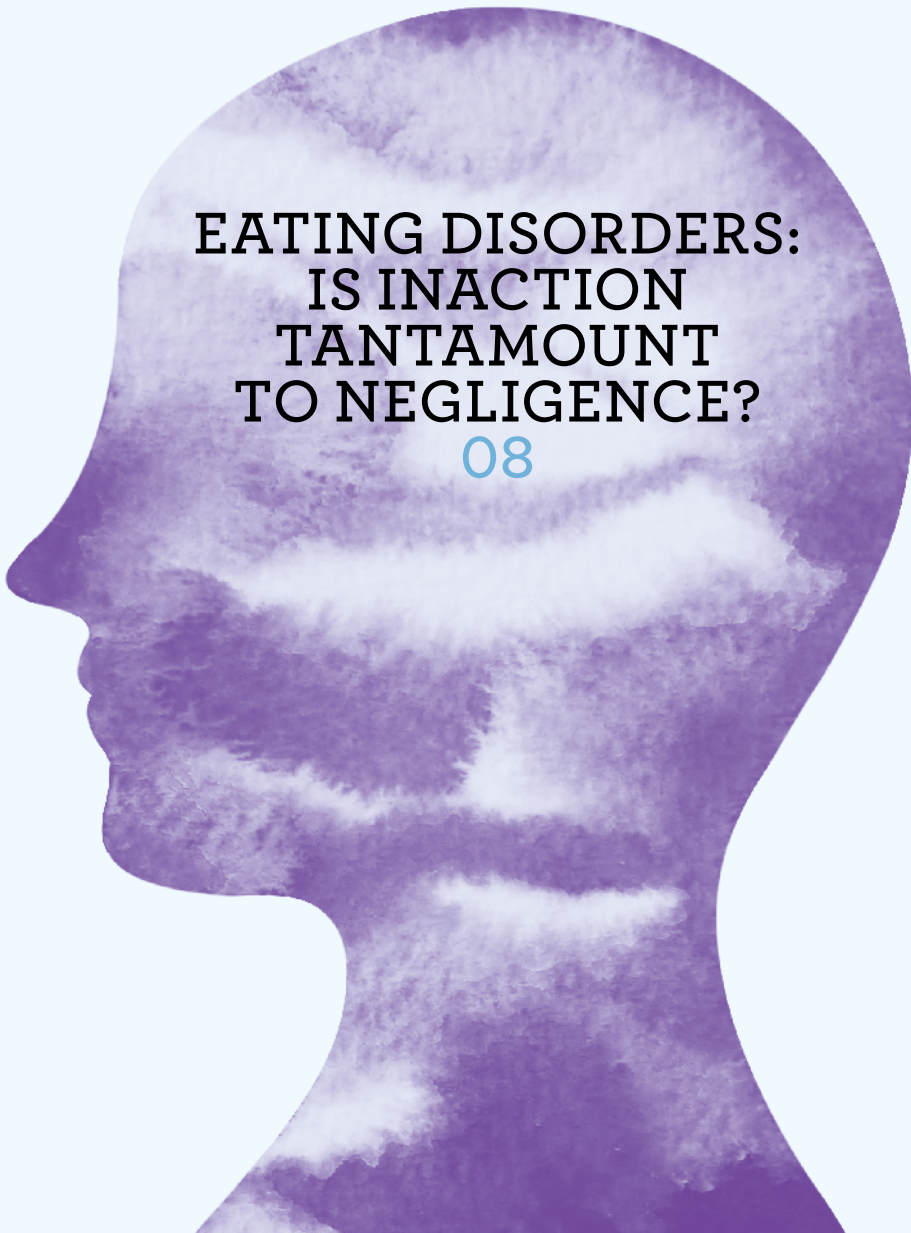


HEALTHCARE

COUNSELLING AND PSYCHOTHERAPY JOURNAL

JANUARY 2018 VOL 18, NO 1

FOR COUNSELLORS AND PSYCHOTHERAPISTS WORKING IN HEALTHCARE



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The *HEALTHCARE Counselling and Psychotherapy Journal* is the quarterly journal for counsellors and psychotherapists working in healthcare.

It is published by the British Association for Counselling and Psychotherapy (BACP): BACP House, 15 St John's Business Park, Lutterworth LE17 4HB
T 01455 883300
F 01455 550243

The journal is sent free to members of BACP Healthcare in January, April, July and October. Membership of BACP Healthcare costs £30 a year for individuals and £50 a year for organisations. For membership enquiries, please email healthcare@bacp.co.uk

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Design

Steers McGillan Eves
T 01225 465546

Print

Newnorth Print Ltd

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ISSN (print) 1475-0724

ISSN (online) 2397-866X

FROM THE EDITOR

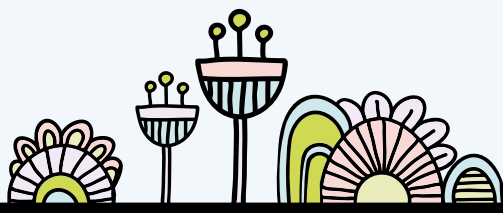
One of the key focal points of healthcare policy in recent years has been the need to bridge the gap between physical and mental health. The NHS *Five Year Forward View for Mental Health*¹ emphasised the need for a greater focus on the psychological aspects of physical illness. In keeping with this, three of the articles in this issue focus on the intersection of physical and mental health, exploring the psychological impacts of eating disorders, severe morning sickness and breast cancer.

Although many of us will have no formal training in working with eating disorders, we may find ourselves with patients presenting with other issues, who also suffer from anorexia nervosa, bulimia or related disorders. In a frank exploration of this topic, eating disorder specialist, Kel O'Neill, challenges us to consider how we work with these clients. Huge increases in the diagnosis of these disorders have led to long waiting times for specialist services, which may increase the likelihood that these patients end up in the consulting rooms of those of us who are not specialists. Kel highlights that, when working with these clients, we will often be working with life and death scenarios, and that we cannot afford complacency. Her article certainly challenged me to consider how I might improve my understanding of the psychological impact of these disorders.

One of the key ways in which we might challenge our work in this area is by bringing it to supervision. At its best, supervision gives us the opportunity to explore our blind spots and identify areas of growth. Michael Worrell considers whether the supervision provided to IAPT CBT practitioners is fit for purpose and supports their needs. His reflections are not only relevant to practitioners of that modality, however. He highlights how good supervision provides the supervisee with a safe space to explore the emotional complexities of working as a therapist. Having recently completed my own training as a supervisor, I found his reflections helpful and pertinent to my future work in this area.

Returning to the interplay between physical and mental health, Carol Morgan presents a case study of her work with a woman who has suffered from breast cancer. She focuses on the positive personal growth in the women she has worked with through the charity Breast Cancer Haven. This organisation seems to provide an excellent example of responding to the needs of the whole person, adopting a holistic and individualised approach, and offering complementary therapies alongside counselling.

At its best, supervision gives us the opportunity to explore our blind spots and identify areas of growth



This need to respond to the whole person is also evident in Michelle Nicholson's article on the psychological impact of severe morning sickness. Michelle's first-hand experience of this issue led her to conduct research into how other women had coped and been supported through their physical and mental distress. Michelle and the women she interviewed shared the experience that, while healthcare professionals took care of their physical needs during their pregnancies, measuring bumps and blood pressure, they were not asked about their emotional needs. Michelle sensitively captures the experiences of the 10 women she interviewed. These are useful reflections to bear in mind, should we find ourselves working with clients suffering from this condition.

It is important to us that we ensure that this journal reflects your needs and interests. If you have any ideas for different types of content that you would like to see in the journal, such as interviews with therapists, or discussions of ethical dilemmas, then do please let me know.

REFERENCE

- ¹ Independent Mental Health Task Force to the NHS in England. Five year forward view for mental health. [Online.] 2016. <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> (accessed 29 November 2017).



Joanna Benfield, Editor
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NEWS & RESEARCH

NHS consultation on mental health services for children and young people

In December 2016, the Government published a Green Paper on transforming children and young people's mental health provision. The proposals in the Green Paper include the creation of new community-based mental health support teams, designed to improve co-ordination between schools and the NHS. The teams will provide early intervention treatment in or near schools and colleges. Several thousand people will be recruited to these teams over the next five years, and will be provided with training in CBT and other evidence-based therapies. Additional proposals include the designation of a mental health lead in every school and college, and the piloting of a maximum four-week waiting time for children and young people's mental health services in some areas. Over £300 million of funding will be made available to support the measures. A consultation on the proposals set out in the Green Paper is open until 2 March 2018. The consultation documents can be found here: <https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper>

Source: BACP

REFERENCE

Department of Health and Department for Education. *Transforming children and young people's mental health provision: a green paper*. [Online.] Crown copyright; 2017.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/664409/Transforming_children_and_young_people_s_mental_health_provision.pdf (accessed 5 December 2017).

New NHS online tools to safeguard mental health patients at risk of radicalisation

NHS England has produced new guidance for providers of NHS mental health services to assist them in carrying out their statutory and professional responsibilities to safeguard children, young people and vulnerable adults who are at risk of radicalisation. The guidance focuses on the Government's Prevent strategy, which is aimed at preventing people from becoming terrorists or supporting terrorism. The guidance covers four key areas: (i) responsibilities of mental health providers; (ii) Prevent referrals from mental health providers; (iii) the role of mental health providers in the Prevent process; and (iv) referrals from Prevent to mental health services. The document sets out the safeguarding pathways that need to be in place and the training requirements for mental health professionals, and also covers issues such as working in partnership with the police. The guidance is accompanied by a new e-learning package, which includes real-life case studies.

Source: NHS England. NHS England Prevent mental health guidance and new e-learning package now available. 2 November 2017. [Online.] <https://www.england.nhs.uk/2017/11/nhs-england-prevent-mental-health-guidance-and-new-e-learning-package-now-available/> (accessed 3 December 2017).

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HM Government. *Introductory e-Learning training on Prevent*. [Online.] HM Government; 2017. <https://www.elearning.prevent.homeoffice.gov.uk/mentalhealth> (accessed 3 December 2017).

PREVALENCE OF DEPRESSION IN ENGLAND

A report published by NHS Digital in November 2017 indicated that 9.1 per cent of patients visiting GPs surgeries in 2016–2017 presented with depression. The area with the highest prevalence of depression was Lancashire and South Cumbria, while the area with the lowest prevalence was London.

The Quality and outcomes framework – prevalence, achievements and exceptions report is an annual report that focuses on 21 commonly occurring medical conditions, including asthma, hypertension, dementia and diabetes. It measures the prevalence with which patients present with these conditions at GP surgeries. The report found that, in 2016–2017, depression was the third most prevalent of all the conditions measured, with only hypertension (13.8 per cent) and obesity (9.7 per cent) having higher prevalence rates. Depression also showed the highest increase in prevalence (0.8 per cent) since the previous year, of all the conditions measured. The report is based on data provided by over 95 per cent of GP surgeries in England.

