BACP PRIVATE PRACTICE JOURNAL WINTER 2017

Private Practice

FOR COUNSELLORS AND PSYCHOTHERAPISTS
IN PRIVATE PRACTICE

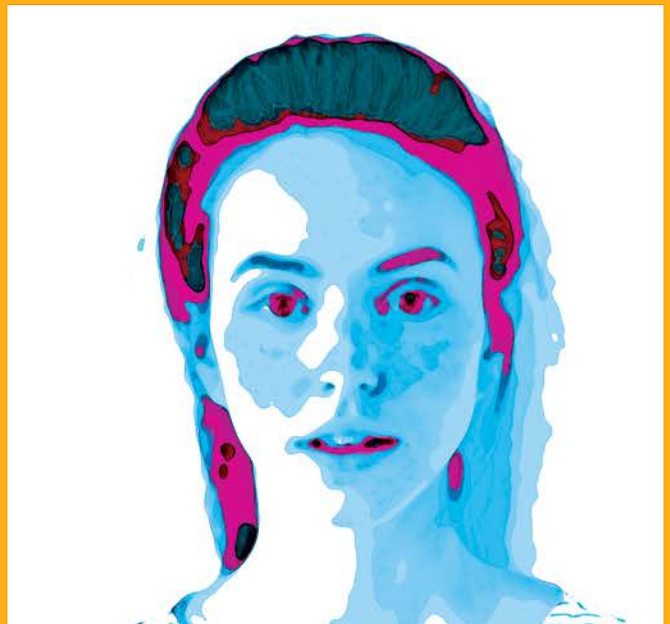
Identity: can you tell me who I am?

The post-conference issue

Gender identity: empowering clients to make healthy choices

Eating disorders: challenges to the personal self

Identity in later life



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

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Welcome

'I don't know who I am.' How often have you heard these words, or similar, spoken by clients within the confines of your consulting room? I have heard them many times, and spoken them myself to my own therapist in times of personal distress, often resulting from losses, endings, transitions, and periods of change and readjustment.

As therapists, we are in the business of supporting our clients to become more fully themselves; guiding them in the process of identity formation or 'I am-ness', which includes a sense of continuity of being, uniqueness from others, and belonging in the world. The *Oxford English Dictionary* defines 'identity' (from the Latin *idem* meaning 'same') as: 'The fact of being who or what a person or thing is'; and, 'The characteristics determining who or what a person or thing is.'

Far from being finite, as the simplicity of these definitions imply, however, identity is complex, multifaceted, always in a continuous and dynamic process of change, and socially constructed. We do not only have a psychological identity but we have social identities too, based on age, religion, nationality, ethnicity, race, social class, culture, disability, education, language, dialect, sex, gender identity, sexual orientation, generation, occupation, profession, political affiliation, veteran status etc.

Writing about the complexities of identity in an inspiring article on the Psychosynthesis Trust website,[1] psychotherapist and trainer Angie Fee points out that in our therapy trainings we are made all too aware of the importance and significance of psychological identity – self-esteem, self-awareness, self-reflection – but perhaps may not have given the same amount of attention to how our social identities have developed within our own particular cultural context, and the conflicting nature of power some of these identities hold. 'This process,' she writes, 'includes a deepening awareness of how systemic and institutionalised models such as racism and heteronormativity, have created privileged and oppressive social divisions. This can be a challenging and threatening process, particularly if we have normalised and internalised our own positions of power and privilege.'

On that note, I am pleased, therefore, to be introducing this special issue of *Private Practice* on the important theme of identity, which includes eight feature articles by some of the therapists who gave presentations at the 2017 BACP Private Practice conference, 'Identity: can you tell me who I am?' The conference theme was particularly prescient at this point in time in which the politics of identity are to the fore in the world in ways that are both progressive – the shift in the understanding of gender identity becoming more mainstream, for example – and, sadly, also divisive, as we see in the rise of white identity politics in the US and Europe.

Writing on the subject of how to support clients who are coming into therapy to explore their identity, Michelle Bridgman (page 30), one of two of the conference keynote speakers, argues the need for a paradigm shift in the way trans people are clinically treated. 'The role of counselling and psychotherapy is not to encourage or discourage any course of action,' Michelle writes. 'If we meet our clients in a meaningful dialogue and accept them wherever

they may be, they have the potential for a healing encounter that will increase their awareness and understanding, while at the same time empowering them to make healthy choices.'

And on the same topic, Debbie Clements (page 6), one of the conference workshop presenters, says that one of the key things she's learned in her work supporting adults and young people around gender and sexuality is: 'I cannot support clients around their gender identity if I subscribe to a traditional model of gender. I must support my clients to express all of who they are – their masculinity, femininity and androgyny, without judgment or restriction.'

Elsewhere in this issue, contributors focus on the impact that significant life transitions – such as the movement from midlife into old age – can have on our sense of identity (page 8), and the particular ways in which grief has a profound and destabilising affect on our 'continuity of being', leading to a redefinition of self and identity (page 26). Also included is a personal reflection by Brian Charlesworth (page 16) on his difficult transition into living life as an ex-soldier in a civilian world, and a compelling feature by Lesley Finney (page 20) on the ways in which eating disorders challenge the concept of the personal self as single, ongoing, consistent and conscious.

And last, but by very far from being least, Kate Anthony (page 34) brings us right back into the 21st century in her thoughtful contribution on the effect that technology is having on identity formation, and the vital importance that, as therapists, we must understand, engage with, and take very seriously this new reality. 'When we dismiss cyberspace as somehow "not being real life",' she writes, 'or shake our heads in despair at young people seemingly glued to their mobile phone, we miss the point that this is where identities are formed and sometimes damaged in the technologically connected world.'

Returning to the article by Angie Fee I cited earlier, she writes about how helpful she has found it is to apply an 'intersectional approach' when understanding the complexities of identity. Growing out of feminists of colour arguing that most feminist scholarship was from middle class/white/educated women, the phrase 'intersectionality' was coined by American civil rights advocate Kimberle Crenshaw in 1989. Fee writes: '...intersectionality challenges one-size-fits-all stereotypes, adding to complexity, rather than reducing it. An intersectional perspective recognises that many of us fall between the cracks of heterosexual, black, class and spiritual discourses – we don't just fit into one of those identities but they all interact with each other, bringing multiple dimensions to our experiences.'

This speaks to me, inspires me, and reminds me of Michelle Bridgman's optimistic view that 'the world now has space for a mosaic of gender identities' – a concept we have attempted to replicate illustratively on the front cover. May the world also have space for an intersecting mosaic of every other identity too.

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2. Fee A. The personal is political: a bifocal vision. [Online.] https://psychosynthesistrust.org.uk/angie-fee-the-personal-is-political-a-bifocal-vision/ (accessed 1 December 2017).

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

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From the Chair

Against all odds

It takes strength, courage and resolve to realise our true selves, particularly in the face of adversity

Mervyn Wynne Jones
mervynwynnejones@hotmail.com

Pegasus, in Greek mythology, is the winged horse sired by Poseidon and tamed and ridden into battle by the warrior Bellerophon. Why, you might reasonably be wondering, should I be thinking about this particular mythical beast? Well, the answer is twofold. Firstly, by association, it explains why I was unable – to my considerable regret – to attend the annual BACP Private Practice conference in London in September, staged and hosted by the division's Executive, with the crucial and expert support of BACP Events specialists.

I was on a long-planned veterans' battlefield tour of Arnhem in the Netherlands, the scene of an epic nine-day battle in September 1944, in which British airborne forces fought against impossible odds in a heroic but ultimately hopeless bid to hold a crossing of the Rhine during the advance towards Germany. The struggle, held in near reverence by the Parachute Regiment to this very day, featured in the 1977 movie *A Bridge Too Far*, and Pegasus was the regimental emblem worn proudly as a patch on the upper sleeve of each of those extraordinary airborne soldiers.

Secondly, and more importantly, it reminds me of my late father, who was himself a paratrooper and who, having earned his hard-won parachute 'wings' (and the Pegasus patch) too late for Arnhem, went on to see active service in the Middle East with Britain's 6th Airborne Division.

And here is the point I am wanting to get to: there was not a day in my father's life when I did not see him wearing his Parachute Regiment tie, which featured miniature outlines of Pegasus. He was in almost every way defined by that formative period of his life during which he served with his regiment. His concept of identity was one of veteran soldier and, specifically, paratrooper. His Welsh slate headstone has Pegasus, still the emblem of the British airborne warrior, engraved upon it. It is as he would have wished.

'Identity: can you tell me who I am?' was the title of our conference, and it is my privilege to welcome readers to this post-conference special issue on the theme of identity. It is brim-full of fascinating articles by many of our conference presenters. The conference explored a range of issues connected with identity, including sexuality, gender, culture, bereavement and loss, abuse, and physical and mental ability. The emphasis was on the issues faced by all of us as practitioners, and on the newer challenges associated with our public and private selves with the advent of social media, and what lies beneath in the more private space of the therapy room.

The programme of conference workshops was designed and tailored specifically for therapists working in private practice, and included Mel Adisu on 'the many layers of *me*'; Kate Anthony on the psychological aspects of online disinhibition; Brian Charlesworth on working with a warrior's identity; Debbie Clements on gender identity; Lesley Finney on archetypal defences and eating disorders; Jonathan Hartley on bereavement; Andelo Tabu Ngandi on spiritual identity; Tamar Posner on identity in later life; and Mary Louise Russell and Dr Gillie Jenkinson on helping ex-members of cults re-establish their identities.

The opening keynote was given by Michelle Bridgman, who looked at working with clients who are either challenged by their gender identity or society's attitude towards it, and the importance of therapists knowing and owning their own identity when with clients. The closing keynote address was given by Adam Pearson, the main speaker at the 2014 TEDxKalamata in the ancient Greek theatre of Messini, who spoke about the significance of self-identity. It was a conference of remarkable diversity and calibre, and I am grateful to all the contributors.

> There was not a day in my father's life when I did not see him wearing his Parachute Regiment tie, which featured miniature outlines of Pegasus

Reading through the articles, I am struck by the nuance and, often, complexity of identity as a concept, and the way we see ourselves, and the way we see, and find ourselves seen by, others. And, perhaps inevitably, I find myself considering my own identity and the experiences that have forged my present sense of self and being. This is indeed a thought-provoking issue.

And I consider those I have met who have given me greater understanding of the profound and absolute importance of achieving identity – sometimes in the face of unimaginable adversity – as a realisation of true self. I have for very many years been hugely fortunate to call 'friend' the first British army officer to transition from a man to a woman, Abigail Austen. Abi is now the world's first transgender foreign correspondent. Her recent Channel 4 documentaries are raw and revelatory, such as *My Trans American Road Trip*, which looks at issues faced by those who have transitioned in the US. Watching the ground-breaking documentary Abi made many years ago as she transitioned from man – and fellow soldier – to woman was utterly humbling. Her strength and resolve were beyond any capacity of my own. Her quest for self was unwavering. And she too once served with the Parachute Regiment and galloped the canyons among the clouds with Pegasus. Hers has indeed been a most remarkable journey.

Identity is a multifaceted and absorbing concept, and I commend the following pages to you with enthusiasm. I do hope you enjoy this special issue.

Mervyn Wynne Jones is a counsellor and trainer with individuals and groups in Llandudno, North Wales.

Getting to know you

In this column, we will be looking at a way to use your unique identity to create marketing messages for your private practice

Martin Hogg
martin@citizencoaching.com

The recent BACP Private Practice conference got me thinking about two aspects of private practice marketing: What is my identity as a counsellor? And how do potential clients see me?

In *Toy Story*, Woody, a cowboy toy, is desperate to be reunited with his owner, Andy. He follows Andy to an amusement arcade and tries to get his attention by climbing into a 'claw crane' arcade game. Woody knows he can get Andy's attention by standing out from all the other prizes, and fights his way to the top of the pile to do so.

Take note: if you don't stand out, people might not find you. Many counsellors' marketing materials have a complete absence of the counsellor in them. They talk about the counsellor, some even in the third person, taking on the tone of an obituary rather than marketing copy, but they don't catch the 'essence' of the counsellor. This 'essence' is the key to defining your own presence in your marketing and is often referred to in the marketing business as 'personal branding'.

It's time to replace the stock photos of rocks, flowers or an air-punching figure on top of a mountain, with a natural head and shoulders photo of you on the first page of your website or leaflet. Maybe you could add a photo of your counselling room to give people a sense of the space you work in. A picture says a thousand words. Let it say: here is a friendly professional counsellor who can help me through difficult times.

The *What Works in Therapy* report by the International Centre For Clinical Excellence reports that as much as 60 per cent of what works in therapy is the alliance between counsellor and client.[1] I would suggest that clients are searching for a professional counsellor who they can 'plug into' and start working with, and that the relationship starts with that initial contact. The challenge is in defining your own essence and differentiation, and then using it to create marketing that will bring in the right clients.

In personal branding, you are the brand, or alternatively you could develop a brand name for your practice and make that the brand. In other words, you could be 'Jane Hudd, counsellor in Hull' or you could be 'Ripples Counselling in Hull'. Most counselling practices are one-person operations and these, typically, reflect the personality, attitudes and personal values of the therapist. In fact, it is difficult to separate the business from the owner in this case. That is why for us, as counsellors, our personal dealings affect our business so much. How people view us, as a person, is not different from how people regard our business. This is where we can use personal branding to our advantage.

Personal branding does have an element of self-promotion and sometimes this makes counsellors uncomfortable. If it feels too uncomfortable, it's OK to pick a company name instead (as in my example above). But before you do, consider that it's common for other professionals – dentists, accountants, solicitors – to create personal brands.

Your personal brand is all about you – your talents, skills, knowledge, traits, beliefs and values. It may also be about a particular 'niche' you work in, but here we are going to concentrate on your personal differentiation. Personal branding is identifying who you are as a person, defining a clear identity, creating a message, and then bringing all these elements together as a business strategy, with the intention of shaping a positive perception of you and, naturally, your business. It should, above all, be authentic.

Try this simple exercise to help you determine what makes you different from other counsellors. If there were a breakfast cereal that was most aligned to your personality, which one would it be? Take a minute to decide. A visit to any supermarket will reveal a huge variety. They are packaged differently, and use different words, colours and graphics to differentiate themselves from each other. Which one did you pick?

When I use this exercise at my Grow My Practice courses, there are two above all that get mentioned: porridge and muesli. Counsellors who choose porridge describe warm feelings, wholesomeness, reliability and reassurance. Those who choose muesli talk of variety, eclecticism, surprise and possibility.

The success of your personal branding relies on your ability to communicate your personal message (I'm more of a 'porridge'), whether verbally, via your website and marketing materials, or through your actions. You need to let your customers know what you are capable of doing and how you deliver that, while reassuring them that they can rely on you. When everything about you speaks a constant message, customers pick this message up and associate it with your personal brand, so that whenever they see you, hear your name, or encounter your product, they immediately know what you are about. This is the foundation of trust – a key ingredient to creating a sustainable private practice. Personal branding is not a one-time marketing campaign. It runs through everything you do. It's an ongoing commitment. Your brand should be evident in your interactions, communications, relations and involvements.

Some questions to consider when defining your personal branding:

- Can I define my mission; the reason I have gone into business?
- Can I define what makes me different from the competition?
- Do I understand why my target audience should be happy to do business with me?
- Do I know what clients in my niche want and need?
- Have I have done market research and do I know who the other counsellors in my area are?

Once we know who we are, we can start to tell others about us.

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1. Miller SD. What works in therapy. International Centre For Clinical Excellence; 2012.

Martin Hogg MBACP is the founder of Citizen Coaching and runs **BirminghamCounsellingServices.co.uk**

Challenging norms

Debbie Clements argues that traditional understandings of gender are limiting and can be harmful

It's the end of our first session and we've agreed our next appointment. 'You gonna write that down then?' Jack asks, nodding towards some paper. 'I don't carry pens – I'm not queer!' He laughs. I'm taken aback and stuck for words. I feel vulnerable and exposed – I am 'queer' and feeling that being 'queer' is not a good thing in Jack's eyes. After some reflection, it occurs to me this isn't about sexuality, it's about something else. I recall his earlier comment that he feels 'weak coming here'; that he needs to 'man-up a bit'. I think about Jack's disclosure of suicidal thoughts and the vulnerability to suicide for men around his age.

Ben sits opposite me, head in hands, declaring his dislike of himself. Growing up, he was badly bullied, not only by his peers, who perceived him as feminine, but simultaneously by a father who felt that if he 'acted like a man' the problem would go away. It's taken Ben a long time to accept himself as gay and even longer to feel any warmth towards himself.

Louise has had a tough day; she's told her parents she's transgender and wants to transition and live socially as a woman. It did not go as she hoped. Walking home, she passes two men who call after her with transphobic abuse. The pain of invalidation hit her hard.

At first glance, these clients may seem worlds apart, yet the collective picture highlights something crucial. Traditional understandings of gender can not only be limiting but can also be deeply harmful.

The dominant model of gender depicts two sexes with corresponding gender identity, gender expression and (hetero)sexuality. An example of this is how a baby is gendered at birth as a boy if a penis is present. They are then socialised as male, expected to see themselves as male, and assumed to experience desire exclusively for females. When presented as natural and the norm, all that falls outside this can only be perceived as abnormal. Questions that arise around what makes someone transgender (or gay), highlight how deeply embedded these norms are in our society.

However, gender is socially constructed. We are born into a system that predates us, and are repeatedly called into gender throughout our lives. We see this in the clothing and toys we are permitted as a child, the prefix before our name, how others address us (eg 'ladies' or 'gents'), the signs on public toilets and, ultimately, the way others interact with us depending on how they perceive our gender. This process is so naturalised that we barely notice it – that is unless we have a strong sense that the way we are being perceived is not who we know ourselves to be. For people who experience this mis-gendering, it can be incredibly painful and jarring to a sense of self. High rates of mental health distress and suicidality in trans communities tell us that, for some, it feels unbearable.

People who are trans (or perceived as 'crossing gender') are highly vulnerable to psychological and often physical violence from those who refuse to accept deviation from 'the norm'. Policing of gender can be seen in 'jokes', transphobic, sexist and homophobic comments – and can be deadly. GLAAD (formerly the Lesbian & Gay Alliance Against Defamation)[1] declared 2016 the deadliest year on record for murders of trans people, adding that figures were likely to be an understatement, with trans people's gender identities often erased/misrepresented in police reports and the media. According to *The Independent*,[2] transphobic hate crimes rose a staggering 170 per cent in 2016. While, across the world, those perceived as crossing gender often face persecution. Globally, we know that being LGBTQ is still a crime in 74 countries, resulting in imprisonment and, sometimes, the death penalty. One might then ask, if the dominant gender model is natural, why does it need to be constantly reproduced and (at times violently) reinstated?

Despite such challenges, we know that increasing numbers of people are coming out as transgender or questioning their gender identity. Gender identity clinics have seen a huge rise in people seeking support, including those with a non-binary gender identity (feeling neither wholly male nor female). Changes such as greater societal awareness, legislation and LGBTQ spaces have made an impact. Older people note they now have the narrative to name their experiences and the space to explore their identity. Meanwhile, children are coming out younger than ever before.

Trans activism has led to greater visibility and created a shift in our thinking around gender. While feminist activism challenged the naturalness of gender roles, and the gay rights movement has shown us that homosexuality and bisexuality are as natural as heterosexuality, trans activism has demonstrated that the sexed body does not automatically denote someone's gender. In addition, intersex activism tells us that babie born intersex are far more common than depicted – with the process of 'correcting' ambiguous genitalia (and then assigning a gender) deeply harmful and inhumane.

The law still only recognises two genders, yet societal shifts reflect changes in the gender landscape. The *Merriam-Webster Dictionary* tells us gender identity is: 'A person's internal sense of being male, female, some combination of male and female, or neither male nor female.' Social media sites are presenting numerous options for gender identity upon registration. At the end of 2016, Metro bank became the first bank to offer 'non-binary' as an option, alongside male and female. Increasingly, organisations and businesses are recognising the need to adapt.

