DECEMBER 2017 | VOLUME 28 | ISSUE 10

THERAPY TODAY

"Could this be my Jungian 'shadow' to my daytime role?"
Page 31

The voice of the counselling and psychotherapy profession

WHAT'S LOVE GOT TO DO WITH IT?

Why we need love in the counselling room

Understanding dissociative identity disorder // Right-brain thinking in supervision
Gender, sexuality and diversity // Groupwork with women who have complex emotional needs

There's a first time for everything, but sometimes in therapy you don't know what you'll be working with until you're well into it.

I have worked with two clients with dissociative identity disorder (DID). Neither knew they had it, and the first time, especially, I didn't realise until quite a few sessions in, when I noticed that my client had started using 'We' when most people would say 'I'. The second sign was that she would often pause to check a fact, as though consulting a partner... 'We first went there in 1985. No, we didn't, it was 86...'

It seems likely that many therapists will come across DID at some point. I know I would have leapt on the feature on page 26 back then, when I was rapidly supplementing my knowledge every which way I could. If there are features you would find helpful in *TT*, please do let us know.

Rachel Shattock Dawson
Consultant Editor

CHARLIE BEST

Editor's note

The media were full of it last month – the Church of England advising its primary schools to let a thousand tutus bloom if that is what children want to choose from the dressing-up box, regardless of their biological sex. A friend of mine wore a tutu to her 60th birthday party – her parents had refused to get her one when she was six, and she was making up for it. Our reasons for choosing a tutu (or superhero cape) are many and varied, and in an ideal world would carry no baggage. As the contributors to the news feature in this issue make clear, the problems around gender and sexual diversity are created by other people's attitudes and beliefs, and rigid ideas of social norms. Gender identity is no different to any other issue a client might bring: if the client is in distress, then explore that distress; if the client is questioning, then help them find their own answers to those questions. For some, that answer will be gender reassignment; others may be comfortable living with a non-binary identity. But this is not a niche area of specialist practice: gender, sexuality and relationships are fundamental aspects of all our lives; if counsellors and psychotherapists can't handle them, who can?

Another potential 'red flag' topic in the counselling room is love. Suzanne Keys unpacks the many forms that love can take – not just passionate (*eros*), but also unconditional (*agape*), parental (*storge*) and companionate (*philia*). To shut love out of the counselling room is to shut off a formidable source of healing, she writes. She quotes Dean Ornish: 'If love were a drug, it would be malpractice not to prescribe it.'

Catherine Jackson
Editor

'... an engaging read... thoughtful and well written... presented in a lively and attractive way'

THERAPY TODAY

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‘There is such a narrow line between support and rescuing.

That is why working as “partners” with as many parts of the client as possible is so crucial. The same applies to the relationship between the therapist and their supervisor(s).’

Remy Aquarone on the challenges of working with clients with dissociative identity disorder (p26)

GETTY IMAGES

On the cover

Love in counselling

Love is a powerful healer, so why are we afraid to let it into the counselling room?

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Here and now

The big issues

Regulars

Your association

bacp | counselling changes lives

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This is your journal. We want to hear from you. therapytoday@thinkpublishing.co.uk

In the news

Our monthly digest of news, updates and events

Public health plea

Counsellors and other practitioners on registers accredited by the Professional Standards Authority (PSA) could help tackle today's public health scourges, such as smoking and obesity, the Royal Society for Public Health (RSPH) says.

In a joint report with the PSA, the RSPH says that, with more support, the 80,000 practitioners on accredited registers (ARs), including counsellors, acupuncturists and sports therapists, could take on a greater public health role.

The report is based on a survey of more than 4,500 of these practitioners, which found that 89% considered their job role to include 'promoting the public's health', and 74% felt they could do more. Many said they were already supporting mental wellbeing (64%), signposting to healthy lifestyle services (36%) and advising on physical activity (29%).

Shirley Cramer CBE, Chief Executive of RSPH, said: 'We know that AR practitioners typically take a holistic approach to wellbeing, and develop long-term and trusted relationships with their patients, putting them in an ideal position to have lifestyle health conversations with them. We are calling for these practitioners to be given the right support, so that we can unleash their full potential to improve the public's health.' **bit.ly/2jqEBn9**

Crisis funding call

The Government will not fulfil its pledge to improve mental health services unless it puts more money into frontline care and ring-fences the mental health budget, BACP and 11 other leading mental health charities have said.

In an open letter published in *The Independent* last month, just before the Autumn Budget, BACP – along with UKCP, the British Psychoanalytic Council, the British Psychological Society, YoungMinds and seven other charities and professional bodies – calls on ministers to act urgently to stop the spiralling rise in mental ill health. 'The majority of children and adults with mental health issues are unable to get the help they need... With a government target for just 25% of adults with mental health issues to access talking therapies by 2020, parity of esteem remains very unlikely. For children... the 2020 mental health access target of just 35% still leaves the remaining 65% locked out of services... The crisis is here, the crisis is now,' the letter says.

The charities argue that the £1 billion extra that the Government says it is investing annually in the mental health services is not enough to fulfil Prime Minister Theresa May's pledge to transform the way mental health problems are dealt with 'right across society'. **bit.ly/2xbLQSD**

MPs to review child abuse impact

MPs are to carry out a review of the evidence linking adverse childhood experiences with long-term negative outcomes, and whether research findings are being fed back into policy-making. The House of Commons Science and Technology Select Committee will also look at the evidence base supporting interventions, and access to funding for research.

Liberal Democrat MP Norman Lamb, who chairs the committee, said: 'By truly understanding the effects of adverse childhood experiences, we may be better prepared here in the UK to prevent and treat mental health conditions, and reduce other problems associated with these experiences, including in education, employment and criminal justice.'

A new analysis of global mental health data has found clear links between childhood physical and sexual abuse, neglect and parental mental illness and a much higher vulnerability to PTSD in adulthood. The links are strongest in childhood, adolescence and early to middle adulthood, and lessen in later life. The paper, from the World Mental Health Organization, using data on more than 27,000 people from its worldwide mental health surveys, says heightened amygdala reactivity to threat may be a 'key pathway', as well as maladaptive regulation strategies and lack of social support.**bit.ly/2yBFqfG**

46.35% of parents say they have never talked to their children about mental health **bit.ly/2idMWXF**

22,456 ChildLine counselling sessions were delivered last year to suicidal young people

Therapy workforce 'in crisis'

Counsellors and psychotherapists are under-employed, underpaid and working under sometimes intolerable stress, a new survey suggests.

The www.survivingwork.org survey drew responses from 1,500 frontline mental health practitioners, including counsellors and psychotherapists. Respondents were asked about working conditions, salaries, management and development opportunities. Overall, the picture is one of job insecurity, poor working conditions, poor management and failure by services to use counsellors to their full potential, Elizabeth Cotton, founder of www.survivingwork.org and an academic at Middlesex University, said.

The results also reveal the growth of unwaged work across the NHS, IAPT services and the third sector, with some qualified practitioners doing 15 hours or more unpaid work, especially in the third sector. Nearly half the respondents employed in IAPT services (48%) said they were working below their qualification level, and 56% (compared with 35% of other mental health workers) raised concerns about client safety and the safety of their own working conditions.

'As a nation, we might be becoming obsessed with mental health, but the debate about the welfare of the people delivering those services is strikingly absent,' Cotton said. **www.survivingwork.org**

Better workplace mental health

Raising awareness of mental health in the workplace is increasing demand for counselling that may no longer be available, BACP warns.

Responding to a government-funded review of workplace mental health, BACP says it focuses too much on awareness-raising and too little on improving access to help for employees.

The review, *Thriving at Work*, led by Paul Farmer CBE, Chief Executive Officer at Mind, and former HBOS Chair Lord Dennis Stevenson, calls on all employers to sign up to six 'mental health core standards' for raising awareness and improving the management and monitoring of mental health in workplaces.

But Nicola Neath, Chair of BACP Workplace, said: 'Access to EAP and in-house counselling schemes is often much quicker than access to primary care mental health. The reality is that our members' services have faced cuts, but at the same time there is a growing demand.' **bit.ly/2h92fjY**

Regulation debate reopened

The Government has reopened the debate about the statutory regulation of counsellors and psychotherapists with the announcement of a wide-ranging consultation on the UK-wide health professions regulatory system.

There are currently 32 professions regulated by nine independent healthcare professional regulators, and 55 occupations covered by 24 accredited voluntary registers, including counselling and psychotherapy.

The Department of Health says the primary aims of 'Promoting professionalism, reforming regulation' are to improve public protection, and both to deal more effectively with misconduct by health professionals and better support their professionalism and standards, and quality of practice. Another aim is to explore ways to achieve more role flexibility between professions in the healthcare workforce.

Centrally, the consultation asks for views about which health professions should be subject to statutory regulation. It suggests the number of regulatory bodies could be cut to just three or four. It also suggests that government oversight of statutory regulation could be devolved to the four UK nations.

The consultation seeks responses from individuals as well as organisations and ends on 23 January. **bit.ly/2z1e0kf**

Trans guidance for CofE schools

New guidance from the Church of England (CofE) says children in its schools should be free to explore 'who they might be', without fear of being bullied or labelled.

The guidance, *Valuing All God's Children*, has gone to all 4,700 CofE schools. According to the Stonewall LGBT campaign group, 84% of trans young people and 61% of lesbian, gay and bisexual young people have self-harmed, and 45% of trans young people and 22% of lesbian, gay and bisexual young people have attempted suicide.

Nursery and primary school children should be able to 'choose the tutu, princess's tiara and heels and/or the firefighter's helmet, tool belt and superhero cloak without expectation or comment... They are in a 'trying on' stage of life, and not yet adult and so no labels need to be fixed.'

Secondary school pupils also should be able to 'try on identities for size' and 'explore who they are... whilst acknowledging that they may struggle and be confused along the way'. Schools should ensure their counsellors have training so they can support pupils going through crises around their sexuality or gender identity, the guidance says. **bit.ly/2yyR36I**

PHOTOGRAPHS : SHUTTERSTOCK

Putting gender on the agenda

At long last, the counselling professions are embracing gender diversity. **Catherine Jackson** reports

How often do you work with issues involving a client's gender and sexuality? Given that they are central to all our lives and at all ages, it has to be most days.

How well do you think you are equipped to deal with them?

Gender and sexuality are among the least well-covered topics in counselling and psychotherapy education and training, yet shrouded in lack of knowledge and misunderstanding. They are also very complex, and intersect with many other factors – age, class, race, culture and religion, as well as personal beliefs and experiences. It has taken a long time for modern medicine and UK law to recognise that difference does not mean disorder or dysfunction with respect to gender and sexual diversities. This is also true for the psy professions.

Last month, BACP, along with all the main psychotherapy and psychology professional bodies, took a further, significant step forward in recognising and righting this with the publication of a revised Memorandum of Understanding (MoU) that has been broadened to include gender identity.

The first MoU, published in January 2015, covered only sexual orientation, and was in response to the practice of conversion (or reparative) therapy – a faith-based model of counselling that sought to 'cure' homosexuality with psychological treatment, which the signatory bodies condemned as unethical and potentially harmful.

The revised MoU extends the ban on conversion therapy to include 'any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or gender identity, or seeks to suppress an individual's expression of sexual orientation or gender identity on that basis'.

It states that diversities in gender identity, like sexual orientation, are not 'disorders' requiring therapeutic intervention, and that counsellors and psychotherapists should ensure they are adequately trained and able to work without prejudice with all clients, regardless of how they identify themselves and their sexual practices and preferences.

Welcoming the MoU, Andrew Reeves, Chair of BACP, said: 'We believe in a society where everyone can express their sexual orientation or gender identity. Every individual should have access to non-judgmental therapy, whatever their sexual orientation or gender identity, and it should be provided by an informed practitioner, committed to delivering skilled and evidence-based therapy.' So far, so uncontroversial, surely? Did this even need spelling out when all the psy professions' codes of practice make it clear that there is no place for personal prejudice in the counselling room?

> 'It takes a decent amount of learning, reflection and experience... to get to the point where you can help clients navigate their gender, sexuality and relationships when the systems and structures around them are often toxic and oppressive'

Meg-John Barker, Senior Lecturer in Psychology at the Open University, therapist and activist-academic specialising in sex, gender and relationships, and author of the new BACP resource on Gender, Sexual and Relationship Diversity (GSRD), says yes: 'Unfortunately, we have a deeply troubling record when it comes to the experiences of GSRD-marginalised people with straight, cisgender therapists. Virtually every client I see, who has experienced therapy before, has stories of counsellors trying to change their sexuality or gender, asking invasive and inappropriate questions, expecting the client to provide free education, and/or implicitly or explicitly suggesting that there is something pathological in the client's gender, sexuality or relationships.'

There is, they* argue, a worrying vacuum of knowledge and confidence among psychotherapists and counsellors about gender identity, into which personal beliefs and prejudices can easily creep. 'Even if you are trying not to see it as a problem, unless you have really reflected on your assumptions in this area and done some CPD training, you may well implicitly give the client that message. We also have to recognise that clients may present their GSRD identity or experience as a problem when it is the wider culture that is actually the problem, not them. It takes a decent amount of learning, reflection and experience on the part of the counsellor to get to the point where you can help clients navigate their gender, sexuality and relationships when the systems and structures around them are often toxic and oppressive in relation to them.'

THEISPOT/DAN PAGE

Pamela Gawler-Wight agrees. A psychotherapist and director of training with BeeLeaf Institute for Contemporary Psychotherapy, she represented Pink Therapy on the working group that produced both MoUs. 'The revised memorandum moves the discussion up to a level of universal human rights and generic ethical principles. We have all been brought up with the belief that binary gender identity is the natural, the only. It isn't. We talk about self-actualisation as being everyone's need and right. If we want our clients to reach a satisfactory outcome, we need to offer safe therapeutic spaces where they can self-declare, without being pressurised, and for that to be a therapeutic process,' she says.

'The MoU simply asks therapists to be research-informed, to get educated and to understand their generic code of ethics. Ninety-eight per cent of practitioners really want to practise well in this, but they are scared to make a mistake and don't know where to get training and guidance. We all have limits to our practice, we have to admit that, and we all have a duty to get educated when there is a new paradigm of understanding in the world.'

Kris Black, integrative arts psychotherapist and counsellor, also represented Pink Therapy on the MoU group. Kris says the MoU is about social justice for marginalised groups: 'Trans and non-binary people in the profession wanted trans to be included in this MoU because it is the right thing to do, because lives are at stake, because minority stress kills, and because there are far too many ill-informed practitioners of all persuasions out there doing damage to young people and adults in the name of therapy and counselling. The MoU may not be perfect, but it represents a start in terms of enabling practitioners to understand the damage – real, not imagined – that they do when they attempt to "cure" us.'

The key message of the MoU is simply underlining ethical practice, Kris says: 'If you are not aware of this stuff, you are telling your clients they are not normal enough because they don't confirm to your idea of what is normal. You are denying them their autonomy. We have a duty to educate ourselves about difference and diversity, and a legal responsibility to think about how we are perpetuating discrimination in our therapy practice. Every person who walks in through the door is not us. You can't operate from the stance that you can only work with people like yourself.'

The MoU commits the signatory bodies to ensure that education and training standards and continuing professional development reflect its principles and equip practitioners to work with gender and sexuality issues. There has been criticism that little was done on this with respect for the first MoU. Kris says GSRD issues need to be embedded at all levels in the education and CPD of all counsellors and psychotherapists: this is not a bolt-on, niche area of practice. 'Mainstream training needs to listen. This is part of the spectrum of human existence.'

The new GSRD resource, published last month, is a strong start in BACP's work towards this, says Fiona Ballantine Dykes, BACP Head of Professional Standards. The current review of the Ethical Framework is also an ▶

opportunity to embed the MoU commitments in its best-practice principles. BACP is also reviewing its course accreditation standards: 'We are able to set standards for what we expect from a BACP-accredited course on how it covers gender diversity. We can't so easily influence other courses, but we can promulgate good practice,' she says.

Exploration

Reaching agreement on the wording of the revised MoU has not been easy; the MoU has provoked criticism that it is both too prohibitive and too affirmative. There are concerns that practitioners may avoid the issue when clients are questioning their gender identity or sexual orientation, lest they be accused of practising reparative therapy.

The revised text states: 'This [MoU] is not intended to deny, discourage or exclude those with uncertain feelings around sexuality or gender identity from seeking qualified and appropriate help... For people who are unhappy about their sexual orientation or their transgender status, there may be grounds for exploring therapeutic options to help them live more comfortably with it, reduce their distress and reach a greater degree of self-acceptance. Some people may benefit from the challenge of psychotherapy and counselling to help them manage dysphoria and to clarify their sense of themselves. Clients make healthy choices when they understand themselves better.'

Says Kris: 'If someone says they want to explore their gender identity, there's nothing in the MoU that shuts down that exploration. What the MoU is saying is that it's not your agenda, it's the client's agenda that matters here.'

'Of course, there is complexity here,' says Meg-John. 'When a client is culturally marginalised in relation to their GSRD, they may well implicitly or explicitly give the impression that they would like to change. This is where the concept of diversity is so important: normalising the fact that actually gender, sexuality and relationships exist on a spectrum, or multiple spectrums, rather than there being a better/normal or worse/abnormal place to be in relation to them.'

Meg-John hopes the new GSRD resource will be helpful here in explaining how counsellors might work with this diversity model. 'Another vital point is that pretty much everyone struggles with mental health and emotional issues relating to their gender, sexuality and relationships, regardless of whether they are marginalised or not. Instead of regarding these areas as only being relevant to those who are considered outside of the norm, we need to shift to addressing them with all clients.'

Children and young people

Work with children and young people who are questioning their gender identity is a particularly sensitive area; psychotherapists may find themselves positioned between a child who is grappling with gender dysphoria and their distressed parents, who are struggling to understand, while staying mindful that the child's mind, body and identity are still developing.

'If a child came into your consulting room and said, "I am a panda", you would say, "Hello Panda, tell me about being a panda". The key issue is what is distressing that child; if I refuse to accept a child's statement about themselves, I am ignoring that distress,' says Pamela. 'A little girl says, "I want to grow up and be a boy". So you ask, "What is it about being a boy that's so great?" "Because boys can be soldiers." When you start talking to them about it, you find that they think girls aren't allowed to be angry or physical. While we live in a gendered society, we are muddying the water. Gender expression is not simply about binary sex.'

> '... pretty much everyone struggles with mental health and emotional issues relating to their gender, sexuality and relationships, regardless of whether they are marginalised or not. Instead of regarding these areas as only being relevant to those who are considered outside of the norm, we need to shift to addressing them with all clients'

Child and adolescent psychotherapist Jeanine Connor says counsellors tend to be nervous about working with young people who are questioning their gender identity. 'I deal with it in the same way that I deal with anything. I am curious, I challenge, I question, I explore. It doesn't matter whether it's about gender or anything else. For some, it's an "Am I?" question and they want to work that out with someone who isn't going to be condemning or condoning. For others who are sure, it might be about how to deal with that in the wider world, at school or within their family. For others, it might be helping a family get a referral to a gender identity clinic.

