSYCHOANALYSIS AS A VALID 21ST CENTURY SUBJECT, EVEN IF IT IS WELL RECEIVED IN MANY PROGRAMMES OF WOMEN'S STUDIES, QUEER THEORY, POSTMODERNIST STUDIES, AND CRITICAL THEORY

5. Challenges from other academic disciplines and critics

The study of the human mind and behaviour is not the exclusive preserve of psychology, nor of any one subdiscipline within psychology. Philosophy has a longstanding claim, and today a strong philosophy of mind and mental health exists. Philosophers concerned with linguistic analysis and epistemological clarity have often been severe critics of the claims of psychoanalysis. Biomedical psychiatry both challenges and is challenged by psychotherapy. Considerable progress has been made in neurology since the time of Freud, much of which throws into doubt the concept of a unified agentic self, and some of which raises reservations about the scope of personal or talking therapist-facilitated change. Evolutionary psychology too produces theories of psychopathology that often diverge significantly from those held dear by the community of psychotherapists.[11] However fashionable, Jacques Lacan, as well as Julia Kristeva and Luce Irigaray, have come under the close scrutiny of physicists and philosophers for their misuse of language and distortions of science.[12]

It is perhaps from certain political, economic and sociological perspectives that some of the most challenging critiques emanate. These suggest, for example, that funding for psychotherapy cannot be a socioeconomic priority from a left-wing position or that therapy must change to incorporate (usually anti-capitalist) political insights.[13] From a right-wing viewpoint, one finds the charge that therapy embodies unrealistically soft attitudes to life and tacitly supports a left-wing ideology.[14]

One important critique concerns the placebo factor. Given the apparently successful outcomes across all theoretical orientations, the argument for 'common factors' is that the explicit claims for therapeutic concepts and procedures matter very little. What actually counts is the therapeutic relationship in all its non-specific warmth, interest, and corrective emotional experience. Therapists' belief in their theories may reinforce their sense of self-efficacy as therapists and hence come across to clients as confidence. This means that practitioners may be benignly deceiving themselves, to the benefit of their clients.[15]

6. Real world challenges

Freud's main focus was on intrapsychic topics (*Civilisation and its Discontents* notwithstanding), and Adler represented one of the earliest analysts to declare a stake in 'social interest and community feeling'. Erich Fromm, Karen Horney and others moved towards explicitly sociopolitical positions, drawing partly from Marxism. Herbert Marcuse was among several left-wing academics to promote a Freudo-Marxist view as part of the 1960s and 70s Western counterculture. More recently, some Jungians have explored the 'political psyche'. Among others, Paul Wachtel has made explicit practice links with social justice issues; Sue Gerhardt with childrearing;[16] and Oliver James with so-called 'affluenza' in the 'selfish society'.[17]

Clinical psychologists like David Smail and the Midlands Psychology Group established a devastating critique of therapy leading to a 'social materialist psychology', locating the causes of distress not in the individual psyche but in capitalism.[18] Critical psychologists like Ian Parker similarly seek to show the limitations of institutionalised psychological practice and the need for far stronger links with social justice.[19] Psychoanalysis and psychodynamic counselling do not appear to have kept pace with such developments. The UK, indeed Europe and North America, have changed hugely in demographic terms over the past few decades. Mass immigration and multiculturalism challenge therapists to provide services that are more ethically and religiously sensitive, sometimes using

interpreters. Individuals whose origins lie in other cultures do not necessarily all share Western assumptions regarding causes of and remedies for distress. The social justice movement calls for much more attention to the claims of feminism, and the black, Asian and minority ethnic (BAME) and lesbian, gay, bisexual and trans (LGBT) communities. Therapists in general, but arguably psychodynamic practitioners in particular, were slow to respond to these challenges. Now we are seeing increased needs for understanding and treating the psychological distress of young men.

7. Better informed and more demanding clients

Gone are the days when most clients were completely naive or uninformed about therapy. Today, not only is therapy much more widely accepted than 30 years ago, but it is written and broadcast about more. More pertinent research and advice is available, especially online, and some websites in the UK (more in the US) are driven by ex-clients sharing their experiences and, often, views on what has been unsatisfactory. Many clients have had one or two, or multiple previous experiences of therapy before seeing their latest therapist. In some cases, complaints and litigation have spurred the profession into clearer ethical statements, but also into less creative and risk-averse forms of therapy. Psychoanalytic therapy has, by far, received the largest volume of complaints (for example, in the writings of Jeffrey Masson, Anna Sands, Rosie Alexander, and Virginia Ironside). In most cases, dissatisfied ex-clients have pointed to mishandled transference, therapist abuse, lengthy and costly therapy, deterioration and ineffectiveness, as the most salient of problems.

...PSYCHODYNAMIC THERAPISTS PROBABLY HAVE NO BETTER MENTAL HEALTH THAN OTHERS, AND SMALL ORGANISATIONS OF PSYCHODYNAMIC PRACTITIONERS WITH PSYCHODYNAMICALLY INFORMED MANAGERS ARE HARDLY MORE EFFICIENT OR CONFLICT-FREE THAN OTHERS

The traditional defence of analysts has been along these lines: all presenting concerns are symptoms of underlying conflicts; clients may feel worse before they get better; therapy is inevitably long term; clients often act out when painful unconscious conflicts begin to surface; well-managed terminations are crucial. Psychodynamic counsellors working in educational settings may ironically find such criticisms helpful in justifying short-term therapy, which not only addresses symptoms but sidesteps many of the above complaints and criticisms. Brief therapy can be regarded as the first treatment of choice for a majority of presenting issues.[20]

8. The passage of time and erosion of tradition

Although psychodynamic treatment has obviously changed since its inception in the 1890s, we might reasonably ask whether its 120-year history has kept pace with developments in science, demographics, and society generally. For many, psychoanalysis already appears arcane and incredible, attempts to refute critics and bring it into the 21st century notwithstanding. I suggest that the main reactions to the above points are as follows. First, psychodynamics does not have the field to itself and cannot command the monolithic position of radical breakthrough it held over a century ago. This must lead to a constant awareness of questioned professional clinical identity and how it fits into a pluralistic framework. Some who would once have entered the psychodynamic field might now well opt instead for CBT training and practice. Secondly, others from within the fold – following Jeffrey Masson, Alice Miller and others aware of psychodynamic-specific critiques – might become disillusioned and seek other careers. Third, in the light of critical psychology, social materialist psychology, and critical thinking generally,[21,22] some might find themselves disturbed by links between socioeconomic factors and the unwieldy epidemic of mental health problems. Despite the repeated call for better government funding for the treatment of non-physical illnesses, we may realise that this is unlikely to materialise. Conscientious practitioners may sometimes feel torn between the entrenched inner voice of their training; the idiosyncratic needs of each of many clients being seen; awareness of new knowledge that is hard to keep abreast of; the cognitive dissonance resulting from different streams of theory and knowledge claims; and the pressing need to continue to earn a livelihood.