Several new models have emerged that reflect our growing understanding of gender, offering gender as a spectrum rather than a binary, and presenting and offering a wealth of possibilities as individual as we all are (google 'the gingerbread model of gender', or 'the gender unicorn' for examples). Despite the newness of some of these models, pluralistic understandings of gender have been around for numerous years and exist in societies across the world.

One of the key things I've learned is that I cannot support clients around their gender identity if I subscribe to a traditional model of gender. I must support my clients to express all of who they are – their masculinity, femininity and androgyny, without judgment or restriction. I see the client who appears as a man but has a female gender identity as the woman she is, knowing that gender expression is not the same as gender identity. Knowing that, whether the client has transitioned or not, they are still valid. Knowing that the therapy room may be the only space that person gets to be seen, heard and recognised by another as who they truly are.

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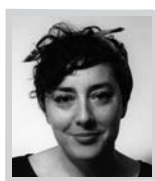
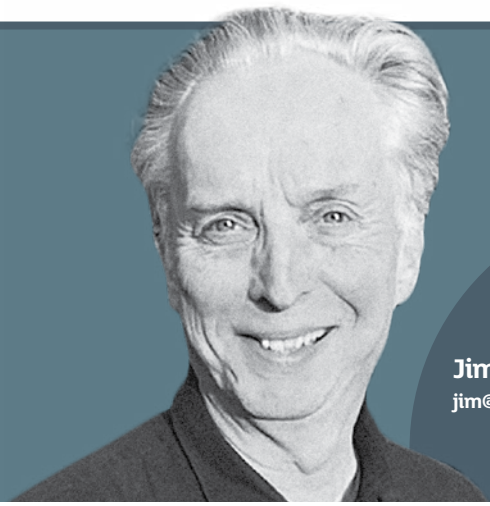
About the author



Debbie Clements BA, PgDip, MA, MBACP, JNC is a counsellor, psychotherapist and trainer who specialises in supporting adults and young people around gender and sexuality. **counsellingserviceleeds.co.uk**

Professing and confessing

What do we mean when we describe ourselves as 'professional'?



Jim Holloway
jim@cambridgecounselling.co.uk

A therapist who wanted help with his application for BACP accreditation recently contacted me. He was young and keen, with a lot to say about his professional attitude, rigour and integrity. He used the word 'professional' so frequently I began to feel it was losing any real meaning. After acknowledging his commitment to a thoroughly professionalised approach to psychotherapy, I asked – more out of curiosity than exasperation – what the term actually meant to him personally.

I've asked myself before what it really means to me too. This self-enquiry can go deep, if you let it. First of all, I think it's simply about the good feeling of doing something well. At another level, it's to do with my self-respect and earning the respect of my peers. The mutuality of this esteem among my co-professionals relates to a deeper need to feel genuinely recognised and appreciated by others. In that respect, gaining BACP's public 'seal of approval' can have profound private significance.

Others I know find the formalised and institutional aspects of professional practice ess significant than their personally felt sense of vocation as a helper or healer. One counsellor took the view that if bodies like BACP didn't exist, she would be working with her clients in the same way she is now. She believed that the strength of her convictions about the meaning and purpose of her therapeutic work would not be diminished in a 'de-professionalised universe', as she put it. That's quite a statement. What difference do you imagine it would make to you to be practising in such a world?

Useful provocations often arise in these reflective dialogues. For example: am I truly professional in my role or is it more truthful to say I behave in such a way that I *appear* to be professional? If that is indeed sometimes the

> Am I truly professional in my role or is it more truthful to say I behave in such a way that I appear to be professional?

This surely connects to a basic need to belong, and to have an identifiable place in the complex social world. Here I could get very personal, having been a sort of lost outsider for most of my life. I'll just say that, for me, being a professional person means I'm not only a marginal person.

Colleagues talking about their own professionalism almost always describe it in terms of maturing, arriving, consolidating, realising their *gravitas*. Becoming a professional requires you to take your work seriously – no longer 'playing' at being a coach or counsellor or whatever – and to commit to a binding code of ethics. It's possibly even a kind of initiation into the grown-up world. Some have spoken of the urge to prove something to themselves or someone else (most often a parent) and this has moved them towards the arduous goal of becoming a qualified and accredited professional. case, what's the critical difference between acting 'as if' and being the genuine article? (It's pertinent to note here that the verb 'to profess' originally meant 'to avow', and it can still carry this earlier ambiguous sense: when we say someone 'professes to be a great cook', for example, we're implying they're really not.)

Asking searching questions like these is necessary for supervisors and supervisees because, in all forms of supervisory work, the pseudo-professional or less-than-professional aspects of the supervised practitioner's work can be – and must be – honestly identified and constructively addressed. Declaring our pretences, vanities, weird lapses and delusions of grandeur can of course feel 'confessional', but this is, after all, how we learn from the 'errors of our ways': by exploring them, not burying them. The latter is all too quick and easy; the former takes time, effort and courage. It's a key professional task to find the time, make the effort and call up the courage.

You might agree that a sense of professionalism builds quite slowly at the start of a career – and ideally continues to grow for as long as the career lasts. I doubt if any of us ever achieve a complete understanding of our professional persona, which is then done and dusted. That sounds like a barrier to lifelong learning. We might even say that a steady commitment to continual learning is a defining trait of true professionalism.

Is CPD the only thing you need to sustain your professional identity and prevent it from becoming jaded? Reflecting in supervision on the current state of your working life, with all its ups and downs, is in itself a resource for the nurture of this identity. Maintaining a sound professional practice is not merely a bureaucratic, timeserving achievement. Any concept of professionalism is pointless unless it's animated and energised by what we actually do in our relationships with clients, and how we conduct ourselves around the work. In this sense, the certificates on your wall – while hard won and proudly displayed – are only details.

To return to the therapist I mentioned at the start, his response was, in short, a hesitant yet brave declaration of his relentless perfectionism. He 'confessed' – his word – that he set such high standards for himself, he could hardly bear to discuss his difficult cases (which he called 'failures') in supervision. Another 'confession' was about his strong need to impress me. Here was an ambitious practitioner (and I have his permission to say this, slightly disguised) whose highly professionalist approach looked and felt to me like an elaborate performance. Naturally, he wasn't exactly delighted to hear this when I gently let him know. What he had not yet realised, we might say, is that it is perfectly professional to confess to not being a perfect professional.

Jim Holloway is a senior accredited counsellor and supervisor, a partner in Cambridge Supervision Training, and a co-author of *Practical Supervision: how to become a supervisor for the helping professions* (JKP 2014).

Second half

Tamar Posner reflects on issues that can impact on our sense of identity in later life

'Memory is identity… You are what you have done; what you have done is in your memory; what you remember defines who you are; when you forget your life, you cease to be, even before your death.' Julian Barnes[1]

Six months after I turned 50, when I was arguably at the height of my former career, I was one day called to a meeting. Having been headhunted five years previously to set up the organisation I was then running, I was informed that I had become 'surplus to requirements' and, without prior warning, made redundant. Within 15 minutes of my arrival at the meeting, I was back on the street feeling as though I had been mugged, as if my identity, my sense of purpose and everything I thought I had known about myself and the world, had been snatched from me by a common bag thief.

Over the next four years, as I struggled to resume some semblance of my former life, I vividly recall how isolated I felt, adrift in days that were no longer structured and all but devoid of human contact; my external world had fallen silent while my internal world was filled with a clamour of voices demanding to know who I was and what I thought I was doing, while simultaneously conveying the message that they couldn't care less and were hard put to understand why I was there at all. It was only once I had retrained as a psychotherapist and was establishing myself as a practitioner, trainer and supervisor that I was able to reflect on and recognise how very different my experience could have been had I not been so alone with it. That is my story, in a nutshell, and while it is unique in its detail, it is also representative of what many people, through age or circumstance, experience in the second half of life.

UK context

In the UK today there are more than 15.3 million people aged over 60, of whom 1.6 million are over 85; more than 0.5 million people, 70 per cent of whom are women, are aged over 90, and there are some 14,570 centenarians, more than half of whom are aged 105 or above, a figure that has doubled since 2005.[2] While these figures are projected to continue to rise steeply, estimates predicting the UK will be one of the most aged countries in the current EU-27 by 2035, it is also apparent that the slowdown in life expectancy across Europe has been particularly marked in this country.[3] Although it is not disputed that austerity measures have had a significant impact on health and social care in the UK, the issues are more fundamental than simply that,[4] and against this background, our media seem to be obsessed by the cult of youth; the phrase 'anti-aging product' describing in a nutshell all our anxieties and fears about getting old.

People now aged 65 and over will have been children during, or very soon after, World War Two, in times that were beset by the dangers of air raids, the absence of fathers, sons and lovers – some of whom never returned – and the hardships of rationing. They will have grown up in an era when survival was the priority. A period when children were primarily expected to do as they were told, and in which any problems they might be experiencing – if those were perceived at all – were deemed trivial by comparison to what the adults, their parents and teachers, had gone, and were going, through. These children learned not to make a fuss – to Keep Calm and Carry On – and for many of them, that is still their attitude to life: adversity is to be expected and endured without complaint. But this is not without consequences – and costs.

It has been established that community-dwelling older people with mental health needs are underserved[5] and that those who do seek help tend to access their primary care provider.[6] Even in the absence of a physical illness, older adults with depressive symptoms are more likely than older adults without depressive symptoms to perceive their physical health as poor, and consequently make significantly higher use of health services.[7] Research has identified social isolation as *the* key risk factor for the health and wellbeing of this sector of our population,[9] and a recent study suggests that social isolation is actually more predictive of death from cardiovascular disease than lack of exercise, blood pressure or raised cholesterol.[9]

My external world had fallen silent while my internal world was filled with a clamour of voices demanding to know who I was and what I thought I was doing

The arc of life

In the first half of life, roughly from infancy to young adulthood, we will first be babies, absolutely dependent on others for our survival; we will then become children and adolescents, focused on learning and mastering what we're taught; eventually, we'll be young adults, striving to prove ourselves and achieve success in whatever form, while shouldering the responsibilities that go with keeping a job, maintaining our own homes and providing for ourselves and the family that we may have by then.

When it comes to the second half of life, things become subtler and more complex. In midlife, if we've largely achieved the goals we set our younger selves, we can lay off striving so hard and begin to consolidate our gains. But then the question arises: What next? Is my identity – as, say, worker, spouse, parent or whatever else we may have become – now fixed? Will I have to go on doing what I've always been doing until death takes me? Is that all there is left to look forward to? The answer, of course, is no, for the world will keep on spinning and life will go on, bringing with it change, transition and transformation – all of which will have an impact on our sense of identity.

Transitions

Take retirement (if you're lucky) and redundancy (if you're not), and consider how often the first question we're asked or ask when meeting someone new is, 'What do you do?' Now think about how you might answer when you're no longer working, no longer have a pressing need to get up in the morning, dress smartly, be anywhere by an appointed time, or have the financial means to do any of those things, even if you wanted to. How likely are you to answer, 'I am a pensioner'? For that is the identity you will likely have assumed in others' eyes, together with the perception that you are now a drain on the economy,

Research has identified social isolation as the key risk factor for the health and wellbeing of this sector of our population

thereby further negating who you once were and what you contributed when you were working.

In my own case, I could no longer say, 'I am chief executive of…', and initially even felt fraudulent because I was still driving the car I'd had then.

And there's another aspect to this: recently, after procrastinating for two years, I finally made an appointment to see a dentist. Why did I procrastinate for so long? Was it because I hate dentists? Was it because I am afraid of needles and drills? No. It was because, when my previous dentist retired, part of my identity changed from Tamar, Patient of Dr X, to that of Unknown Older Woman, and what I feared would be a lecture on my lifestyle. Dentists, doctors and many others with whom we've dealt over the years, will retire and will bring about similar, albeit minor and temporary, changes to our identities.

Then there's bereavement, which can change our identity from 'child' to 'orphan' or, more significantly in later life, from 'spouse' to 'widow/widower'. What does that mean? And does it necessarily imply, as the terms might suggest, that we are the same as other widows/widowers and that there is nothing more to us?

Following on from bereavement, whether by death of a person or of a relationship, many people will find themselves living alone, perhaps for the first time, or, if not, for the first time in many years. All of a sudden, there's no one to talk to, share memories and experiences with, or even become irritated by because they're getting under our feet. How then are we going to retain our sense of self – especially given that research has shown that people with a high degree of loneliness are twice as likely to develop Alzheimer's than those who are less lonely?[10]

By the time we are in the second half of life, our children, if we had any, will probably have left home, taking with them much of the parental role we once enjoyed, assuming that for themselves and their children – and, progressively, for us. It's hard to have to be assisted with the activities of daily living, such as shopping and cooking, and ultimately even with the instrumental activities of daily living, such as toileting, when once you were the one providing the assistance and, on top of everything else, you're *not a child!*[11] And that's not to mention the reverse: the adult son or daughter caring for an elderly parent in whose eyes he or she is still a child; how confusing that can be to one's adult identity. Moreover, if you have been living with a wife, husband or lover, there's the real possibility that you will become 'carer' or 'cared for', where once you were 'spouse' or 'partner'.

Aging is a physiological process; over our lifetimes our bodies lose resilience, and even if we do not succumb to major long-term illnesses, such as cancer, heart disease or dementia – thereby transitioning from 'person' to 'patient' – we will inevitably become more frail, increasingly vulnerable to sudden deterioration, and less able to recover from health setbacks.[12] We will have less energy, our sight and hearing may well become less acute, and we will find it harder to get around on our home ground, let alone travel to friends and relatives or visit places for a change of scene. Lack of mobility is a major contributory factor to loneliness and social isolation and can eventually bequeath us with yet other new identities – 'housebound', 'bedbound' or, worse still, 'potential bed-blocker'. And, yes, we will become forgetful – or apparently so. Increasingly, these days, I can find myself brought up short, wondering why I've gone into a particular room or how I've got to a specific point in my journey from A to B. Initially, I may panic and, aided by scare stories in the press, think I'm getting dementia. But then I recognise that I have in fact been preoccupied with something else and my mind is simply no longer able, or perhaps simply unwilling, to juggle as many balls at a time as it once could.

In the second half of life, when our thoughts are no longer dominated by what we are striving to achieve and our responsibilities to others are fewer, we can become increasingly contemplative. With time on our hands and comparatively little to distract us, thinking about the hurt, however inadvertent, we may have caused others, and the shames and humiliations, perceived or actual, we ourselves may have suffered, can make us into 'penitents' or 'victims', consumed by thoughts of reparation. And, finally, when our own mortality can no longer be denied, what is there left to live for?

But aging can be a time of positive enrichment, personal growth and becoming fully oneself. As Ortega y Gasset writes: 'I am I plus my circumstance and if I don't save it, I don't save myself.'[12] That translation from the Spanish I would amend to read: 'I am I plus my circumstance and if I don't *embrace* it, I don't *embrace* myself.' For what are those 'identities' (pensioner, old man/woman, burden) if not yet more of the 'identities' (son/daughter, student, professional) we have been accumulating all our lives, stepping into and out of them as we step into and out of our clothes, without recognising that they are all but *aspects* of our identity. We cannot destroy or discard them, as we would a garment that no longer fits, for each will have made, will still be making, a contribution to the 'I' for 'Identity' we have become.

How can we help?

Reflecting on my own experience post-redundancy when, because I had lost my professional identity, I felt as though I had no identity at all, I can say without a shadow of doubt that social isolation, the sense of being cut off from the world and no longer of any use, was by far the hardest thing with which I had to contend. But, I reasoned, there must be countless others with experiences not dissimilar to mine, and this was what ultimately led me to set up Silver Circle, a support group for older people.

Of the people who have attended Silver Circle over the years, ranging in age from their 50s to their 90s, referred by their GP, other health services or self-referred, all had been struggling, in one way or another, to come to terms with their changed circumstances and were seeking, in their own words: 'To recover the energy to do things'; 'To re-discover *joie de vivre*'; 'To receive support and stability'; 'To make sense of my life.'

Take, for example, the woman in her 50s who had been a teacher, was caring for her elderly mother, and who believed she had irrevocably succumbed to chronic fatigue syndrome; the doctor in his 70s who had recently relinquished his licence to practice and no longer had, as he put it, 'to put duty before love'; or the woman in her 90s, bored and frustrated because she had no one with whom she could hold a conversation. Each attended Silver Circle for varying lengths of time and each subsequently fashioned for themselves a new identity, the first by becoming a voluntary worker with a charity, which led to a full-time paid position; the second by embracing his identity as partner, father and grandfather; and the third by choosing to become once more a student and learn Chinese. On follow-up, all are still thriving.

To bring about such transformations by using my skills as a group facilitator and the creative techniques I otherwise offer supervisees, has been immensely rewarding. For those Silver Circle participants, and others like them, feedback reveals that factors making a difference include: the rediscovery of a sense of worth through supporting others; having feelings validated (which affirms both existence and identity); being heard; and sharing memories, thereby bringing them back to life.

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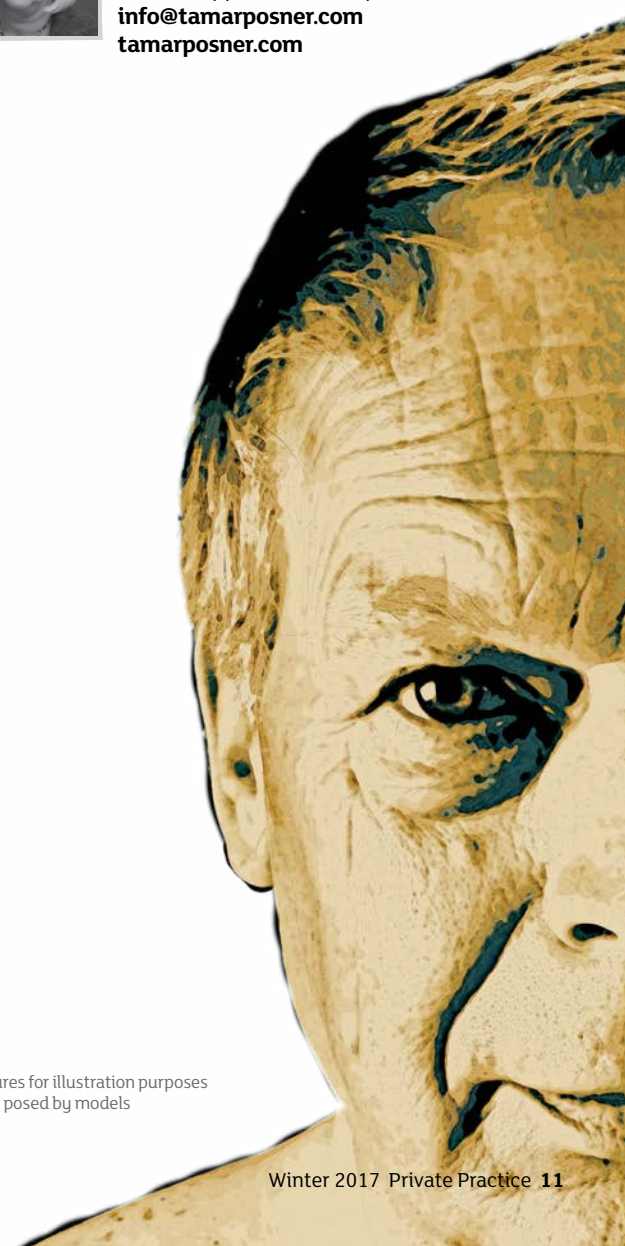
About the author

Tamar Posner MBACP, UKCP is an integrative psychotherapist practising in north-west London. She is also a trainer and a clinical supervisor holding a diploma in creative approaches to supervision.
info@tamarposner.com
tamarposner.com



Pictures for illustration purposes only: posed by models

Identity and spirituality

Respecting our clients' spiritual views is a vital aspect of what we offer as competent therapists, argues **Andelo Tabu Ngandi**

For my presentation at the BACP Private Practice conference, I reviewed the experimental studies on spiritual identity in therapy. My aim was to have some ideas about spiritual identity by answering the following questions: What is a spiritual identity? Is it important? Who needs a spiritual identity? What are the theoretical models of spiritual identity development? What are the available therapies and psychospiritual interventions used to address the spiritual and religious domains of our clients' lives?