'Families don't know where to go with this, even when they are supportive. They may have had a son for 15 years and now they have a daughter, and for them it's mind-blowing. I do my best to acknowledge how difficult it can be for them to support their child while managing their own feelings of confusion and loss.' She doesn't usually work directly with parents, and she worries that there is very little help out there for them, other than what is offered to those being seen at gender identity clinics. 'All I can do is acknowledge how difficult it is for them and tell them they might need their own support as well.'

Michelle Higgins is a school counsellor, working with children aged 11 to 16. She says gender and sexuality issues come up in her work all the time. 'On the whole, the young people don't have a problem with it. What they talk to me about is their difficulties with other people's attitudes – their parents, teachers, people of other generations

who are uncomfortable with it, who see it as "just a phase", or unacceptable. When they come to talk to me, it's not because they're confused; it's to figure things out: "I don't think I'm heterosexual, but I don't think I'm gay." My role is to listen to that uncertainty. If they are sure, then I let them know that I know that.

'What I hear in the room are their feelings of powerlessness, of being shut down, that their inner knowing is being dismissed, and the injustice of it. What I can do is work with them so they feel they have a little bit of power in this, so they can get their voice heard.' Work outside the counselling room can be an important part of that, raising awareness within the whole school community, she says.

Michelle feels young people today are having to manage evermore starkly polarised cultural and social expectations of masculinity and femininity, alongside, paradoxically, this greater acceptance of gender and sexual fluidity. 'Young women think that what it means to be a woman is to wear high heels and short skirts and lots of make-up, and for some girls this doesn't reflect who they think they are – does that mean they are not a woman? And it's the same for boys – what is it to be a man? Personally, I can understand how going down the route of gender reassignment might look to some of them as though it would solve everything. I believe that if schools and society in general were more accepting of young people exploring and expressing that trans journey, perhaps fewer would feel they needed to go all the way down the route of medication and reassignment.'

Watchful waiting

There are just eight NHS gender identity clinics in the UK, and one specialist Gender Identity Development Service (GIDS) for children and young people, run by the Tavistock & Portman NHS Foundation Trust, with clinics in London and Leeds. The service has received a big upsurge in referrals in recent years. In 2009/10 they had 967 referrals; in 2016/17 they had 2016.

'We are offering these young people the tools to help them to think about this big life change. We aim to help the young person go on living a life while they work out what sort of person they are'

The largest rise is among girls aged 13–18. Of 1302 referrals received in April to September this year, 905 identified their gender as female, and 387 as male, and 1041 were in this age group.

The issue of trans children has featured regularly in the national print and broadcast media lately, often in sensationalised reports of very young children being 'fast-tracked' towards surgical gender reassignment, against their parents' wishes.

Bernadette Wren, a consultant clinical psychologist based at the London clinic, says this is far from the case. Most referrals wait up to and over a year to be seen and, in most cases, after the initial assessment interviews, there will be a further long period of watchful waiting. During this, the child may take on their preferred gender identity, and may be prescribed hormone blockers, the effects of which are reversible. Cross-sex hormones – which will begin the physiological process of gender transition, but are partially reversible – will only be prescribed when they are 16, and they cannot progress to surgery until they are 18.

'We don't see ourselves moving to intervention as the main solution or treatment, even though this is something a lot of families and children expect,' Bernadette says. 'The state of knowledge is very patchy and we have an obligation to talk honestly to families about the effects – the impact on fertility, mood, growth and cognitive development – without being alarmist. We don't have long-term data on the effects of blockers during adolescence.'

There is increasing pressure from young people and families to move earlier to medical intervention, says Bernadette. 'Effectively, we have a gatekeeping role. The child is in great distress about their developing body, and the families hope that intervention will mitigate their distress to some degree, and the child will be able to continue with aspects of their life that have been put on hold. Early intervention makes sense in that respect. But we are aware that many young people, particularly in the younger age group, once they start on blockers, will stay on them, and continue on to cross-sex hormones at a later date. It's hard psychologically for them to come off and let the body develop.

'There is a lobby that says only a minority will regret it, and they have the right to make their own mistakes. But the NHS is a caring and paternalistic organisation; we don't want to just hold their hand while teenagers make their own mistakes. That would be to sidestep that gatekeeping role.

'Services like ours are often seen as either reparative or affirmative but I don't accept that. We are offering these young people the tools to help them to think about this big life change. We aim to help the young person go on living a life while they work out what sort of person they are. What we don't want is that they put their lives on hold until they have the body they want. Some people think we overemphasise the possibility that the young person might change their mind. We believe we should never lose sight of that possibility.' ■

The MoU can be downloaded from **bit.ly/2hqmGc3**

The BACP *Gender, Sexual and Relationship Diversity* resource is available at **www.bacp.co.uk/ethics/Resources/**

* 'They' is Meg-John and Kris's preferred pronoun

Catherine Jackson
is Editor of *Therapy Today*

The month

1.7 million people (and counting) from 85 countries have tweeted using the hashtag **#MeToo** in the biggest ever global conversation about sexual harassment and assault

Conference

Core emotions

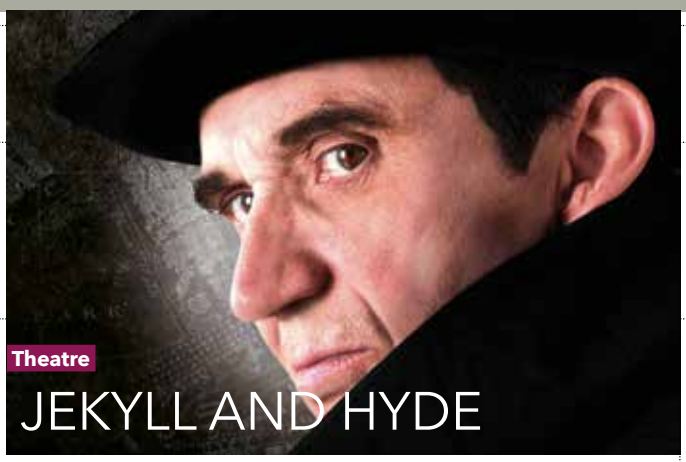
Catch if you can

Proving that all mammals share the same basic emotional system was the life work of neuroscientist Jaak Panksepp, who died earlier this year. He described the core emotional processes as seeking, rage, fear, lust, care, panic/grief and play. Two of his closest collaborators, Lucy Biven, co-author of *The Archaeology of the Mind*, and Professor Mark Solms, author of *The Brain and the Inner World*, explore the relevance of his work to psychotherapy, and how an understanding of the emotional states of our mammalian clients might guide our interventions. *Core Emotional Processes in the Mammalian Mind* is on 3 February, in London.
tinyurl.com/yavr9ttx

Theatre

Mental

'*Mental* is about the mind, my mum's mind, my mind, and your mind.' Inspired by his mother's experience of mental illness, Kane Power's one-man show delves into the complexities of a bipolar diagnosis. Winner of the first Mental Health Fringe Award, sponsored by the Mental Health Foundation at this year's Edinburgh Fringe Festival, the play tells a moving story about a son's relationship with his mother and what it is like to care for a parent while still a child. With storytelling, movement and original music played live, *Mental* is on tour from 22 January.
tinyurl.com/y9jssvsw



Theatre

JEKYLL AND HYDE

Robert Louis Stevenson was a few years ahead of Freud when it came to exploring split personality theories, with his creation of the characters Dr Jekyll and Mr Hyde. Could his gothic novel (published in 1886) also be about a fear of self? Dr Jekyll's fear, shame and hatred of his alter ego, Mr Hyde, amplify the problem until, unable to free himself of his shadow self, he takes his own life in desperation. If only he had been able to find a good psychoanalyst. Phil Daniels takes the lead role in a new, nerve-jangling production of *Dr Jekyll and Mr Hyde*, on tour from February.
tinyurl.com/y8rh3ul5

TOURING CONSORTIUM THEATRE COMPANY

Film

The Mask You Live In

The narrow view of masculinity imposed on boys from a young age has serious consequences. Boys are more likely than girls to be diagnosed with behaviour disorders, fail at school and commit acts of violence. This multi-award-winning US documentary, made in 2015, follows boys and young men in their struggles to be true to themselves. It looks at how implicit and explicit messages encourage boys to disconnect from emotions, objectify and degrade women and resolve conflicts through violence, with insightful commentary from a range of experts in neuroscience, psychotherapy, education and media. *The Mask You Live In* is available to download from online stores.
tinyurl.com/z6xqcg7

THE BRITISH LEGION

Know of an event that would interest *Therapy Today* readers?
Email media@thinkpublishing.co.uk

Exhibition

THE ART OF RECOVERY

Sculptor Al Johnson believes that developing creativity is central to recovery. As part of the Royal British Legion's Bravo 22 Company 'Recovery and Wellbeing Through The Arts' programme, she has worked with armed service personnel and their families to create an exhibition of life-size wire and mesh figures that communicate the experience of injury and its aftermath. The exhibition is accompanied by talks on the theme of post-traumatic stress disorder, including a discussion with Al on 6 January about the body language and symbolism of the work in the show. *The Art of Recovery* is at the Bethlem Museum of the Mind, Beckenham, Kent until 24 February.
tinyurl.com/yc4k97wr

Blog

Under pressure

The Twitter **#MeToo** campaign saw more than a million people tweet their own experiences in the wake of the Harvey Weinstein media exposé. But survivors of sexual harassment and assault should not be pressured to speak out, says Rape Crisis blogger Katie Russell. 'I've always been wary of insisting survivors "must" speak out, not least of all because Rape Crisis work is about supporting and empowering individuals to make the decisions and take the steps that feel right for them, not telling them what to do. And I refuse to draw distinctions between the "brave" who are willing to speak and the silent or anonymous survivors.' Read more at **tinyurl.com/y9s487tq**

Television

Tune in

Wanderlust

Is lifelong monogamy possible? Perhaps more to the point, is it actually desirable? A new BBC drama-in-the-making promises an insightful and funny exploration of how we build and maintain relationships. Scripted by award-winning playwright Nick Payne, *Wanderlust* will feature a therapist as one of the main characters, played by Toni Collette, and the first-ever screen presence of *Therapy Today*, which our eagle-eyed readers may spot in her consulting room. Watch this space for news on broadcast dates.

Television

Child remedy

Social isolation is one of the biggest problems for the elderly, and has a major impact on their emotional wellbeing. Channel 4, in partnership with Age UK, marks the festive season with a return to the *Old People's Home for 4 Year Olds*, a follow-up to the two-part series broadcast in August. The programme was inspired by an American scheme that brought together pensioners and a group of four-year-old children over a six-week period, to prove scientifically that contact with the younger generation can significantly improve mood, memory and mobility of these older care-home residents. The Christmas special *Old People's Home for 4 Year Olds* will air on Channel 4 during the Christmas holiday.

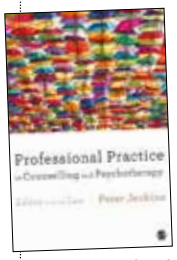
The month

Read a new book worth reviewing? Email reviews@thinkpublishing.co.uk

Reviews

Professional Practice in Counselling and Psychotherapy: ethics and the law

Peter Jenkins (Sage, £24.99)



Ethics underpins counselling and psychotherapy practice, hence the importance given to it by professional organisations, and yet it is a concept that many of us struggle to define. It could be argued that ethics is about what it means to be human. As therapists, we bring our values and identities with us when we work with clients. The main focus of this book is how we deal with this responsibility, especially as it relates to professional practice and the types of therapeutic work we offer.

Jenkins makes no apologies for the style being more textbook than discursive. Yet the book is not dry or didactic, as his explanations of complex legal information are always accessible.

Each chapter offers opportunities for the reader to reflect and exercises to complete – when, for example, exploring ethical dilemmas or when contracting with clients. For those wanting to know more, Jenkins signposts to further reading and gives links to relevant research.

The section dedicated to the organisation and delivery of talking therapies and the changes accelerated by IAPT is of particular interest. As it is becoming more usual for therapists to have a portfolio practice, this exploration of different ways of working and understanding issues such as confidentiality and safeguarding is invaluable in helping us to understand these complex issues from a variety of perspectives.

With its wealth of information, this book is sure to become an established counselling classic, both for those new to the profession and for the more established practitioner.

Wendy Lejeune is a counsellor and lecturer in counselling in Sheffield

Working Together in Clinical Supervision: a guide for supervisors and supervisees

Edward A Johnson (Momentum Press, £38.07)

Johnson is passionate about improving the quality of supervision, and his way of going about it is appealing. The book is written for supervisors and supervisees to work through together.

Each argument is backed up with research, and chapters end with questions to prompt honest assessments of the supervision by both parties. Johnson also offers helpful strategies for conflict reduction and resolution, should difficulties arise in the supervisor-supervisee relationship. I felt particularly informed by his analysis of the ways in which clients can be unwittingly harmed by poor therapists and supervisors, and how to evaluate inadequate supervision.

The major flaw for a UK readership is that the book assumes a US context, where supervision has a different role. There is also an implicit medical framework behind much of what the author writes.

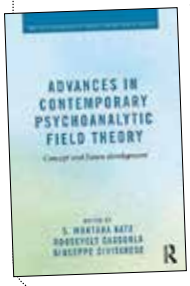
James Rye is a counsellor, psychotherapist, supervisor and trainer in King's Lynn

Advances in Contemporary Psychoanalytic Field Theory: concept and future development

S Montana Katz, Roosevelt Cassorla, Giuseppe Civitarese (Routledge, £34.99)

This edited collection gives a flavour of the range of theories developed by various schools of psychoanalysis on field theory. Most of the chapters focus on the analytic field – the space between therapist and client that is created by neither and is a third presence in the room, where change and analytical events happen.

Some theorists focus on the social aspects of the therapeutic relationship, while others delve into the client's unconscious and past. Others believe that a balanced mix of both is best. I particularly enjoyed the chapter by Cassorla on dreaming as a way of recreating what has happened in the client's past, and working through it with the therapist, who might also be in a dream state with the client during the session, and also outside sessions.

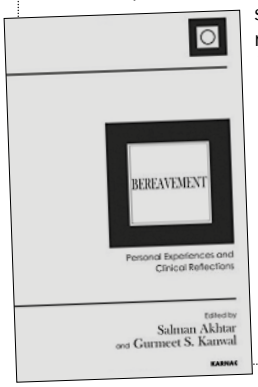


Karin Brauner is a bilingual counsellor in private practice in Brighton and Hove

Bereavement: personal experiences and clinical reflections

Salman Akhtar, Gurmeet S Kanwal (Karnac Books, £26.99)

After experiencing their own losses (death of a mother, father, spouse, sibling, child and pet), the authors enlist six analysts to tell the story of their grief. This sharing of painful experiences, clinical reflections and respective theoretical approaches offers valuable insights into how we cope with bereavement.



In the opening chapter, Akhtar gives a broad overview of the psychoanalytical understanding of normal grief and pathological responses to bereavement. He refers to Freud's early interpretation of mourning as a loss of libido, or life drive, and compares this with later theories proposed by Bowlby, Pollack, Parkes, Meyers, Volkan and others. In the final chapter, Kanwal writes about death itself, drawing from Hindu and Buddhist philosophy and reminding us of our ageless preoccupation with mortality.

Packed with rich research materials, this is essential reading for mental health professionals.

Vasanti G Deenoo MBACP is a counsellor

First lines

'Imagine, if you can, a world without email, Facebook and Twitter, where the word "Amazon", for most people, conjures up images of a tropical rainforest and an absolutely enormous river, and "google" is (if it is anything) the kind of thing that a pre-verbal infant might say to our amusement. Well, these were just some of the features of life in 1987.'

From *30 Years of Social Change*, edited by Stephen Jones (Jessica Kingsley Publishers, £7.99)

Previews

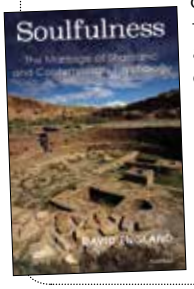
Therapeutic Touch: research, practice and ethics

Martin Rovers, Judith Malette, Manal Guirguis-Younger (eds) (University of Ottawa Press, £18.50)

This book weaves together scholarly evidence, research and clinical practice that support the importance of touch in human physical and emotional development. The contributors argue that not enough is taught in professional training about healthy, non-sexual touch, and that fear of contravening ethical boundaries is denying open and responsible discussion on the use of touch in therapy.

Soulfulness: the marriage of shamanic and contemporary psychology

David England (Karnac Book, £30.79)



This book brings together the wisdom of shamanism with the insights of contemporary psychology to provide an integrated approach to the treatment of trauma. The author presents shamanic theory and practice in a form that can be applied in mainstream psychotherapy, including an extensive explanation of shamanic psychology.

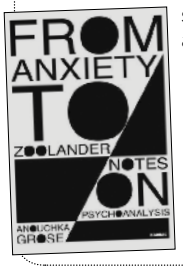
Our Encounters with Stalking

Dr Alex Grant, Helen Leigh-Phippard, Sam Taylor (eds) (PCCS Books, £20)

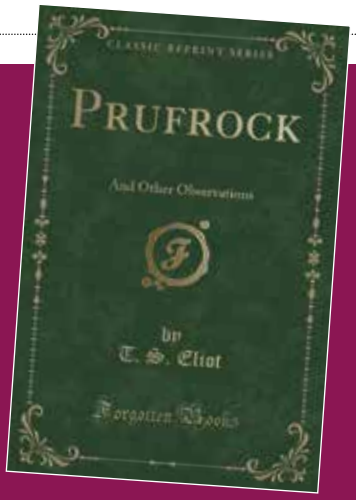
This is a powerful testimony of the destructive, sometimes fatal, effects of stalking on its victims. Alongside sections on the police, the law and court processes, the book foregrounds the narratives of those who have been (and are still being) stalked, offering a unique insight into the harrowing effects and commonalities of experience.

From Anxiety to Zoolander: notes on psychoanalysis

Anouchka Grose (Karnac Books, £26.99)



This is a collection of writings on psychoanalytic themes that were originally delivered as talks, and the book retains the informality of the spoken word. Freudian and Lacanian theories are central, but all areas of psychoanalytic thinking are up for discussion. Topics include acting out, narcissism, gender, transference, diagnosis and the Oedipus complex.



A book that shaped me

Prufrock and Other Observations
TS Eliot (Faber & Faber, £6.99)

When chatter substitutes for real dialogue, I'm reminded of this refrain from 'The Love Song of J Alfred Prufrock': 'In the room the women come and go/Talking of Michelangelo.' Prufrock exemplifies the paradox of the fear of isolation and the risk of exposure to others. In this poem, we flow with his stream of consciousness as insecurities course through his ordinary, unsatisfied life. As a therapist, I try not to be distracted by chatter, whether it is a client's constructed story or psychotherapeutic theory. We need to enter the undertow of our clients' experience if we hope to gain any sense of what it is to be them.

Simone Lee, existential psychotherapist

What book contributed to making you into the person you are?

Email a few sentences to reviews@thinkpublishing.co.uk

Letters

Send your letters to the Editor at therapytoday@thinkpublishing.co.uk

We very much welcome your views, but please try to keep your letters shorter than 500 words – and we may need to cut them sometimes, to fit in as many as we can

Proud to be a counsellor

Many things make me proud to be a counsellor ('10 reasons to feel good about being a counsellor today', October 2017) - the title itself immediately gave me the appetite to reply.