Conclusion

In daily practice, psychodynamic and other practitioners face multiple micro-dilemmas. A client may need long-term therapy but not be able to access it. Compromises may have to be made in the face of

agency and time pressures, entailing clinical decisions; for example, whether to curtail an uncovering process and instead provide a corrective emotional experience and ego-strengthening. Arguably, a particular onus exists for counsellors and wellbeing practitioners within colleges and universities, concerning intellectual integrity.[23] Educational institutions often stand accused of bowing to the pressures of the new public management, dumbing down intellectually, and succumbing to over-protecting students. One of the biggest challenges then is for therapists to 'dare to think' (the ancient Greek injunction taken up by Kant – *sapere aude*) and to encourage students to do likewise. This can embrace radically rethinking psychoanalytic tradition (and indeed all psychotherapeutic tradition), rethinking education, and sharing with students the value of viewpoint diversity that has been eroded in recent decades.[24] The approach sees intellectual maturity as an essential part of wellbeing rather than being in opposition to it. ●

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Twenty-seven years of peer support at Oxford University: a work in progress

Peer support offers a valuable and unique form of support and personal development for those who seek it and those who provide it. **Anne Ford** traces the development of the programme at Oxford University and celebrates its diverse reach to the student population

In 1984, Barbara Varenhorst stated that 'Peer counseling, as a recognized counseling intervention, has a brief past, an active current existence and a potentially strong future if supported by adequate research.'[1] Although the use of paraprofessionals had been around since the 1960s, in 1969 Varenhorst wrote the first formalised training manual for peer counsellors. Thanks to the thoughtful work done during the 1970s, we have been able to benefit from the wisdom of those before us, and to take what worked, add to it and make it our own. Peer support no longer has a brief past: at Oxford University we have been running the programme for 27 years, and peer support programmes have spread across the UK throughout this time in schools and universities. History, including the history of peer support, is important because it sets a context for us: it places us in time and

in relation to what has gone before and what might come in the future. Context is crucial if we are to understand others, whether it is the context of society at large, the institutional contexts in which we work, the student context, or how these all intersect. The beauty of peer support programmes is that they adapt to fit their surroundings, evolving as institutional and student needs change. As long as the aims of the programme are clear, the training material clinically sound, the framework and structure transparent, and communication within and from/to the programme strong, peer support helps to create an environment within universities that encourages kindness, care, empathy and compassion. This creates for students the possibility of deeper connections and a sense of belonging, and promotes and complements existing student support services. Regardless of the type of institution and the people who make

it up, over the years it has become clear that the power of peer support is that it transcends culture and language barriers in a profound way, helping to promote connection and belonging both between students and between students and the institution.[2]

OUR CONTEXT
Peer support began at Oxford in 1991 in response to a university report that showed that students first and foremost sought out their peers when they needed support. This idea was written about in the US before the report came out and has been borne out in the research since then. We first ran the training as a pilot project in 1990, focusing on students who were already providing welfare to other students in their colleges. At the time, within the collegiate system at Oxford, each college had their own welfare network, made up of students elected to the position. Welfare provision was not as

developed or embedded in the colleges as it is today, and initially the aim of the programme was to enhance welfare provision in colleges, and to complement existing professional services within and outside colleges and the university. In the early 1990s there was very little public discussion about mental health and wellbeing, and one of our goals was to reduce the stigma associated with seeking support. It took a lot of hard work to build up acceptance and trust in the programme.

The peer support programme has evolved and adapted to changes in society, one of which is that we are now living in a time when people are experiencing higher levels of loneliness than in the past. In 2010 the UK Mental Health Foundation's survey highlighted that 36 per cent of people in the 18 to 34-year-old age range worried about feeling lonely, and a quarter of people in the UK felt 'emotionally unconnected' from others.[3] There has been a lot of research into the health benefits of feeling connected and having a sense of belonging; we are wired to be social beings, after all. Though we are connected through the internet to more people than ever before, the quality of face-to-face, intimate connections has declined over the past two decades.[4] Our understanding about the increase in loneliness, coupled with more open and frank discussions in society about wellbeing and mental health, shape our thinking about what peer support can offer to mitigate this, especially as those with mental health issues often feel isolated or unable to seek support. The focus of peer support at Oxford is primarily on the emotional and psychosocial experience of students. At an institution where imposter syndrome and fear of showing vulnerability are rife, peer support offers a non-judgmental, compassionate and reflective space, both for the peer supporters and for the students they support, and is therefore often

experienced as counterculture. Students are surprised that through acknowledging and understanding their own and others' vulnerabilities, and the benefits that come from sharing them, they frequently feel stronger and more resilient rather than weaker and not good enough. The equality inherent in peer support is especially important at a time when economic inequality and issues around race, ethnicity and immigration are widespread. Peer support has the possibility of reaching all students, regardless of background.

With the result of the Brexit vote, a rise in Islamophobia and heightened racial tensions, it is imperative that students of colour receive the support they need to safeguard their emotional wellbeing. This is especially important for freshers, who might face additional difficulties in adjusting to a new university environment where the majority of their peers may not be from their ethnic or cultural background. As a peer of colour, I hope to ensure that no student of colour feels left out or unsupported.
Yew Loong, third year peer supporter

As our programme has matured, so we have developed a deeper understanding of what it offers to the peer supporters, those they support and to the university as a whole. The peer supporters at Oxford are all volunteers. They receive 30 hours of training in listening and support skills, assertive communication and on issues relating to families, culture, crisis work, suicide prevention education, referrals and signposting, self-care, limit-setting and confidentiality.[5,6] The peer supporters gain a tremendous amount from the training itself and through supporting others, but, just as importantly, they grow and develop through being a part of the programme. Peer support training is transformative. Through training and supervision, the peer supporters develop close, and often deep, relationships, enabling them to

experience the vulnerability necessary to be open and honest with their peers, and to ultimately offer and be offered peer support throughout the training and supervision sessions. The impact on the trainees themselves should not be underestimated: the skills they acquire – including the ability to practise self-care – have a ripple effect in all areas of their lives and provide skills for life.

Students often comment on how being involved with peer support has had a positive impact on all of their relationships, not just the ones in which they are supporting their peers. A handful of students each year change their career path due to their involvement with the peer support programme. We often hear finalists who are stepping down from peer support say it is one of the most valuable things they have done while at Oxford.

Peer support is one of my key takeaways from the MBA programme at Said Business School. The training and supervision sessions provided an excellent platform to hone my listening skills and to become self-aware. These two skills proved critical not only for the class discussions and group sessions, but also when I joined work. I am more confident in taking part in discussions, and as an outcome, people find it comfortable to be around me as they are aware of me being non-judgmental, empathetic and patient about issues at hand. I benefitted a lot – never thought I would get so much from this experience – friends, compassion, warmth and ability to be there for others!
Ankit, Oxford MBA'16

Chloe, a peer supporter and finalist who has just stepped down from peer support, said the following: *Peer support has actively changed me as a person – without the training we undertook, I wouldn't believe the difference we can make in so many ways to the atmosphere of college and the lives of our fellow students.*

On a personal note, I think my time here would have been far less enjoyable without peer support – it has given me a confidence in my belonging in college and Oxford that I struggled to find in my first term or so, and the amount that we have talked about self-worth and self-care has really changed the way I treat myself and my outlook on the Oxford/university experience. Peer support gave me the confidence and the skills to really bring out my natural empathy and care for those around me; I have always found happiness in helping others, and peer support has allowed me to do that so much more effectively. I have no doubt that I will continue to find use for the skills I've learned.