What is a spiritual identity?

Spirituality does not depend on rules, congregations, assembly, or other group of people. It is mainly defined as a more personal and experiential connection to the sacred or transcendent.[1,2] It can be understood as a 'search for the sacred, a process through which people seek to discover, hold on to, and when necessary, transform whatever they hold sacred in their lives'.[3]

MacDonald, an expert in spirituality and psychology, defines spirituality as 'the extent to which a person experiences and acknowledges the reality of the numinous or transcendent, either or both, as something that exists separately from the person and/or aids the person in ascribing meaning to existence.'[4] Similarly, Brunson concludes that 'spirituality involves the understanding of meaning and purpose. It is related to the spirit of a person, which is thought to give life, energy and power to a human being'.[5]

Let's try to define 'identity'. Identity has multiple facets. It is a complex construct related to the way an individual perceives him or herself in connection to others.[6] It can also be seen as a process where meaning about who we are and who we are close to (and, by implication, who we are distant from) is created.[7]

Based on the previous definitions of spirituality and identity, the following definition of spiritual identity emerges: an individual with a spiritual identity experiences the self as a persistent (or eternal) being (spirit or soul or higher self), separate but capable of connecting to the numinous or the transcendent. This compassionate being gives life, energy and power to the individual. This experience helps the individual in ascribing meaning to existence.

Is a spiritual identity important?

Many studies show that spiritual identity is important. Research by Greenfield, Vaillant and Marks[8] found that higher levels of spiritual perceptions were independently associated with better psychological wellbeing. Richards and Bergin[9] concluded their research by stating that spiritual identity was effective in protecting and restoring psychological health. Addressing issues related to spiritual identity is important because some clients want to talk about their spirituality.[10] We also know that spiritual identity is sometimes integrated into people's identity,[11–13] and it contributes to people's identity development.[14,15]

Exploring spiritual identity

This section presents a small portion of current studies and perspectives on how spiritual identity is understood, interpreted and applied, from the perspective of various specific groups (like LGBTQ, older adults, students etc). I will present here some results of studies with students.

Using a narrative approach, Stoppa[16] found that most students' spiritual identity formation process culminated in experiences of integration, ie their spiritual identities had become 'more a part of' the self. Their new and integrated spiritual identity was experienced as providing a 'way of life' or sense of direction in moving forward. Astin, Astin and Lindholm[17] discovered that most of the students they interviewed were actively engaged in a spiritual quest and they were expecting their colleges to assist them in this spiritual quest. These scientists suggest that providing students with more opportunities to touch base with their 'inner selves', will facilitate growth in their academic and leadership skills, and contribute to their intellectual self-confidence and psychological wellbeing.

Models of spiritual identity development

There are many spiritual identity development models, but those I have found in many research studies are the following: 1) The Faith Development Model;[18] 2) The Model of Spiritual Identity Development;[19] 3) The Structural Model of Spirituality Identity;[20] 4) The Consciousness Transformation Model.[21,22]

Psychospiritual interventions

If religion and spirituality play a role in a client's life, we can use narrative therapy,[23] art therapy[24] and transpersonal therapy,[25] among others. McAdams[26] demonstrated that individuals achieve a healthy identity when they develop a coherent life story that integrates their various self-stories into a meaningful unit. Narration of their life stories can include the spiritual path taken or the spiritual values to which the individual subscribed.[27] Gabriel and her colleagues[28] and Wood, Molassiotis and Payne[29] showed that their patients used art therapy effectively in three ways: 1) To strengthen their

Spiritual identity is sometimes integrated into people's identity, and it contributes to people's identity development

positive feelings; 2) To alleviate their distress; 3) To clarify their existential/spiritual issues. For clients who prefer transpersonal therapy, they experience healing by relating to forces greater than themselves. Transpersonal therapy also offers them the opportunity to be open to these forces and enhance this healing process.[25]

Other techniques:

- If appropriate, engage clients in self-exploration by supporting their needs to discover various forms of religious and/or spiritual expression, such as Eastern and Western religious traditions or reading material on spirituality and religion[30]
- Include a spiritual and religious assessment in your intake (like the visual life map, Ecomap, or the Faith Development Interview[31] questionnaire
- Examine the client's unresolved feelings and thoughts about their particular religious or spiritual upbringing, in order for the client to accept their loss, but also move towards a transformative experience by redefining their spiritual identity[32]
- If appropriate, ask questions such as: What faith, if any, did you grow up with? When did you rediscover your faith? What brought you to this rediscovery?[32]
- As a practitioner, explore your own experiences and conflicts with your spiritual/non-spiritual backgrounds[33]
- Provide the client with a lexicon of spiritual terms with which you can facilitate further identity development, while at the same time normalising discussion of spiritual issues (see **http://innerself.com//Spirituality/dictionary_spirituality.htm for an example)**
- Music can provide clients with the ability to construct meaning in their lives[34]
- Connect with resources in the community (like traditional and non-traditional spiritual or religious leaders) to support a positive self-identity
- Help clients access inner resources (such as, if appropriate, meditation, prayer etc)
- Include bibliotherapy (point clients to recommended reading, such as *The Power Of Now, The Untethered Soul, Buddha's Brain*...)
- Stay up to date, pursue continuing education, follow the literature.

As competent psychotherapists, we can facilitate the discovery of our clients' spiritual identities. We can achieve this by providing high-quality and culturally responsive treatments and by respecting our clients' spiritual views, whether secular, sacred, or religious, and by providing care in such a way that the clients' spiritual needs are not violated.[34] Even with clients who have no formal spiritual beliefs and practices, and don't identify as spiritual in any way, we can inquire about what holds most meaning for them in life.[35]

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About the author

Andelo Tabu Ngandi is a counsellor, psychotherapist and psychologist working for the NHS and in private practice. His main clinical interests are trauma, addiction, bereavement and spiritual identity formation.

andelo_tabu@yahoo.com

Ask an Expert

The future of fees

How your clients pay you is about to change radically, as therapists join the cashless service economy

Louise Chunn
louisechunn@welldoing.org

We live in an increasingly cashless society. Younger people feel safe with no money in their pockets, and all of us are now used to sweeping our contactless bank cards over a retailer's reader in a fraction of the time a PIN number used to take. And as for cheques, they're due to be phased out by 2018, and many people gave them up years ago. But, for therapists, it can seem as if time has stood still. Many therapists still take cash or cheques at the time of their sessions; others take BACS payments, but that comes with some risk.

While we continue to focus on that issue, another therapy problem has become more evident: how to make the booking and payment for appointments 'frictionless', in the tech parlance. Therapists waste a lot of time and effort on making and changing appointments, and much of it has to be squeezed into the time when they are not seeing clients. The administration that goes with taking fees in different ways is often a therapist's most-hated task. Clients, on the other hand, often feel that therapy is a step into a strange and secretive world. They feel unsure about how it works, what they are supposed to do, and when. Booking and payment can seem part of the mystery.

What with no-shows, cancellations and declined credit cards, it's no wonder therapists want to protect themselves, to make sure they are paid, and ensure that their appointments are in order

Here's one therapist's unfortunate experience: 'I generally ask clients who come to an initial consultation to bring cash or a cheque. So, when this particular client signed up, that's what I asked him to do. Then, for the first time ever in an initial consultation, I forgot to ask for payment at the end. His was quite a complicated situation, with lots of elements to it, and we got somewhat caught up in trying to decide which kind of support he needed. When time was up, I didn't ask for payment. I emailed him immediately and asked him to pay me via bank transfer, sending an invoice too. He emailed straight back apologising for not paying and that he would do so as soon as possible. That was the last I ever heard from him.' She emailed him several times but was never paid. 'I was left feeling annoyed, frustrated and used.'

Much of the therapeutic relationship is based on trust, but private practice does bring you up against many challenges in that area. What with no-shows, cancellations and declined credit cards, it's no wonder therapists want to protect themselves, to make sure they are paid, and ensure that their appointments are in order.

Meanwhile, in the modern world, we have become much more accustomed to making payments online. Whether it's supermarket ordering, Amazon book-buying, or paying for parking our car, we know that it makes life easier, and we are used to the transparency. A diary management system can save time; some charge a flat fee per booking while others may take a percentage or offer a monthly subscription. It's important for those who sign up to check that their chosen provider uses a reputable payment service.

Increasingly popular with small businesses, such as therapists, are card payment terminals, which charge a percentage per card transaction. Again, it's simple; though you do need the person and the card in the room for it to work.

From early talks with therapists and counsellors I know that online payments are something of a controversial area. As author and (non-practising) psychotherapist Philippa Perry told me: 'I can imagine that some therapists might think, oh no, I want to do it the old way – it brings us so much more material for the work. But I think whatever the issue, it will come up in some way anyway.' She sees online booking as a sign of therapy 'entering the 21st century'.

Psychodynamic psychotherapist Judith Chamberlain has now had 10 clients pay her online and has started to question the importance of being handed the money by a client. 'I think, in spite of what our training might tell us, using cash is not how people work any more, which means it seems outdated. Buying services and goods online is just what we all do now.' She also believes that the popularity of online booking and paying with clients is about more than speed and efficiency: 'It seems to give clients extra certainty. They are doing something very new to them, and it helps to normalise the process.'

About the author

Louise Chunn is the founder of therapy platform welldoing.org and former editor of *Psychologies* magazine.

We are family

When exploring family history with LGBTQ+ clients, it's important to remember that family has many formations

Alex Sanderson-Shortt
alex@kascounsellingservices.org

'You can't choose your family!' It's a saying that has such ubiquity it's become a truism. You say those words to pretty much anyone and they'll know what you mean. It generally means they might drive you mad sometimes, but hey, they're family. That we have to put up with them because, you know, we didn't get to choose them. They were given to us as a complete and non-returnable package.

I guess for many it's a statement that makes sense. Most people enjoy relatively 'good' relationships with their families. They have their quirks and their foibles, but on the whole, they're an OK lot. There may be an odd outlying cousin, auntie or grandparent who doesn't get much of a look in at Christmas, but most are welcomed into the fold: bad jokes, poor taste in jumpers and slightly odd political views notwithstanding.

Working as a relationship counsellor, attachment theory is a useful tool, so I spend a lot of time looking at the further reaches of the family, as well as asking my clients to revisit and review some of the closer relationships they had growing up. We learn to 'do' relationships while watching those around us do theirs. And sometimes they are good at it, and sometimes they are not. But, as with anybody immersed in a system, we don't always know how or in what ways they are good, or not. We have nothing to compare them with. Getting the adult to rethink their childhood experiences can open up conversations about how relationships are done in the here and now.

This is especially true when working with LGBTQ+ clients, many of whom grew up in incredibly loving, warm, safe families. But in families that were loving, warm and safe while operating in their cis-heteronormative bubble, assuming their child was cisgender and/or heterosexual – following all the usual tropes about gendered behaviours and attitudes; discussing the future, opposite-sex partners of their children in a blissfully unaware manner, assuming this would be the path their offspring would take.

Sometimes parents are not 'just' heteronormative, they are actively trans/homophobic. They express negative views of sexual and gender diversity, not realising that every utterance is a blow to the identity of the child, just starting to learn about their place in the world (and in some cases doing this deliberately, in an attempt to control the sexual or gender identity of the child). This leaves the child in a confused state. They are loved and cherished and cared for, but they also know there is this forbidden element of themselves, an element that causes pain and confusion. So how do we LGBTQ+ folk, when we're growing up, square the circle of the loving parents who might hate this elemental part of ourselves?

How do we LGBTQ+ folk, when we're growing up, square the circle of the loving parents who might hate this elemental part of ourselves?

We hide. We deny our existence. We base our relationships on a fabricated version of ourselves. We know they love us, so we do what we feel we need to do to maintain our family relationships. After all, we can't choose them, can we? But then, through fate, courage or stupidity, the truth is out. The family now has to adapt to learn to accept their offspring for who they are. Or, if they don't adapt, the relationships break down. It is often a journey to acceptance and there are wonderful organisations like PFLAG (Parents, Friends and Family of Lesbians and Gays) (**pflag.co.uk**) and Mermaids (**mermaidsuk.org.uk**), as well as counsellors working in this field, to help families as they deal with these situations.

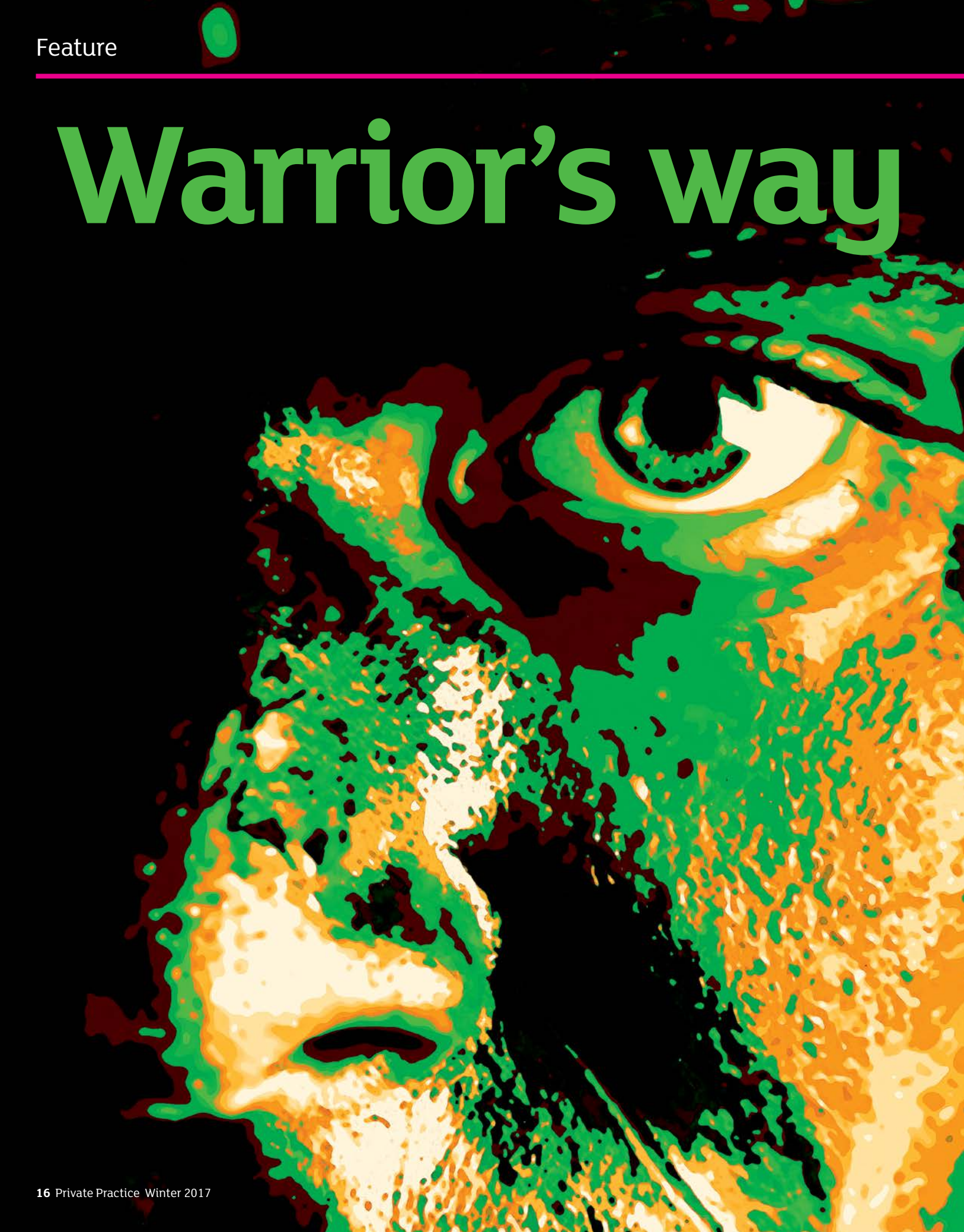
For many LGBTQ+ people, that initial 'coming out' to family is followed by an immersion in 'gay culture' – whatever that may be. It may mean meeting like-minded people: fellow travellers on the outskirts of society, each finding their own way through the morass of normativity to establish an identity that feels authentic, rather than one that meets the needs of people around them. We start to form our own queer families. We do get to choose who is in these families, and we get to create them in our image, rather than being forced to present the image they want of us.

Like all families, these families experience problems. We fall out with people. We meet new people. The membership of the family changes as people grow and change within it. Time, distance, births, deaths, all of these things affect us, both within our birth (or adoptive/fostered) families and within our new, chosen families. So, when I'm working with LGBTQ+ clients, I find it helpful to explore families in all their formations. I try not to just assume that when I ask about their family history, I am only talking about the ones they had 'no choice' over. I try to include also the family they may have chosen to escort them, for better or worse, through life's many and varied challenges and joys. I try and understand what this means to them. Do they recognise it as a family, and, if so, what does that bring? And how do these 'families' interrelate? Do they meet? Do they have shared values? If not, how does the client manage the complexity of having different personas in different family situations? If they don't see themselves as having a queer family, of course that's OK too.

Talking about family relationships can have very different meanings for LGBTQ+ clients. As counsellors, we need to be alert to these differences, and be ready to explore the various meanings with our clients, so as not to exclude their experiences. To ignore their queer family is to ignore their identity. And that's already happened enough.

Alex Sanderson-Shortt MA, BACP (Accred) is an integrative relationship therapist in private practice, a clinical associate of Pink Therapy and a member of Gendered Intelligence's network of therapists. He teaches relationship therapy for Relate and delivers seminars and CPD days on sexual diversity.
kascounsellingservices.org

Warrior's way



Through reflection on his own experience as a veteran, **Brian Charlesworth** argues that there is a perceived 'empathy gap' between veterans and the general public, including the psychotherapeutic professions

Whenever I attend social gatherings, such as weddings, and receive the traditional gift of cake, usually encased in marzipan, I notice a trigger point: my encounter with the dreaded marzipan. I can't eat it. I embarrass myself by removing the outer casing of this noxious substance; then, to show willing, I tentatively nibble away at the remainder. Not a pretty sight.

The fact is, marzipan reminds me of plastic explosive, which gave me headaches after handling it while serving in the army. I know this example isn't an extreme symptom of PTSD, although it serves as a reminder of the legacy of military service. It helped me link to my own more distressing experiences of life post combat and feed a hunger to research the experience of other military veterans.

I realise now that everything that made me a soldier took me further away from being able to relate to those who weren't. Before and after I left the army, I felt unable to make functional contact with anyone other than soldiers. I started to see everyone as the enemy: 'Civvies can't be trusted'. I hope this article serves to bring therapists and veterans together to engage in the transitional process, living life as ex-soldiers in a civilian world.

Some context

The profile of the psychological health of the armed forces has been raised to unprecedented heights in recent years. The legacy of combat in relation to mental health is now becoming a prominent issue in the world of post-service care of military veterans. The charities Combat Stress and Help for Heroes now feature prominently in the social psyche.

British forces have been consistently involved in conflicts, within living memory, from World War One, World War Two, Korea, Suez, Aden, Falklands, Bosnia, Sierra Leone, Northern Ireland, Iraq and, more recently, Afghanistan. The psychological issues of those having engaged in combat can often be complex, sometimes emerging decades later, with serious consequences for the individual and the wider community. This can often take the form of PTSD, substance abuse, relationship problems, aggression and violence. By understanding the unique circumstances this particular client group presents, we have an opportunity to develop more appropriate methods of dealing with their emotional and psychological needs post military service.

Soldier to psychotherapist

I suspect some of these reflections will be familiar to a large number of veterans, and hopefully informative for practitioners. My days at school were fun, but I achieved little in the areas to be assessed by exams. The 'hard' stuff, English and Maths, eluded me, but I was good at art and environmental studies, achieving some CSEs and an 'O' Level in ornithology of all things (I am still an enthusiastic 'twitcher').

From about the age of 12, I held the belief that my physical body was the vehicle for life's experiences, and I believed that my spiritual growth (or wisdom) would be developed through physical challenge. Physical activity – eg martial arts, yoga, climbing, canoeing, boxing – gave me the chance to find out about myself, and this exploration of 'self' continued throughout military training and, in turn, operational deployment.