They include the ongoing professional development that followed in-depth theory in college, witnessing positive movement for the client, and the inclusive working relationship that promotes the shift away from determinism and closer to free will.

But the most prominent thing about being a counsellor, for me, is the acceptance that we show each other in this line of work, whether we are professionals or volunteers.

The many letters that get printed in *Therapy Today* or *Private Practice* show examples of this acceptance - disagreements relating to past articles get a fair hearing. If I have emailed someone about their article, I have received a reply, usually the day after.

Then there is supervision - support that upholds the health and safety of the client and also the counsellor, and the reflection of the client-counsellor relationship therein.

I continue to meet fellow students from our course. Even when there are disagreements, I feel the transference between us is, ultimately, positive. Why? Other than that we have our work in common, I believe it is because there is this sense of acceptance between us.

So, I wonder now what influences all this. Consciously, I feel proud to be a part of the profession: working with clients, useful supervision, friends who are also counsellors, and the things we have in common. I wonder if, unconsciously, we collectively take this standpoint into our practice - enough acceptance of the more difficult aspects of our practice, or, indeed, our lives, to go with our passions and continue to do some great work with our clients.

Robert Baker MBACP
Counsellor in private practice, working with addiction

"I continue to meet fellow students from our course. Even when there are disagreements, I feel the transference between us is, ultimately, positive. Why? Other than that we have our work in common, I believe it is because there is this sense of acceptance"

Cultural contrast

I felt Manu Bazzano was too self-critical in accusing himself of reading a Muslim client's urge to abandon faith and family 'according to [his] western frame' (Turning Point, October 2017). A homegrown Christian might have brought a very similar dilemma, or a western Buddhist might have couched its equivalent in terms of failing to 'abide in the present moment'. Where religious and spiritual crises are concerned, do we sometimes concede too much authority to the lenses of culture and ethnicity?

The degree to which our culture provides a life that adequately expresses truth seems a problem that might find resolution through an encounter with someone outside our cultural norms, which was maybe what this client sought.

Bazzano admits surprise when the client decided his former cultural norms were adequate after all, but did this really indicate the therapist's failure 'to suspend [his] own worldview'? I would suggest instead that, perhaps by providing a suspension of the client's cultural context, something genuinely transformational was able to occur.

Duncan Barford MBACP

Why shouldn't we be paid?

I found the 'Forty years of BACP' feature in your October issue fascinating. In her Editor's Note, Catherine Jackson wrote of 'the tensions between those seeking to make a living from the work and those following a sense of calling'. A similar tension seemed to be implied in the quotation from Val Potter in the feature itself: 'It was the view of some long-standing members that therapy should be free at the point of delivery to everyone. Younger counsellors felt their value and training should be recompensed financially.'

I found myself struggling with the implication that there is a contradiction between following a sense of vocation and the reality for most people of needing to earn a living.

Education and healthcare are free at the point of delivery in this country because, as a society, we have decided to use taxation to make them so. Teachers and doctors feel a sense of vocation, but we do not expect them to work for no financial recompense.

There are, unquestionably, issues at present around availability and affordability of counselling for those who need it. Personally, I work in private practice and also volunteer for a counselling charity, and I am happy that I am able to do this.

But I feel there is an important point about where we stand as an organisation on this issue. Our sense of calling means that many of us do volunteer post-qualification, but I do not feel that our agreement to work without pay should engender or imply a feeling of discomfort about our need to make a living.

In purely theoretical terms, the debate as to whether counselling is sufficiently affordable, or indeed, should even be completely free at point of delivery, can be held without an assumption that this should entail qualified counsellors working for no financial recompense.

Reflecting on the current reality, many of us do make the decision to volunteer, but we should not be made to feel that needing to make a living conflicts with our vocational belief in the value of this work and our desire to do it. I feel it is very important that the BACP supports its members on this point.

Emma Taylor MBACP

Informed choice

I am writing to highlight some of the thorny issues relating to our values as therapists and how these are sometimes in conflict with what we want to achieve as businessmen and businesswomen. How do we make ourselves 'attractive' and stand out in a crowded room without inadvertently falling foul of the temptation to inflate our image or promising more than we can really provide?

Often counsellors will say they have a certificate in a particular model (say, CBT) or disorder (say, eating disorders), when what they really have is a certificate of attendance. The certificate of attendance may represent something quite different – attending a one-day workshop, for example. This is quite different to attaining an academic certificate in a model that usually requires nine months of academic study. This is a large disparity. The implication of this is a possible misrepresentation of a counsellor's skills and ability. I call on all counsellors to divulge the number of hours of a training they have attended and/or use the correct term, certificate of attendance, so as to be more transparent for the client.

My second issue is about how counsellors present their clinical interests versus their expertise. I often see counsellors represented as having expertise in particular difficulties/disorders where an 'interest' would be a better description. I am a huge advocate for client choice, but the client must be fully informed, with no 'smoke and mirrors' to add to the already complicated and confusing landscape of therapeutic models.

Imagine Aileen goes to her local NHS psychology department and is diagnosed with PTSD. She is told there is a very long wait for treatment, so she decides to go privately. Aileen finds a counsellor who she likes the look of; the therapist's profile says she 'works with PTSD'. Aileen attends 20 sessions of person-centred counselling, at great cost, but her symptoms do not abate. What Aileen may not know is that the likelihood of her getting better using this approach is small, and that there are alternative approaches that are more effective in treating PTSD.

This example, although controversial, illustrates some of my experiences with clients who have received quite inappropriate therapy for their difficulties. Furthermore, PTSD can be maintained and exacerbated by particular therapeutic approaches.

I acknowledge that my perspective is heavily informed by the medical model, that there are alternative ways of healing to those the NICE guidelines recommend, and that there are counsellors and clients who do not share my perspective. However, this does not preclude the client's right to make an informed choice.

Sarah-Jane Butler MBACP (Accred), BABCP (Accred)

BACP responds

The points Sarah-Jane raises are very important. BACP is aware of the tensions and difficulties she describes and the importance of clients being able to make informed choices. BACP's current strategy includes the intention to articulate scope of practice linked to evidence-based research and associated competences. As Sarah-Jane says, this is difficult because of the differing views about what constitutes good evidence for particular interventions. However, in time, this could mean a clearer explanation of a practitioner's skills and interests as part of best practice.

Fiona Ballantine Dykes
BACP Head of Professional Standards

"I am a huge advocate for client choice, but the client must be fully informed, with no 'smoke and mirrors'"

Fifty years of counselling

As one of the original members of BAC, in 1977, I congratulate BACP on its 40th anniversary and on much that has been achieved in these 40 years. It was good to see a timeline of the key moments in its history in the October issue.

History-making is always open to the possibility of error, and I hope you will allow me to correct a couple of important mistakes about those early days. When BAC was inaugurated in 1977, two people were employed in the London office, neither of whose names, regretfully, can I remember, but they laid the foundations of the new organisation, and initiated a number of projects that I do remember well. The move to Rugby was the point at which Doreen Schofield was appointed, but not as administrator (that was Celia Sinfield), but as the second General Secretary, with Celia in particular (as Mary Godden remembers) being the other important member of staff.

So, when David Charles-Edwards was appointed in 1982, upon Doreen's marriage and move to Scotland, he took on the same role as she held, but with the new title of Executive Officer - technically perhaps the first, but actually the third person to hold that position.

Although BAC published its first *Directory of Training Courses* in 1984, it had by then already published several editions of a directory of individuals and organisations offering counselling.

I recount in greater detail many aspects of those early days, both before and after BAC, in my new book, to be published early next year, *Fifty Years of Counselling - my presenting past*. They were exciting times, which have largely been forgotten as those of us in at the beginning diminish in number. In that book, I try to convey something of that time for the majority of members of BACP who have trained and now practice in a very different world from those of us who were pioneers.

Michael Jacobs FBACP (Professor) ▶

> **Of the women clients I have worked with, a tiny handful have spoken up and still fewer have been believed**

Syrian refugee appeal

Prossy Kakooza's moving account about seeking counselling ('Treat us like people', October 2017) brought into sharp focus the impact of the asylum process on the mental health of people seeking international protection.

Currently, I am working as a therapist in a Refugee Council pilot project, with Syrian refugees re-settled via the Vulnerable Persons' Resettlement Scheme (VPRS) in South Yorkshire. Without exception, all of the people I have seen have experienced multiple losses during the conflict, which include witnessing the deaths of children/relatives and neighbours/community members. Most of my clients are in their 40s and 50s, and describe the agony of losing the lives they have built. They ask me how they can re-build at this age. They are desperate to bring their families to safety.

This is such important work and it is exciting to be in at the beginning of a project. The Refugee Council is looking for volunteer and sessional therapists who can offer a day a week to work with this group of refugees in projects in Hertfordshire and Sheffield. If you have a day to spare, please contact me at jude.boyles@refugeecouncil.org.uk or on 0114 3990802.

Jude Boyles MBACP (Snr Accred)
Psychological therapist, VPRS
Refugee Council Sheffield

Abuse, gender and power

It was at once heartening and disappointing to read Phil Mitchell's piece about men's experience of abuse ('Boys can be victims too', October 2017).

It is very important that we raise awareness of male victimhood and female perpetration. However, it's sad that, when this happens, it so often comes with a side-attack on feminist approaches to violence.

Mitchell states: 'What is common to all victims of CSE is not their age, ethnicity, disability or sexual orientation, but their powerless and vulnerability', and yet we know that powerlessness and vulnerability can be caused by those very things Mitchell lists. We know looked-after children are more vulnerable to abuse, children in general are more vulnerable than adults, disabled and neurodiverse people more vulnerable than able/neurotypical, etc.

Particularly absent from the discussion is the established research data that LGBT+ children experience higher levels of abuse than their straight counterparts. Around 50% of trans people, whether men, women or non-binary, experience childhood sexual abuse. In a society that stigmatises and marginalises gender non-conformity, and disbelieves or rejects the narratives of LGBT+ kids, it's not hard to imagine the reasons why predators target them.

Finally, Mitchell makes a bold and unsubstantiated claim that the figures suggesting women experience higher levels of abuse are false. And yet this imbalance holds over a number of different studies and methodologies, including anonymous self-reporting. As a practitioner, I can assure Mitchell that women also under-report, and that 15-year-old girls also cling to the idea that having adult 'boyfriends' is something special, and conceal the abusive nature of the relationship from themselves and others.

The myth that women and girls find it easy to speak up about abuse is particularly problematic. Of the women clients I have worked with, a tiny handful have spoken up and still fewer have been supported and believed. Having worked with both male, female and non-binary clients, I can confirm that much of what Mitchell reports is by no means specific to male victims, although of course there will be specific social narratives and dynamics in play for all diverse groups of people, and certainly dismantling our ideas around male power, invulnerability and masculinity is a feminist issue that ultimately will assist male victims.

Abuse is a multi-determined phenomenon and I agree we should take all victimisation equally seriously, as a disadvantage in and of itself that can lead to future inequalities. However, that does not excuse us from noting the many power differentials that enable abuse to happen, including misogyny. If we are not aware of these power differentials, how do we ensure they do not replicate themselves in the therapy room?

Sam Hope MBACP Accred
Therapist, trainer and supervisor specialising in trauma, oppression and abuse

Obituary: John Foskett

John Foskett died in July this year, aged 78. John was instrumental in founding the Association for Pastoral Care and Counselling, which evolved into BACP Spirituality, and was a former President of the division. He also played a major role in promoting pastoral care within BACP.

Tim Bond writes: 'I first met him when he was writing *Helping the Helpers* in the mid-1980s. In our discussions then and since, I was impressed by John's concern with the humanity of counsellors, in all our diversity, and how we can be supported as people emotionally and spiritually. He strove to ensure that this humanity was never eclipsed by expertise in different therapeutic approaches or the professional structures we were developing.

'I remember him as someone who drew people together, sometimes in unlikely combinations, and encouraged dialogue. I valued his intelligent observations about whatever were the current challenges faced by counselling and pastoral care. Above all, I remember him for his open-mindedness and personal warmth.'

An obituary, by John's son, Tim Foskett, was published in *The Guardian* (bit.ly/2AR4mRV), and will be republished in the winter issue of *Thresholds*, out next month, together with an archive article by John about the origins of the division. See www.bacpspirituality.co.uk

The heroine's journey

Diane Parker describes how she combines mind and body in her groupwork with women who have challenging behavioural and relational difficulties

TRINA DALZIEL/IKON IMAGES

I met Valerie when I was working in a community mental health service, managing and processing referrals. She was 42, had a history of eating disorders and depression, and had been referred to us by the local NHS Complex Depression, Anxiety and Trauma (CDAT) service. She had left her abusive partner three years earlier and was raising her teenage son on her own. A short-term programme of counselling was about to come to an end, and the CDAT team hoped we would be able to provide her with longer-term support.

I met a lot of women like Valerie while I was doing that job. They were approaching discharge from NHS mental health services, and they had been sent to us to provide them with some form of ongoing support in the community, such as low-cost counselling or a peer support group. We also saw an increasing number of self-referrals, not all of whom had used mental health services in the past. They all had histories of long-term mental health problems, including bipolar disorder, depression and anxiety, personality and relational difficulties, self-harming and self-sabotaging behaviours, including food, drug and alcohol abuse, and toxic or abusive intimate relationships, and many had multiple psychiatric hospital admissions. Alongside these considerable difficulties, they were struggling to hold down jobs, keep families together and navigate the mental health system. By the time they arrived at my door, they were often despairing, desperate, and bowed with shame and exhaustion.

As I listened to their stories, I felt increasingly frustrated; it seemed to me that a longer-term, more genuinely therapeutic solution was called for than those we had on offer. I was also frustrated because I felt I might be able to help.

> 'As I listened to their stories, I felt increasingly frustrated; it seemed to me that a longer-term, more genuinely therapeutic solution was called for than those we had on offer'

My own journey

I'm an experienced life coach and a qualified dance movement psychotherapist (DMP), with additional training and experience in group analysis and mentalisation-based treatment (MBT). In 2014, as part of my DMP training, I undertook a clinical placement with female inpatients at a medium secure forensic clinic[1] in order to research the therapeutic benefits of a creative, body and movement-based intervention for women who act out in violent and/or criminal ways towards themselves and/or others.[2] My clients had a range of diagnoses -

from schizophrenia to personality disorders, compounded by substance abuse and learning difficulties – and all had troubled histories of childhood abuse and trauma, leading to violent and challenging acting-out behaviour. I based my DMP intervention on Bateman and Fonagy's MBT model,[3] seeking to help my clients increase their capacity to think about their emotional states in relation to others. The creative, embodied, non-verbal aspect of DMP and the use of imagery and creative play gave these women a language to communicate their painful thoughts and feelings that they struggled to put into words. As this was a clinical placement, the group could only be a short-term (16-week) programme, and was offered alongside other interventions provided by the forensic psychologies and psychotherapies multidisciplinary team.

In 2015, I was commissioned by Spark Inside, a charity that provides life coaching to young people in prisons and young offenders institutions (YOIs) in London and the south east. The organisation has been providing coaching in the criminal justice system since 2012, and has gradually developed its own coaching model, based on client/stakeholder feedback and independent evaluation by The Social Investment Consultancy (TSIC). The model is a form of group coaching, delivered through a series of workshops, based on a monomyth, the Hero's Journey, identified and developed by mythologist Joseph Campbell.[4] The Hero's Journey is a basic narrative structure that has been adopted by countless filmmakers, screenwriters and storytellers. A hero goes on an adventure, encounters a decisive crisis, triumphs over this adversity, and comes home transformed by his experience. The model can ▶

be seen in numerous traditional and popular narratives, from ancient myths and legends to blockbuster movie franchises such as *Harry Potter* and *Star Wars* (it is rumoured that *Star Wars* creator George Lucas has a picture depicting the Hero's Journey hanging on the wall of his office). It is also commonly found in psychodrama, where archetypes and narrative are used to provide a structure for self-discovery and to explore, initiate and navigate change.

Alongside, all participants in the workshops are offered a one-to-one coaching relationship, as part of Spark Inside's 'through the gates' programme. This offers a more intensive, individual focus on the client's identified goals, and additional support to help them make the transition from custody back into the community.

I proposed to the community mental health team that I run a long-term, creative movement therapy group specifically for women. It would incorporate aspects of psychodynamic DMP, MBT and a narrative coaching approach, similar to the Hero's Journey model I used with the young men in prison. In effect, a Heroine's Journey. Inspired by the Margaret Murdock book of the same name,[5] I wanted to create a bespoke model that addressed women's issues around femininity, sexuality and relationships, and to provide a space where they could explore culturally sensitive issues and emotions traditionally seen as 'unfeminine', such as anger, jealousy and hatred, and their ambivalence around intimacy, family and mothering/being mothered.

I decided on the name 'Body Stories' to convey the embodied and creative focus of the group, while hinting at the narrative coaching element of the work. In August 2016, I began assessing potential clients and, a month later, the group was launched.

'... simply asking 'How does it feel to share this with the group?' can gently guide clients back into the here and now, and move them on'

MAKING LINKS AND MEANING

The session begins with a brief verbal 'check-in' and a summary of the previous week's session. Valerie says that she was angry with another group member, Jess, who arrived late to the session, but had been unable to voice how she felt at the time. This leads into a discussion about agreeing group boundaries and setting goals for today's session.

I then invite the group to connect with their bodies and to share a movement, sound or gesture with the other members that conveys how they are feeling. Each group participant takes turns to share her non-verbal check-in and other group members mirror each movement. Valerie slumps over in her chair, hangs her head and makes a retching noise as though she is vomiting. There is some giggling and a couple of the women empathise with Valerie: 'Oh god, I know how that feels.'

I gently suggest that they stay in the non-verbal, and introduce some grounding exercises, using visualisation techniques: 'Imagine with each out-breath that you are sending the breath down into the ground... feel the ground beneath your feet... explore your weight against the floor...'

As each group member finds her own movement process, I introduce music, and occasionally offer some verbal direction. I notice that many of the group members are in different places, physically and emotionally: for instance, Jess is in a high-energy state, bouncing her knees and swinging her arms playfully, while Valerie is curled up on the floor in a foetal position. I pick up on the common rhythms and motifs in the group and mirror these for the women as I move alongside them.

As the women continue to move, I suggest that they slowly open their focus to the room, notice how others are moving, and allow themselves to be influenced by others and make themselves available to others, while all the time modelling the shared rhythms and motifs. Gradually, as some sense of group cohesion builds, I direct the group towards an ending, and suggest we 'find an ending together'. The group dance ends with all of us on our knees, hands outstretched as though we are holding a giant beach ball between us. I ask, 'What have we created together, and what do we want to do with it now?' The women offer up words like 'precious' and 'sacred', and Valerie decides that she would like to 'drink' the object 'like an elixir'.