Source: NHS Digital

REFERENCE

NHS Digital. *Quality and outcomes framework – prevalence, achievements and exceptions report*. [Online.] Government Statistical Service; 2017. <http://digital.nhs.uk/catalogue/PUB30124> (accessed 14 November 2017).

Perinatal mental health in Wales

In October 2017, the Children, Young People and Education Committee of the National Assembly for Wales published a report on perinatal mental health in Wales. BACP had lobbied the Welsh Assembly for the re-establishment of a specialist mental health unit for mothers and babies. The Committee took up this recommendation in this report, urging the Welsh Assembly to re-establish the unit as a matter of urgency. The Welsh Assembly has now made a budget available for this purpose.

The report highlights that up to one in five women is affected by perinatal mental health issues; 12 per cent experience depression, 13 per cent experience anxiety, and 15–20 per cent experience depression and anxiety in the first year after giving birth. The report estimates that post-partum psychosis affects one or two women per thousand; 50 per cent of these have no previous history of mental illness.

The report underlines the important role of third sector organisations in supporting women suffering from perinatal mental health issues. It highlights the need for more funding to be provided for these services.

The Committee also focuses on the importance of attachment in early life, and asks the Welsh Government to explore whether specialist health visitors can be employed to support the mother-infant bond, as has been done in England. The committee also calls upon the Welsh Government to undertake an awareness-raising campaign to ensure that healthcare professionals understand perinatal mental health conditions and their symptoms.

Source: BACP

REFERENCE

National Assembly for Wales, Children Young People and Education Committee. Perinatal mental health in Wales. [Online.] National Assembly for Wales; 2017. <http://www.assembly.wales/laid%20documents/cr-ld11234/cr-ld11234-e.pdf> (accessed 14 November 2017).

Older adults and mental health

According to a survey conducted by Age UK, nearly half of adults over the age of 55 in the UK have experienced mental health problems. Age UK commissioned Yougov to carry out the survey, which found that 7.7 million people over the age of 55 suffer from depression, with 7.3 million suffering from anxiety. The most common triggers for mental health problems included the death of loved ones, ill health and financial worries. Over one third of those who were surveyed said that they did not know where to go for help and support. A third said that counselling and talking therapy would help those suffering from mental health problems, while nearly three-quarters of respondents felt that helping people to connect with others and tackle loneliness and isolation was the best way to alleviate these problems.

In September last year, the NHS published guidance on mental health and older people, aimed at helping GPs to spot when symptoms often attributed to ageing are in fact signs of mental health problems and therefore require referrals. Age UK and NHS England are working together to raise awareness among GPs of the warning signs and to encourage older people to access mental health services.

Source: NHS England.

REFERENCE

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THE LINK BETWEEN PERFECTIONISM AND SUICIDE

A team from the University of Ontario has been exploring the links between suicide and perfectionism. They carried out a meta-analysis, studying 45 previous studies on this topic, with nearly 12,000 participants in total.

There is no single agreed definition of perfectionism, with the studies covering 15 different ways of defining the concept. The researchers found that 13 of these were correlated with a likelihood of having suicidal thoughts. Suicidal attempts were particularly prevalent in those cases in which perfectionism was related to trying to meet the expectations of other people. However, having high standards for others, and being tidy and organised to a high standard, were not related to suicidal ideation.

Six of the studies included in this research were seen as being particularly important because they examined data over a period of time, and were able to show that the perfectionist tendencies preceded the suicidal thoughts or behaviours. The research, which was published in the *Journal of Personality*, highlighted the need for more longitudinal studies in order to corroborate these findings.

Source: BPS

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Smith M, Sherry S, Chen S, Saklofske D, Mushquash C, Flett G, Hewitt P. The perniciousness of perfectionism: a meta-analytic review of the perfectionism-suicide relationship. [Online.] *Journal of Personality* 2017. <http://onlinelibrary.wiley.com/doi/10.1111/jopy.12333/abstract?campaign=wolacceptedarticle> (accessed 29 November 2017).

ANTIDEPRESSANT USAGE: A SURPRISE INCREASE?

SATINDER PANESAR

BACP AGM

Happy New Year to everyone, and welcome to 2018! I would like to begin by reflecting on the BACP AGM that was held in Birmingham in November. This event was a useful opportunity for members and everyone who supports BACP in a voluntary capacity to hear about the work of the organisation. It was a valuable day, and I enjoyed the opportunity to hear about the good work that BACP is doing. There really is a lot of positive change happening.

The day started off with presentations from all of the divisions, as well as from volunteers from the board, organisers of the network meetings, representatives of finance and policy, and the *Counselling and Psychotherapy Research* (CPR) journal editorial board. I then attended a workshop on 'A four Nations Approach', which was facilitated by Steve Mulligan, BACP Four Nations Policy and Engagement Lead. I found it useful to hear about the work that is happening in Scotland, as well as the other nations, particularly in terms of forming key relationships and improving the visibility of BACP across the political environment.

*...as I thought about
my current case load,
I realised that around
90 per cent of my clients
were on antidepressants*

ANTIDEPRESSANT USAGE

In the last issue of this journal, I was surprised to read about the recent rise in the prescription of antidepressants. A report published by NHS Digital revealed that there was a greater increase in the prescription of antidepressants than any other drug dispensed in the community in England in 2016.¹

As I reflected upon my response, I realised that my shock was not really at the facts presented, but rather at seeing them written down in black and white. In fact, as I thought about my current caseload, I realised that around 90 per cent of my clients were on antidepressants. This realisation made me feel very sad.

I'm aware that the figures in the NHS report are for England. However, I'm sure that they wouldn't be much different for Scotland, Northern Ireland or Wales. I would welcome any information or reflections that those of you reading this article may have about this.

SEXUAL HARASSMENT AND ABUSE

Recently, there have been a number of media reports about claims of sexual harassment in Parliament and in the entertainment industry. These follow prior disclosures in the media of sexual abuse within the sports industry, and sexual abuse scandals around celebrities, such as Jimmy Savile. When reflecting on these disclosures, my thoughts quickly turned to the ever-expanding demand for psychological support for the individuals who have experienced these issues. From my work in the third sector and the NHS in Scotland, I'm aware that the demand for these services is greater than the resources that are available. Waiting lists are particularly long for specialised services for individuals presenting with historical child sexual abuse. Many services are only taking referrals for clients presenting with mild to moderate issues, and there is a cap on the number of sessions they are allowed to have.

I'm not going to bury my head in the sand and say that all services should provide open-ended counselling sessions, because – putting my manager's hat on – I understand that this is not always possible. But we have to give some serious thought to what is possible, with all the restrictions our services face. I would suggest that

there needs to be a government-led initiative in this area of work. I would very much value your input and feedback on this idea.

What do clients do when they are told they have to wait for a specialised service? My experience is that they wait. However, what impact does the wait have? Well, we go right back to the start of this column, to the deterioration of mental health and the increase in the prescription of antidepressants. So, perhaps I am not really surprised at this after all. ■

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- 1 NHS Digital. Prescriptions dispensed in the community, statistics for England 2006-2016 (PAS). [Online.] NHS Digital; 2017. <http://digital.nhs.uk/catalogue/PUB30014> (accessed 14 November 2017).



Satinder Panesar is Chair of BACP Healthcare. To contact Satinder, please email healthcare@bacp.co.uk

NEW YEAR – NEW INITIATIVES

JUDY STAFFORD

MENTAL HEALTH AND THE OLDER GENERATION

Many of us are affected, either directly or indirectly, by the issues facing the older generation. These are currently very topical, and include people living longer, dementia and NHS service cuts. We may also notice increasing numbers of older people accessing our own practices. Hence, BACP's new older people strategy is very timely. In case this is the first time you have heard of the strategy, I have come up with a snazzy acronym to make it more memorable: CARE.

BACP is:

- Campaigning to challenge negative stereotypes, raise awareness of mental health issues, and promote a fulfilling later life, free from depression and anxiety
- Accessing and influencing policy-makers across the UK to prioritise older people's mental health, and increasing their understanding of the critical role that BACP members can play
- Reviewing and disseminating the current evidence on the efficacy of therapies, as well as carrying out new research
- Engaging BACP members to share good practice and develop further training and support to increase their work with older people.

If you would like any further information about this, you can contact Jeremy Bacon, BACP's new Older People Lead (jeremy.bacon@bacp.co.uk).

In October 2017, BACP hosted a roundtable meeting on older people, with leading professional bodies and charities. Participants included representatives of Age UK, The British Geriatric Society, The British Psychological Society, Cruse, Independent Age, My Home Life and The Royal College of Psychiatry. The meeting provided an opportunity to discuss strategic objectives and future collaboration. It resulted in BACP agreeing to work more

closely with partner organisations to promote positive images of older people, raise awareness about their mental health issues, and call for action to meet their needs.

Research shows that GPs are offering older people tablets rather than psychological therapies, despite NHS England evidence that over-65s are more likely to complete IAPT treatment and have better outcomes than those under 65.¹ Helen Kewell's article, *Waiting for the Southsea bus*,² in the May 2017 issue of *Therapy Today*, explored the provision of therapy for older people, and drew a good deal of support from members; it is well worth a read. BACP will continue to listen to members' experiences of working with older people and aims to increase the number of practitioners available to the older age group.

MENTAL HEALTH IN SCOTLAND

Also in October, BACP attended the SNP party conference in Glasgow and registered our support for the Scottish Government's review of school counselling, which was launched in December 2017. At the Mental Health Foundation in Scotland's reception, we briefly revisited discussions held with the Minister, Maureen Watt, in May last year about the Scottish Government's 10-year mental health strategy.⁴ Although there was little in terms of new mental health policy at this year's conference, the Scottish Government did announce £500,000 funding for NHS 24 to improve its online and telephone mental health services. For more information, please contact Steve Mulligan, BACP's Four Nations Lead (steve.mulligan@bacp.co.uk).

BACP GOOD PRACTICE RESOURCES

BACP has produced additional Good Practice resources,⁵ which incorporate our new design; I hope you'll agree that they look far more modern and inviting. Although the new ones are in pdf format only, I'm assured they are fully accessible for members using screen readers; however, Word format resources will still be available.

Among the topics covered are: retirement, trainee placements, working with an interpreter, female genital mutilation (FGM), using the *Ethical Framework* in supervision, fitness to practise, sexuality and gender, and pre-trial therapy and record keeping when working with children and young people.