As for so many other young people from my cultural and socio-economic background, joining the army at the age of 17 fulfilled the need in me to belong. From a humanistic perspective, I now realise that joining up fed my actualising tendency and I was 'in flow'. I was able to travel, make close friends, become 'uber fit' and achieve things I could not have previously dreamed of. In short, it was a nourishing environment where I was able to grow and flourish.

I realise now that everything that made me a soldier took me further away from being able to relate to those who weren't

The Coldstream Guards drew my attention after watching *Trooping the Colour* on TV. Having not previously left Yorkshire, the thought of living in London appealed to my sense of adventure. This eventually came after basic training and a six-month tour of Northern Ireland at the age of 18. Other service included spells in Gambia, Cyprus, West Germany (in the Cold War era), Canada, Norway, Denmark and then another tour of Northern Ireland as a Section Commander.

Serving in the 1970s and 1980s, the emotional/psychological dimension to enduring life as an infantry soldier went largely unspoken. I now recognise that disclosing any 'weakness' would not have been welcomed in any quarter and would almost certainly have resulted in being ostracised. Being strong is the warrior's way, and within the collective culture I lived in, being weak in any way was not an option; they depended on me and I was dependent on them. Being a soldier, I was required to develop a sense of camaraderie, a 'can do' approach, a code of moral conduct and a collective identity: 'I am because we are.'

On leaving the army after 10 years, I found that the idea of the 'collective culture' evaporated and that 'civvy street' was ironically a very dangerous place. I realised that being a civilian meant that my value systems and coping mechanisms, created in the forces, were ineffective. In short, I found it extremely difficult to adjust to life with less structure and felt that my experiences couldn't possibly be understood by a 'civvy'. Now this sounds extremely arrogant, but at the time it was something I believed in nonetheless. I became depressed

and isolated. Not feeling understood by practically anyone, least of all the health professionals, so not able to share my distress, meant I consequently did not receive the help I required.

On leaving the army, I found work as a further education tutor, delivering outdoor education, and during this time I became interested in personal development and psychology. These two interests seemed to blend naturally for me and I went on to train as a counsellor/psychotherapist. For the last eight years I have worked as a university lecturer, leading counselling and psychotherapy courses. Now, nearly 30 years after leaving the forces and having spent a vast amount of time reflecting on my process, I feel motivated to share my experience and accumulating knowledge with others, both veterans and helping professionals, in the hope that some of it is helpful.

Recognising the cultural differences

It's impossible to know all about a client's culture and inner values, but just as it is for a holidaymaker visiting a new country, a little effort in learning the language, having some background of the world you are visiting, can help make that initial psychological contact required in therapeutic work. It's that starting point we all need in developing relationships further. Making functional contact in the therapeutic professions is now widely recognised as the key to lasting change in the clients we encounter. If you are one of those working in the veterans' world, here are some concepts to ponder.

What veterans say about the nature of military culture:

- It's strength based – you can't afford to show weakness; it lets others down and can be ostracising
- There's a collectivist, 'we', mindset – 'I exist within a unit'
- You are used to operating in the face of overwhelming odds
- It's elitist – 'We are the best'
- There's an emphasis on problem-solving not problem-making
- It's action based, in extreme conditions
- Camaraderie is key – 'people glue'.

What can research tell us

I am currently undertaking a PhD research project looking at life post combat. On the main theme of 'self', the initial findings have highlighted the following areas:

Pre-service self	In-service self	Post-service self
Needed a place to grow	Understood the value of camaraderie	Felt civvies don't care
Needed to find a purpose and meaning	Had a sense of being valued	Felt my expertise was devalued
Had untapped potential	Felt part of something bigger	Felt I was not understood – so why bother?

In addition to the above, a further theme was generated, 'self with other', noting how the participant had found the interview experience. What I found was hidden in plain sight: veterans found talking openly about their experiences was far easier when the other party was a veteran themselves. Some noted the interview experience as 'cathartic'. The message to me here is that veterans process experience more with other veterans or with others where they experience a depth of empathy, or what could be referred to as relational depth.

Being strong is the warrior's way, and within the collective culture I lived in, being weak in any way was not an option

Challenges for the therapist

Through personal reflection on my own narrative as a veteran, now a therapist, coupled with research findings, I have come to the debatable conclusion that there is a perceived 'empathy gap' between veterans and the general public, including the psychotherapeutic professions. Here I suggest some considerations on how to bridge the empathy gap in the counselling room originating in the cultural differences noted:

- Be creative – do more than listen, get involved
- Openly acknowledge the overt and covert differences between you both
- Admit what you don't know – ask, 'What do I need to know to help you?'
- Be empathically inquisitive – employ Socratic dialogue; find out what links to what
- Endeavour to develop an authentic presence, rooted in responding from a sense of self
- Work with the client's strengths – find their inner resources and help employ them
- Decide if you are symptom led or individual led
- Use diagnostic labels with care – you are dealing with more than a set of symptoms. Veterans can find themselves in conflict with a health culture that is individualistic and pathology focused[1]
- Do not patronise or sympathise.

You will be familiar with some of the suggestions, but if you consider the characteristics of military culture, they will hopefully take on new meaning and help promote a more potent therapeutic experience.

What does the future bring?

'On average, veterans wait 13 years after service discharge before seeking our help, by which time their condition can be highly complex.'[2]

'I used to be happy-go-lucky, now I'm serious and quiet. My life seems to be divided into two periods: before trauma and after; it really threw me; my life was derailed; nothing seems sacred or special anymore.'[3]

'We are currently supporting more than 5,400 ex-service men and women across the UK – more than at any time in our long history. Our youngest veteran is just 19 years old, our oldest is 101.'[2]

Considering the quotes above, over future decades I feel that therapists of all orientations will see increased numbers of veterans seeking psychological support, both privately,

Being a soldier, I was required to develop a sense of camaraderie, a 'can do' approach, a code of moral conduct and a collective identity

and via the NHS and charities/services such as Combat Stress. As a result, there will be a need for therapists to engage in appropriate CPD, looking at veterans' issues. There also seems to be a growing recognition that peer support schemes are a more productive way of helping: 'How can I share/explain to anyone other than a brother/sister (ex-military) what I have seen, experienced, taken part in and been challenged by?'

Linked to trauma work, the notion of moral injury is a concept gaining value in the therapeutic world. Moral injury occurs as a result of thinking, witnessing, doing and then living in a culture that finds such acts as experienced in combat abhorrent. For example, take the following testimony of a US soldier: 'I found out we were in a part of Iraq that was supposed to be the Garden of Eden, the cradle of mankind. I had to ask myself: why am I carrying a rifle in the Garden of Eden?'[4] It's plain to see how such an experience may challenge an individual's spiritual and religious values.

Another area linked to traumatic experiences is the notion of 'survivor guilt' (a response to surviving when comrades did not), which can lead to severe and enduring consequences for returning service personnel. All the above areas noted here are worth looking out for when working with veterans.

This area of work is not new to us; most of us know someone who is currently serving or has served in the forces. What is new is the profile of the veteran through the media and even royal connections, such as the Invictus Games and organisations such as the British Legion and Combat Stress. I hope that this lift in profile will result in more veterans seeking support earlier and that readers of this article will be open to receiving them as clients.

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About the author

Brian Charlesworth is a senior lecturer at Leeds Beckett University where he is the course leader for the BACP accredited practitioners' course in relational therapy. He is a military veteran (10 years) and has 16 years' experience as a psychotherapist, trainer, and clinical supervisor working from a relational philosophy. He is undertaking PhD research into life issues post combat.
b.charlesworth@leedsbeckett.ac.uk

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For illustration purposes only: posed by model

Me & not-me

Eating disorders challenge the concept of the personal self as single, ongoing, consistent and conscious, writes **Lesley Finney**

'It is a joy to be alone but disaster not to be found.'
Donald Winnicott[1]

Within this article, I want to address the questions: Who am I with or without my eating disorder? What or who is 'me' or 'not-me'?' In order to explore this, I aim to deconstruct the 'I' as a single, ongoing, consistent, conscious self, and explore the concepts of 'me' and 'not-me' self-states, which arise to protect the client's personal spirit at the expense of the body.[1] If an eating disorder is a solution to a problem, which may actually kill the 'host', then we need to pay serious attention to the problem. We need to fully understand the decision to deprive the body of a fundamental human need for food, and understand its daemonic resistance to recovery.

Food is symbolic of our primary experience of nurturance and survival and is taken into, and processed by, the body. Our bodies are the container of all aspects of our experience of being held and contained and compared with others in terms of 'me' and my needs. The body is also the first indicator of emotional distress or excitement, and an eating disorder can be a form of this expression. 'I am too full up', 'I am empty' or 'I am sick of this' may be expressed through the concretisation of taking in, refusing, eliminating and purging. It can also be an expression of emotions, which a client may feel, but have no language to identify what they are. The eating disorder can also serve as a way of anaesthetising feeling, in the way that drugs or alcohol can.

Threats and defences to the self

Bessel van der Kolk argues that 'the body keeps the score'.[2] It is our body and limbic aspect of the brain that first alert us to threat and to react accordingly. Attachment behaviours are then evoked in order to remain safe and draw others to notice us and respond to our distress. In early childhood development, it is sensation in the body (hunger, fear), which alert us to our need. Symbols (eg the breast) respond and identify what that need is, and eventually internalised images become established

as we begin to link sensation to what our needs are, which we can identify and hold in our own mind (eg the parent's face and touch). Finally, we name our need through language and a narrative that can help us to process whatever the perceived threat to self is. If this process is successful, through our early development, then we internalise the experiences of having a secure base through 'good enough' parenting, which leads to trusting that we have the resilience and resources internally and externally to keep us safe.[3]

Kalsched, a Jungian analyst, explores what happens within the psyche when this process gets interrupted: 'What happens in the inner world when the outer world becomes unbearable?'[1] He argues that when a child experiences unbearable psychic pain or trauma, in early development, then a self-care system is established which protects the personal spirit, even at the expense of the body: 'The violation of this inner core of the personality is unthinkable. When other defences fail, archetypal defences will go to any length to protect the self – even to the point of killing the host personality in which this personal spirit is housed (suicide).'[1]

However, this defence system is duplex in character, and a trickster, who protects the self and persecutes it at the same time: 'And just as an immune system can be tricked into attacking the very life it is trying to protect (auto immune disease), so the self-care system can turn into a "self-destruct" system which turns the inner world into a nightmare of persecution and self-attack.'[1]

Bromberg offers another description of unprocessed affect that threatens to overwhelm the client once again: 'Something inside them tells them that non-being is a real threat, that a powerful and terrible tsunami of chaotic and disintegrating affect lurks within.'[4] If we hold this image in mind, it is not surprising that such a fear of psychic annihilation would be met by what Kalsched calls an 'inner defence league': '"Never again," says our tyrannical caretaker, will the traumatised personal spirit of this child suffer this badly!'[1]

Self-care system

A client wakes up with butterflies in her stomach after recognising that she faces another day battling her eating disorder. If she does not eat, her inner persecutor becomes quieter, but she will not recover. If she eats, she moves towards recovery and pleases her ego-self, and her family, friends and professionals. However, her eating disorder aspect of self becomes archetypal and berates her for being so 'weak, greedy, indulgent, disgusting etc'. It also tells her that if she gets well, her body will no longer show the distress currently demonstrated through an emaciated body. It then adds that family and friends will move away and think all is well in her inner world, and her distress will not be seen. It warns her that giving up her eating disorder will leave her without defences to protect her from any external and internal threats of overwhelming affect, the 'threat of the tsunami'.[3] She has no place to go.

When a client comes into our therapy room with an eating disorder, they genuinely want to get well. This is the adult ego part of the client, who presents for therapy, and wants to recover and heal. However, I believe that within the room with you is potentially another aspect of self who holds another position. This is the self-care system Kalsched speaks of. This aspect of self exists as a defence which believes the eating disorder protects the client from something else, which feels more terrifying than the impact of the eating disorder on its body. As therapists, we need to pay attention to both the ego and the unconscious self who act in this way to preserve the 'personal spirit', even at the expense of the body. If we enter the battle unprepared for its strength, then we can be invited to enact and re-enact archetypal battles to find the innocent personal spirit, or 'true self'[4] that has gone into hiding.

Certainly, an emaciated body or extreme purging through vomiting or laxatives can make us put on our superwoman/man underpants and go into battle with the eating disorder. In reality, this means increasing our sense of control by becoming prescriptive or anxious, or feeling that we are not good enough, or blaming the client for not being motivated enough. I have learnt all these lessons to my cost and to the cost of the client who comes to me for help. My own experience of this process has led me to take a reflective stance with my clients, while naming all that I see happening within the room. I need to address all aspects of self who are present, including my own authentic experience of what is happening in the here and now between us.

The spaces between

Bromberg argues that the goal of therapy is to gradually help the client 'stand in the spaces' between 'self-states', where 'safe but not too safe', 'edgy' moments and enactments within the relationship can be processed in the light of a caring but reflective other, in order to increase affect tolerance and develop healthier neural pathways within the brain: 'The patient's fear of dysregulation, as it is relived in the enacted present, becomes increasingly containable as a cognitive event, thus enabling the mind/brain to diminish its automatic reliance on dissociation as an affective smoke detector.'[3]

Such a process needs courage, in both the therapist and the client, and a strong, trustworthy therapeutic relationship. The golden rope of theory and supervision have helped to ground me and pull me, and my client, back to earth after this process of going down into Hades with the client, to find the personal spirit/'true self' who has been abducted and held captive there. It is a goal within the therapy to support the true self, synonymous with the personal spirit, in daring to believe that it may be safe to emerge. We must, however, pay due honour to the defences for their role in preserving the personal spirit, when desperate times led to desperate measures, in the job they have done for the survival of this self.

Case study

A client told me that she was doing everything she could to regain weight yet, despite this, she was losing weight each week. She was an intelligent woman who was keen to return to university in a couple of months' time. I dared to ask her if she was excessively exercising and therefore burning off the

If an eating disorder is a solution to a problem that may actually kill the 'host', then we need to pay serious attention to the problem

calories. Immediately, I felt an anxious fear in my stomach and saw a flash of momentary anger in her face. Her protector was in the room and evoked because I was threatening her defence.

I named what I saw and felt. We were then able to understand the conflict between two aspects of her self. One part of her felt she did not deserve to recover until she lost more weight and became the 'best anorexic', which would mean hospitalisation. The other part of her genuinely wanted to be free of anorexia and return to university and her life. This exploration led to us discovering a less evident, bullied, innocent self that was either an 'A* student' or 'A* anorexic', or something far less acceptable to her inner and outer world. When these clients are 'A*' in their outer world, this can preserve the fragile self-esteem, but at a huge cost of constant striving to remain in this place of perfection.

However, this can never be achieved because they cannot rest in a place of being OK through anticipation of any threat that this may change. The limbic system has taken over the building. The fear or the experience of falling below this perfection becomes something else that is unbearable. In their minds, they are no longer 'good enough' and become a 'failure'. Then the eating disorder's voice becomes a seducer to their fears. It reminds them that they can remain in a place of safety, away from the demands of the world and adulthood, and have control over something that they can govern and mark as theirs: 'The best anorexic.'

For my client, this was so. If she fell below this perfection to a 'B' in anorexia or her studies, she became a 'failure, weak, not good enough, disgusting, ugly, fat'. Her inner defence league warned her to not give up her eating disorder and expose herself to any hint of failure, inside or outside her world. However, if she then put on weight, or ate something, without asking her inner gatekeeper, she was reprimanded and flooded with self-deprecating thoughts and criticism. It then attacked her for not being 'ill enough' and so she remained in a kind of Hades of attack and counter-attack. I needed to catch that in my countertransference. 'Once the trauma defence is established, it screens relations with the outside world for any threat to further trauma but at the expense of any spontaneous expression in the world. The person survives but cannot live creatively.'[1]

As therapists, we can then experience a parallel process within our countertransference of feeling that we are the 'A* magician', 'good fairy', 'hero/heroine' in one moment, to an 'F-grade' therapist, who is a fool, witch, or devil in the next moment. Our job is not to identify with either position but to recognise the archetypal battle that lies within our client's inner world. It is as if the relationship, in that moment, ceases with me, and instead turns to an internal 'other' with whom they are enmeshed and attached to. For better or for worse, in sickness and in health, until death do they integrate.

The role of the arts and the body

Communication with all these aspects can be explored more readily through the use of the arts. These can provide a container for all that is happening within the client's inner world, and their relationship to you, or others within their lives, including the eating disorder: 'All forms of the so-called "creative-arts" psychotherapies are extremely helpful towards this end and often these will open up traumatic affect much faster than purely verbal exploration.'[1]

Myth, narrative, images and symbols can help a client to begin to articulate internal and external experience, which they may previously have had no words for. The arts can give voice to all aspects of self, including the inner protector/persecutor who has attempted to take care of the beleaguered ego at any hint of threat from the tsunami of unprocessed and overwhelming affect, which threatens to emerge, at any given point.

When a child experiences unbearable psychic pain or trauma, a self-care system is established, which protects the personal spirit, even at the expense of the body

As therapists, we also need to pay attention to shifts in self-states, which may only be noticed in our own bodies, or subtle changes within the client. The 'child in the system is usually a personification of affect in the body... Such a body sensitive approach proceeds from the understanding that past trauma and its defences will be encoded in present physiological states, such as breath, gestures, muscular tension, averted gaze, etc and not in higher cortical regions where they could be recovered as explicit memories.'[1]

We can begin to listen to the sensations and attune to their communication without foreclosing or moving away. In so doing, the therapist is developmentally supporting the interrupted developmental process where sensation in the body is given a symbol/image, words name the emotion, and narrative links the right and left brain towards healing and integration. 'Strong currents of affect reaching the psyche from the outside world or from the body must be metabolized by symbolic processes, rendered into language, and integrated into the narrative "identity" of the developing child.'[3] Then this narrative can emerge in the presence of another, and be met and given cognition to his/her experience. Integration can emerge between left and right brain, body, soul, mind and emotions.

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About the author

Lesley Finney is a UKCP and MBACP registered senior psychotherapist within an NHS eating disorders service in Kent. She has over 35 years' experience working within the helping professions and has trained as an integrative arts psychotherapist and social worker. She also has her own private practice.

lesley.finney@hotmail.com

Cultural Counsellor

Writing for wellbeing

A day on a creative writing course can inspire renewed respect for the therapeutic power of non-judgmental listening

Sue Lyons
writingintheruins@gmail.com

I recently attended a writing retreat. I had decided to try out 'writing for wellbeing', as the retreat was described, as a potential alternative to the weekly therapy I still attend. When I did my training in psychodynamic counselling it was mandatory for us all, during the two years of our diploma programme, to have our own weekly therapy. Over the years since, I have both valued the insights and explorations that my own therapy has afforded, while also sometimes feeling constrained by its format. One of the reasons I originally started writing this regular column was to try to broaden my own therapeutic thinking (and the reader's, too), and incorporate other activities and pursuits into my own self-exploration and into my work with clients. I was curious to find and describe psychotherapeutic ideas outside the confines of our consulting rooms: in theatres, art galleries, books, our social lives and even in politics.

Our clients frequently need our help to engage with the rich deposits of unconscious material that influence their actions, feelings and behaviours. An ecumenical approach to how this material can be elicited can benefit both the client and therapist. However, with the exception of explicitly 'creative' therapies, most talking therapy trainings spend very little time on the use of artistic or literary inspirations, which can inform the therapeutic work. We may, if we are fortunate, be exposed to dreamwork as a route to unconscious material, or, if our work involves young clients, we may have training in the use of play materials, games and sand trays. Most of the rest of us have to find out about creative approaches to therapy through serendipitous contacts with colleagues, or by seeking out CPD that promotes the use of the arts and other creative media.