In the closing discussion, Valerie describes how difficult it was for her to leave her house to come to

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The heroine's journey

As the group draws primarily on my DMP practice, movement analysis methodologies such as Laban Movement Analysis (LMA) and the Kestenberg Movement Profile (KMP) provide the lens through which I see and understand my clients. DMP is based on the premise that how we move creatively, in relationship with others, gives us an insight into our internal world. However, my experience in forensic settings, together with my subsequent training, means my work is also heavily informed by MBT. MBT is primarily used in the treatment of borderline personality disorder (BPD),[3] but, given that BPD is related to difficulties with attachment in our formative years, MBT approaches can be useful for any clients who experience the spectrum of difficulties associated with BPD, including relational and behavioural issues. It has numerous applications, including with children and families, and in the treatment of depression, and it has been successfully incorporated into other approaches.[6] It is also a method that acknowledges the potential of the creative arts in helping clients to mentalise – that is, to develop a clear understanding of themselves and others. Use of creative arts in therapy helps slow down the process of mentalising

the session today; that she feels like a prisoner in her own home. I ask her what made her decide to join us, and she says she was able to recognise that her anger with Jess was irrational and that, if she missed the session, she would just be 'punishing' herself and 'cutting off my nose to spite my face'. She agrees this is a new development for her, and she also tells the group how her relationship with her son has changed: that she is less reactive with him now, and more forgiving and understanding.

I take the group's attention to the movement process they have just created and remind them of the 'precious, sacred' object we made together, and encourage them to make links with the relationships they form both in the group and outside it. Valerie, for example, began the session with a vomiting gesture, symbolising possible rejection and revulsion, but is able by the end to take in the 'nourishment' of the group. We finish by exploring what personal qualities they want to bring to the group (and by extension, into their relationships), and what they would like to take from the group into the following week.

by anchoring mental content in an externalised form, through movement, music or art-making. Mentalising is primarily an *imaginative* process, and essential to our wellbeing, but we can all experience failures in mentalising at times of high stress. According to the Institute for Creative Arts Psychotherapies: 'The arts have a unique role to play in enabling us to dive beneath the surface, to play and imagine ourselves and others with curiosity and compassion, to make the implicit explicit and the unconscious conscious.'[7]

In essence, MBT is a form of treatment that helps clients to make sense of their thoughts, beliefs, desires and feelings, and to link these to their actions and behaviours. I use it, not as the main focus of the group's work, but as a framework – a 'secure base' – from which I can play and explore, and to which I can return if I feel the group is losing direction. MBT practitioners adopt a state of curious empathy, openness and transparency. Asking questions or introducing movement interventions that enhance mentalising give group members space to think about their own emotional states, and those of others. This can be particularly useful when participants get 'lost' or 'stuck' in a repetitive pattern of behaviours and thinking dictated by painful memories or intrusive, unhelpful thoughts. Sometimes, simply asking 'How does it feel to share this with the group?' can gently guide clients back into the here and now, and move them on.

Both MBT and DMP are themselves integrated practices, the former drawing on psychodynamic psychotherapy, systemic, cognitive behaviour and social ecological therapies as an integrative framework, and the latter embracing elements of psychodynamic and body psychotherapies, and systemic, humanistic, creative arts and play therapies. Mapping the group model against the personal consultancy model of integrated practice developed by Popovic and Jinks[8] demonstrates how such an approach, combined with narrative coaching, offers flexibility, breadth and depth in terms of modalities, scope, timeline and approaches – between *being with* the client (authentic listening/supporting) and *doing with* the client (rebalancing/regenerating); from emphasis on internal change to external (behavioural) change, and from a focus on past to present and future. In group work, there is also an additional layer of focus, exploring the spectrum from freedom and autonomy (independence) to group cohesion and community (interdependence).

In the group setting, the use of creative, non-verbal communication, coupled with reflective and active discussion, helps the women access and explore feelings and memories that can be hard to put into words immediately. In addition to the movement medium, I bring to each session a range of audio music CDs, props for creative play such as balls, scarves and stretchy fabric, and colouring pens and paper.

Flexible focus

The shift between creative/reflective process and active discussion, and from past, present and future focus, can vary from week to week, and I use my judgment and intuition to sense where the participants are at any given time. When a new member is introduced to the group, for instance, it prompts much active discussion around group boundaries and agreements, and provides an opportunity for the group to work together to clarify goals. Energy tends to be high in these sessions, and I will work with the group to create more of a sense of 'groupness' and cohesion, through voice, rhythm, music and play.[9] At other times, ▶

perhaps when a member has left the group or is temporarily absent and the women are feeling vulnerable and energy is low, the focus will be on visualisation, reflection, movement, silence and stillness. At such times, I allow the women more time to explore their own feelings, while gently reminding them that they are still part of a group - the knowledge that their individual creative process is being witnessed can be incredibly healing and comforting.

Members can also shift the group into a more active discussion themselves, as when Valerie shares the story about her relationship with her son, and how she feels the group has helped her change her behaviour towards him. The women are also able to use verbal and non-verbal mirroring to 'check out' thoughts, feelings and perceptions with each other, and to get feedback from the group - which in turn enhances their mentalising capacities, their ability to understand their own mental and emotional states, and those of others.

This Heroine's Journey is more fluid, changeable and cyclical than the brief, very structured, three-part Hero's Journey model I use with the young men in prison. The women take many different journeys: journeys within journeys; journeys that can be completed within a single session or over the course of the following week; journeys that continue for the duration of their time with the group, and over their lifetime. Like the young men on the Hero's Journey, these women encounter tests and trials along the way as they follow both their individual and collective body stories (the group also being a 'body'). As they discover, through creating and sharing their stories, their 'reward' is less a clearly defined goal, achievement or acquisition than an internal sense of reconnection and a 'return home' to themselves and their essential feminine nature.[5] Jungian psychoanalyst and storyteller Camilla Pinkola Estes writes: 'Physical sensations and body memories are also stories which can be read and rendered into consciousness... The instruction found in story reassures us that the path has not run out but still leads women deeper... into their own knowing.'[10]

Future directions

Attendance at the group was patchy for the first three months, and the dropout rate was high. However, gradually, the group has attracted a dedicated core membership, which has given me the opportunity to learn lessons along the way and adapt my model.

'... their 'reward' is less a clearly defined goal, achievement or acquisition than an internal sense of reconnection'

These are:

- allow a longer assessment lead-in time before inviting the woman to join the group, and identify her goals earlier in the process
- offer group members the option of regular, one-to-one meetings, in order to identify and address any difficulties arising between participants and help clarify clients' goals - these should be less creative movement-oriented and more solution-focused in approach
- liaise regularly with participants' other group therapists and facilitators and one-to-one therapists, if possible, to avoid 'splitting'.

In this way, the model is moving closer to the MBT model of practice, where group and individual work is offered in combination, often by the same therapist. Regular one-to-one sessions will also enable me to pay attention to clients' individual narratives, and provide extra support as they prepare to leave the group.

Former Chair of BACP Coaching, Gill Fennings-Monkman, speaking at the inaugural Association for Integrated Coach-Therapist Professionals (AICTP) conference in January 2017, posed the question: 'Is integration conscious choice, common sense or natural evolution?'[11] I consider my own journey into integration to encompass all of these - a practice that has naturally evolved from my layers of training, experience and interest, that I have consciously chosen because it quite simply makes sense to bring all that I know and all that I am into my work in the service of my clients.

As my integrated practice continues to evolve, it is continually shaped by clients like Valerie, who, like the young men in prison taking their Hero's Journey, are connected by their humanity, their anger, pain and suffering, and their shared desire for a better and brighter future. ■

Diane Parker
About the author

Diane Parker is a coach, group facilitator and dance movement psychotherapist currently working in forensic and community mental health. She is a contributor to the *Forensic Arts Therapies Anthology of Practice and Research* and the editor of the BACP journal *Coaching Today*.

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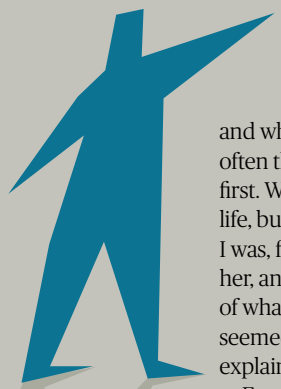
‘I now think that as soon as we think we have the answer and the client does not agree, the therapy is doomed’



Three times in 37 years I have sacked a client. There is not much discussion of this in the literature, and I felt very alone when it happened. Surely we have to be endlessly patient, and stick with the client? I believe it is very rare for a therapist to do anything else.

The first time, I was working with a young man who found relationships difficult. He said he wanted to have a girlfriend, but he always found a way of sabotaging any opportunities that came his way. We went through a long period of exploring how and why he did that. Gradually, he came to see that it was not something that happened to him, but something he did.

After a few months, he acquired a girlfriend, and I felt pleased for him. It seemed as though he had learned a lot about himself and how and why he did what he did, but we continued working together on other issues.

A year later, he told me his girlfriend had left him. I asked him what that made him feel. He shrugged and said, ‘Nothing much.’ After a few more questions, it became clear to me that he had almost no emotional response to the event.

I had been working with him for two years, and he had no emotional feelings about what, to me, was a big event in his life. I thought that if he was immune to therapy, there was no point in giving him more, so I gave him the boot.

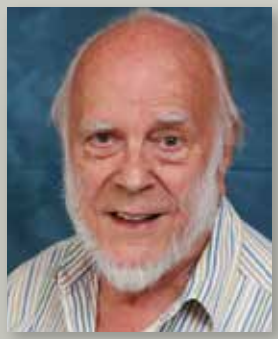
The second time was with a woman who loved two men. When she was with one, she often thought she preferred the other one, and when she was with the other, she often thought she really preferred the first. We did cover other issues in her life, but she kept coming back to this. I was, for a long time, patient with her, and we explored various aspects of what might be going on. There seemed to be nothing in her past to explain it, and I became a bit baffled.

Eventually, I realised that, for one reason or another, she was not willing to give up this pattern. We had a discussion about it, and she argued that she was working on it and could not give it up yet. This happened more than once. In the end, I got fed up, and told her I could not go on with it. She argued, but I stood firm.

Sometime later, I had a client who came with a very specific problem with his relationship with a woman of a different race. He invited her to his house, but she did not invite him to hers. He had a brother and liked to go out to a pub with him on Friday nights; she did not like pubs. There were other issues like this, but when they went on holiday together, there were no such problems. He showed no signs of changing what he did, and I became sure there was no exit from his problems unless he did so. I pointed out the impasse, but he did not move. In the end, I had to tell him to leave, and he was quite ready to do that.

I now think that as soon as we believe we have the answer and the client does not agree, the therapy is doomed.

Is it OK to sack a client? I still don’t know, but I thought it might be interesting to raise the issue. ■



About John

John Rowan has been a therapist since 1980, and is the author of several books, including *Ordinary Ecstasy*, *Healing the Male Psyche* and *Subpersonalities*. He lives in Chingford with his wife, Sue, and dog, James.

Holding the parts as one

Remy Aquarone, **Melanie Goodwin** and **Sue Richardson** explain
how to recognise and work with complex trauma and dissociation

This feature has been written collaboratively by an expert by experience and two therapists who work with dissociation. The partnership offers a model for practice and understanding in a field in which there are no real experts; the expertise resides with the lived experience of the survivors and the professionals who work with them. Although there is an increasing understanding of the connection between trauma-related dissociation and attachment issues, dissociative identity disorder (DID) and other dissociative conditions are still widely unrecognised. Unless they are identified and worked with as the primary condition, sustainable change is usually unlikely to be achieved, and harm may be done by working with the trauma too early. Our experience is that relevant training and supervision can equip counsellors to work safely with this group, which is important when there are so few experienced practitioners in this field.[1]

Attachment and dissociation

A good-enough attachment allows a child to develop the capacity for appropriate self-regulation through the ability to access their feelings, thoughts, sensations, perceptions and memories. A child who experiences enduring abuse will use dissociation to survive, so their feelings, thoughts, sensations, perceptions and memories become fragmented and separated from each other, and are stored, unprocessed, in the brain. When memories do surface, they do so in a raw state, as though the experience has just occurred.

In DID, these memories are held by a number of altered states, who experience themselves as separate identities, and often have different names, gender and experiences. This logical coping mechanism allows the child to continue an ordinary life that is uncontaminated by knowledge of the abuse, and it becomes the normal developmental pathway for their brain. This is invaluable while the abuse is ongoing, but often causes considerable distress when no longer required.

Advances in neuroscience support our understanding of the complex and often confusing presentation of these clients. The parts of the brain that deal with fight, flight and freeze responses are overdeveloped; the parts that calm, sooth and allow thoughtful self-regulation remain underdeveloped. Some clients present as though they are living with constant threat when this is no longer the case.

This developmental process of the brain leads to structural dissociation of the personality.[2] An adult/presenting part manages day-to-day life. This part often will have learnt many ways of 'fitting in' through watching and copying others, but lacks true coping capacity. Other parts hold aspects of the narrative of the trauma that the adult part may not recall. This can be confusing for the therapist, as the client may present with contrasting levels of functioning and shifting emotional states, and their narrative may not 'make sense' as it emerges in sessions. This can also lead to misdiagnosis, since the dissociative person will have the symptoms of many conditions, but present a full picture of none.

Identifying dissociation

Jane is a 37-year-old mother with two young children. She has been married 10 years. Before having children, Jane was a solicitor, regarded as a high-flyer, who worked long hours and rarely took holidays. Since then, she has been actively involved in her community, and is well liked and respected. She describes herself as an easy-going, kind, patient and empathic person, always willing to listen to other people's problems, but it is clear that she continues to live and work in overdrive. Her GP has diagnosed her as suffering from stress and referred her for counselling.

Jane comes to counselling with two issues: uncharacteristically, she is finding herself snapping at her family and friends, and her husband reports that she often now sleepwalks at night.

Jane has little memory of her childhood before the age of six, but has begun to be troubled by dreams and flashbacks of sexual abuse by an uncle figure – a friend of the family who took her to 'parties' attended by other men.

For the therapist, indications that Jane may be suffering from dissociation are her amnesia for a significant part of her childhood and how she presents in adult life, along with her emerging history of childhood trauma. Jane presents as articulate and thoughtful, but she is also very confused and upset. The therapist's primary focus will need to be on non-verbal clues and observations, such as involuntary body movements, interruptions mid-sentence in her conversation and, possibly, changes in her demeanour. These can be gently pointed out to her when they occur.

There are some simple screening tools that the therapist can use, such as the Dissociative Experiences Scale (DES, available

GETTY IMAGES

'The parts of the brain that deal with fight, flight and freeze responses are overdeveloped; the parts that calm, sooth and allow thoughtful self-regulation remain underdeveloped. Some clients present as though they are living with constant threat '

at www.dissociation.co.uk or www.isst-d.org). If the therapist prefers to use conversational approaches, they should focus their inquiry on information relevant to the key features of dissociation:

- Do you have problems with your memory or lose periods of time (amnesia)?
- Do you ever experience parts of your body as unreal or not belonging to you (derealisation)?
- Is there a struggle inside about who you really are (identity confusion)?
- Do you feel and act like different people at different times (identity alteration)?

Dissociation is about remaining hidden, so the therapist needs to take a proactive approach for it to emerge.

Next steps

With potentially dissociative clients, it's important not to focus on childhood trauma in the assessment stage, even when we know of it or can guess at it, and to gently steer away from it. Jane needs first to establish a good working relationship with the therapist, which will give her a safe base from which to develop ways of managing and containing her emerging memories. To focus on her potentially traumatic childhood history at this early stage risks destabilising her further. Instead, she needs help to develop coping strategies, other than overwork and over-availability to others, so she is able to calm and soothe herself. This may reduce the episodes of sleepwalking.

The therapist should explain their approach to Jane, and flag up the possibility that she may be dissociative. One way of doing this is to explain that some people have parts inside who behave differently to parts on the outside, and these inside parts may have a story to tell, but it is important to put the foundations in place so the outer parts can hear and cope with whatever the inner parts might have to say. Our aim from the start is to let the internalised emotional parts that carry the trauma from childhood know that they ▶

DID IS OUR REALITY

DID is our reality: there was never a time when I did not need to use this coping mechanism. My presenting adult parts are very able, and it can be hard for a therapist to grasp how superficial this coping capacity is with regard to many aspects of living. My brain shut down on my emotions at three. All I know, I gained through careful observation of other people's actions; the deeper, meaningful aspects of being human have been a mystery to me.

I had no real memories of childhood; memories would have been much too dangerous. The brain is an incredible organ, but once it has started to carefully store memories in separate compartments that are not connected to feelings, it becomes heavily invested in keeping the amnesic barriers firmly in place. Unfortunately, the brain applies this to all experiences, good and bad. The power of the unknown and unprocessed past greatly influenced how I lived my life, and had a profound effect on how I managed situations – which was often inappropriately, in an automatic, outdated reaction, with no reflection, as though I was still under threat.

DID is a developmental, organic process, not a learned coping mechanism that is only used when needed. It is an integral part of who I am, and this prevented me knowing that how I lived was not how other people manage their lives. It was the only way my brain had ever worked, so why should I question it?

I (the writer here) am one of the apparently normal parts, as described in the structural dissociation model.[1] I do not like this terminology, but I find it helpful in explaining DID to others. My abuse stopped at 16, and for the next 25 years I was in a safe, ordinary environment – married, with children, in a paid job, as well as running a business from home and active in my local community. I was operating like an efficient robot; feelings and tiredness never impinged on me.

At times in my life, I was anorexic, but this came and went quickly; obsessive compulsive disorder and depression were also often an issue, but again with no continuity. This was my 'normal', and others around me accepted it.

I sought help because I had become aware of constant suicidal thoughts, and feeling frightened. I had always fought the urge to take my own life, but it was simply an action I spent a lot of time trying to avoid. A trauma in my current life had permeated the amnesic barriers in my brain, allowing my fear feelings to connect for the first time with the action.

It took a DID-aware therapist four years to get me stabilised. My therapist's clear boundaries and ability to stay consistent allowed this, and was built on a healthy foundation of trust that included times of rupture and repair. He would tell me when he was feeling confused about what was happening, and did it in a way that allowed me to look at what might be going on without being silenced through shame.

We understood the therapist's need to get to know all our parts, and we learned how to communicate and cooperate. We felt that the reality and difficulty of the trauma was always acknowledged and all our roles were respected and heard.

For many years, including some when I was providing training on DID, our default position in the therapy room was an inability to connect with being DID. We were able to accept over time that we were many, but each of us felt so individual, it was hard to grasp the concept that we shared one body. Our therapist held us metaphorically as one, although it was far outside our comprehension. Now we appreciate the importance of his attunement to all of us, which enabled us to eventually accept each other and hold ourselves as a whole.

Melanie Goodwin

have a right to be heard, and that they have something important to say. This will be especially important when trying to help Jane understand her angry outbursts, which often represent some combination of internal parts who have different roles, as a protector or an internalised abuser.