If there are other topics you would like us to cover, or you have any feedback on the existing ones, please do get in touch. We are always delighted to hear from you. ■

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- 1 NHS England. *Adult Improving Access to Psychological Therapies programme: older people*. [Online.] NHS England. <https://www.england.nhs.uk/mental-health/adults/iapt/older-people/> (accessed 19 November 2017).
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This is a regular column by Judy Stafford, who works in the Healthcare department of BACP. Judy is also a registered member of BACP and is a person-centred counsellor working in the third sector.



EATING DISORDERS: IS INACTION TANTAMOUNT TO NEGLIGENCE?

KEL O'NEILL ARGUES THAT COUNSELLORS AND PSYCHOTHERAPISTS NEED TO DO MORE TO RECOGNISE AND ADDRESS EATING DISORDERS

Experience tells me that, if I open this article with the words 'eating disorder', a substantial proportion of those reading will simply skip to the next page, perhaps looking for something that sounds more relevant to them or their practice. However, hopefully I will have caught your attention before that happens. I believe that this is an important topic; it is an issue with which many counsellors are working, whether or not they intend to, and irrespective of the fact that clients with a diagnosed eating disorder are generally meant to be referred to specialist services.¹

The term 'eating disorder' is an umbrella title, used to indicate any of a number of complex mental health issues.¹ Most notably, these are anorexia nervosa, bulimia nervosa and binge eating disorder, along with 'otherwise specified feeding and eating disorder' (which may also be termed 'eating disorder not otherwise specified'). Sub-clinical types of related difficulties are typically referred to as 'disordered eating'.

To those of you who are new to this topic, I believe the minutiae of the diagnostic labels are not relevant to understanding the overall conversation here. So, simply put, eating disorders are those conditions in which food, weight, body shape or size becomes a way of coping with distress. Eating disorders are illnesses of both mind and body, and this is perhaps why they are acknowledged as having the highest mortality rate of any mental health illness.²

A recent update to the relevant National Institute for Health and Care Excellence (NICE) guidelines³ states that those affected by eating disorders should have equal access to treatment, with trained and skilled workers, at the earliest opportunity. However, despite this – and perhaps due to huge increases in the diagnosis of eating disorders³ – specialist services often have long waiting times⁴ or strict referral criteria.⁵ This can result in individuals being referred to less suitable services, such as IAPT, or having to access therapy privately. Since research suggests that 6.4 per cent of the population display signs of an eating disorder⁶ (this works out at over four million people in the UK), we can only assume that this issue is going to continue.

If you have yourself received an 'inappropriate' referral of a client with an eating disorder, you will have perhaps experienced some of the reasoning behind why this could be a problem. Counsellors often tell me that they have no training in this area, while clients report an assumption that all counsellors know at least a little. The fact is that the stereotypes surrounding eating disorders run deep in our society and often this is the only 'knowledge' that counsellors have to rely on. Therefore, I cannot blame you if you are not aware that 25 per cent of those displaying signs of an eating disorder are men,⁶ or if you do not understand what re-feeding syndrome⁷ is, or that the leading cause of death among those with bulimia nervosa is cardiac and respiratory arrest.⁸

The stereotypes surrounding eating disorders often also lead us to believe that the risk associated with them is death as a result of starvation and emaciation. In reality, people die of eating disorders at any weight, as was tragically highlighted recently when a bright 16 year old died from bulimia nervosa – without prior notice – when her heart simply stopped.⁹ In 2014, I also lost a friend to anorexia nervosa. She was ‘in recovery’ and at a healthy weight. She died by suicide, another common cause of death among this group. These are just two examples among many. There is no sliding scale of urgency when it comes to eating disorders, because the risk is rarely visible; it far transcends the weight or appearance of the clients.

Current research suggests that only around half of those who develop an eating disorder achieve a full recovery,¹⁰ and even then the individual might be left with long-term medical issues, such as osteoporosis¹¹ and gastro-oesophageal reflux disease.¹² So, even for those individuals who do survive, and indeed recover, their experience may have a lifelong impact.

Furthermore, the stereotypes around eating disorders paint a particular picture of who develops these conditions and why. While it is true that, in many cases, the onset of an eating disorder happens in adolescence,¹³ there is also evidence of onset throughout the lifespan, including in later life.¹⁴ There is not necessarily a ‘typical’ person presenting with an eating disorder, and this is something certainly reflected in my own practice, where I see a wide demographic of clients each day.

Glossy women’s magazines and general popular media would have us believe that eating disorders are caused by social media and size zero models – that they are perhaps an ‘illness of vanity’. However, the reality is far more complex than this. In fact, I have yet to meet a client who professes either of these factors to be the primary or sole cause of their difficulties. Rather, these influences tend to be more of a maintaining factor, serving to normalise distorted attitudes towards weight,

body shape and food. Instead, the aetiology is far more multifaceted, with genetics^{15,16} and the lived experience both playing interrelated roles. The ‘reasons’ that contribute are as individual and varied as the clients.

Irrespective of the cause, eating disorders ravage people’s lives; physically, psychologically and socially. Clients often describe their disorder as if it were another person – the disorder moves in and takes control. Typically, clients feel powerless and hopeless – feelings often also mirrored in the therapist. They also report feeling misunderstood, so much so that research has identified that the stigma surrounding these disorders can be just as damaging as the illness itself.¹⁷

At its core, an eating disorder is simply a coping mechanism, much like drinking too much, or self-injury. A person with anorexia nervosa might be starving themselves in an attempt to starve away their pain, or a person with binge eating disorder might be attempting to fill an emotional void with food. However, beyond the basics of being a coping mechanism, eating disorders can be exceptionally complex, both generally, and within each individual.

Professionals from across the disciplines of genetics, neuroscience, psychiatry and preventative education are all working to better understand, treat and prevent these disorders. They are uncovering interesting findings that might shape the future of care and treatment in this sector. But what about those affected right now? What can we do, right now, when we receive a referral – perhaps in a time-limited setting, and when the client doesn’t meet eating disorder referral pathway criteria?

From all my years of experience in the eating disorder field, I think the essential points have to be that we do not dismiss the person’s struggles, we do not trivialise them, we do not add to the shame they feel, and we do not overlook the level of risk. This is not supposed to sound condescending, and actually I think it is much easier said than done.

Eating disorders are illnesses of both mind and body, and this is perhaps why they are acknowledged as having the highest mortality rate of any mental health illness

We live in a society where poor body image and dieting behaviours are common place. Weight loss is typically something that is complimented and desired, and therapists have been shown to have less empathy for clients with eating disorders.¹⁸ Unfortunately, it therefore makes sense that clients often report feeling that their struggles are underestimated.

The very nature of eating disorders means that we all have related biases, and recognising these is an important factor in working with this client group more effectively. We have to take a step back, not only from our own 'stuff', but also from the societal norms that risk impacting how we respond to clients with these diagnoses. For example, you may have your own perception of what constitutes 'healthy eating', a 'healthy' body weight or a 'healthy' relationship with food, but how would you make sense of this in relation to your clients, and their experience of eating disorders and eating disorder recovery? Is what you know fact, or is it opinion?

For the above reasons (our biases, and the medical risks), along with the complex nature of eating disorders, I believe it is especially important that counsellors attend CPD or establish a solid foundation of knowledge on the topic. I understand that we cannot be experts in everything our clients bring to therapy, and nor do I think we should be. However, when we work with clients with eating disorders, we are working with life and death scenarios and, accordingly, we must know enough so that we can work safely.

Perhaps you have received a referral of a client who has depression. Upon some initial questioning, it transpires that your client makes themselves vomit when they are feeling negatively towards themselves. Their goals for therapy might be to improve their mood and self-esteem sufficiently, so that they no longer want to use this unhealthy coping mechanism. The client may easily find themselves referred into an IAPT service or to a practice counsellor. The person who placed the referral or conducted the initial assessment may not be fully educated about eating disorders, or the client may not have disclosed the intentional vomiting. Perhaps there is no eating disorder service in your locality, or they were not considered an appropriate eating disorder service referral because they were not displaying 'severe enough' symptoms. I have heard about all of these versions of events happening. However, this client is likely to have an eating disorder – they have 'eating disorder not otherwise specified', of a purging subtype. People with this condition do die.

It is entirely possible that you can help this client. In fact, perhaps, you already have helped someone with a very similar presentation. However, are you aware of the medical risks associated with self-induced vomiting? Additionally, what do you want or need to do about that? Some readers will come from more medical backgrounds, and may very well be aware of the risks. Other readers are perhaps wondering what this has to do with working as a talking therapist with this client

– a completely valid thought! In brief, forced vomiting may have only minor impacts upon the individual's physical health, such as tooth decay and indigestion. However, in some cases this behaviour could result in more dangerous side effects, such as electrolyte imbalances and even oesophageal ruptures, both of which are potentially life threatening. As a talking therapist, this knowledge might seem irrelevant to our role – after all, knowing the risks associated with any given behaviour does not necessarily give us power to do anything about it. We are not medical professionals in the traditional sense. However, you may very well be the only person with any awareness of the potential risk facing this hypothetical client.

Clients often describe their disorder as if it were another person – the disorder moves in and takes control. Typically, clients feel powerless and hopeless

Many counsellors would consider it ethical to breach confidentiality if the client was actively suicidal. There is no similar pre-set response available to those working with eating disorders in non-eating disorder specialist services. There is no clear line in the sand that indicates a need to encourage or take action to safeguard a client. However, as we have already outlined, the risk of death from an eating disorder is statistically higher than the risk of suicide among those with depression.

When the above is acknowledged, I believe there is a clear need for counsellors to have at least some basic education in this field – education that might allow you to establish where you stand ethically with regard to working with clients with eating disorders, supporting them to access additional medical care, and also potentially breaching confidentiality to save someone's life.

I am not suggesting that we become so paranoid about medical risk that we become frightened to work with this client group, or that we lose the therapeutic process to medical management. Rather, I am suggesting that we are better equipped to respond to such clients in the safest way possible, with the knowledge available to us and the skills that we have. I have seen talking therapy make a massive difference in the lives of this client group.

Personally, I consider that holding awareness of someone being at high risk, and choosing not to take any action is negligent. I therefore contract with clients with eating disorders to seek medical monitoring. I state clearly that I am not a medical professional, I bring to

the client's attention the inherent risks of their behaviour, and I express my genuine concern for their physical safety. Perhaps this is a little outside of the typical therapeutic norm, but it has become my way of attempting to ensure that I am working as safely as possible.