I was fortunate enough to find the Writing for Wellbeing retreat (**writeyourmind.co.uk**), and, having enrolled, found myself participating in a loosely but carefully structured day, during which the focus was on short, directed writing exercises. Six of us had signed up for the retreat, and after somewhat shy and cautious introductions, we gathered around a large wooden table and got ready for our first exercise. I am certain that all of us, just like our clients in therapy, were wrestling with fears of being judged, of exposing aspects of ourselves, or of inadvertently disclosing something of which we might be ashamed and which might leave us feeling vulnerable and anxious. The fears of being wrong, stupid, laughed at, shamed or shunned are intense and debilitating and can shut down our 'work' and frustrate our conscious efforts to know more about ourselves and our relationships with others. Creating art – whether it is writing a poem or short story, painting a still life, composing a song or throwing a pot – often involves exposing ourselves to the same fears, and can, again all too often, result in a similar incapacity to engage. Whether we locate the source of this potentially persecutory super ego in others, or inhibit ourselves with our own excoriating self-criticism, the effect is usually the same: we remain cut off from creative inspiration and silenced by a tyrannical internal editor.

> The fears of being wrong, stupid, laughed at, shamed or shunned can shut down our 'work' and frustrate our conscious efforts to know more about ourselves and our relationships with others

During the retreat we were ably and sensitively led through a series of short pieces of writing. The hardest to complete was the one that was utterly devoid of direction: the instruction to just write for five minutes left most of us writing as fast as possible, as though we could outpace the internal editor correcting our every scribbled word. It was far easier to respond to a subtle prompt: use this group of words to create a poem; choose a postcard from this pile and then write about why you chose it; or imagine you are a place – what do you feel like? These gentle instructions created a sense of being gently guided into ourselves and then being left free to explore our internal terrain. Many of us commented on the wonder of writing things that we had no idea were in our minds that day. There was genuine surprise at what we produced. And as we cautiously and then more boldly shared what we had written, our convener was careful to encourage and enthuse, but avoided interpretations. We were held in a creative, collaborative space in which we all experienced the acute pleasure of joyful, uncritical creativity. And as I drove home, musing over what I had written, I felt a powerful gratitude for the women with whom I'd shared the day, and a renewed respect for the therapeutic power of non-judgmental listening.

Sue Lyons is a psychodynamic counsellor and accredited member of BACP. She works in private practice and as a volunteer counsellor for a charity that provides free, open-ended counselling for teens and young adults.

Hello and goodbye

Where do you place yourself on the spectrum of how to greet your clients at the beginning of a session, and say goodbye to them at the end?

Sarah Van Gogh
svangogh@ntlworld.com

How a session starts and how it ends are both usually particularly memorable in ways that the majority of what goes on in between is not. This is linked to the fact that the start and the end of anything – a speech, a session, a relationship, a meal, a story – has a very potent charge.

Because therapists usually have to start and end a session with a client many times a day, we are working in the field of these charged moments a great deal, and have to be able to manage the feelings around starting and ending an intimate exchange, for different people in different ways.

One practitioner's professional containment is another's chilly aloofness. One therapist's human warmth is another's lack of firm boundaries

As a Gestalt-trained colleague of mine once put it: 'Being in relationship with someone is a bit like having a very hot bath in a very cold bathroom – it's not the being in it that's difficult; it's the getting in and out that can be so tricky.'

I have certain memories that played a part in the shaping of my own ideas about beginning and ending a session. I recall how, decades ago, I would stand each week at an imposing front door in a wealthy area of London; be buzzed in, wordlessly; make my way to a thick, carpeted landing which was the waiting area; and, at the time my session began, see the utterly impassive face of my analyst appear at his door, and, in the same tone of voice in which you might inform someone of a death in the family, hear the phrase he always uttered as he saw me: 'Come in.'

I once rang the doorbell of a new supervisor to whom I had been assigned when I began work for a service that offered low-cost sessions in a community setting. It was opened by a woman my own age with a large, friendly smile, who, on seeing me, threw her arms open wide in an invitation to embrace, which so took me aback that, rather than saying, 'Hello,' I found myself stammering an embarrassed, 'Oh! No, thank you.'

Having run from a bus stop, in a thunderstorm, with no umbrella, late for a supervision session, I remember feeling touched and grateful at hearing a different supervisor hurrying down her hall to open the door and let me in out of the downpour.

Early one Saturday morning, I rang the bell, heard no response, rang again, started to doubt myself, checked my diary, rang once more and finally heard someone coming downstairs and along the hall. The door opened to reveal my therapist in slippers and a smart Liberty's dressing gown, with his hair on end; we stared at each other for a few seconds and it would be hard to say who looked the more astonished.

All of this has, of course, shaped how I now tend to try and help clients get in and out of that 'bath of relationship'. I have been like Goldilocks, trying out the porridge that is somewhat cool, and the porridge of instant warmth, or even heat, until I have settled on a porridge that is usually, I hope, somewhere in between. But, in practice, there is always an element of 'each to his own'. One practitioner's professional containment is another's chilly aloofness. One therapist's human warmth is another's lack of firm boundaries. If beginnings are a minefield of simmering feelings and symbolic meaning, then endings are a positive Mount Etna, waiting to blow.

No matter what I might be talking about, or how intensely I was expressing some emotion, my analyst would always end our session with a single phrase: 'We're at time'. I still remember the crushing effect this had on me, especially if he cut across me as I was speaking, if that happened to be as the 50 minutes elapsed. I had a friend who told me her therapist would invariably let her sit in her kitchen, after their session, in order to 'get herself together', before she left, which I tutted about at the time ('So unprofessional!') but realise now that this was at the same time I was seeing the glacial analyst, so my disapproval had a large dollop of jealousy mixed in.

I have had a client who became suddenly so disorientated and distressed in the last minute of a session that I decided to sit with her for a little while after we had formally ended, in silence, to help her gain the strength to feel she could head out of the door and into the everyday once more. I have sat in a supervision group with a colleague as they have agonised over the pros and cons of managing a situation with a client who had a terminal illness and had recently begun to ask for a hug at the end of every session.

So where might you place yourself on the spectrum of how to begin and end? Do you tend to offer some cool 'bookends' to the heat of the session? Do you prefer to make it apparent that you can be warm and approachable, from the word go, all the way to the moment the client leaves the premises? For myself, I would say that the most important thing to bear in mind about beginnings and endings is... I'm sorry; the word count is up. We'll have to leave it there for now. Perhaps we can pick that up again, next time.

Sarah Van Gogh is a counsellor in private practice in south-east London and for Survivors UK, a charity that supports men who have experienced sexual violation. She is also a tutor at Re-Vision in north-west London.

Breaks in the continuity of being

Grief often involves a lengthy, complex and painful process of reorganisation of who we are, what we do, how we function, and our relationships with others, writes **Jonathan Hartley**

Bereavement breaks the 'continuity of being' and challenges us to answer the question: 'Who am I now?' My client, M, aged 53, was the main carer for his cousin for seven years as his health slowly deteriorated. Two weeks after his cousin died, he told me: 'I think I'm in trouble. My whole life has been about caring and my momentum has gone. I don't know who I am any more, don't know about my future, don't know what the next steps are. I feel devastated, depressed, don't see a future. I feel I've stepped out of a tornado and there is no wind blowing. Something has happened, and that has changed me. I always felt confident in myself but now don't feel equipped to deal with my situation.'

While each bereaved person's reaction in grief is unique and individual, I hear variations on this statement from bereaved clients every week. Many bereaved describe what in their view was a traumatic experience, which they feel has challenged their sense of themselves and their identity, and left them feeling lost and lacking purpose and meaning in their lives. This underlines that grief can often involve a lengthy, complex and painful process of reorganisation of who we are, what we do, how we function, and our relationships with others. Each of these is key to our sense of identity.

Reflecting on this, I recall attending a training exploring the use of CBT with patients with life-threatening illness, in which the trainer referred to trauma as a 'break in the continuity of being'. This concept felt important to me, as it resonated with my witnessing of many bereaved people's reactions and responses to the loss of a significant relationship. Exploring it further with the trainer, she explained that she was drawing on the work of Winnicott. As I understand it, Winnicott maintains that the ego develops out of reactions to primal threats to existence and developing a 'continuity of being': 'With the care that it receives from its mother each infant is able to have a personal existence, and so begins to build up what might be called a continuity of being. On the basis of this continuity of being, the inherited potential gradually develops into an individual infant…'[1] And, if the holding, generally provided by the mother, is not there, 'the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement.'[1]

Grieving can, for some bereaved people, lead to a changing sense of self-identity, as they acknowledge their resilience in facing and going through the trauma of bereavement

This resonates with Klein and the idea that the infant transitions from undifferentiated unity with the mother to independence and awareness of the mother as a separate person, the 'not-me'. More significantly for bereavement, there are clear echoes of attachment theory, with the basic assumption that people are driven to form relationships with others, and further, that failure to form early successful relationships leads to problems later in life. It follows from these interpretations that an individual's self-concept is formed, in part, as a reflection of the positive and negative aspects of the parent-child relationship. So, 'when a parent dies, the loss of this source of self-definition can challenge an adult's psychological well-being and lead to a redefinition of the self'.[2] For me, this reinforces the notion that a break in the 'continuity of being' leads to a redefinition of self and identity.

Applying this to the therapy context, there is a clear role for the therapist in providing a holding environment for the client, so that they can start to meet neglected ego needs and allow their true selves to emerge. As Winnicott suggests: 'If only we can wait, the patient arrives at understanding creatively and with immense joy… The principle is that it is the patient and only the patient who has the answers.'[3]

My client, F, 45, was the carer for her mother, who had dementia and cancer for three years before her death. F was also the carer for her disabled daughter and son with a mental health diagnosis. F's mother was an archetypal East End matriarch, domineering to the end, and their relationship was ambiguous. At session one of her bereavement counselling, F acknowledged the fundamental fault line her mother's death had created: 'I've never not had a Mum before.' At the start of session four, F came into the room with a renewed energy and excitement as she declared: 'I've just realised! I'm learning to be me.' For me, F redefined her self-identity post bereavement. Her mother's death broke the holding yet constricting environment, which provided an ambiguous continuity of being, and she became free to explore being herself in the world.

Making sense of bereavement

All bereavement takes place in a sociocultural context, and any theories and models that help frame our thinking about the grieving process need to take account of the increasingly diverse and complex situations in which bereaved people adjust to their loss. In exploring a variety of theories and models that have influenced thinking in the UK about bereavement over the last 50 or so years, it is important to acknowledge that they are predominantly Eurocentric and white Western. Their relevance needs locating inside a variety of cultural contexts.

With roots in attachment theory,[4] one approach to thinking about the grieving process, which has seemingly dominated attitudes to bereavement in the second half of the 20th

century, is that of 'stages and phases'. This proposes that adapting to loss through death means progressing through a series of 'stages', commonly described as going from denial and isolation, through anger, bargaining, depression, and acceptance, to a 'relocation' of the deceased and 'moving on'. This has been attributed to the work of Elizabeth Kubler-Ross[5] and Colin Murray Parkes,[6] though is, in my view, an over-simplification of their ideas.

This model continues to be questioned for the implication that bereaved people go through all of the stages, and sequentially, which for many does not reflect the chaos of life post bereavement and the consequential processes of grief.[7] At the same time, it provides a helpful safety net for some bereaved people to guide them through that chaos.

Integral to the model, and also reminiscent of Freud, is that grief, though a natural reactive processing of loss, is a temporary interruption to functioning for the bereaved person. The loss triggers an acute form of separation anxiety, after which the bereaved person will adapt to, and move beyond, their loss, and become fully functioning again. This requires that the bereaved person severs the attachment bond to the deceased loved one.

By telling our stories, we can make sense of our lives, find meaning and integrate our experience of bereavement into a new sense of self and identity

While holding to the principles of attachment behaviours, the theory of 'continuing bonds'[8] challenges the idea of severing attachments in order to resolve grief. It argues that death ends a life but not a relationship. The deceased can be both absent and present. This draws on research that most bereaved people retain a continuing bond to the deceased. By internalising their relationship with the 'other', it remains available to bereaved people to support the continuation of their sense of self and identity that was dependent on their relationship with the deceased.

With continuing bonds, the deceased continues to provide a supportive holding relationship to allow a 'continuity of being'. As a simple illustration, when most bereaved people respond to the question, 'What would [the deceased] have said about this?', they can readily call on the internalised relationship to answer. A parent whose child has died at the age of four, may continue to be a parent as they wonder one year later if they would be taking them to school, seven years later if they would be taking themselves to school, right on until wondering if they would be a grandparent by now. The loss doesn't change but the relationship with the deceased child continues to develop.

Another influential model has been the 'Dual Process'.[9] Adaptive grieving, coping, means moving between avoiding and engaging with the grief. The bereaved person alternates between behaviours focused on reactions to the loss and activities focused on restoring a functional life. Maladaptive grieving is seen as staying within either focus over a prolonged period. As an example of this oscillation between avoidance and engagement, a bereaved client whose partner had died three months previously described her life as it had now become: 'I get up in the morning, wake the children, get them dressed, washed and breakfasted, then drop them off at the child-minder on my way to work. I work full time now because we need the money. After work, I pick them up, take them home, feed them, wash them and put them to bed. Once they are all three asleep, I pour myself a glass of wine and cry myself to sleep.'

In this way, my client alternated between a restoration focus and a loss focus to maintain a balance between avoidance and engagement. While she needed to maintain the family and the home, if she had not allowed herself some time to focus on the loss, her emotional and psychological reactions to her bereavement would most likely have surfaced elsewhere, such as impatience with the children.

A model which I feel has a lot to contribute to addressing identity post bereavement is that of 'narrative and meaning making', as articulated by Robert Neimeyer:[10] '...our sense of self is established through the stories that we tell ourselves and relevant others, the stories that others tell about us, and the stories we enact in their presence. Importantly, it is this very self-narrative that is profoundly shaken by "seismic" life events such as the death of a loved one... the bereaved are commonly precipitated into a search for meaning...'

By telling our stories, we can make sense of our lives, find meaning and integrate our experience of bereavement into a new sense of self and identity. For example, the choice of tense, from present to past, when talking about the deceased, indicates whether the bereaved person has accepted their loss and incorporated it into their narrative. Telling their stories also helps bereaved people understand any break in the continuity of being. For instance, after both parents have died, the bereaved children become orphans whatever age they are, and this may pose issues in their narrative about mortality ('There is no buffer zone now, I am next'). At the same time, if the bereavement has been anticipated and already incorporated into our narrative ('Well, they were old anyway, so we knew they would die soon'), bereaved people are more likely to adjust to the loss without major changes in their sense of self and identity. The absence of a search for meaning in the narrative is one predictor of positive bereavement outcome.

Supporting resilience, not pathologising vulnerability

While these models help to frame what is happening when people grieve, supporting bereaved clients requires understanding that grief usually involves a natural set of reactions to the loss of a loved one and the relationship with them. Because grief is commonly a natural response, it can be important to recognise that bereaved people can mediate their experience of loss through their own resources. Indeed, research shows that about nine out of 10 bereaved people manage to adjust to their loss without additional support. Further, offering support to people who have adequate internal and external resources can be disempowering and detrimental to coping.[11]

The Range of Response to Loss Model,[12] developed by Linda Machin, emerged from contrasting expressions of grief observed in research and practice. Resonating with the Dual Process Model, it focuses on the need to balance the

competing overwhelming feelings and the desire to control functioning. This balance is achieved through the mediating factor of resilience. Rather than pathologising grief and perceiving bereaved people as inherently vulnerable, with associated negative connotations, it explores their levels of resilience and how these may have been compromised by their bereavement.

Reminiscent of post-traumatic growth, grieving can, for some bereaved people, lead to a changing sense of self-identity, as they acknowledge their resilience in facing and going through the trauma of bereavement. Initially, they feel overtaken by their grief, but for a less significant bereavement, the grief usually shrinks over time. However, where the bereavement is significant, the level of grief may stay the same but they grow around and beyond it. The break in the continuity of being arising from the bereavement leads to a new appreciation of a stronger self-identity.

Grief, though a natural reactive processing of loss, is a temporary interruption to functioning for the bereaved person

Who am I now?

Bereavement can fundamentally challenge our sense of identity and force us to readjust and find new meaning inside a changed world. This can range from the practical, such as finances and housing, to the existential search for meaning – why did God allow this to happen? Or a significant aspect of the relationship – who am I now that I am no longer a partner, parent, child of?

My client, W, had been profoundly impacted by the killing of his son K, aged 25, in a knife crime. For me, W's story illustrates how identity can be fundamentally challenged by bereavement, which can be experienced as a break in the continuity of being, as the world in which he lived has changed forever. In T's words: 'For me, the knife that killed him, destroyed me as well. I was born into a very poor family in West Africa. We had very few things and very little money, but I had a dream that one day I would have a child. When the moment came, I would take my child far, far away to a different culture, a different place, where I would bring my child up to be a happy, successful and safe person.

'K was and always will be in my mind a beautiful, happy little boy. When he was five years old, having saved and saved, I fulfilled my dream. We broke that link with my home country, with poverty, and with my family, and K and I set up home together in London. Slowly we began to shape our future. Our new way of life was nothing like before. I worked hard and saved hard, to support us both. Bit by bit we got used to our whole new way of life, to the customs and traditions of this country.

'A few months ago, K decided to go to a party with some friends. He told me he would be home late. It was the last time I saw him. There was a fight at the party and K and others ended up in the street outside. A few seconds later, he was dead. In that split second my life finished. Now I have no future. I just exist in a dark and painful present. I spend no money, I don't save it. There's no one to save it for. My Ivory Coast dream has become a daily nightmare. I don't sleep any more – I just suffer.'

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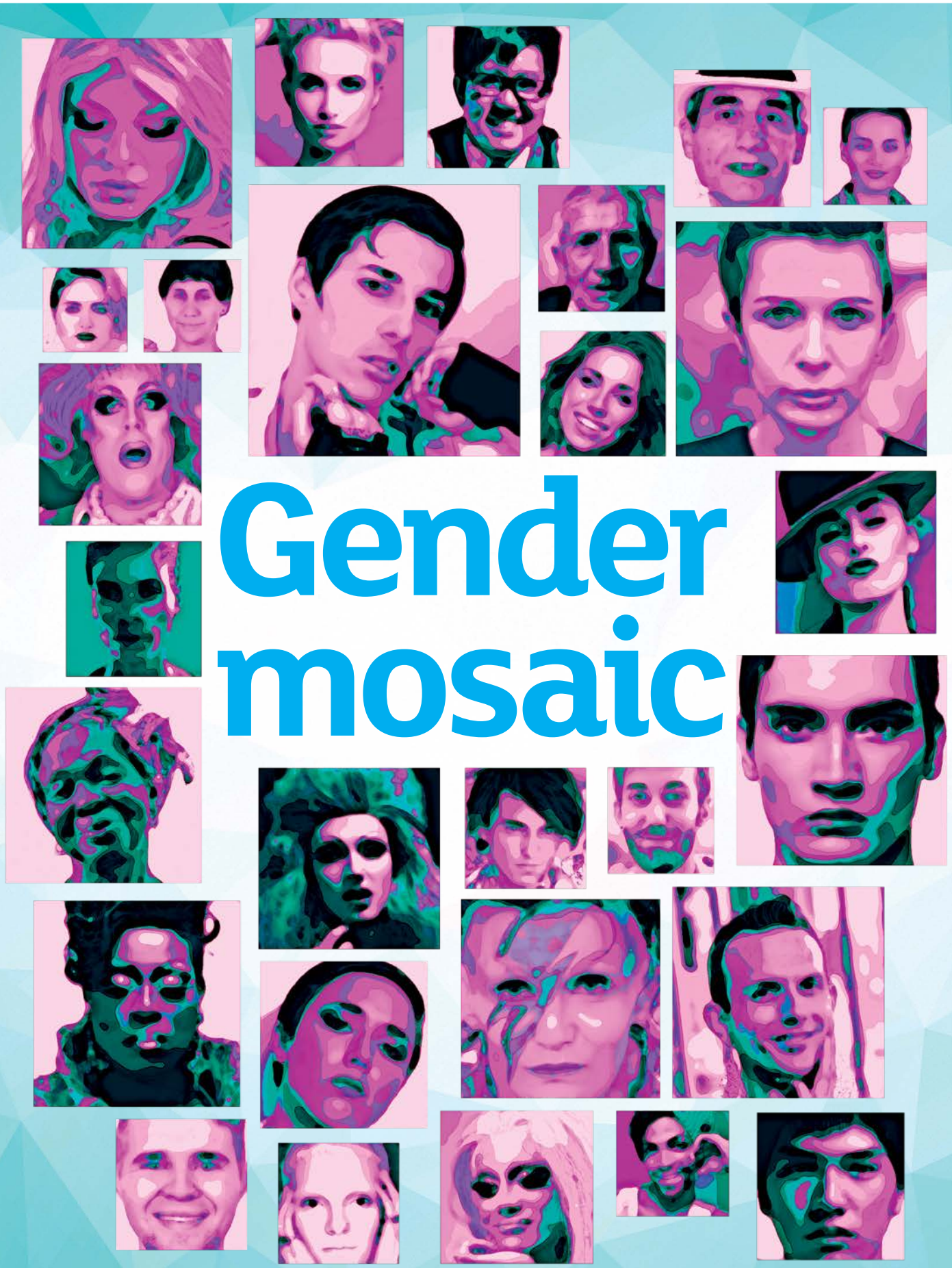
About the author

Jonathan Hartley has worked as a counsellor in a variety of cancer charities and, for the last 10 years, as a bereavement co-ordinator, counsellor, supervisor and trainer in a hospice in East London. He also has a private practice as a counsellor and supervisor and works predominantly with bereavement and the impact of a cancer diagnosis. He delivers loss and grief training to health and social care professionals across the UK and lectures on the master's bereavement course for the Irish Hospice Foundation. He is a member of the National Bereavement Alliance and the Bereavement Assessment and Evaluations Task Group, and has written the guidance on implementing the Bereavement Care Service Standards in Palliative Care.

jonathan_hartley@talk21.com



Gender mosaic

If we empower clients who bring the topic of gender identity into the therapy room with an awareness of their psychological process, and help them to become emotionally robust, they will make healthy choices, writes **Michelle Bridgman**

The majority of people will never be challenged by their gender identity, or how they express it. They may explore their presentation but are likely to be comfortable with the expected binary model of male/female, man/woman, and experience it as perfectly acceptable. Heading into 2018, however, the number of people questioning their gender identity, and how they express it, is far greater than anyone could have predicted. I will give an overview of the historical context behind this phenomenon, how clinical and medical treatment regarding gender reassignment has evolved and, finally, a suggested way forward, including the role of counselling and psychotherapy.