WORKING TOGETHER

Peer support programmes cannot work unless there is a belief in, and understanding of, the values they embody, and the good they do. Collaboration is paramount in starting and sustaining a programme, and this includes collaboration with key people in the institution, within the service hosting peer support (Student Services, Counselling Service) and with the peer supporters themselves. In my experience, problems arise with collaboration when there is a lack of understanding about the aims of peer support, what the training *actually* involves and how students provide peer support post-training. One issue that arises in all institutions is whether students can 'handle' being a peer supporter. Over the years I have had to address the fallacy that it is unsafe to use students to support their peers, something I strongly disagree with: after all, as mentioned above, students naturally seek out their peers. Surely, it is better to equip a group of designated students with the skills to listen, support and the knowledge to potentially refer on as needed. It is imperative that those running a peer support programme have a belief in, understanding of and enthusiasm for

the goals and ethos of peer support programmes: equality, mutual respect, compassion and kindness, accessibility, approachability and support. They need to *trust* that students can take on the work required to be a peer supporter; if there is doubt about this, it will negatively translate consciously or unconsciously into the programme and training. Therefore, it is essential that when starting up and/ or running a programme, it needs to be well planned to fit within the particular institution, and have a safe, clinically sound and formalised training, followed by regular and consistent supervision sessions, both of which are mandatory for our students.

At Oxford, the welfare systems in colleges and departments have hugely changed since we started peer support. Working closely with them to develop our relationships, we identify a Designated Link Person (DLP) whose role it is to back peer support in college, to discuss the applications with the trainer and to meet with peer supporters periodically. The best practice that has developed among some of the DLPs is that they meet once or twice a term with the peer supporters to check in with them, making clear it is different from supervision with the Peer Support Trainer. Students feel valued in the colleges that do this, and the DLP can more clearly communicate to other senior members ways in which peer supporters are using their skills, from running events to drop-in sessions, from saying hello to someone sitting on the periphery to actively chatting to incoming students during Freshers' Week.

Within the Counselling Service, we work collaboratively with counsellors in a number of ways. Feedback from many of the counsellors is that they appreciate knowing when they are meeting a student that a peer supporter has referred to the service, as they have already begun the work that needs to be addressed. In addition,

counsellors sometimes refer their clients to peer supporters, especially around issues of loneliness and friendship issues.

Finally, through listening to and collaborating with peer supporters, in 2016 we launched two additional strands of peer support: Rainbow Peers and Peers of Colour. Rainbow Peers is a group of LGBTQ+ Peer Supporters that offers support to any students who feel they would be better helped by someone from the queer community.

I realised that what I really needed was someone like me who I could confidently speak to – there were so many things about my experience as a queer person that I really wanted to get off my chest. This is what Rainbow Peers is about: giving LGBTQ+ identifying people, like me, an opportunity to speak to someone they are comfortable with, about issues that may be troubling them. They are all willing to listen to what you have to say, and to help you understand and solve problems that you may not have even properly been able to visualise.

If I had had access to the support of Rainbow Peers when I started university, I may not have been able to completely come to terms with the issues I was facing, but I would have definitely been far more confident and assured when I was working through them.
Charlie, Rainbow Peer

Peers of Colour is made up of trained peer supporters who are from varying cultural, ethnic and racial backgrounds and who may be better equipped to deal with any specific concerns of students around these issues.
As a student of colour and an international student, I had a hard time settling in during my Michaelmas of my fresher year. Although my friends were kind and I did not face outright racism, I faced challenges in adjusting to the different weather, food, culture and language. I had difficulty in finding other students who could empathise

with my situation. This is why I feel Oxford needs Peers of Colour. It can help students of colour find support from those who can understand them well and have been in similar situations.
HK, Peer of Colour

Students do not have to contact these groups with regards to those issues exclusively; they are available to provide a non-judgmental, apolitical space for LGBTQ identified students and/or students of colour to talk about their experiences.[7,8] All peer supporters involved with these groups undergo the 30-hour training with their college or department, and volunteer additional time to participate in these groups. There have also been active referrals by counsellors to Rainbow Peers and Peers of Colour.

WHAT TO KEEP IN MIND WHEN STARTING UP PEER SUPPORT:
- Peer support is not new. Although it might be new in your institution, the value of it is well researched.
- The case for running a peer support programme must be made based on its therapeutic value and enhancement of student wellbeing, and not as a cost-cutting or PR exercise, in order for it to become embedded in the university culture.
- It is important not to measure the success of peer support programmes on the number of times in a year a peer supporter has been approached; rather, it is a better measure to find out from peer supporters how they use their skills every day. Through asking this question, you will get a rich and diverse picture of how peer supporters perform daily acts of kindness – such as speaking to someone they have noticed who is on their own – as well as how they support their peers more formally. These acts matter.
- Before starting peer support, it is important to reflect on any stereotypes or misgivings you

have about it. These need to be worked out before taking your ideas forward – it takes tenacity to get a programme up and running, and a belief in the concept needs to be at the heart of it.
- Those running the programme need to have a belief in and positive regard for the students participating in the programme.
- Peer Support is hard work, rewarding, transformative and fun. Though some of the sessions contain especially difficult material – families, crisis, and suicide prevention education – it is important to bring humour, flexibility and joy to the trainings.

Ultimately, we humans are here but for a moment in time, building on what has come before us and aiming to leave the world a better, kinder and more connected place. The Oxford University Peer Support Programme started as a small pilot project, training 10 students in the first year, and now has 490 students involved either in training or as active peer supporters at any given time. It has had a clear, positive impact on the peer supporters and those around them, and on the trainers in our team. Peer support programmes bring hope, connection and a sense of belonging to those involved with them, something we desperately need to nurture as we face the future. ●

About the Author
Anne Ford has worked at the Oxford University Counselling Service since

1988, both as a counsellor and as the Co-ordinator of the Oxford University Peer Support Programme, which started in 1990. She trained peer supporters for four years at the London School of Economics, and for two housing associations in London. She co-ran a Peer Support Training for Trainers course in Estonia and currently co-runs the course in Oxford. She is passionate about peer support as a means of helping young adults develop themselves emotionally, socially and psychologically, and now spends all her working time in this area. Anne is the author of Peer support in Colleges and Universities: a training manual, *and* Peer Support in Teenagers Aged 15–18.
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Profile

Ruth Caleb reflects on her long career in student counselling, including eight years at Thames Valley University, and most recently 17 years as Head of Counselling at Brunel University, London

HOW DO YOU THINK THE CULTURE IN HE HAS CHANGED OVER THE YEARS?