A therapist's view

I still get a sinking feeling when encountering clients like Jane, despite all my experience with this client group. Her presentation indicates that she is likely to be dissociative, so I can expect her to be facing a long therapeutic journey, in which she may well recall childhood trauma she is currently unaware of. I need to ask myself if I am prepared to hear about experiences that, from the little I know of her history, may well be of an organised, sadistic nature. The challenges for the therapist of encountering this kind of abuse in a client have been explored with great courage and honesty in a previous issue of *Therapy Today*.[1]

At the same time, I know how difficult it would be to refer her on. There is little out there for people like Jane. So, to displace my ambivalence, I look to the creative dimension of forming a partnership with all parts of Jane and enter a territory where some parts will welcome my recognition of their plight and others will be fearful or hostile. Stabilisation is the first, and often the most difficult, phase. We will revisit it in a recursive loop throughout the therapy. Jane may well have no concept of safety or self-regulation beyond her existing coping strategies, which rely on dissociation. Parts of her that formed at different developmental stages will bring conflicting needs to the therapeutic relationship. Our partnership will not go smoothly.

I can expect crises, so I will be especially clear about the boundaries of my availability between sessions, including emails and texts. I will try to steer a course between supporting and strengthening the adult Jane, communicating to her other, often younger parts that they are also essential to our work together, and advising them not to push forward with too many traumatic memories too soon. My training and the received wisdom of stage-orientated treatment[3] can only take us so far; I need to draw on as many therapeutic modalities as I can, without being overcommitted to any. My main anchor is the working alliance I make with as many parts of

'... a capacity for exploration, curiosity and, above all, an attuned relationship will help us find a way through. Counsellors and therapists should take heart – you have something to offer'

Jane as possible. Here I am on home ground: a capacity for exploration, curiosity and, above all, an attuned relationship will help us find a way through. Counsellors and therapists should take heart - you have something to offer when someone like Jane walks through your door.
Sue Richardson

Supervising work with clients like Jane

Therapy with dissociative clients is probably the most challenging relational work a practitioner will ever encounter. At the core of this relationship is the need for these clients to form what may well be their first healthy attachment to another adult. It requires openness and honesty from the therapist and a clear, professional, boundaried awareness of appropriate responses.

My experience over many years as a supervisor is that the therapist's equivalent appropriate relationship with their supervisor is even more important than their working model. So many of the multidimensional projections from the client will interact with the therapist's own countertransference, because of the client's fragmented sense of self. I do not use the term 'projection' here in a negative way. Projections and our countertransference reactions are at the root of any change. After all, a newborn baby, in a good-enough environment, begins the journey of self-realisation by a somatic flood of projections onto the main caregiver, whose own positive countertransference reactions offer reassurance and physical comfort.

Many therapists work in isolation with such clients, often because no one else is willing or able to take them on, but also because they may well mirror the extreme isolation that many clients feel themselves. Often such clients have had repeated bad experiences with mental health professionals, and have been disbelieved or controlled.

As therapists, we are dealing with polarities: opposite emotional states that relate to different stages of development. The requirement to split off overwhelming experiences blocks emotional development and means that traumas are stored in an unprocessed form. So, things are experienced as either good or bad, and the client is either completely self-reliant or compliant, or shows a childlike need to be looked after forever. There will also be fluctuating moods that alternate between hyper- and hypo-arousal within this paradigm.

I have found that the biggest challenge for the therapist is not to become a rescuer, forever available to the client, or to assume that their client is functioning well because they are only seeing the outside part. There is such a narrow line between support and rescuing. That is why working as 'partners' with as many parts of the client as possible is so crucial. The same applies to the relationship between the therapist and their supervisor(s).

None of us, however experienced, are experts here: only the person living with their condition has the expert knowledge of what it's like for them and the challenges they face. As with the relationship between therapist and client, the relationship between therapist and supervisor is one of exploration. In my role as supervisor, I need to encourage the therapist to work with unprejudiced curiosity. Good-enough parents are forever encouragingly and enthusiastically surprised by their child's unique developmental journey towards gaining a sense of self; people who have experienced trauma and abuse of power while growing up have had all natural inquisitiveness extinguished from early on.
Remy Aquarone

Conclusion

Our shared conclusion is that acknowledging dissociation is both challenging and rewarding. Developing a sense of partnership with the client promotes positive outcomes, especially if the dissociation is recognised early in the process. ESTD UK provides networking and training that builds on therapists' transferable skills and knowledge, addresses feelings of deskilling and encourages them to find the confidence, courage and resources to engage with this client group. ■

About the authors

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Melanie Goodwin is a co-founder of First Person Plural, the dissociative identity disorders association, and has worked in a voluntary capacity for more than 20 years to raise an awareness and educate as many people as possible from all walks of life about the reality of living with DID.

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Remy Aquarone is an analytical psychotherapist and Director of the Pottergate Centre for Dissociation and Trauma. He is Past International Director of the International Society for the Study of Trauma & Dissociation and Past President of the European Society for Trauma and Dissociation. He works as consultant to a number of psychiatric services across the country.

Sue Richardson

Sue Richardson is a UKCP-registered psychotherapist in independent practice and a member of The John Bowlby Centre. She has over 30 years' experience in the helping professions, and a special interest in the study and treatment of dissociation.

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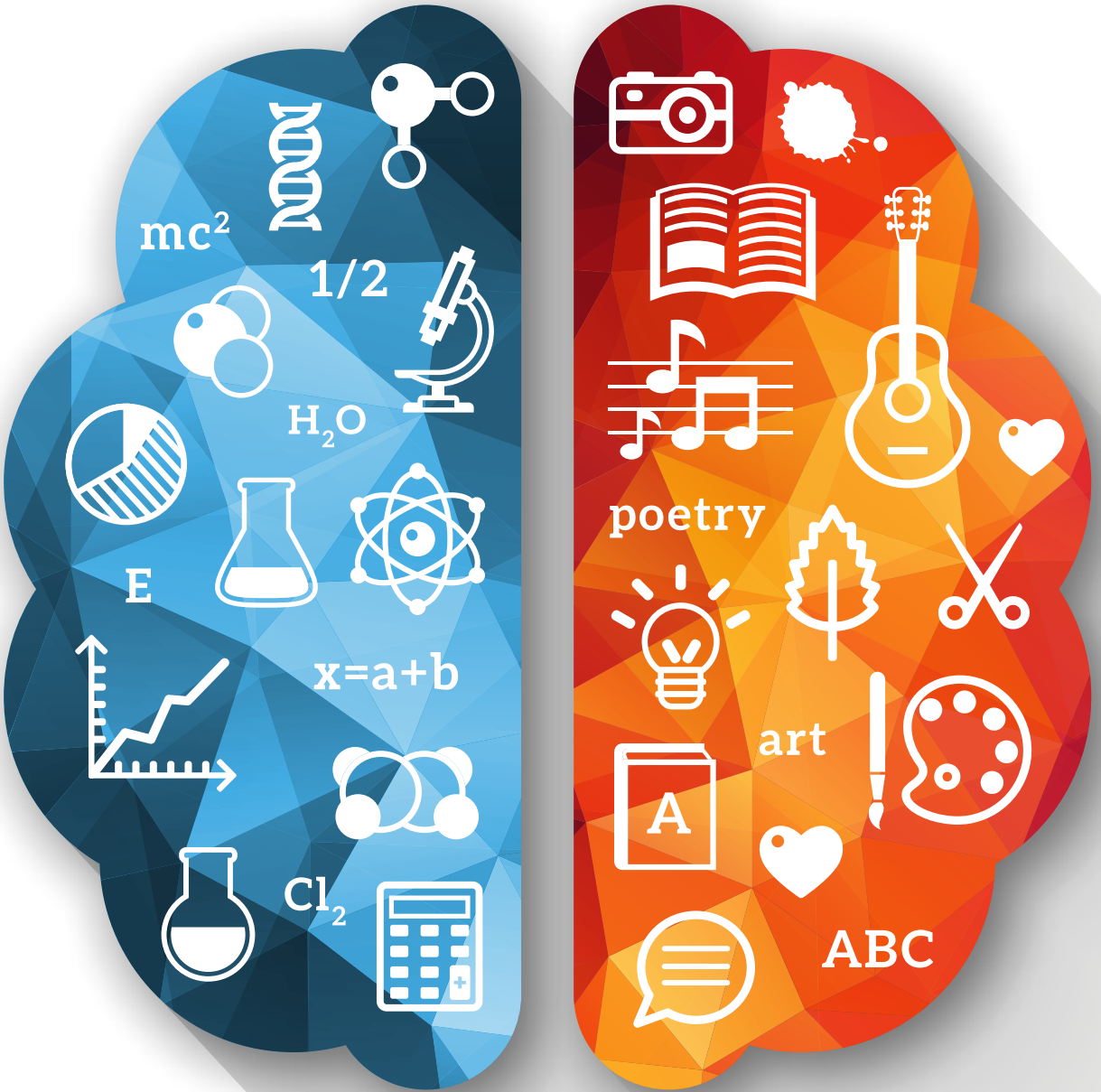
WE ARE IN THIS TOGETHER

Robin Shohet questions the growing dominance of the left brain in how we live and work



I was brought up in a very left-brained environment, but, even though I was very successful in that way of operating, I knew somewhere it (I) was not truthful. So, I gave up the comfort of left-brained chess, bridge and crosswords, in which I excelled, and plunged into the world of improvisation drama, where I felt lost, unimaginative and uncreative a lot of the time. A drug-induced temporary psychosis and a near-death experience both catapulted me out of my left brain, and gave me direct experience of something much vaster than the problem/solution paradigm that is its province. I believe most of us, at some point in our lives, have glimpsed this altered state, the territory of the right brain, which sees a bigger picture and is attuned to connection and relationship, but is not so easily talked about.

The purpose of this article is to look at how we who work in the counselling and related fields may have been influenced by the current left-brain dominance in the zeitgeist, which focuses on analysis, logic and separation, to the possible detriment of our freedom to be creative and imaginative, and to take risks.

Until recently, I would not have had the language to put this into words. But neuroscience is not only confirming many of the findings from the world of therapy, it is also showing us that, if either hemisphere is dominant, the whole suffers. And it seems that the left has the ability to override the right.

A word of caution: I could not write this without use of the left brain; it is essential to my and your functioning in the world. What I am suggesting is that the essential balance between left and right has shifted, so that, put very starkly, measurement and evidence are replacing creativity and relationship.

Left/right split

This left/right brain split has been described by Jill Bolte Taylor in her book *Stroke of Insight*.[1] She is a brain researcher (this is significant, as she was able to understand what was happening scientifically, as well as personally) who, at 37, had a major left-brain stroke. In her book, she describes what it was like to live from her right brain, feeling deeply connected to everyone and everything. Gradually, as she recovered, her left brain came back, and she realised that it fibbed and made things up, using strategies of comparisons, blame and judging, in order to survive. Because she had lived so long not in that place that society considers normal, she could firmly reject its fabrications.

Subsequently, I have read that the amygdala (our main survival set of neurons in the brain) is connected to the parietal lobes, to reinforce stories of separation.[2,3] A friend described this connection as a 'partnership in crime'. And where separation is emphasised, I believe there is more fear, which means we need to concoct stories, commonly called beliefs, to keep us feeling safe. This article will offer a structure that can help us safely dismantle some of the beliefs that no longer work for us.

Perhaps the most seminal text in this field is Iain McGilchrist's *The Master and His Emissary*.[4] McGilchrist recognises that both hemispheres have their place. Like Bolte Taylor, he sees the right brain as connected to the world, while the left brain stands aloof. Thus, as the left brain begins to have more and more influence, we move into a world that becomes increasingly bureaucratic and mechanistic, and devalues the essence of therapeutic work, which is rooted fundamentally in relationship and connection. We move into a world of measurement and audit: of manualised treatments, measurable outcomes and evidence-based practice, and, as is the way of the left brain, anything other is dismissed as unscientific and therefore invalid.

A more right-brained approach

I will give three very different examples of how, in my work, I move towards a right-brain approach. In the first, I use a form of inquiry to help dismantle predominantly left-brained beliefs or stories that do not work. The second, from group supervision, shows the potential when we do not work towards goals but stay with what is emerging. The third involves a more (in my view) integrated right-brain approach to accreditation.

1. Is that true?

As part of helping to demonstrate faulty left-brain survival thinking, I run workshops on fear and love in supervision. I tell people I believe (my core belief) that love is who we are and that it is covered over by fear. I ask people to share their fears and help normalise them (given that fear thrives on secrecy and is often fuelled by shame). I believe that much left-brain thinking, such as blame, comparisons and self-righteousness, is not recognised as fear but, on examination, can be traced back to it. I use the approach of Byron Katie,[5] a woman who became a spiritual teacher after she had an awakening that led her to question all her thoughts (www.thework.com). She asks four questions, the first being: 'Is that true?'

Because the left brain invents stories to keep the illusion of control, Katie dismantles the stories with that question (and others). People laugh when they realise they have been holding on to untrue stories and making themselves miserable. In the language of therapy, they could be called scripts – stories we tell ourselves.

As one way of going beyond these stories, I ask people to finish the following sentence, and write it down: 'What I would least like my supervisor to know about my work is...' I do not ask them to share their answers to this question, as I do not want them to self-censor.

Then I ask them to finish the next sentence: 'I would not want them to know because...' But this time I ask if they would be willing to share their completed second sentence with the whole group (they don't have to). Responses typically include: 'I wouldn't want my supervisor to think I was unprofessional', ▶

'Thus, as the left brain begins to have more and more influence, we move into a world that becomes increasingly bureaucratic and mechanistic, and devalues the essence of therapeutic work'

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or 'I would feel judged', or variations on the theme of 'They would think I wasn't good enough'.

I show how these thoughts, which come from fear, do not stand up to scrutiny, by asking, 'Is it true, you are unprofessional?' or, 'Are you in fact judging them?', or I normalise their feelings of inadequacy by asking if there is anyone in the room who has not felt this way about their work. I tell them, if they are really not good enough, they should not be practising, so why do they believe the voices in their head?

The reasons for not sharing these thoughts with their supervisor invariably turn out to be left-brain chatter, and I invite participants to challenge this faulty thinking. Very often, they look at what they have written and see it simply is not true and that they would be perfectly willing to share with their supervisor their answer to the first question. They have been held hostage by not challenging their own left-brain thinking. Frequently, they express huge relief.

2. Group supervision

My second example relates to group supervision. One of the supervisees is presenting a client, and I ask the rest of the group to pay attention to what is happening to them now – it could be a physical sensation, a thought, a fantasy, an image or a feeling. There is no right or wrong response; I just want them to notice. I urge them not to censor what they notice with thoughts like 'This can't be relevant', or 'This is not nice', or 'It might just be my stuff'. Typical responses might be, 'I am suddenly feeling very weary', or 'I switched off', or 'My heart is beating very fast', or 'I am feeling full of anxiety'. I describe the theory behind this way of working, based on the seven-eyed model of supervision;[6] my aim is for the group to begin to move into the here-and-now and not try to fix. In sport, we would describe this process as 'getting into the zone': we just sit and share without trying to work things out (left brain).

Very often, something magical happens that none of us could have predicted – there emerges a sense of knowing about the client, similar to what happens in constellation work. Even when nothing appears to be happening, the group allows the experience of apparent stuckness, and accepts that it could be an important part of the work.[7]

What I am wanting to convey is the experience of moving into a place of curiosity about what is arising in the moment, which is the province of the right brain, rather than fixing (the province of the left brain). So, for example, I am leading a two-day workshop on group supervision. One supervisee is sharing what is happening in their client work. I move us on, even though nothing has been resolved and it feels awkward. In fact, my co-leader challenges me afterwards, saying that it is important to leave people with a goal they can commit to. The next day, I reconvene the group to check on the impact of the previous day. The supervisee who was presenting says he woke up in the night, full of shame that we had finished without an apparent resolution, and feeling inadequate and a failure. Then, he says, it suddenly dawned on him that this was how his client was feeling: he had had a felt experience of his client's world. From having felt stuck with the client, he is now really looking forward to simply being with his client and seeing what emerges in the space between them.

This supervisee was generous and self-reflective; it may not always be that simple. My point is to show the potential in moving away from goals and action plans (left brain) to a place of letting things emerge (right brain). But, more than that, by sharing what is happening for them in the moment, without trying to make sense of it, the group starts to work together in a very profound way. Separation dissolves and we move into a shared space in the service of something bigger than us. We invoke right-brain thinking that transcends concerns about which intervention is best, how to fix this, what the correct procedure might be, which have become part of the current zeitgeist, perhaps influenced by a medical model of cure.

> 'What I am wanting to convey is the experience of moving into a place of curiosity about what is arising in the moment, which is the province of the right brain, rather than fixing (the province of the left brain)'

Ben-Shahar writes: 'In shamanic cultures, the self is first and foremost a community and only later an individual. In such cultures, illness is seen as an imbalance of the societal self. When a person is ill, the village elders thank him for carrying the symptom for the community and gather to discuss how to retrieve the communal balance.'[8] When the individual self is no longer placed centre-stage, we each become responsible and responsive to something more than our separate selves. The individualistic framework is so deeply embedded in us that we cannot really comprehend what it means to see a criminal as part of ourselves, and to thank the criminal, or the apparently insane, for taking that part of us. Nor, for that matter, can we inwardly appreciate our clients for carrying the stuck part of ourselves.

3. A community approach to accreditation

In the early 1990s, I helped organise two conferences to discuss the dynamics of accreditation, out of which grew the Independent Practitioners Network (IPN). Recognising that practitioner accountability is essential, the IPN devised a method whereby small groups of practitioners met to share their work. What makes this different from usual ways of operating is that, if there is a complaint against one individual in the group, it is seen as a complaint against the whole group. The individual is not isolated and the group takes collective responsibility. Moreover, a member of another group is present at each group's meetings, both to support and to challenge group norms and reduce the possibility of collusion. In this way, accreditation increases a sense of community and connection, rather than isolating out the individual, thereby reversing the predominantly left-brained sense of separation.

As part of the preparation for the conferences, we also tried a process whereby everyone spoke for a few minutes about their

love for their work and their clients. This was a forerunner of something called appreciative inquiry, which also runs along these lines and aims to look at strengths in a non-linear way.[9]

Beyond the individual

Counselling is, I believe, at risk of becoming absorbed into the dominant, left-brained zeitgeist of control, separation and fear. I am inviting us to question many of the assumptions we might take for granted. So, for example, I question the word 'emergency' when it is used. As long as it is not a matter of life or death in the moment, emergency is very often a fear-based concept that can be triggered by a need to avoid blame if something goes wrong. Can I simply sit with the anxiety of not knowing what to do for, say, someone who is a potential suicide risk, without thinking I should cover my back by reporting it?

I am running a day's training for clinical psychologists. It is the morning break, and one of the participants suggests we all go over to her department for coffee, as it is much nicer than the canteen. After the break, she does not return with us. When she does rejoin, 20 minutes later, I ask her why, and she says there was an emergency. She was told that a staff member was feeling suicidal, and she had to check that they were OK. I say I am puzzled: 'If we hadn't had the coffee break at your department, you would not have known this until the end of the day, so why was it an emergency?' She, and the group, say I am being very uncaring and rigid about time boundaries, and that I am punishing her. I ask her for her thoughts before she decided not to come back. She pauses, then begins to cry: 'Once people knew that I knew, I had to do something,' she says. I ask why. 'Because last time I didn't phone immediately, and she made a suicide attempt. If I had phoned her earlier, we would have known earlier.'