Historical context

People have changed their gender presentation since the beginning of time. Around 1480 BC, Hatshepsut was one of Egypt's most successful Pharaohs, but no word existed for a female ruler, so she used the male title. She wore men's clothing and used both male and female pronouns. Joan of Arc, when sentenced to death, pleaded to be allowed to wear the garb of a man. History is littered with examples of women who took a male role in order to pursue a calling or career, and we'll never know for certain what the motivation was in these examples. In the modern era, Adam Hart had a mastectomy and hysterectomy in 1918. Michael Dillon appears to have been one of the first transmen to undergo a phalloplasty when Dr Harold Gillies operated on him on shortly after World War Two. Another important figure was Reed Erickson, who sought medical intervention with Harry Benjamin in the 1960s.

I believe we need a paradigm shift in thinking in the way trans people are clinically treated

Early examples of transwomen date back to ancient Greece and ancient Rome. In the modern era, we can cite pioneers such as Lucy Hicks-Anderson, born in America in 1886, and the 'Danish girl', Lilli Elbe, in the 1920s. Roberta Cowell, Christine Jorgensen and April Ashley in the 1950s and 1960s were all individuals assigned male at birth, who sought surgery to reassign their genitalia and were sensationalised by the media.

When we look at current treatment methods, we find their roots with Harry Benjamin, who, along with clinicians such as John Money, Robert Stoller and others, worked with trans people in the 1950s and 1960s in the US. It's probably true to say that Benjamin is the most influential figure in terms of clinical treatment in this field. He wrote *The Transsexual Phenomenon* in 1966 and credited pioneers such as Christine Jorgensen as being pivotal to his work and understanding of the phenomenon, as he saw it. His Standards of Care have been adapted over the years and to this day form the bedrock of clinical treatment in the form of the World Professional Association for Transgender Health (WPATH) guidelines.

One of Benjamin's team reportedly said, 'If we can't change the mind, surgery must change the body', thus laying the foundation for modern sex reassignment surgery. In short, to obtain hormone therapy and/or surgery, the patient would have to prove they totally identified with, and were totally committed to, living in the opposite binary gender role for the rest of their lives. They had to illustrate their beliefs about their gender had been deeply embedded and persistent for as long as they could remember. They then had to convince the clinicians that they could only attain peace of mind by living permanently in their desired gender role.

The advent of transgender

The 1990s heralded a big shift when we witnessed the emergence of 'transgender' as an identity. This was a challenge to the 'born in the wrong body' or 'known from my earliest memory' criteria for the suitability of treatment. Kate Bornstein, who wrote *Gender Outlaw*,[1] challenged the notion that we could only ever be at the end of one gender binary or the other. Bornstein, and many others, refused to be terrorised into either changing from one gender polarity to the opposite, or alternatively being consigned to the box marked 'deluded' and/or 'mentally unsuitable'. Many patients began to argue that they wanted cross hormones, even if they were not certain or committed to surgically altering their genitalia. This was, of course, contrary to the rigid philosophy emanating from the 1950s and 1960s.

DSM-5

In 2013, DSM-5[2] reclassified 'gender identity disorder' to 'gender dysphoria' in a move intended to recognise this shift and to classify transgender as an identity rather than a pathology. Since gender dysphoria means being extremely unhappy, distressed or feeling deep-rooted unease with one's gender identity (the opposite of 'euphoria'), and is not a condition, one might question why the treatment of gender dysphoria is still largely in the hands of psychiatry and psychology to determine whether a referral for medical intervention may be made. The answer is, in part, of course, that pathology or not, medical practitioners will not prescribe hormone therapy and surgeons will not operate on a 'healthy body' without a confirmation from a psychologist or psychiatrist that hormone therapy and/or surgery is in the patient's best interest.

Furthermore, gender identity clinics want to assess psychological and physical 'suitability' for treatment. It is possible that a patient may be suffering from a psychosis or other mental illness that may be informing their decisions, and clinicians who have referred patients for gender identity-related surgeries have been known to have been on the wrong

end of legal action when a patient later regretted their decision. This then places clinicians in a difficult position, resulting in patients who are well adjusted, having to go through a lengthy process of assessments prior to receiving the desired medical treatment. So how does one make a decision on treatment or confirm a diagnosis of something that is not a disorder, and how can trans people be better supported?

It is little wonder that many clinicians working in the field are faced with a difficult task, as they can ultimately only really act as gatekeepers who endeavour to ensure that patients have thought their decisions through and do not display any emotional or mental health issues that may be influencing their choices. In short, they often see their task as one of preventing patients from making irreversible mistakes.

Prime Minister Theresa May has stated that people should be allowed to officially change gender without medical checks. She went on to say, 'Being trans is not an illness and it should not be treated as such.' We are, therefore, closer to allowing people to self-determine their gender for the first time. This may be a positive step, for why shouldn't we all be free to express our gender identity in whatever way we wish? Does this mean people who not only desire to have the freedom to define their gender and gender role, but who also wish to have hormone treatment and surgery, should be granted this wish without any form of assessment?

A way forward

I believe we need a paradigm shift in thinking in the way trans people are clinically treated. Despite improvements, we are still working with a model that is based on deciding whether or not patients meet the criteria that deem them suitable for hormone treatment and surgery to change their bodies, in order for them to live comfortably in a different gender role.

The problem is that gender is now recognised as being more fluid than a pure binary identity. Many trans people will have an identity that suits the standard model, ie is binary but opposite to the gender assigned at birth. However, as was mentioned earlier, many have an identity that does not fit this model and may not be as clear-cut. They may be transgender, non-binary, gender nonconforming, gender fluid, gender queer, queer, or one of countless other identities in addition to male or female. As the WPATH Standards of Care emphasise: 'Gender nonconforming is a matter of diversity, not pathology.'[3] Each individual, in addition to having a choice of gender expression, may also have varied wishes in respect of medical interventions and surgeries.

The role of counselling and psychotherapy

Counselling and psychotherapy have an invaluable role to play in this field. So what is that role? Clients who seek support around gender identity and who come into therapy, do so for a variety of reasons. They may wish to explore what their gender identity means to them, they may be distressed and suffering from dysphoria, although it should be stressed that not all trans people who wish to change their gender have 'dysphoria', and they may simply want support while going through a process of change. Essentially, the goals for the therapeutic relationship will be determined between client and therapist at the outset.

What does exploration mean? Not just their gender identity but also the freedom to explore their emotions and beliefs in a supportive, non-judgmental and non-diagnostic environment. Although there has been a shift since the 1960s, 1970s and 1980s, I don't believe the current system allows for sufficient permission to display vulnerability or perceived emotional weakness or be given permission to feel uncertain or confused about anything, lest the patient is prevented from receiving treatment. Many of the participants in my doctoral research reported a perceived need to adhere to a stereotype.

Psychotherapy is particularly valuable in order to explore the meaning attached to past experiences and what part these experiences play in the client's beliefs about themselves. Unlike other clinical approaches, psychotherapy is ideally placed to work with any neurosis and resulting beliefs that may be causing any negative feelings regarding behaviour.

You may ask what this has to do with gender identity? Having completed literally thousands of clinical hours with clients who have brought the topic of gender identity into the therapy room, I believe that if we help to empower our clients with a healthy awareness of their psychological process and to become emotionally robust, they will make healthy choices. These healthy choices include choices in respect of their gender identity.

I also feel that clients who are prepared to can benefit from being given space to explore what their gender identity means to them. As already stated, the world now has space for a mosaic of gender identities. There are some who have transitioned from one binary gender to the other binary,

The role of therapy should be to increase the client's awareness and wellbeing. It is not to judge or make assumptions about what is right for the client

only to find they are no happier. While this is a minority, I believe some of those who have regretted their decision might have benefitted from exploring where they may have been most comfortable in the aforementioned gender identity mosaic, prior to making irreversible physical changes and switching from one gender binary to the polar opposite.

There are plenty of detractors who will want to find any evidence to support their view that all trans people are deluded in their belief that they should or can change gender. I want to stress that I am referring to a minority. A minority who may have felt terrorised by a society with rigid gender markers that does not allow for a gender-variant expression. They may have then seen a binary transition as the only option. I have also known clients to pause and rethink their decisions as a result of working through painful neurosis. The role of therapy should be to increase the client's awareness and wellbeing. It is not to judge or make assumptions about what is right for the client. It is to empower the client.

Reparative or conversion therapy that sees gender or sexual identity as something that can be cured or 'corrected' is, at best, an immoral, unworkable approach, which is not supported by any credible evidence. At worse, it is extremely damaging and is likely to cause great harm. Thankfully, there is now a long overdue Memorandum of Understanding[4] signed by the important organisations, including BACP, to this effect.

I believe the goal of therapy for many clients is, at least in part, a desire to be heard, acknowledged and validated. The demographic in question commonly comes from a place where these needs have not been met. The role of counselling and psychotherapy is not to encourage or discourage any course of action. If we meet our clients in a meaningful dialogue and accept them wherever they may be, they have the potential for a healing encounter that will increase their awareness and understanding, while at the same time empowering them to make healthy choices.

Sometimes this may mean affirming them, and other times it may mean working with the client and their pain. A good therapist can offer open communication and a safe space where the client can find their own truth and vulnerability, thus providing the fertile ground where they can explore who they are in the world, ie their own identity, not the therapist's and not the gender identity clinic's. Instead of being seen as a sometimes-helpful bolt-on, counselling and psychotherapy should play a larger role in a multidisciplinary clinical team.

In summary

People are winning the right to choose their gender identity. If they are supported in adopting an identity they can embrace, and are able to express themselves in a way they can own, rather than being pushed toward an uncomfortable outcome that meets the expectations of an unforgiving society, they are more likely to enjoy a successful resolution.

It is not the job of the therapist to make judgments about the client's decisions in respect of gender presentation, hormone therapy and surgery. However, the therapist can play a vital role in helping their clients deal with any neurosis or negative beliefs, to enable them to make decisions from a grounded, emotionally robust place. As an advocate of field theory, I believe that by placing our focus on the client's holistic wellbeing, rather than rigidly being drawn to their gender, we are likely to be of more value to them. In short, if we all stop playing God and stay with the process, we may provide our clients with the opportunity to make healthy choices and live fulfilled lives.

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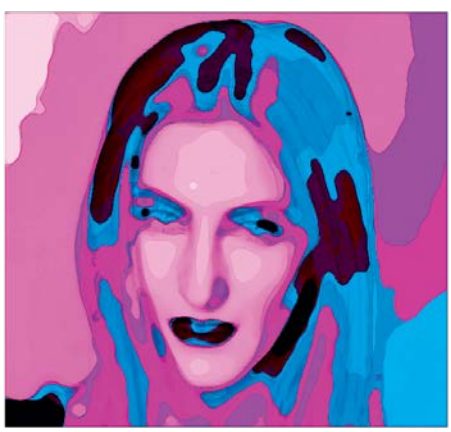


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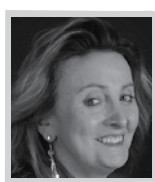
About the author



Michelle Bridgman MSc is a psychotherapist in private practice and keynote speaker on gender identity and change. She is currently concluding a doctoral project, 'The role of psychotherapy in the clinical treatment of gender dysphoria', via Middlesex University. She is married with two adult daughters and a granddaughter.

shelleybridgman@gmail.com
genderidentity.co.uk

Virtual self

It is essential to recognise that technology, and the changes in culture it brings, should be embraced if we are to find our virtual selves sitting comfortably within it, argues **Kate Anthony**

Of all the psychological aspects of living a life online, and one that is particularly relevant to the field of online counselling, the 'disinhibition effect'[1] stands out as being the one that often causes the most emotional distress, while also being of huge benefit in a contained therapeutic environment.

Put simply, the theory is that when we communicate online, or explore online environments, we lose many of the socially constructed inhibitions we possess. For the online client, this generally means that fear of judgment or shocking the therapist (which may be experienced in a room when sitting opposite a professional) is considerably lessened, allowing the client to access and communicate feelings and emotions that they would otherwise keep hidden. For professionals, this often means experiencing surprise that the client shares so much early on in the relationship, and often requires skilled management of the client's emotions to avoid them feeling overwhelmed and therefore at risk of not returning.

Exploring disinhibition

One of the first exercises that my trainees undertake on the Online Therapy Institute's Certified Cyber Therapist training is to examine their own experience of disinhibition, not necessarily in a therapeutic environment. Many of the responses demonstrate relief at recognition of an effect that explains their unusual behaviour in over-sharing with a stranger in an email conversation, for example.

Society has changed in ways that are often uncomfortable for those of us who remember a world pre-internet and mobile technology. The culture of cyberspace is often unfamiliar and confusing if one tries to apply offline societal norms to the online world. What is essential is to recognise that technology, and the changes in culture it brings, should be embraced if we are to find our virtual selves sitting comfortably within it.

Increasingly, clients bring presenting problems that have occurred as a result of disinhibition online. This could be a relationship problem as a result of online reconnection with a past relationship, for example via Facebook. Disinhibition encourages intimacy, which is often mistaken for a valid romantic or erotic entanglement that affects and threatens offline relationships.

However, it is the wealth of experiences available online that often causes clients to question their actual identity. For example, the client with masochistic tendencies that are kept well hidden in their day-to-day offline environment, may discover that they are able to explore these fully in a virtual environment, such as Second Life, or create an intimate relationship with a stranger who is exploring their submissive side through themed chat rooms or other online environments. Such experiences may trigger usually well-managed issues, leading to depression, anxiety or addiction.

It is often at this point that the client seeks therapy to help with feelings of confusion around their identity, and sometimes curiosity about where these previously well-defended tendencies stem from. Disassociation is not uncommon here, as the psyche seeks to reject the newly discovered part of itself, and the client identifies his or her online behaviour as 'not really me'.

There can be a danger within any therapeutic relationship if the therapist colludes with the client in not giving attention to issues of identity that stem from online behaviour in light of online disinhibition (often citing that 'well, online relationships aren't real, are they?').[2] It is worth noting that the disinhibition causing issues conversely works positively in an online therapy relationship, allowing deeply buried facets of the self to be freely expressed within session. Whether or not we are interested in practising online, there are now many elements of cyberpsychology that need to be known and understood by all in the counselling and psychotherapy professions. This is particularly true of those working with gender identity issues, since clients are able to explore and act out as a different gender easily online.

Identity formation in the modern world

When we dismiss cyberspace as somehow 'not being real life', or shake our heads in despair at young people seemingly glued to their mobile phone, we miss the point that this is where identities are formed and sometimes damaged in the technologically connected world. It may not be the method of identity formation that many practitioners experienced growing up, which can sometimes make empathy challenging, and it is likely that the practitioners of the future will be much better placed to work with client identity as it is formed in the modern world.

In the meantime, and as technology gets evermore embedded in our day-to-day lives, and those of our children, we have a duty to become competent practitioners in light of how that technology affects human lives and identity.[3] Common sense allows us to educate clients that the number of 'likes' or 'favourites' they get on social media platforms need not define them or their identity in the offline world.

I worry for a profession that ignores or dismisses the fact that identities are formed and lives conducted online, and in particular one that focuses almost exclusively on face-to-face experience as the defining factor. It was my pleasure to recently discuss these issues with delegates at the recent excellent BACP Private Practice conference.

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About the author

Dr Kate Anthony FBACP is the leading UK expert on the use of technology in therapeutic practice. She is a psychotherapist, coach, supervisor, trainer and consultant. Kate has trained practitioners and organisations worldwide in online therapy, coaching and related fields for over 15 years, with both her online training courses and offline workshops and lectures. She is co-editor and co-author of five textbooks in the field, as well as numerous articles, chapters and journal symposiums, and several ethical frameworks for the use of technology in mental health. She was made a Fellow of BACP in 2008 and is also Past President and Fellow of the International Society for Mental Health Online. She is co-founder of the Online Therapy Institute, lives in Scotland, and is a double stroke survivor.

onlinetherapyinstitute.com
kateanthony.net

Book Reviews

Trans voices: becoming who you are

Declan Henry, Jessica Kingsley Publishers; £12.50

Declan Henry set out to address his ignorance of trans people. To this end, he has interviewed dozens of trans and non-binary people and here presents their words to help provide insight into their many and varied experiences. Henry is a social worker, not a therapist, and this is not an academic book. As such, it will not, in and of itself, give any insights into working therapeutically with trans and non-binary clients. It is not full of grand theory or analysis, and is all the better for that.

The book is split into topic chapters, within which Henry provides some commentary but then gives over the space to the voices of his interviewees. This approach creates a very readable book, which can be read cover to cover or just as easily dipped into to give valuable insight into the lived experiences of the contributors. What comes across well, and is refreshing to read, is a real sense of the range and variety of experiences; that there isn't one way to be trans or to experience gender variance. The book outlines, with great respect, the complexities of being trans, as well as the simple truth that trans people exist and should be able to identify in whatever way suits them.

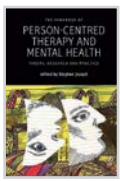
Language around this subject is an area of fast change and emerging ideas. Within the trans community there is not always agreement about which words are OK and which best sum up the way people want to identify themselves – and why should there be? Henry presents a wide range of opinions from trans and non-binary people and makes no judgments about these, instead letting the speakers speak for themselves. The chapter on sex and sexuality provides some especially helpful insights into how sex, gender, sexuality and identity intersect, demonstrating that this is a grass roots change – that young trans and non-binary people are driving the debate and creating their own meanings, not waiting for academics to research them and tell them what their identities are.

This book is a great way for people to start gaining insights. Any counsellor working (or likely to work) with trans and gender variant clients would do well to read it. It may also be useful for clients who are family and friends of trans people, and are looking for some basic information and understanding. There is a helpful section in the back with a list of relevant organisations.