Perhaps one of the main changes I have experienced is the movement of colleges and universities from simply being educational establishments to becoming businesses. One consequence of this is that we are now seeing the emergence of Student Services directors and managers who have not come through the trained professional services, but are brought in for their business qualification or administrative acumen. It is not necessarily a major problem that our managers may have no training in our particular role, as long as they consult with the experts they manage and are enthusiastic about our work together, supporting their services for the care of students. I think it's vital that counselling managers get onto committees and working groups that develop strategic thinking. They will bring you into contact with influential managers, directors, academics and the students' union. Look out for those senior managers who appear to take an interest in the Counselling Service and mental health. It is also important to meet with those who ask what might feel like negative or challenging questions – in an informal atmosphere, they may be more sympathetic and understanding.

HOW HAVE SECTOR CHANGES MANIFESTED IN YOUR OWN SERVICE?

There was a decision to restructure the whole of Student Services, including the Counselling Service. Major changes that will be introduced include a 'single entry point', which will be through student welfare advisors, who will assess and signpost students to all services.

I felt that this would be a new start for the service and the time had come for a new manager to move it forward.

AS YOU LOOK BACK OVER YOUR CAREER, WHAT HAVE BEEN THE STANDOUT MOMENTS OR EVENTS?

Some of my most touching memories include having watched students who have used our service at their graduation ceremonies. Many of them had been on the cusp of leaving their courses, but managed to persevere with the support of the Counselling Service.

Winning the BACP award for Improving Access to Counselling and Psychotherapy in 2013 was a wonderful experience. The whole counselling team went to receive the award, accompanied by our manager. I felt extremely proud.

The experience that was the most fun was appearing on 'Woman's Hour' with Jane Garvey. Her questions were challenging but she made it easy to relax and chat about student mental health.

WHAT WILL YOU MISS MOST?

I will miss HUCS enormously. In particular, I feel sad at leaving London HUCS, my regional group. I now think of many HUCS colleagues as friends and all have played a part in making me feel part of a highly professional, yet warm and sharing community. I thank you all for being such an amazing support.

WHAT LIES AHEAD FOR YOU AT THIS POINT, RUTH?

I will continue to work for Brunel part-time as a Wellbeing Consultant, remain on the Universities-UK steering group for the Mental Health in HE programme, and as Chair of the Mental Wellbeing in HE working Group (MWBHE). This role has involved me in working at strategic level with senior managers to support student services.

I have an academic role supervising doctoral students at Metanoia Institute/Middlesex University. I am also currently co-editing a book with Nicola Barden, Head of Student Services at Winchester University, on student mental health.

So as you can see, I will be kept very busy, not to mention trying to spend more time with my four grandchildren, going to the gym more regularly (unlikely!) and practising the ukulele which I currently play rather badly. ●

IN OR OUT OF CONTROL? VIEWING SEXUAL COMPULSION OTHERWISE

The concept of sex addiction is not without its critics. **Dominic Davies** argues in favour of alternative understandings of compulsivity to inform our work with clients concerned about their sexual behaviour

Sex addiction is a term coined by Patrick Carnes in the 1980s, emerging from the 12-step fellowship movement of Alcoholics Anonymous. Carnes was a prison psychologist and a devout Christian.[1] His concept of sex addiction needs to be seen as rooted in the social context of a time in which many gay men were being diagnosed with what was then thought to be a fatal sexually transmitted disease. It was common for certain Christian commentators to describe AIDS as God's wrath on homosexuals for their promiscuity. While not addressing homosexuality per se, the cultural moment when Carnes was writing, and the religious influence on his thinking around promiscuity,

inevitably pervade his work. The diagnosis of sex addiction is most commonly made by clients themselves, their partners or friends. However, many therapists have uncritically accepted these diagnoses, despite there being no agreed diagnostic criteria. Some have begun 'treatments' when there are no evidence-based programmes for this concern. It is a serious concern when mental health professionals accept pop psychology concepts and agree to treat people on that basis. This is neither scientific nor ethical practice. Many of us suffer from 'Fiscal Insufficiency Syndrome' (running out of money at the end of the month) and may even mention this in our therapy appointments, but we don't see

a booming market in therapists trying to treat it. Maybe because there's not enough money in it?

In over 35 years' practice I have never met anybody in my professional or personal life who I would term a 'sex addict'. I've worked with people who have a lot of sex and many have been concerned about their sexual behaviour, but I have never met someone I consider an addict. 'Addict' seems to me an incredibly unhelpful term, with no agreed clinical definition. When the American Psychiatric

THERE ARE NO... NICE APPROVED EVIDENCE-BASED TREATMENT PROTOCOLS

Association produced the last edition of the *Diagnostic and Statistical Manual* (DSM-5), they found insufficient scientific evidence to support the inclusion of hypersexuality disorder.

Given that sex addiction is not an officially recognised mental health condition, how can mental health professionals and their governing bodies agree to provide 'treatments'? In recent years the British Association for Counselling & Psychotherapy (BACP) has promoted sex addiction training workshops as has the College of Sex and Relationship Therapists (COSRT). This is in stark contrast to the stance recently adopted by their sibling organisation in the US – the American

Association for Sexuality Educators, Counsellors and Therapists (AASECT) – who released a position statement in December 2016 on the issue of sex addiction, as follows:

'AASECT recognizes that people may experience significant physical, psychological, spiritual and sexual health consequences related to their sexual urges, thoughts or behaviors. AASECT recommends that its members utilize models that do not unduly pathologize consensual sexual behaviors. AASECT 1) does not find sufficient empirical evidence to support the classification of sex addiction or porn addiction as a mental health disorder, and 2) does not find the sexual addiction training and treatment methods and educational pedagogies to be adequately informed by accurate human sexuality knowledge. Therefore, it is the position of AASECT that linking problems related to sexual urges, thoughts or behaviors to a porn/sexual addiction process cannot be advanced by AASECT as a standard of practice for sexuality education delivery, counseling or therapy.'[2]

America has a strong religious culture, and sex addiction tends to be diagnosed among people with faith-based beliefs. In particular, it's been noted that white middle- and upper-class men, including celebrities and those with high social capital, are the major client group. It is worth reflecting on why this is so. Is it a 'disease' of privilege, or one affecting people of religious belief? Is it coincidental that here in the UK, the major training providers for sex addiction treatment are also Christians? Sex addiction treatment is largely available through private therapy and there are no National Institute for Health and Care Excellence (NICE)-approved evidence-based treatment protocols.[3,4]

Turning to the university student population, late adolescence is often a time of sexual discovery and experimentation. This may be more so for gay and bisexual people who have suppressed or repressed their same sex attractions while living at home. Most people will have seen porn by the time they get to university, but it is the freedom from parental gaze which permits more direct sexual exploration. High levels of testosterone and a considerable amount of opportunity encourage the young to explore their sexuality. Some explorations will be positive and some less so. The majority of these young people will eventually reach a point

THE DIAGNOSIS OF SEX ADDICTION IS MOST COMMONLY MADE BY CLIENTS THEMSELVES, THEIR PARTNERS OR FRIENDS

of greater self-regulation. However, the inadequate sex education most people receive often results in significant sexual ignorance, and leaves people unskilled and unprepared for relationships, and – for anyone who feels outside the mainstream of what their peers claim to be experiencing (whether this is atypical sexual attractions, behaviours, frequency of sexual activity or absence of relationships) – with a propensity for sexual shame.