Similarly, I feel a duty – knowing that counsellors often frequently are not educated in the risks of eating disorders, and how to handle them – to take action by bringing this topic to the awareness of as many practitioners as possible. I can only hope that, upon reading this, at least some will take notice, and take action. Perhaps, by doing so, you will save someone's life. ■

Kel O'Neill is a registered MBACP (Accred) counsellor and supervisor with a specialist interest in eating disorders. She combines her professional practice with teaching and writing, and is currently researching therapists' responses to working with clients with eating disorders. You can follow Kel's award-nominated blog at: www.mentalhealthbites.com

READER RESPONSE

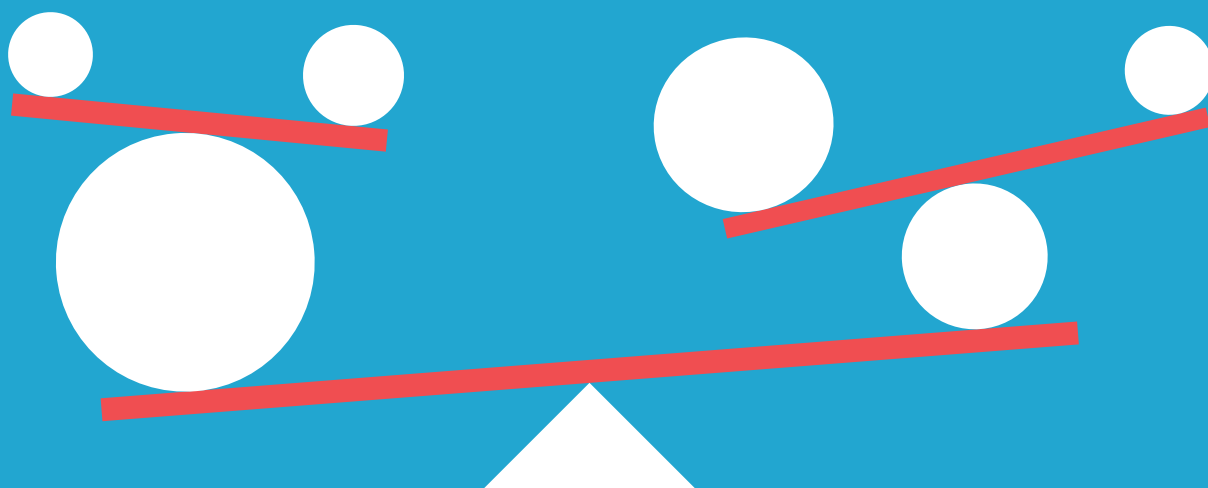
If you are interested in contacting Kel with regards to CPD opportunities, or to offer feedback on this article, you can email her at contact@counsellingandtraining.co.uk

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SUPERVISION AND TRAINING SUPERVISORS FOR IAPT: ARE WE GETTING THE BALANCE RIGHT?



MICHAEL WORRELL EXPLORES WHETHER THE PROVISION OF SUPERVISION FOR IAPT CBT PRACTITIONERS IS ADEQUATE AND FIT FOR PURPOSE

INTRODUCTION

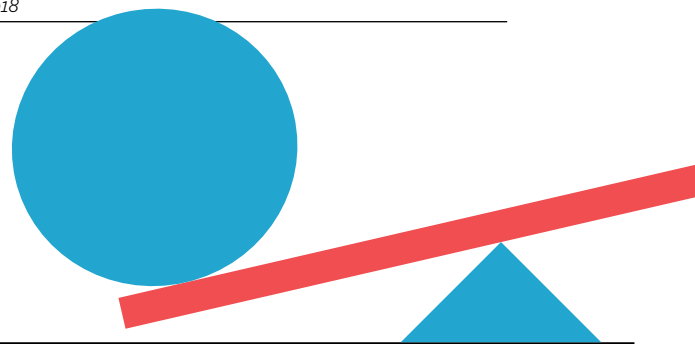
Supervision is generally regarded as essential to the formation, maintenance and enhancement of psychotherapeutic competencies. This holds true across different therapeutic modalities and professional disciplines. The literature and research on supervision is advancing at a significant rate, and training programmes in supervision have gained in popularity. They are increasingly seen as an essential step in the formation of competence and identity as a supervisor. This is in contrast to the situation as little as a decade ago, when many practitioners became supervisors through being recognised as having become 'senior' and experienced; the assumption was that years of clinical

experience would somehow translate into competence as a supervisor.

Supporting the development of supervisors has been central to the advancement of the national IAPT programme. In part, this is related to the original argument for the creation of IAPT – namely, it was asserted that, providing practitioners were given a similar level of training and supervision to that provided to therapists working on randomised control trials, it would be possible to replicate the results of such trials in routine clinical practice. Since its inception in 2008, the IAPT programme has included training for supervisors of psychological wellbeing practitioners (PWP) and high-intensity CBT therapists. This has also been supported by the

construction of a competence framework for the practice of CBT supervision, as well as a recommended curriculum for the development of supervisors.¹

In this brief article, I hope to reflect on both the process of training high-intensity CBT supervisors, as well as on some of the challenges of providing clinical supervision to trainees and qualified staff in IAPT services. Specifically, I am interested in the question of whether the models and processes that have been developed to support this work are adequate in the current context of IAPT. Through this, I am also interested in the possibility of cross-modality dialogue in regards to what constitutes good practice in supervision. I think this cross-modality dialogue may be important as the range of psychological therapies provided in IAPT services increases. It is likely that some of the current challenges and dilemmas facing high-intensity CBT and PWP supervisors are also likely to be experienced by supervisors of the other non-CBT modalities, as these supervisors



and therapists are subject to the same contextual demands and dilemmas.

COMPETENCY-BASED SUPERVISION

The shift towards 'competency-based' training and supervision is itself consistent with international developments in the field; it is the most significant shift in the way in which training and supervision have been undertaken in the last 20 years. As Watkins and Milne claim, 'there has perhaps never been a more sweeping and all-pervasive singular change to so rapidly impact the entirety of the supervision enterprise than the advent of the competency movement itself'.²

The developers of the competence framework for supervision within the IAPT context faced a specific challenge: the empirical evidence regarding the role of specific components and competencies of supervision lags behind the near

non-CBT-based models of clinical supervision. Issues of contracting, assessing competence and working with difference are all covered. Problem-based learning includes challenging participants to reflect upon how they might manage a range of ethical dilemmas in supervision. A key aspect of the programme is that it allows participants to practise supervision in small groups, with feedback from workshop leaders as well as peers in a safe, non-critical atmosphere. Participants are able to reflect upon the extent to which particular models and supervision 'interventions' are helpful and useful, as well as being challenged to extend the range of supervision options that they might typically use. This is particularly the case with more experientially based strategies, such as live demonstration and role play.

The training in supervision also incorporates a significant degree of

refers to the necessary educative aspect of supervision. The restorative function relates to the role of emotion and identity in supervision and therapy. In good supervision, the supervisor is able to offer the supervisee a safe place to express, explore and gain some sense of wider meaning related to some of the emotional complexities of working as a therapist.

Watkins⁴ has described a stage model of the development of supervisors and notes that, initially, a trainee supervisor may experience 'role shock'. Watkins describes this initial stage as often one involving anxiety, confusion and a sense of fraudulence. Over time, as the IAPT programme has progressed, I have noted that supervisors in training are themselves often still in a stage of consolidating their identities as CBT therapists. Thus, the restorative aspect in supervision training has involved the creation of a safe place where these trainee supervisors are able, for example, to reflect upon their experience of high-intensity training and their evolving relationship with the CBT model, as well as their experience of working as a fully qualified therapist in an IAPT setting.

DEFINING 'GOOD' SUPERVISION

Trainee supervisors generally have no difficulty in describing those aspects of supervision that they have found to constitute 'good' or helpful supervision, versus those aspects that they have experienced as 'poor' or unhelpful. In terms of poor supervision, the following appear to be key themes:

- A blurring between managerial and clinical supervision, so that the needs of managerial processes take priority and the clinical supervision needs, particularly the restorative needs, of the supervisee go unattended
- A lack of clear, reliable boundaries around the supervision. The supervisor is unreliable, inconsistent or seemingly un-invested in the importance of the supervision process
- The supervision becomes 'too supportive' and general, and there is a lack of any direct feedback or challenge

...the empirical evidence regarding the role of specific components and competencies of supervision lags behind the near universal agreement regarding the importance and effectiveness of supervision

universal agreement regarding the importance and effectiveness of supervision. Thus, there was reliance upon expert consensus regarding what constitutes good practice. Research on supervision is certainly advancing; however, there are still open questions as to which aspects of supervision, which supervisor strategies, supervisor and supervisee attitudes, and so forth, are essential in promoting good supervision outcomes.

In part reflecting this greater reliance on 'accepted wisdom', the curriculum for the development of high-intensity CBT supervisors is somewhat more broad and diverse than may have been expected. The training programme consists of five days of workshop-based training. The programme aims to introduce participants to a broad range of CBT-specific as well as

structured reflection on the trainees' experiences of receiving supervision (both within IAPT and their prior experiences). This includes reflection on how their own supervision has affected their hopes and expectations for what type of supervisor they would like to become, and what values they would hope to express and embody as competent supervisors. This type of reflection is somewhat outside of, or in addition to, the official recommended curricula. However, in my view, supervision training itself can be seen to hold the three functions of supervision identified by Inskipp and Proctor.³ These include the 'normative', 'formative' and 'restorative' elements. The normative function broadly refers to the necessity of the supervisor to maintain some evaluative role; in the current IAPT context, this may relate directly to the competence framework for CBT. The formative function

that might allow the supervisee to consider where they need to grow or change

- The supervision is 'too directive and challenging', such that the supervisee experiences anxiety and/or shame and takes steps to protect themselves from the supervisor in an effort to survive and maintain their self-esteem.

By contrast, 'good' supervision has been characterised as the following:

- The supervision is experienced by the supervisee and supervisor as a co-constituted and collaborative enterprise; while the supervisor must maintain their overall responsibility for the integrity and progress of the work, there is, nevertheless, an effort to establish an egalitarian partnership
- The supervision is characterised as having a balance between support and challenge. Interventions that increase or provoke shame or anxiety are avoided
- The supervisor uses interventions that are appropriate to the developmental level of the supervisee
- The supervisor shows a willingness to share their own experience including, on occasion, allowing forms of direct observation of their work with clients.