Alex Sanderson-Shortt MA, MBACP (Accred), is a relationship and LGBTQ specialist counsellor in private practice
kascounsellingservices.org

The handbook of person-centred therapy and mental health

Stephen Joseph (ed), PCCS Books; £27.99



In terms of sentiment, this remarkable 500-page tome sits somewhere between Hunter S Thompson's 'fear and loathing' and Carl Rogers' 'fear and trembling'. Its authors range from the astutely radical (by mainstream standards) to the collaborative and stoical. What starts off as a refreshingly unrestrained rollercoaster ride, courtesy of Pete Sanders ('Opposition to the medicalisation of distress'), middles out with the delicate brilliance of Jan Hawkins ('Living with pain'), before coming to a near-halt with the thought-provoking revisionist Lisbeth Sommerbeck ('Evaluation of research').

For what is at stake is not just the future of person-centred therapy in its grab for a warranted slice of the mental health arena, but also its past. Sommerbeck manages to destroy the myth that has persisted since the late 1960s and ultimately dogged this 'eminently suited' mode of therapy: that, following Rogers' Wisconsin project, it was shown that person-centred therapy (PCT) (or, as it was known, client-centred therapy) has limited scope and offers only disappointment when it comes to dealing with complex cases, such as schizophrenia.

A project in which motivation for help was low, the style of client-centred therapy questionable, and the therapists inexperienced, was bound to fail though, Sommerbeck asserts. She then manages to turn the tables and do battle with the psychiatric fraternity, peppering her work with subliminal messages ('psychiatric back wards') while pointing out their shortcomings: 'reality correction' in order to avoid colluding – through empathy – with severe/psychotic clients; believing that 'non-directive' equates to 'unstructured', 'passive' and 'laissez-faire'.

This method of attack is a relief as, too often, those with the Rogers baton in hand settle for a meek and grateful 'draw' with CBT and solution-focused therapy, citing research that shows that 'no particular model of therapy is more effective'. The heavyweights, Laing, Shlien and Szasz, would beg to differ, and it is encouraging that they are still inordinately referenced here.

Handbooks can, at times, be excuses for jumbling together obsolescent articles with no obvious foothold in contemporary thought. This, along with its similarly mighty brothers, *The Handbook of Person-Centred Psychotherapy and Counselling* (Cooper et al) and *The Person-Centred Counselling and Psychotherapy Handbook* (Lago et al), is a pivotal purchase for any library, though if only to discover the swathe of erudite books sourced. There are moments when the inclusion of counter-arguments from other schools would help the reader more fully understand why the NHS, IAPT, clinical psychology and psychiatry stridently and subtly rebuff person-centred approaches, but these are outweighed by the piercing inside knowledge that Rachel Freeth, Stephen Joseph and particularly Gillian Proctor bring.

Jeff Weston is a trainee existential psychotherapist
jaweston1970@gmail.com

We're all mad here: the no-nonsense guide to living with social anxiety

Claire Eastham, Jessica Kingsley Publishers; £12.99

As Natasha Devon writes in the foreword to this book, 'Claire Eastham's personality leaps from the pages of *We're all Mad Here* and gives you an enthusiastic cuddle'. Sharing her experiences in such an easy-to-read way provides a wonderful resource, which not only shows an understanding and acknowledgement of the seriousness of social anxiety, but also provides practical tips and reassurance that things will be OK.

Having shared this book with other counsellors and clients too, the main things that people seem to like about it are the down-to-earth language used, clear layout, and excellently judged dollop of humour. As Eastham says, 'I don't write like an academic and I like to swear.' Each chapter is clear and concise and, as such, it is a difficult book to put down. Although Eastham does not write like an academic, she certainly does not shy away from fully exploring social anxiety – 'What the hell is it and why is it happening to me?' She speaks openly and honestly about the role of medication in her experience and

uses medical jargon only when followed by a no-nonsense, simple definition.

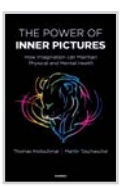
This book is full of lists of 'tips', useful suggestions and practical exercises; all presented in a gentle, 'try this', kind of way. The section about therapy – 'The talking part' – provides useful guidance about choosing the right therapist, as well as a little detail about CBT and exposure therapy. The 'Advice for Caregivers' chapter provides a useful reminder to us, as therapists, to keep things simple and calm. It could also be shared with a client who is perhaps struggling with a loved one who has anxiety or panic attacks. As Eastham writes: 'Comfort is a precious thing to someone who is suffering with mental illness. The presence of a friendly face and calming words can do wonders.'

This handy little book would be a great addition to your bookcase, and has certainly been an interesting conversation starter with some clients who spot it on mine. As Eastham writes, she is 'just a normal girl who has a great deal of experience with feeling anxious and generally freaking out'. She does not claim to be an expert and that is what adds to the value of this book. Through sharing her own therapeutic journey with social anxiety through writing her blog and her book, Eastham succeeds in her task of helping others realise that anxiety is more common than you think and yet it is a very treatable condition – one that you don't have to be ashamed of or deal with alone.

Elisabeth Hughes MBACP (Accred) is a counsellor in private practice and the voluntary sector in Liverpool

The power of inner pictures: how imagination can maintain physical and mental health

Thomas Kretschmar and Martin Tzschaschnel, Karnac Books; £20.99



This book appealed to me as I visualise vividly and this can be helpful in counselling, for example, in offering metaphors. Early chapters broadly describe the 'power of representations' and 'how internal images heal us', while later ones become more specific about the approach, containing examples involving transcripts.

I found the early chapters interesting with their broad-brush exploration of the role of imagery in our lives. The power we possess to help ourselves is outlined: 'The brain deems the inner world as equal to the outer world', thus we can combat stress and build immunity through effective use of imagery. Jungian ideas are referenced: 'archetype structures' are 'imprinted' in us to keep us safe, such as a fear of snake-like objects or heights. This common understanding is then used to lead a visualisation where a meadow represents our mood and environment; a stream or river represents our sense of vitality; a mountain represents a father figure or our career and ambition; a house represents self; and a forest represents fears.

The client is also encouraged to create their own images, such as a horse signifying power to one client. Different members of the family, in this example, also take on different forms, a little like internal family systems, where clients are encouraged to step back from self and others to view the roles of parts of themselves and significant others. The premise here is that through sticking to metaphor, a client is able to approach and access hard-to-reach feelings and experience, similarly to play or art therapy principles. For example, 'If you were the bull, how would you feel?', bringing the client closer to the emotion, but at a distance. The authors give a variety of examples, including using symbols to recover from the emotional effect of trauma without reliving the experience.

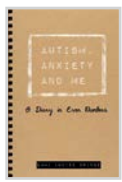
While interesting, to use this as a guide in my own work would feel too much of a departure from my core approach. I had hoped I might be able to highlight ways I already work, but a very specific approach is described. If you do choose to follow the guide, you may feel there is sufficient information here to try. Considering the ethics of working within our competence and the power of working with the unconscious, this may not be advisable, however.

Although I continue to believe imagery can be healing, I don't feel more equipped by this book to use it than I did before. I think this is because the approach ('catathym imaginative psychotherapy') is described in a prescriptive fashion, which I wouldn't feel comfortable replicating without further training.

Katharine Cossham MBACP (Accred) is a person-centred counsellor working for IAPT as a counsellor and trainee Couples Therapist for Depression

Autism, anxiety and me: a diary in even numbers

Emma Louise Bridge, Jessica Kingsley Publishers; £12.99



This is a poignant, easy-to-read diary from a young yet mature author – with a difference. The author's mother follows each entry with a commentary, list of key points and advice. This combination provides a valuable insight into the author's way of thinking, feeling and being, and her mother's developed understanding of living with children with autism (the author and her sister both have autism).

This is not a textbook or academic work, it's Bridge's account of her experiences, thoughts and dreams. It is also a strong reminder that people with autism are individuals first. That should be obvious for counsellors, but as a supervisor I have observed counsellors default into stereotypes when labels accompany those who are referred. Bridge wrote this diary to give 'an insight into her mind' to anyone who is interested in autistic spectrum disorder and social anxiety. She has done this admirably. She has created a book that is both enticing to read and informative.

Like any diary, Bridge shares anecdotes of her life. But she has specifically crafted them as openings for the reader to understand how confusing the world is for her, and for many adolescents and young adults on the autistic spectrum. She writes flowing, descriptive, honest prose, sharing her everyday experiences and challenges, and exploring 'big' questions about identity and fitting in. I sense that her words and dilemmas would resonate with many of the young people and young adults I know or counsel. Like so many coming through our counselling rooms, she is a young adult trying to find her way through life, and to 'fit into society and be accepted'.

Bridge is a vibrant, funny (mostly unintentionally, she explains), generous young woman. She challenges the notion that people with autism are 'all the same'. Like every individual we meet and who may come into our therapy rooms, she is unique. Each of her entries is honest and raw.

This book deserves a place on the bookshelves of all who know or work with people on the spectrum, or, as her mother concludes in the introduction, 'those who think they may be on the spectrum or just feel different and for whom the book may trigger the thought "that sounds like me"'.

Augene Nanning MBACP (Accred), is a counsellor and qualified supervisor in private practice and manager of Caris Islington Bereavement Service

info@augenenanning.co.uk

Psychoanalysis, identity and the internet: explorations into cyberspace

Andrea Marzi (ed), Karnac Books; £27.99

The essence of this book lies in the profound changes to our lives and our world in the 21st century: changes precipitated by the internet. The contributors endeavour to identify the radical shift in our thinking in the world of psychoanalysis, as it incorporates the traits and scope of the internet and cyberspace. The book aims to include associations that define how particular behaviours are played out, including that of internet addiction.

But the thesis is unclear, and the book remains emphatically technology driven, despite attempts to convey the unintended consequences for 'users', which are exacerbated by the very accessibility of the internet. The aims therefore appear incidental to the main thrust of the elaborate power and quality of the internet revolution.

The book is structured as a model of discovery and engineering evolution. It is Darwinesque in its approach. But after ploughing through this scientific maze, much of which would be alien to the therapeutic bookshelf, I could understand, even as a New Luddite, how the book (and the reality) fascinates, with the prophetic vision of the pioneers, and illuminating history of the gestation, birth and development of its main focus, the internet and cyberspace. It presents, ultimately, as curiously similar to the life cycle. In this respect, it is both unique and familiar.

Gems include the insights of Norman Holland, who observes that people tend to humanise the computer, enabling the user to have uninhibited relationships with others, filling them with their own projections. He describes how some may use the internet as an alternative to everyday life. He believes that unconsciously transferring relationships or power to the computer could be seen as an analogy to a parent who 'does not judge'. This, according to Holland, makes the computer a mirror of ourselves, an ideal partner, and a true friend.

Longo continues the theme of the internet as a place of freedom to be oneself. He sees 'the screen' as an external part of our minds, and describes the internet as a 'non-space', which can facilitate 'pseudo-activities', which he compares to the ideas of Winnicott's 'playing and reality'; space for play and ideas, and the 'splitting and detachment from reality'.

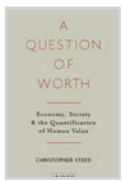
The authors, particularly Antinucci, frequently return to familiar authorities, such as Freud, Bion, Russo, Lacan and Winnicott, to authenticate internet and cyberspace emotional connections, with 'the gaze', sense of space, the early environment and relationships. As Antinucci puts it: 'the good enough experience'.

This parallel universe, advancing from floor-standing computers to the improbable success of slimline transitional objects, with their own internal world, language, digital dependence, and 'enslavement', has become, for many, including me, a welcome diversion from the mundane business of having to communicate as nature intended. But at a price.

Norma Yam MBACP, UKCP, is a psychodynamic psychotherapist and counsellor
normayam@sky.com

A question of worth: economy, society and the quantification of human value

Christopher Steed, IB Tauris; £58



A *Question of Worth* provides a harsh critique of the damage caused to the individual by the post-industrial revolution obsession with quantity and productivity as the primary measures of value. Steed, a practising counsellor and former civil servant, explores how financial assets and productivity came to supersede quality. This is contrary to the teachings of Thomas Aquinas, for whom the drive to improve social status through the acquisition of wealth was highly dangerous. Steed argues that an obsession with quantitative value leads to negative effects on the individual when monetisation nosedives: 'When banks fail, it is people who are devalued.' He argues that the pernicious sense of injustice, magnified by the global economic crash, was outwardly expressed in the 2011 riots across the UK and in Greece: 'The disaffected, devalued self requires compensation'.

To connect socio-economic theory to counselling practice, Steed uses the psychoanalytically infused metaphor of 'capitalism on the couch' to critically examine the presentation of the UK in the 21st century. Ultimately, this feels unsatisfying, as the case study metaphor is not fleshed out enough to be truly illuminating. The political impact of inequality has been addressed extensively elsewhere and greater exploration of the 'client' at depth would have made this work more compelling and original.

Steed argues that three central factors lead to a dysfunctional relationship between the individual and their society at large: perceived indifference, inequality and indignity. This provides a forceful reminder to practitioners to avoid regarding the individual in isolation, removed from the impact of social transactions: a personal sense of worth is deeply affected by the value society places on us. Steed argues that while clients rarely cite inequality as a direct reason for their emotional distress, their presentation is often driven by everyday frustrations, magnified and exacerbated by status anxiety. While this provides an explanation of extreme and seemingly directionless anger, dedicated case studies would have been helpful to illustrate this more effectively.

In terms of modern work, the subject matter and approach share similarities with both *The Spirit Level* (Wilkinson and Pickett, 2009) and Oliver James's *Affluenza* (2007) and *The Selfish Capitalist* (2008). These texts all report the detrimental impact of mistaking unsatisfying extrinsic goals with deeper intrinsic motivations, a tendency more prominent in unequal societies. While Steed's work is frequently interesting, it suffers in comparison. Whereas Wilkinson and Pickett provided a rigorous analysis of global health, sociological and criminological research to analyse the impact of inequality, Steed's work is comparatively light on data. Conversely, while *A Question of Worth* can be dense and conceptually overloaded by its ambition at times, both of James's books are extremely readable and render complex psychological ideas accessible to the public.

Tom Livesey is an accredited integrative counsellor working in both private practice and the voluntary sector

Trauma and countertrauma, resilience and counterresilience: insights from psychoanalysts and trauma experts

Richard B Gartner (ed), Routledge; £34.99

This collection of essays explores the significant impact on therapists of working with highly traumatised clients through the lens of the twin concepts of countertrauma and counterresilience. The editor, American psychoanalyst Richard Gartner, makes a strong case for the usefulness of these terms over similar ideas, such as compassion fatigue and vicarious traumatisation, situating his argument within 'a fluid, intersubjective, two-person system'. Interestingly, not all of the contributors follow this terminology, and the language varies somewhat from chapter to chapter.

Aside from furthering these new concepts, perhaps the other distinctive feature of the book is the use of frank, sometimes visceral, language to describe both the traumas experienced by clients and the impact hearing about these traumas has had on therapists. There is very little attempt by the authors to conceal traumatic events in formal or academic language and their own experiences are equally alive on the page; the reader invited to share these experiences as closely as possible. On the one hand, this makes for undeniably powerful accounts of important work. On the other, it is tough reading at times, especially in the descriptions of severe childhood sexual abuse. At one point, in describing his work with a highly traumatised client, Gartner asks: 'Why did I have to envision such things? Why did he put them in my head?' There were

moments in reading when the same questions came to my mind.

Inevitably, with an edited collection such as this, the contributions vary quite widely in subject matter, tone, and in how usefully and successfully they grapple with the concepts introduced by Gartner. I would like to pick out four chapters that I found particularly interesting: Sheldon Itzkowitz offers perhaps the most theoretically useful account of countertrauma and counterresilience in terms of intersubjective-relational theory; Richard Chefetz describes very movingly how a highly traumatised female client is able to reconnect with her body through dancing in their sessions, and the impact this has on him; Jill Bellinson offers a very powerful account of her work in disaster mental health, responding in the hours and days after disasters such as 9/11 and Hurricane Katrina, when the security of the traditional therapeutic frame was impossible to hold; and Karen Saakvitne writes helpfully about the distinctive challenges and requirements of supervising therapists engaged in trauma work, especially regarding self care. Other readers will no doubt have their own preferences.

In all, this is a powerful and important book. Although by no means an easy read, it has a lot to offer anyone interested in the field of trauma work.

Paul Brand is a psychodynamic counsellor and trainer in Hampshire and West Sussex

The psychoanalytic craft: how to develop as a psychoanalytic practitioner

Laurence Spurling, Palgrave; £24.99

Please don't be put off by the title, as this book explores in depth a topic all counsellors and therapists need to think about; though, as Spurling confirms, it's not written about or even spoken much about, except in the vaguest of terms. I have long thought about what we bring to our work based on our clinical models, values, life experience, intuition and sensitivity, so it has been very positive and inspiring to see it explored here.

Spurling attributes evaluation to the psychoanalytic approach, but it's surely crucial for reflective practice in any approach. The craft analogy centres on 'finding the live edge of the work' – the coming together of our theoretical knowledge and what he terms our 'implicit clinical thinking', based on an internal clinical template. He describes how psychoanalytic working parties attempted to map and categorise interventions, challenging as key differences were found, even in interpreting terminology, before suggesting his own 'map' and drilling down to how we decide which interventions to use in a session. He explores how these constant choices ('contingency'), involving thinking on our feet and forever monitoring how the client responds, take the session in one direction or another, choices which could profoundly influence how the work develops.

Whereas his categories of six basic interventions include some specific to psychoanalytic work, for example, those aimed at facilitating the unconscious process, his model of the internal clinical template could apply to any approach – for example: What is wrong with the patient? What needs to happen to change the patient's psychopathology? What is the listening priority? How is each session conducted? What constitutes the therapeutic setting? (Not the physical setting, but the relationship, a place for playing, for past experience to become present, and so on).

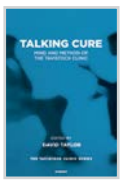
I found the most interesting and revealing sections to be the dissection of his sessions with Mr A, and where he presents the work of his supervisees and final year students, to ascertain how they work and whether (or not) they could articulate it. Key overarching questions are: What is the analytic task and how am I addressing it? How can we integrate and negotiate between all the different inputs – the implicit, explicit, personal experience and values – so we can articulate this and develop some objectivity about how we work, what we think we are doing and who we are as practitioners? Another aspect is the capacity (citing Thomas Ogden) to disentangle ourselves from role models, at the same time as honouring them.

There is some repetition in the text but generally Spurling is an excellent writer, as many readers of his *Introduction to Psychodynamic Counselling* would agree, and I felt this was crucial reading on a rarely explored topic.

Roslyn Byfield is a counsellor in private practice

Talking cure: mind and method of the Tavistock Clinic

David Taylor (ed), Karnac Books; £14.99



Many therapists are already aware of The Tavistock Clinic as an international centre of excellence based in London and concerned with mental health from a psychoanalytic perspective. This book was written to accompany a TV documentary series made in the 1990s about the day-to-day work of the clinic. I remember watching the programmes and being fascinated by the breadth of the work, particularly around 'the mind' of organisations, as well as the mind of the infant, the adolescent or the couple mind.

The 2017 edition of the book has been a pleasure to read and I have once again been drawn into the world of the unconscious and the things that can't be spoken about but that get acted out, in our daily lives or in the therapeutic conversations and relationship we have when we try a talking cure. The book devotes a lot of space to detailed snippets of casework and the therapist's interpretations or understanding of what's happening and how to progress the work.

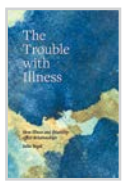
The work ranges across the lifespan, from conception through infancy to old age and death. There's a focus on family, love, work, dreaming and play. The book also discusses the spectrum of mental distress and mental illness and the range of therapeutic interventions that can help. There's a chapter on groupwork and chapters on time, age and looking to the future. The writing style is like the work itself, both straightforward and very human and yet immensely complex.

There is so much here for the beginning therapist curious about psychodynamic concepts (including a glossary of 'often used terms' and recommended other reading) or the seasoned therapist reminded again of the 'unknown known' from the very first encounter we have with our clients. Its strengths lie in the casework illustrations described, alongside the struggles of the therapist trying to understand what is being communicated from the unconscious.