Many adolescents and young adults are also shamed into feeling bad about their interest in porn or sex. Websites such as yourbrainonporn.com are full of pseudoscience.[5] Such forums are replete with young men expressing fears about their performance and something called 'porn-induced erectile dysfunction' (PIED). This is another pseudo-diagnosis, not found in DSM-5. Prause and Pfaus, eminent neuropsychologists researching 'porn addiction', conclude that the concept does not hold up to scientific scrutiny.[6] Their findings indicate that people who watch a lot of porn are, instead, likely to have higher than average desires for sex.

Sex addiction treatment bears some similarities to 'sexual orientation change efforts' (sometimes referred to as conversion or reparative therapy), which trades on religiously motivated and conflicted individuals who feel tremendous fear, guilt and shame about their attractions, desires and behaviours. There is no evidence that reparative treatments work, and plenty of evidence that they cause great harm. The majority of UK and US professional medical, psychological and psychiatric bodies now prohibit their use.[7]

The criteria for meeting a definition of sex addiction are fairly lax, and people (85–92 per cent are men) are able to positively self-diagnose via a number of sex addiction screening tests that generally enquire about specific sexual behaviours: watching porn, cruising/anonymous sex, sex in public sex environments (even those set aside for such purposes like gay saunas and sex clubs), fetishes and bondage, discipline, dominance and submission, sadomasochism (BDSM), secrecy about sexual behaviour, and favouring non-monogamous styles of relationships.

I have never been convinced by these kinds of diagnoses, which seem to be based on heteronormative assumptions. The basic messages that such self-assessments convey, albeit indirectly, are that sex ought only to take place between two people within the context of monogamous relationships, in private, and not too frequently. They discriminate against people who are single, in non-monogamous

relationships, or who have higher than average sex drives (and no-one can agree what a 'normal' sex drive is). Sex addiction theories fail to take account of what we know from sexual science about the diversity of human sexual behaviour and of the various subcultural norms and values within certain communities. (Gay men tend to have a bit more sex with more partners than heterosexuals and our relationships might not privilege sexual fidelity over emotional fidelity.)[2]

INADEQUATE SEX EDUCATION... OFTEN RESULTS IN SIGNIFICANT SEXUAL IGNORANCE, AND LEAVES PEOPLE UNSKILLED AND UNPREPARED FOR RELATIONSHIPS

Yet clients may come to us for help precisely because they believe that they are sex addicts. In the same way that gay clients may, in the past, have sought therapy because they wanted to be cured, it is incumbent on therapists not to collude with the pathologising of sexuality, and to have clear alternative understandings of clients' distress.

For over a decade, I have been co-running training workshops which offer 10 alternative, non-pathologising lenses through which to view compulsive sexual behaviour in men who have sex with men (MSM). I will briefly introduce two and mention a third new model for treating what I refer to as out-of-control sexual behaviour (OCSB).

The first alternative paradigm comes from transactional analysis (TA) theory and Eric Berne's six psychological hungers: stimulus hunger, recognition hunger, contact hunger, time structure hunger, incident hunger and sexual hunger.[8] Men whose sexual behaviour is out of control may be unconsciously seeking to fulfil one of these hungers through sexual activity, which fails to address that specific hunger: this would be the case where there is compulsive use of porn when the individual actually has contact hunger, or they are bored or lonely.

The second paradigm comes from Jungian analyst Vittorio Lingiardi.[9] In his fabulously titled chapter 'Sacred precincts of Sodom', Lingiardi talks about how men who have sex with men may be drawn to cruising grounds (parks, disused cemeteries, saunas etc) to meditatively cruise for sex, occasionally dropping to their knees in worship of the phallus and, when 'anointed', move on to further devotions. Sex between men in these spaces can, for some, represent profoundly intimate and spiritual connections. Frequent visitors might be considered to be more devoutly seeking psycho-spiritual connection. The analogy with priests is an interesting one, too, as

TABLE 1: COMPARISON OF SEX ADDICTION AND OCSB MODELS

SEX ADDICTION	OUT-OF-CONTROL SEXUAL BEHAVIOUR
No universally agreed definition or criteria	States that sexual science and psychological research fail to find empirical evidence to support linking sexual behaviour with an addictive process
No agreed evidence base for treatment	Uses an evidence-based Dual Process Sexual Health-based model of behaviour change, integrating a client-centred, 'Stages of "readiness-for-change"' treatment approach (motivational interviewing)
May require a chastity contract	Client-defined personal vision of sexual health
Act-centred sexual value system that generally relies upon 12-step religious principles, a Higher Power and sexual standards established by traditional cultural sources for moral/approved-of sexual behaviour	Principle-centred sexual value system that guides sexual values by alignment with six sexual health principles: • Consent • Non-exploitation • Being safe from risk of STIs or risk of unwanted pregnancy • Honesty • Shared values • Mutual pleasure
Treatment can be administered by unqualified peers after unscientiific pop-psychology self-diagnosed 'Sex Addiction Tests'	Treatment usually provided by qualified sexologists and mental health professionals, after careful assessment
Not endorsed by any major psychological body	Consistent with AASECT position statement on sexual addiction
Proscribes consensual BDSM and non-monogamous relationships	Does not pathologise consensual sexual urges, thoughts or behaviours
Is largely sex-negative	Is sex-positive

no-one ever thinks of priests as being 'religion addicts'. In our society formal worship is deemed more noble and worthy than sexual connection, despite what we know from tantric practices and the transpersonal connections which can flow from ritual and sexual sacred practices.[10]

The last paradigm is a new model developed by two sex therapists, Doug Braun-Harvey and Michael Vigorito, which meets the sexual health principles of the AASECT policy statement mentioned above.[11] It is based on six principles of sexual health: consent, non-exploitation, protection from disease and unwanted pregnancy, honesty, shared values and pleasure. It also uses the well-evidenced 'Dual Control' model of sexuality to bring sexual science into the treatment of out-of-control sexual behaviour.[12] I think this gives us a robust, evidence-based paradigm to help people who present with OCSB. It doesn't discriminate against certain sectors of society or relationship styles and it seeks to help people bring out-of-control behaviours in line with their personal values. This comprehensive model utilises sexual science, careful and extensive assessment to increase self-awareness, and to identify other underlying mental health difficulties. It also offers a framework for client-centred goal setting through individual sexual health plans, utilising motivational interviewing (MI) as a core modality. MI has a very strong evidence base of facilitating lasting behavioural change.[13] It also makes use of group process as it is delivered both one to one and within a group context.

GIVEN THAT SEX ADDICTION IS NOT AN OFFICIALLY RECOGNISED MENTAL HEALTH CONDITION, HOW CAN MENTAL HEALTH PROFESSIONALS AND THEIR GOVERNING BODIES AGREE TO PROVIDE 'TREATMENTS'?