A central feature of the training is the notion that supervisor training should support the development of a 'supervisory identity'. Trainee supervisors are encouraged to engage with the range of available supervision models in a critical and flexible manner, so that they ultimately develop their own personal model of supervision. The supervision competence frameworks and models of supervision are regarded as touchstones and resources, rather than fixed models that must be 'adhered' to. Feedback from participants seems to indicate that they experience different models as being of help at different times and for different purposes. Some models, such as the 'seven-eyed supervisor model',⁵ seem to provide a useful challenge to broaden how and where attention is placed during supervision sessions; they act as a reminder not to

become stuck on only a limited range of focus points. This model also has the advantage of being relatively easy to recall during supervision sessions. Other models, including the supervision competence framework itself, are very difficult to hold in mind during a session. However, they can function as a very helpful reference point, particularly when the supervisor and supervisee need to reflect upon, and come to some understanding of, where a particular supervisee may be 'stuck' in their work and what types of supervision input they may find useful.

PRINCIPLES AND PROCESSES FOR CBT SUPERVISION

Trainee supervisors also appear to particularly value those models of CBT supervision that have advanced the notion that good CBT supervision should express many of the same principles and procedures as a good CBT session. Several such models have been constructed, including one specifically for the IAPT context.⁶ These models can be seen to express the underlying 'problem-solving' perspective inherent in CBT approaches. The following features seem to particularly characterise how central CBT assumptions and procedures are carried across into supervision:

- The supervisee is given the responsibility of taking the lead on stating and defining a 'supervision question', which becomes the focus point for each supervision session
- An explicit educational focus is taken, such that the supervisor may frequently be required to instruct the supervisee in key CBT concepts or interventions and to demonstrate or role play such interventions when this may be useful
- Frequent use is made of review of client progress and outcome monitoring information
- There is a concern with ensuring that the supervisee is working from and adhering to a viable clinical formulation of the client's difficulties, which itself will be expressive of central CBT assumptions and principles regarding the nature of client difficulties and the process of psychological therapy

- An emphasis on direct observation of supervisee practice and the provision of feedback on the demonstration of specific competencies
- An emphasis on assigning supervisees 'homework' so that it is clear exactly what it is that the supervisee may attempt to carry forward or do differently as a result of the supervision session.

These features are also frequently replicated in the practice of routine clinical supervision in IAPT services. For PWP's, a model of 'outcome-focused' supervision has been developed that is seen as appropriate to their high caseloads. This often requires the supervisor to review a supervisee's entire caseload on a frequent basis, as well as spending time reviewing the case planning decisions made by the supervisee, in order to ensure these are consistent with the stepped care model and remain appropriate to the level of intervention that PWP's are able to provide. High-intensity therapists (HITs), by contrast, may spend more time with specific cases; however, an emphasis will be maintained on the review of clinical formulations, the routine review of outcome-monitoring scores and on ensuring that the therapist remains 'on model', rather than 'drifting' from the evidence-based intervention they intend to provide. There are many advantages of such a supervision process. The structured, goal-directed process and its explicitly collaborative nature ensure that the supervision agenda is tailored to the supervisee's current developmental stage. The focus on clinical formulation ensures that supervisees are able to develop clarity about why they are doing what they are doing with clients. The focus on outcome monitoring allows supervisor and supervisee to target those cases where there is a risk of deterioration.

Of course, any proposed structure or model may also entail a range of weaknesses or disadvantages. In my view, one of the potential weaknesses of these models for CBT supervision is that they appear to emphasise the formative and normative aspects of supervision, while potentially de-emphasising the restorative function.

For example, it is possible that a process that requires a supervisee to routinely commence sessions with a 'supervision question' will reinforce the supervisee's need to provide questions that can be more clearly answered within a time-limited framework. Such supervision questions are more likely to focus on technical aspects of the treatment, or on aspects of the client's formulation. Supervision questions that are more 'restorative' in nature are often more difficult to operationalise clearly at the beginning of a supervision session and require a supervisor who is willing to 'stay with' an unclear initial statement, knowing that it is often the unstated question or the question behind the question that is potentially more important.

In good supervision, the supervisor is able to offer the supervisee a safe place to express, explore and gain some sense of wider meaning related to some of the emotional complexities of working as a therapist

SUPERVISION AND BURNOUT

A key issue emphasised in many supervision theories is the need to take account of and be responsive to the context in which clinical work is undertaken and in which the supervision process itself occurs. The rapid expansion of training for the IAPT workforce has resulted, at the present point in time, in a new workforce that is relatively young and relatively clinically inexperienced. Additionally, some concerns have been raised regarding the degree of stress experienced by PWPs and HITs and the associated risk of 'burnout' that this may entail. In a recent article, Westwood, Morison, Allt and Holmes⁷ report on a study of emotional exhaustion, disengagement and burnout among PWPs and HITs. The research involved an online survey of 201 practitioners, and results indicated that the prevalence of burnout was 68.6 per cent for PWPs and 50 per cent for HITs. These authors discuss a range of factors characterising the IAPT context that may be related to these findings, including high caseloads, a heavy focus

on targets and outcome monitoring, and frequent telephone-focused work. Of particular relevance to this article is the finding that, among PWPs, higher hours of clinical supervision predicted lower odds of burnout. This indicates that the supervision being provided to PWPs is of particular importance and value. It also suggests that, while the supervision model for PWPs appears to be promoting a process that is more normative and formative, PWP supervisors are still able also to address restorative functions as well. However, these figures for stress and burnout, if representative of the wider workforce (and this cannot be assumed), are cause for concern.

For those counsellors and therapists working outside of the CBT model, it might be that the concerns raised here are seen as evidence of weaknesses or problems within the CBT model itself. However, in my view, this is not the case. Over recent years, a range of developments within the CBT perspective have provided a great deal of support for re-emphasising the central restorative function of CBT supervision. These developments include, but are not limited to:

- A greater emphasis on the role of emotions in the practice of therapy and supervision including client, therapist and supervisor emotions⁸
- Empirical research that demonstrates that the quality of the therapeutic relationship is essential in the practice of CBT and also in the practice of CBT supervision⁹
- A recognition that paying more attention to the 'person of the therapist' is essential in CBT and that processes that support the development of a capacity to engage

in reflection can be an important aspect of training and supervision.¹⁰

REVALUING RESTORATIVE SUPERVISION

It seems to me that, in a context where there is increasing evidence that PWPs and HITs are experiencing considerable degrees of stress, it is essential that our models and practice of clinical supervision include a recognition of the centrality of the restorative function. This emphasis on the restorative function does not necessarily mean that the current models and structures for supporting CBT supervision need to be abandoned. Rather, it requires that supervisors attempt to develop and maintain a broader contextual awareness in contrast to maintaining a narrow or indeed naïve view of supervision as problem solving or skills training. The potential weakness of all attempts at following a problem-solving model is that the definition of the initial problem statement may be too quick or too narrow. While it might often be helpful and appropriate to proceed from the supervisee's initial statement of a clinical or supervision problem, the ability of the supervisor to help the supervisee 'stay with' the definition and experience of the problem may be of use in helping the supervisee to clarify what is at stake or what a particular problem statement may mean to them, before discussion proceeds to looking at potential solutions. Additionally, at times, it may be that the outcome of supervision is that supervisor and supervisee come to the conclusion that the original problem is in fact not the most central, interesting or important factor.

Sally (a pseudonym) is a high-intensity trainee therapist. She reports struggling to keep up with the demands of her course and the caseload expectations of her service. Hardworking and idealistic, there is no real evidence of her falling behind or failing to develop the fundamental competencies in high-intensity CBT. She reports, however, that she frequently works additional unpaid hours, as she struggles to complete the administrative aspects of her work. She begins her contribution to a group supervision session, as she often does, in a manner that appears highly organised and motivated. She states her supervision question as: 'I have a client, Mr X, with whom I really struggle to finish on time...I want to learn how to be more efficient in my sessions and to learn how to bring sessions to a close appropriately.'

This supervision question – certainly an appropriate one, given the supervisee's context and learning needs – initially appears to be consistent with the more normative and formative aspects of the supervision process. Certainly, some productive work may be achieved through focusing on assisting her to develop strategies to structure and pace her session so as to allow a smoother ending phase. It could be argued that developing these more technical skills will also be of benefit in assisting her to avoid future burnout or exhaustion. On this occasion, however, the supervisor opts to spend some additional time clarifying with Sally what it is like for her to struggle with ending her sessions on time. The supervision question, although not formally stated, becomes instead: 'What are the emotions, beliefs, concerns and dilemmas that you experience with this client at the ending stage?' This exploration reveals that session endings are, in fact, a frequent concern and difficulty for her, and one that is associated with significant anxiety about not providing 'enough' to her clients and, in a sense, not 'being enough'. As this exploration could potentially trigger further shame and anxiety for the supervisee, particularly as it is occurring in a small group context, the exploration is only possible due to the fact that there is a strong supportive relationship established between the supervisor and supervisee, as well as between the members of the supervision group. This allows for a good degree of validation of the supervisee's concerns. The possibility of providing educational input is not neglected, and nor is the possibility of challenging the supervisee's beliefs regarding what it is that she should be doing or providing in order to be a good CBT therapist. However, it seems that it is more the chance to express, explore and open up this question that is of value. In a sense, the supervision question is not fully answered by the end of the session; however, it becomes a significant turning point for the supervisee and the group as they start to find greater room to explore and challenge some of their beliefs, concerns and anxieties about working as CBT therapists.

MAINTAINING BALANCE

One of the biggest challenges of providing more room for restorative supervision is time. Both while on the training programme, and while working in clinical services, trainees and qualified staff are dealing with many demands. Supervision

that prioritises more behaviourally observable competencies will also often support supervisees in meeting their most pressing demands and, in this sense, is an essential contribution to ensuring that they are appropriately supported and less likely to experience burnout. My sense is that many CBT supervisors in IAPT settings are paying attention to the restorative function and are finding ways of expressing this within the problem-solving framework for CBT supervision that they have been given. However, there is cause for concern. Another study of stress and burnout in IAPT staff has been conducted by Steel, Macdonald, Schroder and Mellor-Clark.¹² These authors surveyed 116 IAPT therapists via a web-based method. They concluded that there was evidence that this workforce was experiencing 'exhaustion', but had not yet become 'cynical' and recommended that supervision within IAPT focused on assisting therapists to process and manage their reactions to in-session experiences of anxiety. This would require a greater privileging of the restorative function, while also maintaining the good practice of addressing normative and formative functions.