She and the group see how her checking on the staff member was not caring but a form of self-protection, a very understandable but unconscious fear response. There is great compassion in the room, where before there had been anger. We understand, and share examples of similar situations where we have acted to cover our backs. We move from separation to connection.

For those interested in a more right-brained approach, I would recommend the work of people like Byron Katie[5] and Eckhart Tolle,[10] who have seen past the personality to something much more vast. Both encourage us to dismantle our habituated, conditioned (left-brain) mind, having themselves had a personal experience of going beyond it. From this place of vastness, a different level of connecting and possible healing can emerge. The snag is there are no guarantees, but there aren't anyway; the zeitgeist is demanding certainty where none is possible.

> '... it can be very effective when two people or more sit together and... stay with what is in the moment. Most times, slower is faster, as the fear-based rush often means today's solutions become tomorrow's problems'

With a more right-brained approach, instead of asking how to fix a problem, we can ask: 'What part of me has the problem?' In this way, we move from a preoccupation with problems to seeing that the source of our suffering is that the mind believes its own stories: a move from ego to eco (connected to whole), as someone once said to me. Our connection to each other is so much more, and more immediately accessible, when we lead from the right brain, and neuroscience is beginning to show this.

I am not suggesting that we ignore the problems, but that we approach them with openness, believing that it can be very effective when two people or more sit together and, instead of rushing to fix, stay with what is in the moment. Most times, slower is faster, as the fear-based rush often means today's solutions become tomorrow's problems.

I will end with a story that illustrates, perhaps, the futility of seeking safety in continually raising the bar in terms of professional qualifications.

Long ago, somewhere in the Middle East, close to where the Tigris meets the Euphrates, there was a little village where the people were full of regret. It was their currency. 'If only we had built a road through our village, all the trade would have passed through and how wealthy we would be now.' 'If only we had planted wheat instead of rye, which now fetches a much higher price, how much wealthier we would be now.' And so on. So the elders decided they would bury the word 'if'. They dug deep and buried it well under the earth. They felt very satisfied, and were enjoying their celebration, when someone said, 'If only we had buried it deeper.' ■

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About the author

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Where is the love in counselling?

Suzanne Keys offers a framework within which love can be present, in all its forms, in the therapy relationship

People are taking to the streets with placards asking, 'Where is the love?' I want to ask it of our profession.

BACP Fellow Professor Brian Thorne wrote in 2005:[1] 'There can be few professions where loving and being loved and the experience of intimacy are part of daily life.' After 17 years of working as a counsellor in the largest sixth form college in London, I am thankful for this daily experience of loving. And yet love is very hard to talk about openly in a professional context without feeling embarrassed, fearful of being thought naïve, or worried about being misinterpreted and considered unethical. Love certainly doesn't feature in the list of competences required to work in the Further and Higher Education sector published recently by BACP.[2] Love doesn't have a place in a context where expert technicians deploy skills, make treatment plans and deliver interventions with measurable outcomes, based on goals and targets. Just when people all over the world are taking to the streets to ask 'Where is the love?', counselling, a therapeutic relationship permeated by love, is becoming more mechanised, dehumanised and instrumentalised.

It is time to listen to the people we work with: the people who come to us in distress

because they feel unlovable or they realise they have never been loved, and who also yearn to know themselves as capable of loving. Day in, day out, young people come to me, wanting what I understand to be elements of a loving relationship: to be listened to with respect, to be taken seriously, to be understood, to be cared about, to be genuinely related to. They want me to trust their experience, and to do that I need to be able to trust my own experiencing, not to be fearful that, if I don't follow the manual, I will be considered incompetent and unethical.

Of course, as a profession, we have to be aware that people do have harmful experiences in counselling, and we have to be ethically accountable, but the risk is that, by not talking about love, and by retreating from the person-to-person encounter, we are also harming our clients. Not talking about love won't stop abuse happening. In fact, if we cannot talk about the strong, intense feelings and sensations that are inevitable for both counsellor and client in the intimacy of a counselling relationship, it may perpetuate it. Maybe the strength of our feelings frightens us off talking about love, or maybe we don't want to enter into the unknown in the relationship, where we feel vulnerable and not in control. Maybe there are now so many counterfeit forms of love that it is too difficult to talk about it without misunderstanding. However, avoiding love won't make counselling safer. If anything, I believe it can lead to unethical and unprofessional practice. It is time to reclaim love as central to the counselling encounter.

A theory of love

I first started thinking about a theory of love in counselling when I was reviewing with a young client our two years of working together. He said: 'If you didn't have the love for me, you wouldn't do what you did.'[3] I was shocked by his use of the word 'love', as what I had been bringing repeatedly to supervision in relation to this client was my sense of inadequacy, confusion, frustration, powerlessness, exhaustion and stuckness. However, he started me thinking how showing up week after week, not giving up, being there and believing in our potential as human beings are crucial aspects of loving. Loving in therapy is not only about warmth, flow and close connection, but also about being committed to the process of relating, with all its disconnections. I also realised that love is not a thing to be given and received but, rather, an emergent property of the relationship. With this client, being politically aware of the context in which we were working and facing the challenges of our differences and the power dynamics in the relationship were also key to the loving. He was a 17-year-old, working-class, Muslim-British, entry-level male student with a disability, and I am a middle-aged, middle-class, Protestant-Irish, university-educated, able-bodied, female professional.

'Loving in therapy is not only about warmth, flow and close connection but also about being committed to the process of relating, with all its disconnections'

I have developed a taxonomy of loving in therapy in order to identify and articulate, without shame or embarrassment, what I experience with my clients, and what they say helps them to carry on. I want to be able to talk openly and usefully about love to colleagues and counsellors in training. I have based this taxonomy on Rogers' conditions for therapeutic change:[4] that two persons are in contact and enter each other's perceptual field, and that the client experiences the therapist's unconditional positive regard (UPR), empathy and congruence. These conditions, working together in a relationship, can create a climate of love that sustains growth.

My work has led me to dig deeper into these conditions, rather than seeing them as merely the first step to establishing a rapport or alliance with a client before intervening to bring about change for them, make them happier, fix them, or help them adjust to oppressive, unjust systems. I like the irony of pinning love down in boxes in order to free us from the boxes of instrumental and mechanised relationships.

The taxonomy (see page 37) has four columns based on UPR, contact and perception, empathy and congruence, and five rows representing five aspects of relating: psychological (our mental and emotional ways of relating); transpersonal (what is beyond me and you, here and now); physical (the experience of relating as two embodied human beings); political (the power dynamic of the relationship involving not only our relationships to self and other but also to our contexts), and ethical (the underpinning values and qualities). Where these columns and rows intersect are the emergent elements that define and allow us to articulate love in counselling relationships.

Unconditional positive regard: *agape*

In person-centred therapy theory, 'love' became UPR as a way to articulate the 'warm, positive' therapist feelings within a therapy relationship in a way that the psychology profession would find acceptable. Rogers[5] writes that this kind of loving is like the Greek concept of *agape* in the Judaeo-Christian tradition: a divine, generous, unconditional outpouring towards another.

The psychological aspect of this kind of loving would be altruistic, compassionate care for another human being, with no contractual requirement for a return on the investment – an economy based on abundance rather than scarcity.

The transpersonal would see the potentiality of the person, beyond what is present here and now: their Buddha nature or their divinity within. This loving acknowledges and accepts ourselves and the other with respect, awe and reverence for the utterly unique human beings we are. It affirms and confirms the other in their existence. Prayer, meditation, mindfulness and other disciplines enable therapists to develop their loving skills in UPR.

The physical manifestation of this kind of loving is tenderness, often experienced as irradiating heart warmth.

The political intersection is equality and diversity. We are all acceptable and of equal value as human beings, but also different, so need different treatment. Loving acceptance of a person as they are does not mean acceptance of the oppressive structures and behaviours that cause distress. This is not a passive, anything-goes kind of stance. As Martin Luther King wrote: '*Agape*... is an ▶

IMAGE: SUZANNE KEYS

entirely "neighbor-regarding concern for others", which discovers the neighbor in every man (sic) it meets... *Agape* is not a weak, passive love. It is love in action... *Agape* is a willingness to go to any length to restore community."[6] The ethical aspect of this kind of loving is humility: recognising and acknowledging the complexities of our human strengths and frailties.

'... *philia*, or empathy loving, can become manipulation and exploitation if it is not accompanied by *agape*, or unconditional positive regard love, where awe and respect for human beings are central'

Contact and perception: *storge*

Storge is a Greek word for parental love - the kind of love that characterised my relationship with the young client I described above.

The psychological aspect of this loving is attachment: being open to being contacted and perceived; the struggle to perceive each other and come into each other's perceptual field, and the process of connecting and disconnecting with another. It is the commitment to keep trying to come into contact with each other in spite of ambivalent, simultaneous feelings of wanting and not wanting, being separate and together, loving and hating, pulling and pushing. This is the 'counter' of encounter in the process of coming face to face.

Transpersonally, this kind of love is about interdependence, in that I am dependent on the other to know myself; I am helpless without the other. It is the South African term '*ubuntu*': I am because you are. It is about ecological awareness of our interdependence on the human and other-than-human for existence and survival. This loving requires belief that the struggle for contact is worth it, in spite of real, here-and-now, incomprehensible difficulties, conflicts and pain.

Physically, this aspect of loving is manifested in nurturance: acts of kindness that are often remembered by clients as powerful, therapeutic and nourishing moments.

The political aspect of *storge* is the acknowledgment of the mutuality of interdependence - each is changed by facing each other and by the struggle of the encounter. There is a powerlessness in dependency on the other and a powerfulness in being depended on that is different for therapist and client. We cannot avoid the politics of interdependence: by existing, we impact on human and other-than-human, whether we want to or not.

The ethical qualities of this kind of loving are the courage, perseverance and stamina needed to withstand the struggle of coming face to face, taking the risk of depending and being depended upon, and having the resilience to live with the powerlessness and helplessness of the unknown.

Empathy: *philia*

Philia is the Greek word for friendship or companionate love. In therapy, the psychological aspect of *philia* is accompaniment - a deep understanding of another's world, but alongside rather than in it, together but separate. Transpersonally, it is about what emerges in between - the co-creation of a unique relationship, a shared understanding and common purpose. I use the term 'communion' to describe this.

Philia manifests in resonance. Physically, we change each other through limbic attunement, altering each other's neural pathways as we tune in to each other.

Politically, *philia* is shown in solidarity - through knowing the world of the other and acting from that knowledge. This is demonstrated when, for example, we advocate for a client, or challenge oppressive, unequal systems, discrimination and prejudice that cause distress. Activism is fuelled by the energy created from being alongside someone.

The ethical aspect of *philia* is wisdom: knowing what I know and don't know, and using that knowledge with discernment to speak and act without harming the other. Wisdom is also about tuning into different ways of knowing: rational, intuitive, relational, and is based on lived experience, ethical frameworks and institutional policies.

Congruence: *eros*

Eros is the Greek word for passionate love and desire. The psychological aspect of this kind of relating is the desire for the right relationship: truthful relating with self, other and the world. It is a longing to belong, to find our 'fit' within the world. Most of my experiences in relationship are of incongruence, with a yearning for more congruence - a lusting for a fuller experience of the vitality of living.

Transpersonally, *eros* is a reaching out beyond self to other and a responding to the call of the other. Moments of congruence, or coming together, are moments of epiphany or flow, of feeling part of a life force. In Rogers' own words: '... it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present.'[7] Rogers refers to this as the formative tendency: '... an evolutionary tendency toward greater order, complexity, greater interrelatedness... as the individual moves... to a conscious awareness of the harmony and unity of the cosmic system, including humankind.'[7] Creative, playful, joyful, transformative energy is released at these deeply congruent moments.

Physically, *eros* in therapy is being aware of feeling attracted, or turned on, as sexual, embodied beings. For a therapist to deny or subceive this inevitable aspect of relating means to risk practising unethically. Acting on it also risks practising unethically. It is vitally important that we are able to be honest about *eros* in supervision and training so that abuse does not happen through our shame, fear or embarrassment about erotic desire and loving. Although there are external codes of practice that prohibit sexual touch between therapist and client, these are meaningless unless the therapist has their own, internalised ethical reasons for not acting on their sexual attraction. For me, because of the therapist's own, inevitably unresolved erotic life and process, and

because of the power imbalance inherent in the therapy relationship, acting on physical desire harms the therapeutic relationship and privileges one kind of loving over another.

Politically, *eros* describes the desire for right and truthful relationships with self, other and the world that leads to the desire for social and environmental justice. Finding your ecological niche, where you fit in the world, enables congruent, sustainable activism. Ethically, erotic loving needs the integrity of congruence between the inner, relational and ecological.

A love ethic

The erotic aspect of loving in therapy clearly demonstrates how unethical and abusive practice is located not in the love dynamic, but in the power dynamic. The lust for life of *eros* is not the same as a lust to possess, appropriate or dominate the other. These are all abuses of power, which may involve a lack of awareness on the part of the therapist of the inevitable asymmetry in their role-power. Likewise, *philia*, or empathy loving, can become manipulation and exploitation if it is not accompanied by *agape*, or unconditional positive regard love, where awe and respect for human beings are central. With empathy comes awareness and knowledge of the other, which calls for wisdom on the part of the therapist, in terms of discernment and an awareness of the powerfulness that comes with this knowledge.

The four aspects of loving I've outlined work together to maintain ethical therapy relationships. If, for example, I was talking to my supervisor about a relationship purely in terms of the erotic, I could helpfully ask myself where the other aspects of loving were in the relationship. Likewise, if there was no erotic there at all, I might be wondering whether, in fact, I was able to engage in a meaningful relationship with this client. I'm thinking of times when I've been depressed, yet carried on working, and, in retrospect, have realised my relationships with clients lacked the vital hope, joy and creative energy of *eros* loving.

Often my therapy relationships have a lot of the struggling kind of *storge* loving – the turning up and being there and not really knowing why, but having some faith that hanging in there is somehow worth it. Sometimes I experience huge tension between *agape* loving and *eros* loving: an open, receptive accepting alongside a yearning, wanting and longing for change. I am coming to see that it is these tensions, the interplay between these often-contradictory aspects of loving in therapy, that are at the heart of a love ethic in therapy relationships. So, there is the integrity of the truthful holding of tensions of *eros*, the courage in the struggle of contact of *storge*, the humility of the non-possessive *agape*, and the wisdom of the non-exploitative *philia*.

The most radical political and ethical impact of this multidimensional understanding of loving in therapy is that it is underpinned by an awareness of the interconnectedness and interdependence of human beings on each other and also on the animate and inanimate world of which they are a part. So, for example, erotic loving cannot be confined to a human dyad, as it is about transformative life force and energy, and desire for social and environmental justice; *storge* loving acknowledges our powerlessness to exist on our own, our inability to be self-sufficient and our struggles with our dependence, powerlessness and vulnerability; *agape* recognises difference and commonality, and *philia* is based on awareness of otherness and contextual knowing.

Having a framework to articulate a theory of loving in counselling relationships helps ensure the highest standards of professional accountability in a culture of suspicion and surveillance, where relationships are mechanised and manualised and therapist competences have to be quantifiable and measurable. As Dr Dean Ornish asserts, in his book *Love and Survival*, about the scientific basis for the healing power of intimacy: 'If love were a drug, it would be malpractice not to prescribe it.'[8] ■

A framework for love in therapy

DIMENSION OF LOVING	UPR (*AGAPE*)	CONTACT AND PERCEPTION (*STORGE*)	EMPATHY (*PHILIA*)	CONGRUENCE (*EROS*)
PSYCHOLOGICAL	Care	Attachment	Accompaniment	Desire
TRANSPERSONAL	Potentiality	Interdependence	Communion	Transformation
PHYSICAL	Warmth	Nurturance	Resonance	Attraction
POLITICAL	Equality and diversity	Mutuality	Solidarity	Justice
ETHICAL	Humility	Courage	Wisdom	Integrity

Suzanne Keys
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STIGMA, HOMEWORK, ADOPTION, DESPAIR

Liddy Carver highlights new research on topical issues

This month's Research into Practice reviews papers on medical students' perceptions of counselling, the usefulness of homework in psychodynamic therapy, the psychotherapeutic needs of looked-after and adopted children, and an exploration of the practices and methods used by existential therapists.

Medical students and counselling

Medical students like the idea of counselling, but tend to shy away from it themselves, unless they have had a positive experience in the past. The same could probably be said for many of us, but when these attitudes are influencing their willingness to refer patients on, and persist post-qualification, then the situation becomes more troubling.

A paper in *Behavioral Sciences*[1] reports that stigma is the most powerful barrier to medical students either using therapy or referring patients on for therapy. Even more concerning, this includes self-stigma: 'the social barrier of "... I don't wanna go and see a psychotherapist, I'm not crazy, I'm not that person"'.

Costas Constantinou and colleagues recruited 127 first- and second-year medical students enrolled on the St George's University of London Medical Programme at the University of Nicosia Medical School, and asked them to take a psychological help scale test. The results suggest that male and female medical students have equally positive attitudes towards psychotherapy, but white students are more positive towards counselling than mixed-race students. Constantinou and his team think this is probably due to differing cultural perceptions of the use and effectiveness of psychotherapy.

Next, the researchers asked 12 medical students to complete in-depth interview questionnaires. Questions included: 'What comes to mind when you think about psychotherapy?'; 'At what point would you personally consider seeking psychotherapy for yourself?' and 'What would prevent you from referring a patient for psychotherapy?' In response to the first, participants who had experience of therapy used words such as 'great', 'wonderful', and 'powerful'; participants who had not could only manage 'helpful', 'useful' and 'treatment tool'. These medical students were also concerned about affordability issues.

As the researchers note, medical students' unwillingness to either use psychotherapy themselves or refer patients for it kicked in 'when the perceived stigma outweighs the perceived benefits and outcomes'. Taken as a whole, these findings underline how important it is to provide medical students with further education about and exposure to the positive effects of psychotherapy, the researchers conclude, both for their patients and for themselves.

Have you done your homework?

Homework is often associated with cognitive behavioural therapy (CBT). But what about its use in other therapeutic approaches? A paper in the *Journal of Psychotherapy Integration*[2] describes three case studies reporting the impact of assimilating 'between-session activities', or 'homework', into psychodynamic-interpersonal therapy for depression.

The paper refers to the extensive literature demonstrating that homework activities can be useful. As well as making recommendations, therapists can tailor their interventions in collaboration with clients, or encourage clients to suggest therapeutic alternatives that they feel happier with.

The therapists involved in the case studies were three advanced doctoral students. Their three European-American clients (one male and two female) had all been diagnosed with major depressive disorder (MDD), with a score of 21 or greater on the Beck Depression Inventory (BDI). One of the therapists viewed every session in its entirety, while each therapist collaborated with their own clients, negotiating meaning, making use of evocative metaphors and inviting correction of misunderstandings.