Conclusion:

While sex addiction is a commonly used model for describing problematic sexual behaviour, other, non-pathologising models exist which do not collude with client shame or societal stigma surrounding different sexualities. It is incumbent on us as therapists not to heighten client shame, and to educate, where necessary, with regards to alternative understandings of sexuality and sexual behaviours. ●

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In defence of trigger warnings

Does alerting students to potentially upsetting material in lectures or other settings infantilise them, or allow them to take responsibility for their mental wellbeing? **Amy Beddows** advocates in favour of warnings and the choices they enable individuals to make

Trigger warnings – verbal or written cautions attached to potentially distressing material – have been the subject of much recent discussion. Initially developed in feminist forums to protect those who have experienced sexual violence from potentially traumatising content, trigger warnings have spread to clinical settings, education, art and entertainment and are often attached to online material.[1] A passing glance over the debate would suggest that trigger warnings are a problem: that they threaten free speech and foster a culture of over-sensitivity,[2] that they are weapons against teachers, administrations and new ideas.[3,4] that they impair learning and 'soften' students.[4,5] Prominent celebrities have denounced trigger warnings as symptomatic of a growing culture of 'victimhood', and at a recent BACP conference they were accused of 'pathologising' student distress.[6] Considering such vocal criticism, it is unsurprising that there has been a backlash against their use, especially in academic settings.

> *I believe that (trigger warnings) can be of great value and... they can be used to foster autonomy, empowerment and resilience*

However, I am writing in support of trigger warnings. I believe that they can be of great value and that far from blocking free speech or inhibiting learning, they can be used to foster autonomy, empowerment and resilience, especially for those who have experienced trauma.

SEXUAL VIOLENCE AND ACADEMIC SETTINGS

Exploring the prevalence of sexual violence among a student population, as with any population, is a difficult task. The personal nature of questioning and the variety of factors affecting disclosure make it difficult to find a clear estimate. A survey by the National Union of Students (NUS) found that one in seven female students at UK universities had experienced serious assault and 68 per cent had been victims of sexual harassment.[7] More modest estimates still assert that significant numbers of women and men sitting in lecture theatres, seminars and classrooms will have experienced some form of sexual violence, making this a relevant issue for academic institutions.[8]

CRITICISMS

Trigger warnings have been accused of undermining free speech by demanding censorship of material that is deemed to be distressing, challenging or offensive; a notable example is the oft-cited removal of rape legislation from law curricula at several North American universities. Any rhetoric around free speech will provoke strong reactions; however, I believe that this argument is diversionary.[2,10] Trigger warnings were initially intended to avoid the need for censorship, by allowing people to make informed choices prior to accessing material that might negatively affect them, rather than demanding an outright ban of such material.[11] This can be especially important for those who have experienced trauma, as intrusive memories and difficult emotional states can be triggered by small, unexpected and sometimes obscure reminders.[12]

There have been very few referenced instances of trigger warnings resulting in censorship. Their use as part of a protest at a lecture on rape culture was described as an infringement of free speech, yet the lecture went ahead uncensored.[4] There is often misunderstanding, as protest is not censorship but another form of free speech.

As practitioners working with trauma, we are aware of the value of exposure work and in this context, trigger warnings could help clients to identify appropriate and meaningful exposure material (for example, a lecture on rape legislation). A recommended CBT protocol in the treatment of post-traumatic stress disorder (PTSD) involves first identifying triggers to flashbacks or emotional disturbance and, until the client is ready to process the trauma memory, applying caution or even avoidance of such triggers.[12] However, it has been argued that trigger warnings feed the avoidance mechanism of PTSD and therefore that students should seek treatment rather than request changes to their academic environment.[5,13] My question is: why can't they have both? As unexpected exposure to triggering material can lead to traumatisation and other difficulties, some form of warnings in certain contexts would seem helpful, considerate and not unreasonable.

> *...unexpected exposure to triggering material can lead to traumatisation and other difficulties*

From a clinician's perspective, we are also aware of vicarious trauma. We might make certain choices – where possible – when considering referrals or perhaps we balance the number of clients that we see in a day or at certain times, in order to protect ourselves. Depending on our lives outside of the therapy room, we may decide to not work with certain problem areas at all. Is this best practice or avoidance? When considered in this way, are client referral forms not a potential trigger warning for therapists? As a non-clinical example, both the Imperial War Museum in London and the Holocaust Memorial Museum in Washington DC include warnings at the entrance to their concentration camp exhibitions. Is this censorship or encouraging avoidance of the grislier parts of human history, or does it allow visitors the opportunity to prepare themselves for the emotional impact of an important – but potentially distressing – experience?

Similarly, a 'heads-up' in academic settings can allow for challenging discussions and make the learning environment more accessible for students with trauma in their backgrounds.[14,15] Informing a class that a text or film includes rape or violence provides the opportunity for students to prepare and look after themselves. Is this much different to discussing relapse prevention plans and self-care strategies, to foster resilience and maintain wellbeing? If there is a line between acceptable and unacceptable levels of distress, it would appear that this differs between the therapy room and the classroom.

Another familiar criticism is that trigger warnings impair educators' ability to teach, and allow collusion with student 'unwillingness' to experience discomfort.[5,6,9,16] This issue is with the implementation of trigger warnings rather than the warnings themselves. Students have always fought to change the system – and isn't that a point of further education? – but the system has not always buckled to their demands. As universities are coming under increasing pressure to provide 'safer' spaces (especially with regards to sexual harassment and assault), it is understandable that they would look for quick solutions which may be frustrating, time-consuming and disruptive for individual educators.[14,15] If trigger warnings were seen as comparable to audio-visual adjustments – adaptations that may benefit a few students but can be easily (and harmlessly) applied to an entire class or lecture – would they seem like such a chore?

It has been suggested that the rise in mental health problems among students is partly caused by 'coddling' and 'infantilisation', with demands for trigger warnings as evidence of this.[4,5,10] Yet there has been little focus on causality: do trigger warnings damage mental health or is their request a symptom of increased mental health issues among student populations? It could also be

evidence of increased awareness and autonomy, if students are requesting adjustments in order to protect their emotional wellbeing.

Additionally, it is important to distinguish between 'uncomfortable' feelings, such as anger, unease and outrage, compared with (less common) panic, terror or severe distress. Perhaps we cannot (and nor should we) demand the right to not be offended or annoyed, but what about the right to not be traumatised or terrified? Is this pandering to a culture of 'victimhood' or self-protection? We know that high levels of emotion can impair the cognitive processes involved in learning and memory, so if a student is traumatised to the point of panic, dissociation or flashbacks, how does that affect their intellectual growth and education?[14] Conversely, dismissive criticism of trigger warnings could send the message that people need to 'toughen up' and not be affected by traumatic experiences. A greater acceptance of trigger warnings could contribute to the destigmatisation of mental health in general and make it more likely that people will ask for help. There is the suggestion that trigger warnings can help people access online support around issues such as self-harm.[21]

IMPLEMENTATION
Interestingly, there has been little discussion regarding the implementation of trigger warnings; perhaps there is a danger of wording them in a way that raises the expectation of psychological threat (and therefore avoidance). But they can also be used to demonstrate the function and value of distress (for example, with provocative artwork).[17] Educators could use them as a springboard for discussion about the importance of different emotional states, a conversation that may be as important in the classroom – if not more so – as it is in the therapy

room.[14,15] As they shift responsibility for learning and wellbeing back to the student, this may reduce fears of teachers being 'blamed' for causing upset and 'cover the backs' of institutions in a similar way that age restrictions and ratings reduce the liability of producers of films or video games.[9]

GENDER
It is worth considering whether this impassioned debate is indicative of something deeper than fears for freedom of speech or student autonomy. As already mentioned, trigger warning are most commonly used in relation to sexual violence, which affects vastly more women than men. There is also a history of pathologising women's emotions as hysteria, instability and insanity, as well as minimising the impact of sexual violence and victim experience.[22,23] In online discussions, trigger warnings are used to ridicule, denote weakness or impose 'political correctness' onto others, especially women.