Supervisees experiencing the stress of high caseloads and complex and demanding presentations may bring this experience to their supervisors; however, there may be a risk that supervision itself becomes experienced as yet one more demand. Sensitive and responsive CBT supervision can enable the supervisee to acknowledge, express and explore the experience of stress and can allow the supervisor to express validation of the supervisee's experience. It can also provide a reflective space for the supervisee and supervisor to reconnect with and to reinforce the values and meaning that the supervisee wishes to embody in their practice of CBT. Good supervision, from whatever perspective, should support the supervisee in taking a narrative of client problems saturated with notions of stuckness, difficulty and complexity and allow for a broader perspective that makes room for possibility and meaning, which can further support the supervisee in the demanding work of being a therapist. ■

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READER RESPONSE

The author would welcome feedback on this article. To contact him, please email michael.worrell@nhs.net



TENDING THE GROWING EDGE:

COUNSELLING
WOMEN FOLLOWING
BREAST CANCER





CAROL MORGAN EXPLORES THE ROLE OF COUNSELLING IN FACILITATING POST-TRAUMATIC GROWTH

OVERVIEW

For the past 12 years, I have worked as a counsellor with women who have been diagnosed with breast cancer. In this article, I would like to share a key area of that experience, namely the positive personal growth that I have witnessed in women as they seek to come to terms with what has happened to them. The nature of this growth has some specific characteristics, which I explore through a case study, fictionalised to protect confidentiality, but highlighting actual issues brought to me.

The concept of post-traumatic growth (PTG) was first introduced by Richard Tedeschi and Lawrence Calhoun in 1995¹ and refers to the positive changes that individuals often report following adversity. Ongoing research in this area has included exploration of the experiences of post-traumatic growth in those who have suffered a life-threatening illness,² and the development of several psychometric tools, such as the Post-Traumatic Growth Inventory (PTGI)³ and the Psychological Well-Being Posttraumatic Changes Questionnaire (PWB-PTCQ),⁴ which assess individual differences in positive changes following adversity. The facilitation of post-traumatic growth is being increasingly recognised as a valid focus in therapy.⁵

As a person-centred counsellor who believes in the growth potential, or actualising tendency, of human beings, the concept of PTG chimes with my own philosophy. Other key principles guiding my work are a belief in each individual's unique instinct as to the direction in which they need to go to achieve personal growth, and that the therapist's main task is to harness this 'exquisite inner compass'.⁶ So my own approach is facilitative and non-prescriptive, closely attuning myself to my client's own process and tailoring what I do to this process. In closely following them and responding to them, I work in a pluralistic way,⁷ drawing upon all of what I may have to offer by way of knowledge, experience and skills and providing these as part of a collaborative, facilitative dialogue. I am committed to ongoing learning about what is helpful and unhelpful to my clients, learning from them and from others, with the aim of constantly growing as a practitioner.

The environment and context within which I work supports my counselling in several ways. I work for the UK-registered charity, Breast Cancer Haven, which offers holistic care to people diagnosed with breast cancer at six centres around the country – in London, Leeds, Hereford, Wessex, West Midlands (Solihull)



and at the Royal Worcestershire Hospital's breast care unit. Founded in 2000, the charity offers individuals up to 10 free sessions of complementary therapies, which can include acupuncture, reflexology, hypnotherapy, nutritional therapy and counselling. It also offers two hours of healthcare professionals' time at the beginning and end of their programme. All therapies are tailored to the individual, with close dialogue with NHS teams in order to ensure that the therapies dovetail with the person's medical care. In addition, up to four free hours of counselling can be accessed by family or close friends of people diagnosed with breast cancer.

Breast Cancer Haven's aim of responding to the needs of the whole person, through a programme tailored to the individual and supported by group sessions and workshops, gives me an important sense of being part of a team, who are working together to promote the individual's wellbeing and quality of life. I gain personal support and understanding from my colleagues, as well as the opportunity to learn from them about the ways in which their therapies help

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those who access our services. This learning from others has increased my capacity and confidence to have helpful conversations with those from other disciplines, including those from a medical background. Although we speak differing languages, we share a mutual aim to support those living with breast cancer.

Since its inception, Breast Cancer Haven has fostered close collaborative relationships with the NHS, with the aim of supplementing its aftercare services for breast cancer patients. Information about the charity's work is distributed in hospitals, to GPs and district nurses. Haven staff also join multidisciplinary meetings when invited, as well as local cancer networks and study days. NHS staff are regularly

invited to the charity's Health Professionals Days, where they can come to a centre and learn first-hand about our services.

The following case study gives a flavour of my work as a counsellor within this setting, with the aim of sharing some of my professional experience and in the hope that it may interest and inspire others who work in this field.

CASE STUDY

Maggie, aged 49, came to see me 14 months after her initial diagnosis. She had undergone a mastectomy, chemotherapy and radiotherapy, all of which had gone well, and she was shortly to go back to her job, teaching children with special needs. However, she was overwhelmed with feelings of anxiety around the cancer coming back and about coping with the stresses of returning to work. A single mother of two teenage boys, she also worried about them and how they might cope if she became ill again. At the same time, she felt bitter and angry towards her sons, who never mentioned her breast cancer or helped out much at home and she admitted to shouting at them a lot. She felt she was only valued if she was looking after others and she resented her own needs being 'constantly relegated to the margins'. Maggie's mother had died 18 months previously and Maggie, who had looked after her a lot since she had been injured in a car accident when Maggie was eight years old, also acknowledged continuing complex feelings of loss and grief.

My foremost aim in working with Maggie was to foster a collaborative relationship with her, one which would create safety and build trust. I wanted to enable her to focus on her current concerns and to find her own way forward. In listening to her, conveying empathy, unconditional positive regard and genuineness, I was seeking to understand all the dimensions of her experience, including the context in which she had experienced her breast cancer.

Our first two sessions focused on her intense, complicated feelings of grief over her mother and how she had felt somehow detached from her own breast cancer. She knew that she needed to focus on the medical aspect of her treatment, but could not and did not really want to access any feelings over this at the time. 'It was almost like it wasn't happening to me', she said; 'I just got on with it.'

In my reflections on these sessions, I noted how Maggie seemed to have sidelined her grief over her



breast cancer at the time, even dissociating herself from it, in order to cope. This trauma response is one that I often see in the women I work with. I noted, too, Maggie's strong internal belief that she must care for others in order to feel valued and how her identity,

thinking around self-nurture. We explored her interests in more depth. As she spoke, I was very affirming of the attempts she was making to help herself, saying things like, 'You're really finding ways of supporting yourself at this time.' She said she had enjoyed art at school and that she had recently picked up a colouring book for adults that someone had given her; she had enjoyed selecting a picture to work on and choosing the colours she would use. 'How did it feel, doing this?' I asked her, and she spoke about feeling silly at

A key area of growth in the women I have counselled after breast cancer is in their relationships with others. In reflecting on what matters to them now, their core relationships take centre stage

both personally and professionally, was bound up with this. I wanted her to feel unconditionally valued and accepted by me, as I believe these consistent therapist attitudes create a climate of stability and foster self-acceptance and self-valuing in the client.

In line with this, my early interventions involved helping her to acknowledge, articulate and begin to accept her own feelings, as they were, without judgment. My reflective responses and affirming acknowledgements helped her pace her narrative, and she was able to talk with increasing openness about her feelings, and to focus on how she might help herself to be with them in ways that helped her cope. Maggie talked about the interest she had had in meditative practice when she was younger. We discussed this and she commented on some of the literature on mindfulness and meditation that she had seen at the centre. I noticed an energy and enthusiasm in her when she began to get in touch with her own growth-promoting resources.

In session three, Maggie said that she was sleeping better and feeling a lot less anguished. She had begun to think more about what she would like to do to nurture herself. She said that she now felt ready to access the acupuncture sessions, which had been selected as part of her programme of therapies at the centre, when she had seen our breast care nurse for her first consultation. She felt more confident to try this now to help with her hot flushes. I acknowledged her progress and invited her to say more about her

first, but then getting very absorbed in it, losing track of time and feeling very relaxed. 'I must have spent an hour or more doing it,' she said. When I asked her how she might develop this creative side of her to support her healing, she talked about how she had particularly enjoyed sketching at school and thought she still had some art materials in a cupboard somewhere.

In my reflection afterwards, I noted the difference in Maggie's tone of voice and body language. There was an energy and lightness in her, especially when she remembered her enjoyment of sketching. She made much more frequent eye contact with me and there was a sense of fun. We also shared some laughter when she talked about her colouring attempts and how she had given herself 'permission' to colour outside the lines! I felt a sense of freeing-up in her. She continued to talk about her mother at times in the session, too, though I noted how she now seemed able to oscillate between feelings of grief and loss, and feelings of enjoyment and motivation; the accessing of her own trauma and her own enthusiasm for life seemed to go hand-in-hand. She was now very open in expressing and exploring her feelings with me and seemed much more accepting of them.

In sessions four and five, Maggie continued to nurture her creative side. She also focused on returning to work and she began to talk about her vocation for working with children with special needs and the values underpinning this that mattered to her. She felt that she would like to update her training, develop



some new skills and think about how she might move forward in her career. She also highlighted some of her present difficulties in communicating with her sons and was able to express her disappointment, anger and resentment towards them for not being more helpful at home or ever mentioning her breast cancer to her. Although she knew that her sons were growing up, she wanted to explore ways of remaining close to them.

I felt that Maggie was getting back in touch with her own strengths and abilities. She sounded confident when talking about her work with children; I reflected this back to her, fully acknowledging, too, the values of compassion and altruism that shone through. I felt that her own drive for self-fulfilment was very much in evidence and I could see her looking to the future more readily. Harnessing Maggie's professional confidence and teaching skills, we worked together to devise appropriate communication strategies to use with her sons, where she would seek to understand how this period of time had been for them, share how it had also been for her and invite them to work with her on a way forward.

Session six revolved around return-to-work strategies, which included rehearsal of responses to use when facing questions from staff and pupils about her illness. Maggie also talked about a 'shift' in herself around creating greater balance between her own and others' needs and a desire to ensure that she took

perspective' about her relationship with her, and what she had gained, as well as lost, from her caring responsibilities. Maggie felt she was really moving on. Although she could still get anxious at times about her health, she felt she was enjoying the present so much more and deeply appreciating life.

REFLECTIONS

A key area of growth in the women I have counselled after breast cancer is in their relationships with others. In reflecting on what matters to them now, their core relationships take centre stage. There is a reassessing of relationship strengths and difficulties, together with a strong motivation to work to improve things, with practical problem-solving featuring strongly, especially in the area of communication skills. I have noticed how, in developing their own abilities to communicate effectively around breast cancer, women also often gain greater confidence in tackling other communication difficulties. They often experience a general deepening of empathy in their relationships.

Similar to most of the women I work with, I noticed a significant shift in Maggie's relationship with herself. She seemed less self-critical, more accepting of her strengths and weaknesses, and more compassionate and forgiving towards herself, with a resulting growth in confidence that had a tender quality about it. In particular, there was a noticeable shift in her need to find self-worth by looking after others, while denying

her own needs. She had been able to accept both practical and emotional support from her family and friends, and this freed her up to spend more quality time with them.