Julia Greer MBACP (Snr Accred) is a counsellor, supervisor and psychoanalytic psychotherapist in private practice

The trouble with illness: how illness and disability affect relationships

Julia Segal, Jessica Kingsley Publishers; £13.99



'This book draws together some of the insights I have gained from working with clients who either have a serious health condition themselves, or live with or care for someone who has one,' says Segal. Her book will do for her readers what she's tried to achieve as a counsellor to those affected by illness and disability: help them to understand the rage, guilt, grief or terror that draws them to such chapters as 'Illness, disability and sexuality' or 'Pain'. Parents, adolescent children, nurses, carers and doctors will all find useful the practical ideas and insights here. Counsellors and therapists will find this book invaluable.

When serious illness strikes, and disability follows, unwanted feelings, and thoughts which breed guilt, can ambush those concerned. It is human then to disavow frightening thoughts – such as the urgent wish for an ill family member to die; and natural to look away from blinding emotions: to deny them, suppress them, or find ways of projecting or enacting them that threaten to undermine the accommodations – the small ways we forgive and accept each other – that sustain family life. It is then that understanding is so important. Segal says: 'Just knowing that people have bad thoughts, that illness and deformity evoke them... can help.'

Chapter by chapter Segal lays out the ways serious illness and disability can affect families and relationships, and suggests how those affected can be helped or help themselves. She gives vivid examples, and draws often on psychoanalytic ideas and insights, showing how useful they can be in helping us understand the complexity of her subject.

Her examples can be moving as well as illuminating, as is Hannah's testimony in the chapter titled 'Children'. Her father had a stroke when she was eight years old. 'Until I was 21,' she tells us, 'I didn't know what a huge affect Dad's stroke had had on me... it took me more than 13 years to express the anger/sadness that I felt.' Counselling helped her to feel that she has finally come to terms with what happened in her family: 'I am sure there will be times in the future when I am upset... but I now know that... being honest about such feelings makes them easier to live with.'

Some of Segal's examples are arrestingly easy to imagine: 'a partner who has been told they are useless or they should leave may be too distressed to wait for their loved one to say this isn't what they feel all the time... and just avoid all conversation as much as possible.' She knows her subject deeply. I emphatically recommend her invaluable book.

Jim Pye is a UKCP registered psychotherapist

Teaching the world to sleep: psychological and behavioural assessment and treatment strategies for people with sleeping problems and insomnia

David R Lee, Karnac Books; £25.99

This book's catchy title made me initially hopeful about its contents, as did the recognition of insomnia's multiple and complex causes and the need for a tailored approach. It's targeted at 'people who do not sleep well' (the 'interested insomniac') as well as professionals.

Insomnia is defined as a state of hyperarousal, involving difficulty with initiation or maintenance of sleep or early waking/non-restorative sleep, for at least three nights a week over a period of three months, causing significant dysfunction during the daytime. Lee describes the biological aspects of sleep (this could be tempting to skip but it is best not to, as he explains the important functions of both Slow Wave and REM stages, for example in schema formation); how poor sleep affects mental health; a wide range of sleep disorders; assessment and treatment. Factors controlling, moderating and mediating sleep are explained and how DSM-5 added some 'interesting' new domains, such as impact on others.

Lee points to the massive cost to society of sleep problems and the lack of appropriate awareness, understanding and training, even among professionals. He expresses concern about poor sleep being medicated, due to a lack of appropriate services offering tailored treatments, and the long-term risks and side effects of medications. Added to this are the myths and misunderstandings about sleep and that it seems (along with death) to be a 21st century taboo. People don't openly talk about sleep but it's interesting how often a conversation will bring insomniacs out of the stigmatised woodwork. As counsellors and therapists we know clients often complain of poor sleep, closely allied to anxiety and depression, yet we are not generally trained to address it.

Lee quotes many research sources and is committed to the evidence-based agenda. He makes some interesting (and worrying) points; for example, how people in institutions are often medicated to suit a timetable, rather than allowing them to follow their natural sleep pattern.

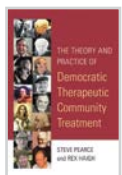
Despite its useful content, downsides include a verbose style rather than plain English, some surprising examples of bad grammar, eg 'whom' instead of 'which', the American framework, and that the author directs a private sleep improvement company: the book could be seen as an advert for this company's CBT-based REST programme, which he describes in detail.

Two key issues CBT-based books omit are that obligatory sleep scheduling, keeping diaries and changing habits are hard work, often leading patients to backslide and drop out of programmes. The other is that sleep problems often relate to longstanding and unrecognised trauma, leading to hypervigilance and leaving imprints in the limbic system, not accessed by CBT. In my view, we urgently need to get beyond sleep hygiene and CBT (useful though these are) to explore non-cognitive approaches, to complement current practice.

Roslyn Byfield is a counsellor in private practice

The theory and practice of democratic therapeutic community treatment

Steve Pearce and Rex Haigh, Jessica Kingsley Publishers; £25.99



The authors say, 'The purpose of this handbook is to enable members of therapeutic communities to live a more fulfilling and satisfying life.' They appreciate the irony of writing a book about democratic therapeutic communities (DTCs) that contains templates, guidelines and structure, while also asserting and emphasising the importance of fluidity, flexibility, equality and patient empowerment and responsibility, which are essential elements within a successful DTC. They present a good balance between these two sides to create a valuable, instructive and inspirational book.

The book is divided into five parts with an extensive appendices section, which is an invaluable resource for those interested in setting up and running a DTC. It focuses on DTCs for people with a diagnosis of personality disorder, but the theory and practice can be applied to other areas, such as education and learning disability. It begins with a fascinating insight into the history of the therapeutic community. The second section explores the people, philosophies, ideas and movements that have influenced the continuing journey of DTCs. Some of the subject matter is, as the authors acknowledge, quite dry, but it is written in a clear, digestible way. For example, the topics on belongingness, responsible agency, social learning and emotional progress and narrative are introduced briefly before being reconsidered in detail later, enabling the reader to develop an understanding of these and other concepts easily.

Part three is a practical section looking at the assessment and selection process, the preparatory stage followed by the full programme and finally the steps towards leaving the DTC. Full of useful ideas, it also takes the reader cleverly through the participation an individual may experience within the group, through the use of examples and vignettes.

Part four looks at the financial practicalities of setting up a DTC and explores the National Personality Disorder Programme. Part five considers the people required to run a DTC and how to optimise their working experience, again considering practical ideas alongside the relational and experiential way of being.

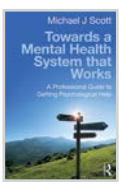
The authors' passion for their work is palpable and Haigh outlines his 'quintessence' of a therapeutic

environment (attachment, containment, communication, inclusion and agency) with elegance and humanity. The book is aimed at 'those setting up or running DTCs or who want to introduce an understanding of relational methods of treatment to existing programmes', and so is not essential reading. However, I would recommend it for its fascinating historical perspective and exploration of the therapeutic value of a relational approach, which is a missing part in the lives of so many and which benefits the individual, the group and society as a whole.

Fiona Croston MBACP is a psychotherapeutic counsellor in Hull and East Yorkshire
fiona@croston.karoo.co.uk

Towards a mental health system that works

Michael J Scott, Routledge; £24.99



This book aims to give an overview of what shape our current mental health system is in and how it got to this position, and looks at possible ways to improve it going forward. I particularly liked the section on evidence and publication bias, along with conflict of interest – if we allow the people who make the decisions to work in this manner, we can't expect a fully functioning system to emerge. The author raises many questions throughout: Are our evidence-based therapies really suitable for use? Would increased access and easier access really benefit our system? And can psychometric test results be misleading? All of which invite debate.

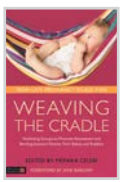
This book is a must read for anyone with an interest in our mental health system; whether you're a service user or family member, practitioner or decision maker, this book is for you. It's a call to arms, a plea for all of us to engage with the subject of how we want our mental health system to look and work, so that we can influence its growth. Like an untended garden that's been allowed to wither, wilt and reform, neglect has led us to this point and it seems some serious pruning and planning are now needed. We've been so intent on fixing our physical health delivery system that our mental health system has needed to take a back seat, but this can and must change. In order for our mental health system to fulfil its full potential we now need to tend to it and help it to become healthy, meaningful and fit for purpose. In order to achieve this, we need to get involved and use our voices and ideas to drive the debate and ensure that it's as all encompassing and inclusive as possible.

This book is not always an easy read; I struggled in places. The title, subtitle and graphics all helped to build my expectations of an easy-to-follow map, leading us to the ultimate, flawless mental health system. This expectation caused me a lot of frustration as I read, and, for a while, blocked the true message of the book. It's definitely worth persevering though, as the more I engaged with the subject matter, the more this book had to offer, and I'm quite sure it will keep on giving.

Leona Smith-Kerr is a person-centred counsellor

Weaving the cradle: facilitating groups to promote attunement and bonding between parents, their babies and toddlers

Monika Celebi (ed), Jessica Kingsley Publishers; £19.99



This is the first book on early years and family interventions that brings together so many different approaches and speaks both an academic as well as everyday language. Hence it is accessible to a wide readership, including parents. Celebi has edited the work of professionals whose backgrounds range from psychotherapy to outreach work focusing on groupwork with parents and children under five years old. The chapters describe the practice of 31 experts in the field, with emphasis on a combination of verbal and non-verbal interactive approaches that promote and strengthen the dyadic relationship between a baby/toddler and his or her parents.

Departing from the recent trends in early years work, the authors show no intention of giving 'good parenting' or being didactic. Rather, they show how depth therapeutic approaches (including video interaction guidance, dance movement psychotherapy, group analysis and mentalisation-based treatment) have the potential for drawing out the healthier relationships within families from difficult and/or vulnerable backgrounds. These potentials are released, in part, by paying attention to how the parents' history and emotional state can be perceived as having a direct influence on the baby.

Another of the book's achievements is that it brings to light the importance of locating inclusive psycho-educational groups in ordinary settings, such as healthcare baby clinics and children's centres. Culturally diverse approaches (eg the use of lullabies in languages other than English) and an actively non-stigmatising perspective on 'mental health' states (eg postnatal depression), coupled with playful and creative sessional work, are present in all the chapters. So, too, is the crucial importance of a preventative philosophy. Celebi has also given space to hear from professionals who support the work of other professionals, either via supervision or reflective method groups. This shows that, in order for early years professionals to offer viable services, they also need to be 'held' in some way.

The book is a great resource for counsellors, psychotherapists, social workers and other professionals, as well as for families with children under five years old. The chapters make it impossible to forget the sociocultural context in which such work is taking place these days – austerity, cuts, neoliberal indifference both to human distress and to the societal roots of such despair.

Sissy Lykou is a UKCP and ADMP registered integrative psychotherapist and dance movement psychotherapist
lykoucounselling.co.uk

Could you write a review?

We have the following titles for review in a future issue of *Private Practice*. If you would like to review one, email **privatepractice.editorial@bacp.co.uk** stating your preference and including your address and brief details of your areas of professional interest. Review guidelines will be sent out to reviewers by email on request. After publication of the review, the title is yours to keep.

Psychological therapies for survivors of torture: a human-rights approach with people seeking asylum
Jude Boyles (ed) (PCCS Books)

From Anxiety to Zoolander: notes on psychoanalysis
Anouchka Grose (Karnac Books)

Journey to release: counselling in a UK prison
Mo Smith and Toni Close (Waterside Press)

The art of the first session: making psychotherapy count from the start
Robert Taibbi (Norton)

Soulfulness: the marriage of shamanic and contemporary psychology
David England (Karnac Books)

Time line therapy and the basis of personality
Tad James and Wyatt Woodsmall (Crown House Publishing)

Psychoanalysis, the NHS and mental health work today
Alison Vaspe (ed) (Karnac Books)

Mastering the clinical conversation: language as intervention
Matthieu Villatte, Jennifer L Villatte and Steven C Hayes (Guilford)

Catch up on the latest news from BACP Private Practice

South London network group celebrates third birthday

It might have been overcast outside, but the attendees of the BACP Private Practice South London network group were all smiles as they met to celebrate the group's third-year anniversary on 28 July 2017. Following the usual format of a discussion on a themed topic, the meeting ended with a bring-and-share lunch and the obligatory birthday cake.

The group, which was founded in 2014, is facilitated by Hatice Ocal and Lesley Ludlow, both experienced counsellors in private practice in South London. Held every two months from its base in Brixton, the meetings regularly attract 40 counsellors. Fuelled by the group's interest and enthusiasm in sharing issues encountered in private practice, the group has gone from strength to strength by attracting consistent regular attendees. In the last year the group has explored topics including sex in the counselling room, sex and porn, ethics and the new BACP *Ethical Framework*, and understanding and working with difference.

VOLUNTEERS WANTED TO TRIAL OUTCOMES MONITORING SYSTEM

BACP is asking for expressions of interest from private practitioners who would like to be involved in a 12-month pilot trial of an online outcomes monitoring system. It is hoped that training will take place in early 2018, with a view to starting data collection in spring 2018. Contact **research@bacp.co.uk** for more information.

Annual conference

For the fourth year running, our annual conference sold out, with a total of 334 people attending the event in London. The event was broadcast live online to an additional audience of just over 1,200 people, and this number increases to 1,359 including bookings that have continued to come in during the on-demand service. Plans are already underway for the 2018 conference on the subject of loss, which will be held next September. The conference title is 'Loss: what does life mean for me now?' Watch out for further information in the next issue of the journal. To be sure of a place, you will need to sign up as soon as possible when booking opens around March 2018.

CHANGES TO THE EXECUTIVE COMMITTEE

Committee member Catherine O'Riordan has resigned from the BACP Private Practice Executive. A very experienced practitioner, Catherine joined the Executive early in 2017 and quickly brought her considerable knowledge to discussion on a range of topics. Catherine's input in particular to the regional network groups and to planning in terms of wider strategic intent for the division was much valued.

We will shortly be advertising for new Executive members. Look out for further information in the next issue of this journal.

Regional network groups

Regional network groups are held in a number of locations across the four nations and offer the chance to meet, network and share learning with other BACP Private Practice members in your area. Whether you are a regular attendee or are interested in finding out where the closest network meeting is to you, please visit **bacp.co.uk/events/network.php** for further information.

Dates for your diaries

Members are invited to attend forthcoming meetings in:

Nottingham on 6 January and 10 March
Birmingham on 12 January, 2 March and 20 April
Glasgow on 15 January and 23 March
Cheltenham on 18 January and 13 March
Ashford, Middlesex on 20 January
Ilford, Essex on 20 January and 21 April
Holloway, London on 25 January
Brixton, London on 26 January and 23 March
Peterborough on 5 February

For further information, visit **www.bacp.co.uk/events/network.php**

Letters

Special interest group?

I was delighted to have the opportunity to present a workshop on an aspect of working with bereavement for 75 delegates at the BACP Private Practice conference in September. Some years ago, I ran a 'working with bereavement' workshop at the BACP Counselling in the Workplace conference, with only nine delegates attending.

Historically, between 40–50 per cent of counsellors and psychotherapists listed in the BACP Directory named bereavement as an issue with which they work. In September 2017, 85 per cent of therapists listed within 20 miles of London in the BACP online directory state they work with bereavement.

It seems a reasonable assumption that BACP's private practitioner members deliver a significant proportion of emotional and psychological support to bereaved people across the UK. Yet there is no BACP special interest group for bereavement. And the voice of the independent practitioner is rarely heard in national bereavement policy forums.

Given that the complexity of many bereavement presentations is increasing, with an estimated four per cent of bereaved people in the UK experiencing complicated or prolonged grief, I believe it is high time to develop a special interest group focused on supporting bereaved clients. If anyone is interested in contributing to such a group, please contact me at **jonathanhartley@talk21.com**.

Don't go down online route

I have just joined BACP Private Practice and have received the journal. I just wanted to feed back how impressed I am with it. I have found the autumn issue very interesting and informative.

I note that Mervyn Wynne Jones writes, in 'From the Chair', that the journal, in hard copy, is guaranteed for at least 12 months. This concerned me, as the idea of transferring it to an online service would, I believe, be detrimental for all the current subscribers. In hard copy format you can read it in the car while waiting to pick up the children (which I did), in bed, in the park during lunch breaks etc. Going online would deny all these possibilities, as well as not having a tangible collection to refer to at any point.

People want a break from the screen or just haven't got time to log in separately but prefer the more casual usage in a tangible format. So, please, I am requesting in advance that *Private Practice* does not go down this route.

Thank you again for the journal!
Martin Bulpitt

Members of BACP Private Practice can place a free entry on the Bulletin Board under one of four headings: supervision, placements, research and not-for-profit networking groups. Email your wording (approximately 40 words) to **privatepractice.editorial@bacp.co.uk**. The deadline for the next issue is **30 December**.

BACP PRIVATE PRACTICE MISSION STATEMENT

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

The division has the following goals:

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

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

BACP PRIVATE PRACTICE EXECUTIVE CONTACTS

Chair:
Mervyn Wynne Jones
mervynwynnejones@ hotmail.com

Deputy Chair:
Lesley Ludlow
lesley.ludlow@counselling-in-croydon.co.uk

Finance Officer:
Rabina Akhtar
peterboroughcounsellor@gmail.com

Martin Hogg
mthogg@mac.com

Rima Sidhpara
rima.sidhpara@rhcp.org.uk

Susan Utting-Simon
s.uttingsimon@btinternet.com

Visit the divisional website at
www.bacppp.org.uk

RESEARCH

Seeking gay psychotherapists
Gay psychotherapist seeks other gay psychotherapists willing to share their story of being outed by a client during a therapy session, for master's research dissertation.
Contact: Alan
Tel: 07803 531132
research@talkingspace.co.uk

NETWORKING

Manchester
Monthly networking event for therapists. First Saturday of every month, 10am to 1pm. Connect, develop and grow your private practice. Costs £10 including refreshments. Near Old Trafford Cricket M16 0PQ. Excellent transport links and parking.
Contact: Elizabeth Farrow
Tel: 07832108546
liz.farrow.cpt@btinternet.com

SUPERVISION

Essex/Herts border
Supervision for individuals and groups. Twenty-three years' experience counselling in statutory, voluntary and private sectors, working with children, adults and couples; 14 years' experience as a supervisor.
Contact: Caroline Powell-Allen MA, MBACP (Snr Accred)
Tel: 01371 873270

Manchester/Cheshire
Looking for a supportive group for your private practice? Come and join us. We are looking for members to join both an open and a closed group.
Contact: Elizabeth Farrow
Tel: 07832 108546
liz.farrow.cpt@btinternet.com

Worcs/Warks/Glos/Herefordshire/South Birmingham
Experienced integrative psychotherapist, counsellor and supervisor in private practice offers supervision to individuals and groups from an integrative and psychodynamic approach.
Contact: Justine Barrett UKCP, MBACP (Accred)
Tel: 01386 792148
justine_barrett17@hotmail.com

Leeds/Pudsey
Experienced person-centred/integrative supervisor. Significant experience in safeguarding and working with sexual abuse.
Contact: Phil Mitchell
Tel: 07780 946568
phil@counsellingwithphil.co.uk
counsellorinleeds.co.uk/supervision/

BACP divisional journals

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

Healthcare Counselling and Psychotherapy Journal

This quarterly journal from BACP Healthcare is relevant to counsellors and psychotherapists working within healthcare settings.

Coaching Today

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

BACP Children & Young People

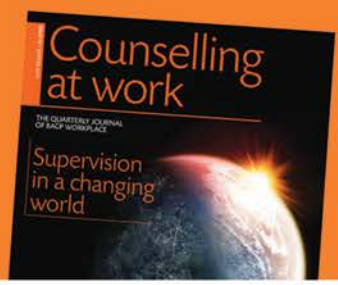
The journal of BACP Children & Young People is a useful resource for therapists and other professionals interested in the mental health of young people.

University & College Counselling

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

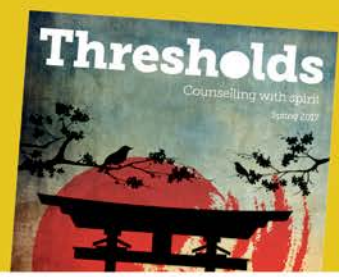
Counselling at Work

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



Thresholds

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



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