There is... a history of pathologising women's emotions as hysteria, instability and insanity, as well as minimising the impact of sexual violence and victim experience

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'Triggered' has become an insult. This gendered divide is particularly apparent in the gaming world, where trigger warnings have been used to attack female gamers who complained about sexually violent content.[8] Hostile and dismissive responses have been linked to an increased likelihood of self-blame, depression and PTSD following

sexual violence, which, again, will affect more women than men.[19,20]

Within this debate, it is important to see who would be most affected by trigger warnings or their absence. The vehement backlash to their use could be seen as a symptom of the gender inequality still apparent in our society; if so, then we need to consider this within a much wider discussion around individual, institutional and societal responses to those who have been victimised by sexual violence, especially in relation to gender.

IN DEFENCE OF TRIGGER WARNINGS
As should be apparent, I believe that trigger warnings have value. From my therapeutic work with clients to my own experiences as a student studying sexual violence, I believe that trigger warnings can empower people to figure out what they can cope with, rather than highlighting what they cannot manage.[14] They also state that rape is not acceptable. Regardless of opinion on rape culture or Stephen Fry's feared 'victimhood',[6] hopefully we can agree on two things: sexual violence is bad and it happens more than we would like. Trigger warnings can reinforce both these truths to everyone, not just those who have been directly affected.

Of course, it is important that we have this discussion. Trigger warnings have become synonymous with coddling and censorship, yet like any tool, they are only as useful as the hand that wields them. Developed from a place of compassion, they were designed to make environments more, not less, inclusive. The discussion reminds me of a comment I saw online recently: 'If we replaced the term 'political correctness' with 'human kindness', would it seem like such a chore?'. In a world with so much suffering on individual, national, societal and global levels, is there really much harm in a little kindness

and consideration for the emotional wellbeing of others.

Trigger warnings are often caught in the crossfire of wider issues in education and it is their function and implementation that should be up for discussion, not their existence. Warning is not censorship, it is informed consent. Giving people a 'heads-up' is not regulation, it is helping people be mindful and responsible for their own responses. Trigger warnings can help people to see challenging emotions as inevitable, tolerable and, in some contexts, worthwhile. Considering this, I suggest that we reflect upon the potential value of trigger warnings in the classroom and other settings rather than dismiss them completely and demonise those who would benefit from them. ●

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* The sources referenced here are intended to be representative but not exhaustive.

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DIVISIONAL NEWS

Notes from FE

Following the internal BACP review it seems that divisions will continue to function, so the BACP-UC Executive and the FE/Sixth Form Counselling (SFC) subdivision will continue to try to represent the views and wishes of the wider counselling community within our respective areas of work. To that end, Jane Darougar has already spoken at a Westminster briefing conference on the state of mental health in FE, and she and I attended the STORM Student Mental Health Conference in Manchester at the start of September. It was good to catch up with a variety of colleagues in various settings from up and down the country.

We really hope there will be a BACP-UC Conference next year, although it will almost certainly be a one-day event at only one location. Another busy year is already underway. Recent threads on the JiscMail include helping a new lecturer establish professional boundaries, questions about college-wide support following a student suicide, and issues affecting pre-trial therapy. I'm hoping to keep these topics regularly updated on the new BACP website, when it is live. As an Executive, we've been asked for input and suggestions on how to make the website appropriate and accessible, but once it is live, any contributions from you will be very welcome.

We are hoping to plan an FE/SFC-themed edition of the journal, but need your contributions to make this possible. Please contact either David Mair or me with articles, or ideas to be developed into articles, so that we can explore the sector-specific issues we are all contending with. I hope you're all surviving what is often the busiest term of the year: at least by the time you are reading this, it will nearly be Christmas. ●

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Notes from the Chair

By the time you read this journal in November, the updated sector resource for university and college counselling services' will have been published.[1] This resource is the latest in a series published over the past 30 years and it takes into account new working practices. Many of you value the sector resources, and we have received frequent requests for an updated version.

It might take me a while not to refer to them as the 'guidelines', having used them for many years under that name. I am probably also attracted to the idea of a set of specific rules that underlie good practice. For instance, that the '...caseloads of trainee and volunteer counsellors should be commensurate with their levels of training and experience... and that the work of such counsellors forms no greater than 30 per cent of the total work of the service'.[1] When I started working in a university, I found the guidelines very helpful and I valued working in a sector with such specific and defined parameters regarding good practice. I have continued using them in various situations, such as when writing essays during my supervision training, and when I became a head of service. I have found them particularly useful when illustrating the need for adequate

resources with senior managers. When a service I worked for was reviewed, it was very useful to be able to argue that 'An experienced counsellor should be appointed to lead the counselling service', and helped in saving the Head of Service role. And now, years later, I still find the sector resources a very useful frame of reference.

So as Chair of the division, I feel very privileged to have been able to contribute to their new iteration, having edited this 2017 edition.

On behalf of the division, I want to thank the authors who worked so hard at updating the new resource:

Barbara Lawton, who worked as a counsellor for many years at the University of Leeds.
Anne-Marie Bradley, counsellor at University of the Arts London.
Trevor Butlin, Counselling and Wellbeing Team Leader at De Montfort University.
Jane Darougar, counsellor at Leyton Sixth Form College.
Mary Jones, Student and Staff Counsellor at Newcastle-Under-Lyme College.

I hope you find the new edition of the sector resource useful in informing your practice and supporting the work of our BACP-UC Counselling Services. ●

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Notes from HUCS

In September, a report was published by the Institute for Public Policy Research: *Not By Degrees: Improving Student Mental Health in the UK's Universities*.[1] This was commissioned by Universities UK (U-UK) as the first stage in developing a sector-wide response to the growing level of mental health problems in the student population. The summary of the report states:

'The higher education sector and government both have an interest in helping to improve the mental health and wellbeing of students. Universities should make the issue a strategic priority and adopt a "whole-university" approach based on prevention and promotion, early intervention and low-level support, responding to risk and crisis management, and referral into care and treatment. There is currently too much variation in the extent to which universities are equipped to meet this challenge. This sector-led approach should be complemented by strengthened NHS provision and new government initiatives to ensure that no student is held back by their mental health.'