In talking about the deepening of her own vocation as a teacher, Maggie reflected on how her own suffering, vulnerability and confrontation with

Having confronted their own mortality, there is often a deepening of their daily enjoyment of life. Many women re-engage with or deepen their personal spiritual practices, or develop an interest in doing so, for the first time

sufficient time to care for the deeper, more spiritual needs she felt were developing in her. Maggie had one more session in her programme and wanted to take this a few months' later, after she had returned to work.

In this final session, Maggie was overwhelmed by the response she'd had from school. She had felt listened to, supported and cared for, which had meant so much to her. She now felt glad to be back at work. She looked really well and was taking time to be with her sons and enjoy their company. They had started cooking together and going for walks with the new dog they had recently acquired from a rescue centre. Maggie had been to visit her Mum's grave to take some flowers, and she felt she was beginning to 'gain more

mortality were prompting her to learn more and be more open towards others who were struggling, especially other women with breast cancer. This increase in altruism and personal vocation is another key feature of the growth I regularly witness in women following breast cancer.

My sessions with Maggie also highlighted something else I often observe in women at this time – a deepening of their sense of what matters to them and a reaffirming or development of their personal faith or personal philosophy. Having confronted their own mortality, there is often a deepening of their daily enjoyment of life. Many women re-engage with or

deepen their personal spiritual practices, or develop an interest in doing so, for the first time. This growth is transpersonal, accessing those aspects of us that search for higher meaning in life. The development of women's wisdom, creativity, unconditional love and compassion is notable, linking them to the growing fulfilment of their highest potential as human beings.

CONCLUSION

My work with women following breast cancer has influenced my own practice in one particular way. I have become ever more in touch with and accepting of my own vulnerability, especially my own conflicting emotions around my own mortality. Moreover, I have become much more open in sharing this vulnerability with my clients, who often ask me how I feel about these things. I feel very much in tune with the fundamental life issues they grapple with, and by being so in tune, I have noticed that my clients are increasingly able to recognise both their own fragility and mine, with this leading them to access a deeper empathy for themselves and others. There is a growing sense of synergy in my therapeutic relationships – a sense that our mutual searching, our mutual openness and our mutual collaboration creates a combined power for growth that often feels greater than both of us. ■

READER RESPONSE

The author would welcome feedback on this article. Please contact her through the editor at hcpj.editorial@bacp.co.uk

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HYPEREMESIS GRAVIDARUM: WHO CARES?

MICHELLE NICHOLSON REFLECTS ON THE EXPERIENCES OF WOMEN WHO HAVE SUFFERED THE PSYCHOLOGICAL EFFECTS OF SEVERE PREGNANCY SICKNESS

INTRODUCTION

Have you heard of hyperemesis gravidarum (HG)? I hadn't. The first time I encountered these words was when I visited my GP, five weeks pregnant with my first child. He explained that this medical condition was the reason that I was vomiting every time I swallowed food or drink, experiencing back spasms due to relentless fits of uncontrollable dry retching, and battling nausea so debilitating that I was unable to move my head without the room spinning. In this pregnancy and my next, it was the reason I struggled to function physically and to cope emotionally.

For 17 weeks, I was rarely able to leave my home and I struggled to focus on the longed-for baby inside me because I didn't feel pregnant – I just felt ill. Hearing other pregnant women talking about 'blooming' or 'glowing,' as their lives just went on as usual, I began to feel increasingly isolated, low and abnormal. Being asked by so many well-meaning friends if I had tried ginger or travel sickness wristbands, I sensed the reality of my situation was just not being acknowledged or understood. Sobbing, when I finally admitted that, with HG, I could no longer look after my three-year-old

son by myself, I felt like a negligent and estranged mother. Physically heaving at the smell of shampoo on my partner's hair or toothpaste on his breath and watching him empty my sick bowl into the toilet yet again, I became a patient rather than a wife. Having to let colleagues take over my client work, I lost my sense of being a useful member of society. I managed to endure these four-month periods of HG physically and emotionally by focusing on surviving one day at a time.

Several years on, I was still perplexed by this all-consuming question: while the healthcare professionals with whom I came into contact did a wonderful job of measuring my 'bump', my urine and my blood pressure, and providing the necessary physical care, why did no-one ask me how I was feeling emotionally? As a counsellor and an HG survivor, I wanted to understand more about the emotional effects of HG and I was curious about other women's experiences of this pregnancy-related illness.

Pregnancy sickness research has been dominated by pharmaceutical approaches to physical care. Studies have been

predominantly quantitative and biologically orientated,¹ with minimal reference to women's voices and the emotional impacts of HG. Studies of emotional symptoms following HG pregnancy remain limited.² Consequently, I decided to focus my postgraduate counselling research study³ on the therapeutic value of emotional expression around HG. Ten women who had previously lived with HG participated in one-hour qualitative, semi-structured interviews. A number of themes were identified around the emotional impacts of HG:

Overwhelming debilitation: one participant, Joan, described living with HG as 'so overwhelming; it just debilitated me for months; I couldn't do anything else but lie in bed'. Another, Freya, recounted 'the fear and the sadness and the uncertainty of it all'. Ellie spoke of the sense of seclusion, saying, 'I was just so in my own little bubble of awfulness, it was truly terrible, truly, truly awful.'

Loss and disruption: women told of numerous disruptions and losses in their HG illness narratives. These included loss of role, with Ann describing, 'not being able to do this and that and cook and whatever'. Greta spoke of the loss of social contact, recalling, 'It's very lonely, I'd just lie at home on my own for hours, just lying in that bed'. She also mentioned the loss of quality time with older children, explaining, 'I made lists of days out we were going to have together when I was better, things to look forward to.' Joan spoke of loss of physical agility, saying,



'I went from skiing in the mountains to shuffling down a hospital corridor with a drip in my arm in 10 days.' Cath described a loss of agency, with the words, 'I didn't want to be admitted [to hospital], I wanted to control it myself'. Donna mourned her anticipated 'normal' pregnancy, describing it as, 'the kind of pregnancy that I wanted, but didn't have'. Bea commented on the loss of relationships, observing that 'people have lost friends and family due to people not understanding'. For Freya, the grief was around the lack of freedom to disclose pregnancy in her own timeframe, due to symptoms. She lamented, 'I never had that ability to keep it secret for the first 12 weeks.'

Shame and reticence: for some women, there was a sense of shame around their HG. Holly reflected, 'I felt embarrassed the whole pregnancy, embarrassed that I was that ill, that I wasn't enjoying being pregnant, of how I looked.' For Ellie, there was shame around feeling different due to her illness experience. She remarked, 'I felt like I was a freak, like I can't cope and everybody else can manage.' Ann described how her emotional experiencing of HG did not fit with the dominant discourse around transition to motherhood, asserting, 'There's so much we're not allowed to say, we're not allowed to feel, when we're pregnant.'

Somatic disconnection: a number of participants described a sense of separation from their bodies in their HG illness. Ivy encapsulated this with her perception that, 'I felt very much like an observer at times in my pregnancy, like things were happening

to me and I wasn't in control of it.' For Holly, this was accompanied by a loss of somatic agency: 'When you're that ill, you feel totally out of control of your own body.' Donna reported a disconnect from her sense of self, which she described as, 'That sedated feeling of it not being me'.

A lot of the health care professionals that I encountered weren't interested that I'd got HG. I was feeling so sick all the time and it was really getting me down and they just sort of ignored it

Impact on relationships: HG impacts on women's relationships with key others, and it can leave them feeling desolate: Cath spoke of her relationship with her partner, recollecting, 'I felt really isolated because he couldn't support me.' Ann felt belittled and described how her sister could not relate to her experience: 'She just didn't get it. She'd had three pregnancies and didn't have a day of nausea in any of them so she just didn't understand.' Greta felt alienated from her friends, and conceded, 'I find it really hard to be around people who are having normal pregnancies, when they moan about their very ordinary pregnancy sickness while they're having a meal or doing normal things.'

Destabilised maternal role identity:

HG can destabilise a woman's emotional connection with her baby in utero. Donna described how, 'It made it very hard to bond at that point in the pregnancy.' For Greta, this affected her enjoyment of the transition towards motherhood. She explained,

'I couldn't look forward to the baby at all because I couldn't find any joy in that. Obviously, when he came, I felt differently.' It can also affect a woman's parenting of previous children, as Ellie confirmed, claiming, 'I wasn't a very good parent, I just used to wait for my husband to get home so I could go to bed; it was awful.'

Minimisation of HG by others: several participants reported that their HG experience had been minimised by other people. Examples cited include: 'It's just a bit of morning sickness, why can't you cope?' (Ivy); 'Oh well, no wonder you're ill, you're not eating' (Greta); and 'she's crazy, she's exaggerating' (Holly). In some cases, such

comments resulted in women undervaluing their own lived experience of the illness. Freya captured this aptly, commenting, 'Sometimes it doesn't feel real because of the way it's treated and the way it's seen.'

Cognitive impact: many women find that the cognitive impact of HG leaves them unable to fully focus. Holly recalled, 'It feels so stressful and you can't process it all and you can't think properly.' Ellie found it hard to engage, reasoning, 'You just withdraw into yourself.'

Feeling unheard and unacknowledged: in the context of their HG experience, women described feeling unnoticed, with Ann realising, 'I don't really feel like I was ever heard.' Donna described how she felt unacknowledged, suggesting, 'It's quite an unseen illness; people don't want to see it.' Greta felt misunderstood, pointing out, 'Even well-meaning people that really love you, or professional people, didn't get it.'

I experienced so much trauma and these things weren't picked up; nobody seemed to be bothered; I know that more could have been done for me

Anxiety around further pregnancy: the distress inherent in HG can render women unable to contemplate further pregnancies. Ellie captured this in the words, 'I'd have to be really crazy to do it again, I couldn't put my family through it; I couldn't put my body through it.' For Joan, this meant limiting her family size. She maintained, 'My experiences were just so horrific, I wouldn't want another child.'

Inadequate professional emotional healthcare: while Joan described her GP as 'brilliant and surprisingly engaged', seven participants shared examples of inadequate emotional support from healthcare professionals, in terms of their HG symptoms. This left them feeling overlooked. Cath stated, 'A lot of the healthcare professionals that I encountered weren't interested that I'd got HG. I was feeling so sick all the time and it was really getting me down and they just sort of ignored it.' Bea felt neglected, maintaining, 'I experienced so much trauma, and these

things weren't picked up; nobody seemed to be bothered; I know that more could have been done for me.' For Ivy, this resulted in dissatisfaction. She told me, 'They didn't treat me as well as they should have done; I should have shouted louder or kicked up more of a fuss, but I was just too weak.' Holly described how she felt abandoned, expressing, 'There wasn't anyone for support; I just felt totally isolated.'