The therapists all followed a treatment manual for the integration of homework into a psychodynamic model. Following treatment, all three clients' scores dropped below the threshold for MDD. Client 1's score went from 21 (moderate) pre-treatment to 13 (mild) by session 16 (the last session). Client 2 went from 28 (moderate) to two (minimal) by the last session. Only client 3's improvement, from 31 (severe) to 26 (moderate), remained below the 'functioning' threshold on the BDI.

The authors acknowledge that failure to complete systematic ratings or have observers rate the therapists' adherence to the treatment model are limitations in these studies. Yet clients and therapists viewed the homework activities as highly relevant to the therapy process. Nelson and Castonguay conclude that homework is a useful adjunct: 'Psychodynamic practitioners working with clients who seem to be having difficulty translating awareness or insight gained in session into changes outside of session... may find it especially helpful to incorporate [such] activities into their work.'

Looked-after and adopted children

Children who are adopted or grow up in local authority care or in a family in crisis have some of the most complex emotional and

'... stigma is the most powerful barrier to medical students either using therapy or referring patients on for therapy'

behavioural problems. This paper, reported in the *Journal of Child Psychotherapy*,[3] provides powerful arguments for providing more support to them and the professional and informal carer network around them, including foster carers and adoptive parents.

In the first survey of its kind, Fiona Robinson, Patrick Luyten and Nick Midgley argue that child psychotherapy is 'an appropriate and suitable approach for addressing the depth of many of these children's difficulties, particularly in comparison to other treatment approaches'.

The challenge was to nail down exactly how beneficial long-term, often intensive psychotherapeutic work with these children is. But, given that organisational and resource constraints sometimes make long-term work impossible, the research also sought to find out if short-term therapy could be detrimental to the most vulnerable of these children.

The study sample were members of the Association of Child Psychotherapists, who were surveyed about their working practices with looked-after and adopted children (LAAC). The survey received 215 responses (24.5% of the membership) from around the UK. Most worked in NHS CAMHS services, 81% were qualified child psychotherapists, and 88% currently worked with LAAC in a wide variety of roles, from assessment to education and training of other professionals.

Direct psychotherapy threw up attachment-related issues (72.1%), and the impact of trauma or maltreatment (70.2%). Even with long-term, one-to-one therapy, 'the level of difficulty that these children present as a consequence of early neglect and abuse takes a great deal of time to shift'. By building rapport, the child can, however, 'learn gradually that the adult does not want to exploit or hurt the child'. Consultation, which provides a useful framework for professionals, is poorly resourced. Surprisingly, research and evaluation, which might bring in funding, were only undertaken by 26% of respondents.

From these accounts, child psychotherapists' work with LAACs is likely to remain under-resourced and, at times, under-valued by services and commissioners, the research team concludes. Organisations probably need to be mindful that children with complex difficulties (and their carers/support networks) will need a range of therapeutic solutions, which might well be short term, reflecting organisational pressures. But at no point should they be a 'last resort'.

> 'Even with long-term, one-to-one therapy, "the level of difficulty that these children present... takes a great deal of time to shift"'

What is existential psychotherapy?

Existential psychotherapy has been practised for almost 100 years, yet only now has an international survey been conducted into existential phenomenological practices and methods.

In a paper in *The Humanistic Psychologist*,[4] Edgar Correia and colleagues report a survey of 971 existential practitioners from 46 countries, with different theoretical and cultural backgrounds. More than 90% of their sample (n=883) had, or were having existential/existentially informed training at 239 institutions worldwide. Participants could be grouped into five distinct categories. First, there were those (n=497) who adopted phenomenological practices considered fundamental to existential and existentialist practice, which included 'authentic and open engagement with each client, without medicalising and pathologising their experience'.

The second category were methods associated with specific existential branches, comprising 'logotherapy' and 'Sartrean-based therapy methods', which might help clients 'to select their purpose and meaning of life'. The third category comprised practices informed by existential assumptions, including 'addressing the existential givens' - freedom, choice and responsibility - and the client's worldview.

In the fourth category, Relational practices, the focus was on 'relational stance', 'addressing what is happening in the therapeutic relation', and 'person-centred related attitudes' of empathy and equal power. Finally, practices from other therapeutic paradigms included 'experiential and body practices' (focusing), 'deepening awareness' (mindfulness), 'interactive interventions' (challenges) and 'directive interventions' (psychological evaluation).

Coreia and colleagues conclude that 'phenomenology, existential assumptions, logotherapy, and existential analysis's specific methods, relational practices [and] techniques and practices from other therapies... define the core constitutional practices of existential therapies'.

Existential crises can wreak havoc on the wellbeing of those who ask, 'Is this all there is?' This study opens new avenues for research into the applicability and effectiveness of existential practices to guide those seeking to help clients work their way through these powerful feelings. ■

Liddy Carver
About the author

Liddy Carver is a BACP-accredited counsellor. She works as a counselling educator at Wrexham Glyndwr University, volunteers at a student counselling service, and is Managing Editor of *Counselling and Psychotherapy Research*.

Get in touch
If you would like to suggest papers for these pages, please email Liddy Carver at research@thinkpublishing.co.uk

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THIS MONTH'S DILEMMA:

My neighbour could be my client's abuser

Mei, a counsellor in the NHS, is working with a young man, Micha, who is presenting for counselling to help him deal with issues relating to his sexual abuse by a sibling, seven years his senior, from age seven to 11.

Micha does not disclose the name of his abuser, but, on the basis of other identifying details, after the second session, Mei suspects it is his sister, who happens to be her neighbour, with whom she is on friendly terms and who volunteers with the Brownies and has provided childcare for Mei's own sister-in-law.

Before the third session, and having discussed this with her supervisor, Mei decides to tell Micha she knows his sister and knows that she is his abuser, and to discuss with him what steps to take.

He does not turn up for the session. Mei twice leaves messages on his phone, asking him to make contact, but he doesn't return her calls. Mei is anxious about whether her neighbour is a risk to local children and does not know how to manage her safeguarding concerns, because Micha has not disclosed the name of his abuser. Her nephews and nieces are now all of school age and no longer in need of childcare, but Mei is worried for other local children, and concerned that their parents may be unable to take steps to keep them safe because they are not party to the information Micha has disclosed to her.

WHAT, IF ANYTHING, CAN MEI DO?

Please note that opinions expressed in these responses are those of the writers alone and not necessarily those of the column editor or of BACP.

Responsibility to act

Sharon Campbell MBACP
Counsellor with Base 51 and the NHS in Nottingham

Ideally, Micha should have been made aware of the exceptions around confidentiality at the contract stage, and that managing risk is part of the practitioner's duty of care. Mei has to make a judgment about sharing appropriately what information Micha has already shared with her, in order to safeguard potential children at risk in the greater public.

Although Micha hasn't made a full disclosure, Mei feels that she has adequate identifying details that would indicate the sister is the perpetrator. Therefore, she has an ethical responsibility to act, and should make an appropriate referral to the local safeguarding team to initiate an investigation. She should trust her instinct to act, rather than ignore it.

The NHS will work to a legislative framework and to the principles set out by the Safeguarding Children Board, so Mei will have direct support from a team within her local NHS trust. It is to be hoped that she is eventually able to contact Micha and have an open and honest discussion about why she has made the disclosure, involving him fully as well as offering him ongoing support.

Mei needs to ensure that she has acted in a timely way and that the facts she is aware of are recorded and shared appropriately and sensitively. She has her own supervisor for support during this process, to help with both the practical and emotional aspects in this situation. I can imagine that she will worry about a disclosure not being definite and fully factual, but the most important message is to act on her safeguarding concerns and to manage risk.

> 'I can imagine that she will worry about a disclosure not being definite and fully factual, but the most important message is to act on her safeguarding concerns and to manage risk'

She can't act on a suspicion alone

Helen Cleverley
Therapeutic counselling trainee, Coleg Y Cymoedd

Mei is not in a position to act on her suspicions. While she clearly has a very strong suspicion that she knows the identity of Micha's abuser, it remains just a suspicion, which seems to be largely based on the 'other identifying details', and the exact nature of these details is not revealed. The facts in this case remain that Micha hasn't given the name of his abuser and is no longer in contact with Mei. Mei's loss of contact with Micha means he will not be able to confirm her suspicions.

The other information available doesn't completely support Mei's suspicions. Micha hasn't given the name of the sibling, and it's possible that he has a large family, with several sisters. Mei may be correct in her assumption that Micha and her neighbour are siblings, but this does not necessarily mean that her neighbour is the one who abused him.

It seems unlikely that Micha intends to return to counselling with Mei, so she will not have the chance to act on her supervisor's previous advice. Mei should take the issue back to supervision to discuss whether she can justifiably report her neighbour when Micha has not named or identified his abuser.

Responsibility lies with her employer

Jonathan Harris
Psychotherapist,
Combe Martin, Devon

This case highlights the complexity of being a counsellor in our community. As Mei is an NHS counsellor, responsibility for safeguarding lies with her employer. The possibility that Mei's client's abuser could be her friendly neighbour complicates Mei's difficulties. Counselling the relative of a neighbour is not advisable, as this case demonstrates.

Sexual abuse is a serious matter, and the safety of other children comes before that of confidentiality for the client or his sister. Mei, or the lead clinician, should contact the local Multi-Agency Safeguarding Hub (MASH) and discuss these concerns with the duty social worker. The responsibility is then passed to the correct authority.

Mei, or the lead clinician, can up the ante with the client (who may or may not have ended the counselling) by leaving a third message offering support and stating that they need to have a conversation about his sister. They could add that they are going to approach the sister (if this is what they have decided to do).

Mei's position with her neighbour needs addressing, too. As she is on friendly terms with the sister, she or the lead clinician may wish to tell her what her brother has revealed and tell her that the local authorities must, by law, be informed.

We do not know how old Micha is, only that he is a young man, suggesting he is 18 or older. He may be freaked out by his own revelations, and more vulnerable and in need of support than before he opened up in counselling. Consideration should be given to informing Micha's GP, so that the GP can contact him and ensure that he receives ongoing psychological support. A home visit by a crisis team may be indicated, if there is one in Micha's area.

> 'As the criminal act of sexual abuse was a presenting issue, opportunities to avoid this dilemma were missed, both when Micha was first assessed and, again, when Mei contracted with him'

Missed opportunities

Jill Swindells MBACP
Person-centred counsellor in the criminal justice system (victims and offenders) and pre-trial therapy trainer

Micha disclosed neither his abuser's identity nor any fears about current risks to children. So, unless he returns, there is nothing Mei can do directly, other than reflect on her assumptions and work through her anxieties in supervision. To help avoid similar difficulties with future clients who disclose crime(s) against themselves or others, Mei and her supervisor would benefit from reviewing relevant aspects of NHS policy and reflecting on the key principles of Crown Prosecution Service guidance for pre-trial therapy (PTT), even though it is designed for situations proceeding to trial.

In my view, as the criminal act of sexual abuse was a presenting issue, opportunities to avoid this dilemma were missed, both when Micha was first assessed and, again, when Mei contracted with him. The assessor should have explained and explored with Micha: 1) his options and intentions around reporting his own abuse; 2) any concerns he has about current risks to children and related ethical/legal consequences; and 3) the implications for his own therapy, particularly contracting/confidentiality, if he and/or others report it, whether now or in the future. Without such discussions having taken place, the counsellor to which the client is allocated cannot be appropriately briefed and, consequently, their clients cannot give fully informed consent when contracting – as with Mei and Micha.

Until the situation is clearer, Mei should begin PTT, rather than generic counselling. Otherwise, significant details of the abuse might be discussed and documented inappropriately in the client's notes. In the event of a criminal investigation, prompted by the client or others reporting, these notes could be used as evidence in court. Counsellors then risk being accused of contaminating evidence or coaching the client and, consequently, criminal proceedings are likely to fail. If there is no known risk of reporting or a possible trial, Mei can safely re-contract for generic counselling. ■

April's dilemma:

Godfrey has recently qualified as a counsellor following a previous career in business, which he left after being diagnosed with fibromyalgia, a chronic condition that causes physical pain and exhaustion. The change in his lifestyle has led to a general improvement in his symptoms, which he also manages with conventional medical and complementary treatments for pain relief, alongside yoga, mindfulness and diet. Godfrey continues to suffer from periodic relapses in his health, which can be sudden and unpredictable, and render him unable to work.

During his training, he had time for rest and recovery when he was seeing clients on placement alongside the coursework. Now he is qualified, he intends to set up in private practice. He plans to pace himself by working only three days a week and seeing no more than four clients in a day, with hour-long breaks in between each.

He is mindful, however, that there will be times when he will have to cancel sessions at short notice, and he is uncertain how or if to raise the issue with clients at the initial contracting stage.

WHAT WOULD YOU DO IF YOU WERE IN GODFREY'S POSITION?

Please email your responses (300 words maximum) to John Daniel at dilemmas@thinkpublishing.co.uk by 31 January 2018. The editor reserves the right to cut and edit contributions. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but they will not be answered personally.

The richness of religions

If you'd like to join our Talking Point panel, email therapytoday@thinkpublishing.co.uk

As we approach a time of great significance in the Abrahamic religions, **Sally Brown** asks readers how their clients' spiritual beliefs feature in their therapeutic work

Neelam Zahid
Counsellor and psychotherapist in private practice

I am a Muslim Pakistani woman and my clients are from diverse cultural heritages and religions. Sometimes clients seek counselling with me because they are specifically looking for a Muslim or Asian counsellor. If a client has a religion that I am not familiar with, I make an effort to research it, so that I have an awareness of the significance of their religious festivals and practices. Above all, clients want to feel understood, and I feel that my being familiar with their terminology helps. Some clients are curious about my religion, but I rarely disclose it unless I am sure it would be of therapeutic value. I don't celebrate Christmas or give gifts or cards, although I do take the days off between Christmas and New Year, as clients are rarely available then. I am aware it is an important time of year for many clients, even those who don't consider themselves religious.

Keith Hackwood
Counsellor, psychosynthesis therapist, supervisor and mindfulness teacher

I enjoy, and actively seek to work with, people who wish to explore and work with their spirituality and the ways spiritual identity interacts with psychological processes and outer life circumstances. I have a baseline awareness of most major traditions, but I am always inclined to let the client lead and be the main source of my information on these matters. I'm especially interested in indigeneity – the place-based nature of identity – and the ways in which awareness of ancestral traditions shows up in the work as symptom or insight. I do take some time off at Christmas and observe the cultural convention of the period. Often, I try to get away for a few days to contemplate the mysteries and bear witness to the midwinter shift. I am not a Christian as such, but I find the story of Christ a compelling narrative for reflection at this time, together with the cyclical turning of the year and nature's movement. Only once in 17 years has a client brought a Christmas present for me, which was a surprise. It felt important to receive the gift, a driftwood sculpture of a bird, which I still have in my room.

Elizabeth Clarke
Person-centred psychotherapist and counsellor in private practice

My Christian faith is my reason for being. It informs my relationships and feelings of connectedness to the world. But I work as a Christian who counsels, rather than a Christian counsellor, in a number of settings, including a charity that holds Christian values. I welcome clients with different frames of reference, and have worked with people who identify with Atheism, Spiritualism, Judaism and other belief systems. Everyone is on their own journey and I'm not offended by a client's denial of the existence of God. We all have a choice in what we believe and I honour that. I do wear a cross sometimes, but the counselling rooms I work from are neutral spaces. I would never put up Christmas decorations in a counselling room, as it's rarely a positive time for clients – one reason why we see a spike in referrals as we approach the season – nor is Christmas relevant for everyone. I will only work with a client's spirituality if it's brought into the room, and in these cases, there is often a sense of relief that they can talk about their spirituality without ridicule.

SHUTTERSTOCK

Maureen Slattery-Marsh
Counsellor at ICAP (immigrant counselling and psychotherapy) West Midlands, and Chair of BACP Spirituality

I live and work in Birmingham, a multicultural city, and I am aware that Christmas is situated in the midst of other great festivals: Solstice, Yuletide, Jewish Hanukkah and the birth of the prophet Muhammad. I take my cue from the principle of respect in the Ethical Framework. If a client's core identity is rooted in their faith, religious or belief system, it behoves us as practitioners to be curious and open to what a client might bring. I work a lot with my own ethnic community, the Irish Diaspora. We have specific rituals, like lighting a candle in the window on 24 December as a symbolic guiding light for the family on their way to Bethlehem. There is also a festival on 6 January, the twelfth day of Christmas, in parts of Ireland; it's called Nollaig na Mban, or 'Women's Christmas', when, having expended their energies on others, the women gather to spend time together and share hopes and dreams for the year ahead. I do try to declutter and simplify in the four weeks of the Advent period, which, in the Christian calendar, has a strong theme of moving from darkness into light. I also try to take a retreat day to stand back and think about the bigger questions as an antidote to consumerism.

Jacqueline Samuel
Psychotherapist in private practice

While I personally don't celebrate Christmas as a religious holiday, I do mark it as a time of festivity, friends and family, and will take at least a week off from work. When deciding to disclose my religious beliefs, as with all personal disclosures, I give due consideration to the impact on and meaning for my client. Some may infer my Jewish faith from information about me that is in the public domain – for example, on my website, or from my surname, the timing of my holidays, or my appearance. Others may have sought me out as a therapist who shares their faith. When it comes into the room, it can invite rich explorations of themes such as sameness, mutuality and kinship, whether in matters of religion, politics, attitudes and values, or of otherness, dislocation and difference. As I have a special interest in working with people who are grappling with their relationships with religion and with religious communities, I suspect that my practice has a higher proportion of clients for whom religion is a central concern.

Liz Bondi
Psychodynamic counsellor and psychotherapist in private practice and lecturer at the University of Edinburgh

I don't think Christmas is really much of a Christian festival any more. I typically refer to the 'Christmas and New Year break'. I take a break at this time, of variable length, although I often offer sessions on one day between Christmas and New Year. No cards or decorations appear in my consulting room. I have been given cards but never presents. If given, I would accept if a token gift, and talk about its meaning. I aim to be open to each client in their totality. If that includes matters of religion, faith and spirituality, I am happy to work with those themes. The situation arises less in terms of the major religions and more about expressions of faith and religiosity. It is not the task of the client to educate me about their religion, but at the same time, my curiosity is important. I am also always interested in their curiosity, if any, about me.

HOW DO YOU TAKE CARE OF YOURSELF?

Nicola Griffiths gets her self-care kicks from acting in her local pantomime

Up until three years ago, I had never been in any kind of theatre performance since school. Then, one day, I went for a haircut, and, after a short conversation about a princess being needed, I came out with a cut and blow dry - and a pantomime script.

My motivation at the time was to meet other locals, as I was new to the area. I didn't anticipate at all the benefits for my self-care.

It allows me to play - something I feel may have been lacking in my life. I can be silly. I don't usually enjoy being the centre of attention, but being silly on stage, in a glammed-up disguise, is somehow different, and liberating.

When I am acting, I am concentrating on the role. It gives me a complete break from work, which I feel is necessary for me to stay refreshed and effective.

Isolation is common in private practice, and being part of the 'project pantomime' team is invigorating. I am a people person and my energy levels get a real boost from our weekly rehearsals.