In the coming months, U-UK will develop a strategic plan to implement the recommendations of this report. This is a great opportunity for the sector to develop a more coherent and thoughtful response to offer a joined up 'stepped level' of support, covering prevention and mental health promotion through to care, treatment and management of those students with more serious mental illnesses. However, what seems to be missing from the paragraph above is the need for counselling services which can provide effective support to students who are currently experiencing mental health problems which are negatively impacting on their studies and overall experience. There will always be a need for professionally staffed and clinically trained counsellors/clinicians to offer brief interventions to act as a real, positive change agent for a significant proportion of the student body at every UK HE institution. There is a huge gap between prevention strategies requiring 'low level support' and 'crisis management'/'treatment'.

There is a narrative being advanced from some quarters which incorrectly stereotypes counselling services as offering a 'deficit model', only responding to students once they have problems. Psycho-education prevention strategies are essential (and many of the most effective examples of these are already being delivered and developed by counselling services) but not at the cost of counselling support in the HE sector.

My former clinical supervisor and mentor, William Halton, always impressed on me that at times of anxiety, institutions and senior managers see things in very black and white terms, as being either part of the problem or part of the solution. We must be confident in demonstrating to the wider sector that we, as a counselling profession, are very much part of the solution. ●

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REFERENCE
1. https://www.ippr.org/research/publications/not-by-degrees (accessed 28 September 2017).

BOOK REVIEWS

AUTHENTIC: HOW TO BE YOURSELF AND WHY IT MATTERS
Professor Stephen Joseph
Piatkus Books
ISBN 978-0-349-40484-4 | £14.99

This self-help-style book aims to help adults live better by encouraging a more authentic way of being. It begins with an overview of how the author came to believe that authenticity is key to living well. He then guides the reader through four sections: 1. How to be yourself 2. Why authenticity matters 3. Three steps towards practical authenticity and 4. Authentic living in the 21st century.

I found this book warm and welcoming in tone. It was factual without being dry and I particularly liked the many case studies which helped bring theory to life. Most of the concepts in the first part of the book were familiar, but I appreciated how a newcomer would find it clear and enlightening. I found the section about positive psychology and the authenticity scale most absorbing, as I was unfamiliar with them and they are an interesting direction in which to take the core beliefs of the person-centred approach. However, some of the American terminology was rather off-putting. 'Owning yourself', for example, struck me as rather cheesy, distracting from the usefulness of the ideas. As is often the case with self-help books, the exercises were well explained and could help explore the internal world, but they assume that the reader has enough insight and ability to engage fully alone. I wonder if some may find the prospect of 30 exercises daunting without support.

There is a definite adult emphasis in the case studies, focusing on the workplace and how to raise authentic children. This would be a good resource for clients who are interested in improving their self-awareness and who want something to consult in addition to therapy. It will be of less relevance to practitioners working in FE, but I would be interested to see how it might be adapted for a teenage audience as I suspect this is a time when inauthenticity really takes hold and might be prevented.

I liked this book very much. I believe that more should be done to explain the humanistic approach to wider society and this is a nice addition to that work.

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AUTISM AND THE FAMILY
Kate Fiske
WW Norton & Co
ISBN 9780393710557 | £27.50

This is a valuable book for professionals working with children on the autism spectrum. Kate Fiske offers an interesting perspective and reminds us that the child is usually surrounded by family, who also need to be understood, so they can collaborate in the child's journey of progress. Fiske suggests that professionals need to listen to parents, siblings and the extended family in order to help them reduce their own stressors and improve their wellbeing. Fiske makes

it clear this is not a book about supporting the autistic individual, but rather the family which surrounds them. Family can contribute insight into the child and can enhance interventions by extending them into the family home. Professionals need to ask themselves how much they can involve family while they are supporting the autistic individual.

Fiske clearly identifies the feelings of confusion, isolation and frustration which relatives might experience and offers suggestions of how professionals can help. Tensions within the family arising from generational gaps or cultural differences are also explored.

There are some barriers which readers outside the US might experience with the book. The first is use of language. Terms such as 'treatment' as opposed to 'intervention' might connote a search for a 'cure' to some people. In the UK many professionals focus on strategies to overcome impairments with a view to promoting strengths and skills. Fiske uses terms such as 'problem behaviors' and 'tantrums', which imply control, as opposed to 'meltdowns' or 'closedowns', which acknowledge that the individual can simply become overwhelmed.

Another difference is that the processes for diagnosis, support, access to interventions and funding in the US are very different from other countries and, therefore, practical suggestions might not necessarily apply. However, the emotional rollercoasters and day-to-day hurdles that relatives experience are very similar, and Fiske offers useful suggestions for each stage of the relatives' journey.

Each chapter of the book has a helpful list of take-aways for clinicians and there is a useful list of resources at the end of the book. In all, this would be a useful book for professionals, including therapists working with individuals with an autistic spectrum disorder, who can also work collaboratively with the family.

Manar Matusiak
Managing Director, Living Autism
http://www.livingautism.com/
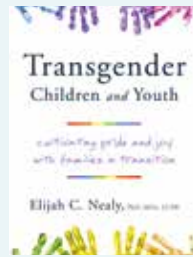
TRANSGENDER CHILDREN AND YOUTH – CULTIVATING PRIDE AND JOY WITH FAMILIES IN TRANSITION
Elijah C Nealy
WW Norton and Company
ISBN :978-0-393-71139-4

The author of this book is an American professor of social work, a therapist and pastor. He is also a transgender man. The book is a comprehensive guide to the issues facing young transgender and gender-variant people and their families and is written from a trans-affirmative stance. It has something to offer to young people, parents, teachers, youth workers and counsellors and would be a useful addition to university and college counsellors' bookshelves.

The author's passion for and knowledge of his subject come across very clearly. The book covers core concepts such as sex, gender expression, gender identity and sexual orientation, and basic vocabulary used within trans and gender non-conforming communities. It goes on to explore gender variance and gender diversity in children and adolescents. It looks at the development of DSM criteria for gender identity disorder and discusses the advantages and disadvantages of the current DSM-5 shift to a diagnosis of gender dysphoria.

The author outlines how gender dysphoria is diagnosed and discusses supporting children whose gender expression varies from the so-called norm. He then talks about issues for young people and their families around disclosing a transgender identity and looks at social transitioning and the various aspects of medical transition.

There is considerable detail about different surgical procedures and the use of hormones and hormone blockers and possible concerns these raise. Case examples are used throughout the book. There are chapters on navigating school and college and another on the role of mental health professionals in helping transgender and gender-variant young people. The book is good at highlighting the impact of discrimination and transphobia.

For me, the most engaging and at times moving section of the book is the chapter on helping families to get alongside their transgender or gender-variant family member. There are lots of clinical vignettes that illustrate the complexity of emotions families face and how these can be worked through. The author shows how this improves outcomes for young transgender people whose mental and physical wellbeing and safety are closely linked with how supportive their families are able to be.

I enjoyed the book and would recommend it to counsellors in HE and FE.

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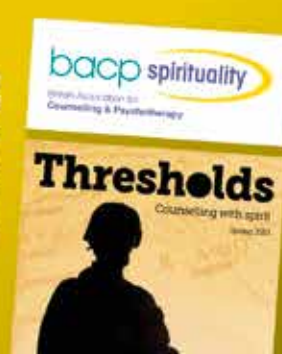
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