In my second performance, I was cast as the Wicked Queen in *Snow White*. I was both surprised and a bit scared at being given such a lead part, but it stroked my ego, and I felt so proud. The following year, I was the Evil Vet in *Jack and the Beanstalk* (the Evil Vet teams up with Simple Simon, who is making Old Mother Hubbard's animals into pies to feed the giant). My part this year is Dr Frankenstein, in a panto called *Pantostein*. Am I being typecast? Could this be my Jungian 'shadow' to my daytime role as a goody-two-shoes counsellor? I have to admit I enjoy being evil, but (I hasten to add) only because there are no real casualties.

The part I'm playing is not important - so long as it isn't the pantomime cow. The break from client work, being in a team, overcoming my fears on stage, and getting the chance to play are what tick my self-care boxes. ■

'Am I being typecast? Could this be my Jungian 'shadow' to my daytime role as a goody-two-shoes counsellor?'

About Nicola

Nicola Griffiths is a counsellor and social worker based in Somerset, with her own private practice, Aqua Counselling. She volunteers for Elim Connect in Wells, and, until June, was a volunteer with Somerset and Avon Rape and Sexual Abuse Service. @GriffithsNicola; www.counselling-directory.org.uk/counsellors/nicola-griffiths

How do you take care of yourself? Email therapytoday@thinkpublishing.co.uk

From the Chair

'... in my 25-odd years as a paying member, I have never doubted BACP's commitment to the very best standards in therapy, to pushing the boundaries in ethical thinking, and to holding the vulnerability of the client at the very centre'

We are all but one heartbeat away from a crisis. I have known this throughout my practice, both as a mental health social worker and as a therapist working in crisis settings. But I have been forcibly reminded of this recently by a personal crisis that descended on me in the past few months, including a diagnosis of a (fortunately) contained form of skin cancer. Indeed, I am recovering from surgery as I write this. I was particularly reminded, as I lay on the operating theatre table and the surgeon took to my face with his scalpel, how much trust - in that moment - I invested in him. I was relatively powerless and he was entirely powerful; I just needed to know that he knew what he was doing.

The same is true for our clients and their mental wellbeing. When they first walk through our door, they invest so much trust in our capacity to hold their vulnerability safely and respectfully, and help them find their way through to a different place. It is critically important that - in that moment - we negotiate with care the power difference between us. We need to know that we know what we are doing.

CHARLIE BEST

In that context, I am genuinely honoured to have been re-elected by the Board to serve for a second term as Chair of this fine association of professionals committed to the highest standards of practice. Oh, for sure, we get all sorts of things wrong; BACP can be experienced as defensive, bureaucratic, infuriating, obtuse and, well, I could go on. But, in my 25-odd years as a paying member, I have never doubted BACP's commitment to the very best standards in therapy, to pushing the boundaries in ethical thinking, and to holding the vulnerability of the client at the very centre.

At the time of writing, we are nearing our 2017 AGM. Employment and fair payment for therapy, training standards, mapping our scope of practice, the re-emergence of statutory regulation, and the nature of evidence are all on the agenda for debate. I believe that BACP, with support, guidance and challenge from its members, has never been better positioned to tackle these issues and consolidate the therapeutic frame to which we are all committed.

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BACP round-up

Our monthly digest of BACP news, updates and events

Working with children in their world

Our children and young people conference 'Working with children in their world' is in London on 24 February 2018.

The day is tailored to members who are working with children and young people, and focuses on working with children in the context of their family. You'll explore how therapists connect with children and young people in the child's own world, and how this can lead to better outcomes.

Selected content will be available to watch live via webcast. For £25 (including VAT) you'll be able to watch a selection of presentations, talk to other members using live chat and have 24-hour access to recordings for a limited time after the live stream. You'll also be able to download your CPD certificate.

For more information about the conference and the webcast, please visit our website.

Book for the Research Conference 2018

Our annual Research Conference takes place in London on 11 and 12 May 2018. The theme is 'Counselling changes lives: research that impacts practice'.

The conference brings together researchers, students, practitioners, academics and trainers from different backgrounds and traditions for lively exchange and critical debate.

We're delighted that Professor Dr Pim Cuijpers will give a keynote address on 'Four decades of research on counselling for depression: Directions for the future'.

A key topic of discussion will be how research that is embedded in routine practice can provide new insight into the therapeutic process.

Find out more about the conference on our website.

Thriving at work report

We were interested to read the new report *Thriving at work,* a review of mental health and employers, commissioned by the Government in January 2017 and published last month. The report was written by Lord Dennis Stevenson and Paul Farmer CBE, Chief Executive at Mind, and sets out what employers can do to support their employees in the workplace, including those with mental health problems.

Nicola Neath, Chair of BACP Workplace, says: 'We believe that it's vital to ensure that employees, as well as having support systems at work, have access to people that they can talk to outside of the workplace. Access to EAP and in-house counselling schemes is often much quicker than access to primary care mental health services and our members working in these provide a vital, often lifesaving, support service that would otherwise fall on the burden of public services.

Copies of the review can be downloaded from **bit.ly/2h92fjY**

SHUTTERSTOCK

Older people mental health roundtable

In October, as part of our strategic commitment to improving access to talking therapies for older people, we hosted an older people roundtable meeting with other professional bodies and charities, including The British Geriatric Society, The British Psychological Society, Cruse, Independent Age, My Home Life and the Royal College of Psychiatry.

Working with other organisations is central to helping us tackle a range of issues to improve our recognition of and response to the mental health needs of older people.

We'll work closely with partner organisations to highlight the susceptibility of older people to mental health problems and to promote the fact that more must be done to meet their needs.

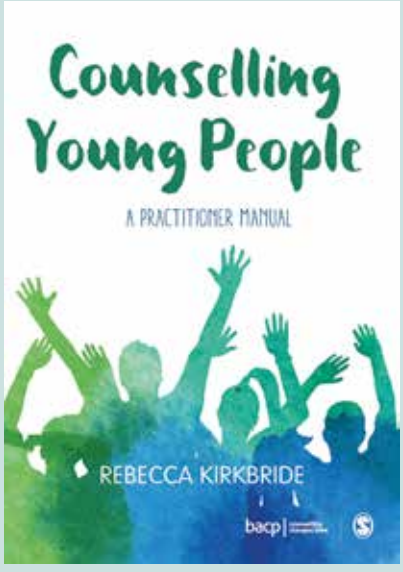
Helen Kewell's article 'Waiting for the Southsea bus' in the May 2017 issue of *Therapy Today* explored the therapeutic benefits of counselling for her older clients, as well as her positive experience and learning from her work. We'll continue to listen to your experiences of working with older people with the long-term objective to increase the numbers of older people whose mental health needs are being recognised and therapists who are actively engaged in this area of work.

Counselling for young people

One of our members, Rebecca Kirkbride, has written a book called *Counselling Young People: a practitioner manual*. The book takes a humanistic approach to counselling young people and each section maps onto a different area of our 2014 *Competences for humanistic counselling with young people (11–18 years)*.

Children, young people and families are important client groups for us, and this book supports our work in this area, establishing humanistic counselling as an evidence-based psychological intervention. The book translates our competences framework into a comprehensive and easy-to-follow guide to all aspects of counselling young people, providing a clear sense of what is required at each stage of the counselling process.

Our Joint Head of Research, Dr Naomi Moller, said: 'I welcome this important new guide for practitioners, which builds on our competences for humanistic counselling with young people to support counsellors to develop effective, ethical and evidence-based practice with children and young people.' The book is available now from the Sage Publications website, at uk.sagepub.com. As a BACP member, you'll receive a 25% discount if you type in the code UKCOUN25 at the checkout.



BACP round-up

CQC phase one report

We're part of the expert advisory group for the Children and Young People's Mental Health Review. The review is being led by the Care Quality Commission (CQC), which recently published the phase one report of the review.

We've long campaigned for a school-based counsellor in every secondary school in the UK. Our input into the review has promoted the positive impact that counselling can have on the emotional and mental wellbeing of children and young people, particularly for those seen in a school setting.

We're pleased to see that the report acknowledges that counselling in schools is effective and recognises that there still are variations in school counselling provision across the country and between the four nations.

Dr Andrew Reeves, BACP Chair, said: 'BACP welcomes the CQC report and the opportunity to be involved in such an important review into children's mental health. The report confirms what we already knew, that school counselling is effective and valued by children and young people, but access is variable across the country. We remain concerned that, despite the expectation set out in the Department for Education's report *Counselling for Schools: a blueprint for the future*, there has been no progress towards a trained counsellor in every secondary school in England.'

'Working with' days in 2018

You can now book your place to attend a selection of our 'Working with…' days scheduled for 2018.

Highlights include 'Coaching specific client groups, identifying your niche, and marketing your offer effectively', in London on 22 January 2018. The event will help you develop your therapeutic skills to work with a broader range of client groups in different contexts and give you the tools to grow your practice.

'Working with critical incidents – Prepared not scared; are you ready to respond?' is in Edinburgh on 17 April 2018. This event will help you develop an understanding of how therapists work with critical incidents before, during and after an event.

If you feel challenged by your client's complex experience of trauma, 'Working effectively with trauma in healthcare settings' will help you explore how outcome measures can be used to support trauma-focused counselling. The event is on 8 March 2018 in Manchester.

You can find out more about these events, and book your place, on our website.

Membership renewals go online

Once our new website is launched, you'll be able to renew your membership online, making the process quicker and easier.

All declarations and terms and conditions will be online, in one accessible place, so you won't need to send us any paperwork unless you're making changes to your membership.

We will still send out your renewal letter, and will let you know when online renewals are available. In the meantime, please make sure your email address is up to date in your member's area so that you're ready for the changes.

Private practitioner outcomes trial

If you work in private practice and would like to be involved in a 12-month trial for an online outcomes monitoring system, we'd like to hear from you.

We expect training to take place in early 2018, with data collection starting in the spring. If you're interested, email us at research@bacp.co.uk for more information.

SNP annual conference

In October, we attended the Scottish National Party's annual conference in Glasgow. The conference saw the announcement of £500,000 funding for NHS 24 to improve its online and telephone mental health service, which is an agreed action from the Scottish Government's mental health strategy.

We met Health and Sport Secretary Shona Robinson MSP at the conference, and expressed our eagerness to support the Government's review of school counselling, which is expected to be launched this month.

We also caught up with Maureen Watt MSP, Mental Health Minister, at the Mental Health Foundation in Scotland. We revisited discussions we had with the minister in May about the Scottish Government's Mental Health Strategy 2017–2027.

SHUTTERSTOCK

Perinatal mental health enquiry

The Welsh Assembly Children, Young People and Education Committee has recently published its report into perinatal mental health in Wales. In June, we submitted written evidence to the committee calling on the Welsh Government to re-establish a specialist mental health unit for mothers and babies in Wales. We were pleased to see that the committee adopted our recommendation.

The unit was closed down in 2013, which has meant that vulnerable mothers from across Wales have had to travel to England for specialist mental health treatment.

You can read the full report on the Welsh Assembly website.

BACP in the media

BACP has seen a range of coverage during the past few weeks, showcased as usual, through our twitter feed **@BACP**.

Members have been featured following enquiries into our press office, which we've been able to respond to through our great media spokespersons network. Kate Anthony provided an element of reasonable warning in a piece on the possibility of virtual reality paying a part in mental health treatment, and Nicola Banning spoke about her role as a workplace counsellor, both in *The Guardian*. Hansa Pankhania provided a wealth of hints and tips for stress management in *The Independent*, as part of International Stress Awareness Day last month.

A lot of our media work is in the specialist media. The women's magazine *Reveal* featured Vanessa Oliver giving her expert opinion on the issues raised by the revelations about Harvey Weinstein. *Funeral Service Times* magazine featured Nicola Neath, Chair of BACP Workplace, commenting on the need for funeral directors to have access to counselling.

We've also loved seeing members and the organisations they run celebrated in their local media, such as the newly renamed Worthing Counselling Centre and the anniversary of the counselling service exploringU.

Please let us know if you or your organisation are featured in the media, or if you would like to find out more about becoming a media spokesperson.
Email **media@bacp.co.uk**

BACP round-up

BACP accreditation

Newly accredited members, services and courses

We would like to congratulate the following on achieving their BACP accredited status:

Counsellor/ psychotherapist
Gillian Boyd
Christopher Brennan
Debbie Carmody
Natasha Clewley
Ivana Coombes
Rachel Cutler
Simon Eve
Pippa Fairhead
Tim Faldon
Richard Gale
Joan Giller
Kristina Greaves
Harriet Hay
Natasha Hood
Alison Jones
Natasha Lewis
Mabel Marron
Michael McDonough
Pamela Meere
Samantha Middleton
Farzana Nooren
Robert Oglesby
Liane Oldham
Joanne Proctor
Dawn Purver
Mahwish Qamar
Wendy Robertson
Hefina Thorne
Paul Turk
Juliet Walker
Alison Wood

Senior accredited counsellor/ psychotherapist
Stephanie Bushell
Sandra Mckeever

Senior accredited supervisor of individuals
Rae Jack

Accreditation reinstated
Clare Davies
Zakiah Talbot
Sheila Towfighi

Members not renewing accreditation

Counsellor/ psychotherapist
Roy Adams
Robin Bailey
Catherine Bradley
Angela Carr
Sharmini Chaytor
Peter Dominey
Linda Eliot
David Flanagan
Ria Foster
Lesley Gault
Amanda Gaylard
Anne-Marie Gent
Nadege Gent
Justine Gibson
Linda Glover
Susan Hartley
Elizabeth Helm
Sue Hook
Gail Jackson
Sue Jackson-Game
Nigel Jacobs
Charlotte Joseph
Chrystalla Kyriakidou
Helen Lealman
Christine Lee
Theresa MacIntyre
Susan Maciver
Catriona Macnab
Monica Mason
Jo Miller
Joan Morris-Ashton
Anne Norman-Alldrick
Anna Pearson
Gail Platt
Helen Ralston
Gillian Richards
Sharon Ridgeway
Anne Roberts
Jackie Rodger
Tana Sheridan
Susan Showell-Westrip
Jacqueline Sirota
Mary Swale
Catherine Tench
Linda Walker
Sara Wiltshire
Chris Woodcock

New and renewed accredited services

We would like to congratulate the following services on achieving and/or renewing their BACP accredited counselling/ psychotherapy service or professional training course:

Primrose Hospice
Quaggy Development Trust (QCCS)
Springhill Hospice

All of the details listed are correct at time of going to print. Disclaimer: Please be aware that BACP may have more than one member with the same name. To check whether someone is a registered accredited member, please visit the BACP Register at www.bacpregister.org.uk/check_register. For a full list of current accredited services and courses, please visit the relevant BACP Accreditation Directories at www.bacp.co.uk/accreditation

2018 EVENTS CALENDAR

22 January
Coaching specific client groups, identifying your niche and marketing your offer effectively
London

14 February
Professional development day
Integrating artwork into your counselling practice. With Pauline Andrew
Norwich

24 February
CYP Conference
Working with children in their world
London

8 March
Working effectively with trauma in healthcare settings
Manchester

12 March
Professional development day
Working with partners of trans-identified people. With Tina Clark
Cardiff

24 March
Professional development day
Supervision: relationship, authority and ethics. With Steve Page
Southampton

PROFESSIONAL CONDUCT NOTICES

Re-admission to BACP membership

Rob Stuart

Reference No: 712505 London E17

The Article 12.3 Panel considered Mr Stuart's re-application for membership, together with the disclosure relating to a professional conduct decision published in *Therapy Today* and on the BACP website, in light of the Article 12.3 Procedure. Mr Stuart provided the Panel with substantial evidence of his reflections, understanding and learning in relation to the allegations previously upheld against him. The Panel, having considered the disclosure and the submission made by Mr Stuart, concluded that he be allowed into membership subject to this notice being published.

Full details can be found at www.bacp.co.uk/prof_conduct/notices/hearings.php

Analyse me

Dina Glouberman speaks for herself

Where is your happy place?
A café, if possible in the sun and/or by the sea, with good coffee, sitting with a *cornetto al cioccolato*, thinking about life, writing little notes to myself, and watching people chat and read. More generally, wherever I feel the sun shine on my face.

Why did you become a therapist/counsellor? There was never anything else I wanted to be. I've always been fascinated by consciousness and symbols, and by making a difference to how people live on an inner as well as outer level.

Where do you work?
I tend to move between London and Hastings in the UK, Skyros in Greece, and Monopoli in Italy - or wherever I am invited, or organise my own courses. I work face to face or by Skype, with individuals and groups.

How do you work?
I am a humanistic psychotherapist and specialise in imagework, my own approach to harnessing our authentic imagination to guide our lives and facilitate positive life choices and profound life changes. I also love creating healing environments.

What's your special interest?
Burnout as a positive step on the soul's journey - my book *The Joy of Burnout: how the end of the world can be a new beginning* is now in its third edition and shortly to come out in Italian translation. More generally, people in crises, transitions or turning points. These are ideal moments for transformation, even in a few sessions. Also the transformational power of healthy communities.

What do you do for self-care?
I meditate and do my own imagework, visioning and co-listening. I also walk, swim, work with my trainer, hang out with my friends, family and partner, go to cafés, concerts and museums, and seek sun, sea and a sense of community. Laughter is probably my best healer.

A client offers you a small gift - do you accept or not, and why?
Yes. It happens so rarely, perhaps a box of chocolates on a Jewish holiday, and seems a simple human gesture that it would be churlish to refuse.

Why do you think therapy works?
It allows you to look and listen deeply in the presence of another, let go of whatever is blocking you, and open to a new sense of self, world and life. A great gift.

What gives your life meaning?
The incredible joy of transformation, contributing to the evolution of consciousness and culture; being there for people when they need me; love, truth, learning, creative fire; sunrise over the sea; community, friendship and magical moments. Knowing something will always emerge to light the way.

What do you think happens when we die?
Our consciousness goes on, and continues to evolve and to contribute.

Cats, dogs or horses?
None of those, really. My favourite encounters with animals have been with sea turtles laying eggs on a beach in Trinidad, and a leopard ambling along on its own in a South Africa safari park.

What's the longest you've seen a client?
I have a client I met in the first Skyros Holidays session back in 1979, and we've worked together on and off ever since, sometimes taking up again after many years. I am still available when she wants a session - the psychological equivalent of the family doctor.

What gets you up in the morning?
My first cup of tea, over which I sit quietly and happily, reconsidering everything all over again.

How do you sleep at night?
Sleep, blessed sleep! Usually I sleep well, but emotional vulnerability can rock it, and then I have to get up in the middle of the night and drink cocoa and seek wisdom.

When will you retire?
I call myself semi-retired, but I'm planning to establish a new imagery training centre in Puglia, Italy, and to write an imagery handbook for therapists and counsellors. I may run out of steam, but I hope I will always be able to create and contribute. ■

About Dina

Now: co-founder of Skyros Holidays, a love of my life since 1979; individual, couples and group therapist/coach; international imagework trainer; author of four books, with a memoir, *Into the Woods and Out Again* (Karnac), coming out shortly; mother, grandmother, partner, friend.
Once was: senior lecturer in social psychology; consulting editor of i-to-i magazine.
First paid job: psychology research assistant.

Who would you like to answer the questionnaire? Email your suggestions to the editor at therapytoday@thinkpublishing.co.uk