These findings are consistent with those of the first British National Conference on NVP (2010),⁴ which highlighted the lack of professional healthcare support offered to women, describing pregnancy sickness as 'underappreciated'. The extant literature outlines how women's accounts of their HG suffering are often minimised⁵ or disbelieved⁶ by maternity workers, and a third of women with HG describe their healthcare providers as uncaring.⁷ Power et al⁸ document the 'unhelpful attitudes'

of medical practitioners that impede women's access to 'timely and appropriate care', with women often perceived as 'time wasters or someone else's responsibility'.

EMOTIONAL IMPACTS PERSIST POST PREGNANCY

HG is clearly not something that women are able to instantly recover from or forget about with dissipation of nausea and vomiting or end of pregnancy. Emotional recuperation following HG is an enduring and complex process and the emotional impacts of HG can persist with cessation of physical symptoms, into the post-partum period, and months and years beyond. In the sample interviewed for this study, this ranged from one to nine years. Joan declared, 'I suffered then and I'm still suffering from it now; it's something that's really quite major in my life.' Ivy echoed this, remarking, 'I had quite a lot of other pregnancy complications as well, but emotionally, it's always the sickness I go back to.'

Participants described experiencing flashbacks, with Cath stating, 'There are certain things like smells and songs that bring it all back to me.' Donna told me, 'I would relate it to post-traumatic stress. My Uncle has got PTS after being in Iraq and we often talk about the same things; the symptoms are very similar.' Holly described an altered sense of self, claiming, 'It changed me as a person'. For Freya, there was a lack of resolution, and she acknowledged, 'There's still more to think about and go through.'

A PSYCHOTHERAPEUTIC APPROACH TO HG HEALTHCARE

HG is an emotional, as well as a physical, lived experience. As a counsellor, having empathically witnessed these women's stories, I was left wondering about the potential role of the counselling profession in offering a more effective level of emotional care to women, both during and following HG pregnancies.

Wall⁹ advocates for research that makes available 'evocative stories of experience that contribute to our understanding of the social world and allow us to reflect on what could be different because of what we have learned'.

Having identified a lack of specialist psychotherapeutic support options for women around HG, and feeling ethically compelled to reflect on how current modes of practice might be improved, my research findings led me to set up the UK's first counselling service for women affected by pregnancy sickness. It is early days, but feedback from clients thus far suggests that counselling in the context of HG is something that is experienced as valuable and beneficial, both during and following the illness experience.

While voluntary agencies such as Pregnancy Sickness Support provide vital assistance to women in terms of information, advice and peer support, formal counselling is warranted where emotional symptoms are clinical. This might include postnatal depression or PTSD following HG, bereavement following termination of a planned pregnancy due to HG, coping strategies around anxiety or depression in HG, and issues around trauma, self or identity. Counselling aims to alleviate distress, reduce isolation and increase personal resilience in the context of the HG illness experience.

McLeod¹⁰ refers to a 'reconstruction of practice' as 'new groups of people seek counselling' and the importance of maintaining an empowering and 'user-friendly' approach. This might involve, for example, counselling a woman by telephone if her vomiting is such that she is unable to leave her home, or enabling her to bypass counselling service waiting lists in order that support is available while HG symptoms are at their peak.

Bochner¹¹ describes how illness stories 'bring suffering bodies out of the darkness ... in the name of the right to speak and the longing to be heard', since 'ill persons want to know that their suffering matters'. My own lived experience of HG, my academic research around it, and my counselling practice with women currently suffering from this distressing and debilitating medical condition, all suggest that professional healthcare that places an increased value on emotional support is not only needed, but long overdue. For clients who are affected by HG, the provision of a safe, therapeutic space where they can have their suffering acknowledged, can significantly facilitate emotional resilience and emotional recuperation. When women are currently suffering or have survived the illness experience of HG, as counsellors we are ideally placed to empathically hear their stories. ■

HYPEREMESIS GRAVIDARUM – THE FACTS¹²

- Nausea and vomiting of pregnancy (NVP) affects up to 80 per cent of pregnant women
- Hyperemesis gravidarum (HG) is diagnosed when there is protracted nausea and vomiting, with more than five per cent pre-pregnancy weight loss, dehydration and electrolyte imbalance
- HG affects 0.3–3.6 per cent of pregnant women
- HG typically starts between the fourth and seventh weeks of gestation, peaks in the ninth week and resolves by the 20th week in 90 per cent of women
- HG is a prolonged, severe, chronic illness
- HG reduces quality of life, impairs functioning and negatively affects relationships with partners and family
- Increased stress is caused by persistent nausea and vomiting, lack of understanding and support, inability to eat healthily, fatigue, absence from work, financial pressures, isolation, grief for loss of 'normal' pregnancy, inability to care for family, others' belief that it is psychosomatic and reluctance of doctors to treat the condition
- HG is associated with depression, anxiety and psychological distress. Poor mental health is the result of the suffering caused by HG, rather than being causal
- Ten per cent of pregnancies complicated by HG end in termination, in women who would not otherwise have chosen this. Prominent reasons cited include inability to care for self and family, fear that they or their baby could die, and inadequate healthcare support.

Further details of this research can be found in the March 2018 edition of *Counselling and Psychotherapy Research*.³

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READER RESPONSE

The author would welcome feedback on this article. To contact her, please email michelle@hyperemesiscounselling.co.uk

PRIMARY CARE IS CHANGING – IT IS TIME TO HAVE THE CONVERSATION

ELAINE DAVIES

THE UNPREDICTABILITY OF PRIMARY CARE

The Welsh Government defines primary care as referring to ‘all people and services providing care locally to meet the physical, mental and social health and wellbeing needs of a local community’.¹ It seems to me that this model of primary care is currently under threat.

I live in a small mining village in the South Wales valleys, with a population of approximately 12,000. It has a higher than average percentage of older adults, and a larger than average proportion of the population receiving benefits than in Wales as a whole. Recently, one of the local GP surgeries closed, making more than 10 staff redundant, including receptionists, the practice manager and nurses. The GP relocated elsewhere. This probably has been one of the most difficult – and, for some, unbelievable – experiences that the town has endured since the closing of the mine in the 1970s. With the closure of the surgery, all patients were transferred to another larger surgery. However, three months later, that surgery informed patients that, due to GPs retiring, it would be run by the local health board and locum GPs. This news has been hard to digest. When did primary care become so unpredictable?

THE CHANGING FACE OF THE GP

Primary care is the first point of care for patients, designed to take the load from all other services in the NHS. The GP has to consider the physical, social and psychological welfare of the patient. They have often been described as the centre of the community, and the heart and voice of general practice, along with other primary professionals such as the pharmacist, optician, dentist, midwife, health visitor and nurse.

Traditionally, the GP was the doctor who knew everything about you and your family; they were known as the ‘family doctor’. GPs would always have surgeries located in small towns, like my home town. In the 1960s, the GP practice would be a terraced house on a residential street. Queues of people would stand in the passageway, spilling out onto the pavement. At that time, there would be up to 20 people waiting to see the doctor. Now, we have large community health centres. Demand has visibly increased. The GP would be the fount of all knowledge, a generalist, someone who could signpost to other services, addressing the needs of all his patients, from head to toe. He had overall responsibility.

It seems that some of this is changing. In my experience, trainee GPs are now less attracted to GP partnerships, preferring to

work as a locum or salaried GP. Just like other services, GPs are feeling the pressure of workloads, targets and lack of resources, which deter them from the longevity of GP practice.

For a while now, all of us working in primary care have acknowledged the difficulty of the lack of resources and the increase in patient demand. With demand outweighing capacity in primary care in GP practice and all other services, waiting lists are becoming longer. Gone are the days when you could see your GP on the same day. At some surgeries, patients now have a two-week wait for appointments, with a one-week wait for acute issues and, thankfully, same-day emergency appointments. In one local surgery in my town, there is a two-minute answerphone message about all the ways not to seek help from your GP, before the dialling tone to connect to the surgery begins.

Only recently, when a young relative of mine was ill, I reflected on how I demanded more effective and timely care from the NHS. Even though I did not verbalise this, I still felt it keenly. Like everyone else, I will have to adjust to change if primary care is to be sustained.

CARE NAVIGATION

We are being told that change is required. Some talk of empowering the patient to make more choices and have more autonomy about their health. Some argue that engaging clients will save money and reduce demand. This is exactly what is happening in England at this moment. ‘Care navigation’ is the new trend.² Scotland and Wales are likely to follow. GP staff receptionists, practice nurses and nurse prescribers are being upskilled to signpost patients to the best service, rather than encouraging patients to seek an appointment with the GP. On arrival at the

In the 1960s, the GP practice would be a terraced house on a residential street. Queues of people would stand in the passageway, spilling out onto the pavement.

surgery or in the initial telephone conversation, the patient is now met with an upskilled care navigator who will ask a number of questions and then offer different services, in place of the usual appointment with the GP. For some people, this could mean an earlier referral into a particular

health placement; 82 per cent of practice nurses feel ill-equipped to deal with mental health issues, and 42 per cent of practice nurses have had no mental health training at all.³ Already, we can begin to see a role for therapists, counsellors and all those involved in mental health in supporting,

...we can begin to see a role for therapists, counsellors and all those involved in mental health in supporting, training and upskilling the primary care workforce

service. However, the level of responsibility of the newly upskilled care navigator concerns me. GP receptionists are already at the receiving end of huge amounts of blame for standing in the way of access to the GP. I wonder whether these new developments will open them up to further judgments, criticism and, sadly, abuse.

I am particularly interested in how this will alter the experience of primary care for patients who need psychological help. According to Mind, nine out of 10 adults with a mental health problem are treated within primary care.³ Imagine that a patient arrives at the surgery feeling weepy, with a low mood, and thoughts of not wanting to be here. Potentially, in future, they will be met by a receptionist, rather than their GP. This designated person will have attended a care navigation course and may simply provide the patient with the names of organisations who can help. I am sure I do not need to point out how harmful such an approach could be. While, in England, people can self-refer for their psychological needs to IAPT services (Improving Access to Psychological Therapies), Scotland and Wales have yet to adopt this provision.

In GP surgeries today, only 45 per cent of trainee GPs have undertaken a mental

training and upskilling the primary care workforce. In the future, I wonder whether mental health could form part of the national training curriculum, not just in professional training, but also in schools. Preventative training needs more investment financially and socially, in order to improve education and destigmatise the issue, so that this country can improve its relationship with mental health.

Long-term conditions seem to be 'on trend' right now. In my opinion, they have never gone away; but maybe our political leaders have now come to the realisation that those who have long-term health conditions also have mental health issues, and those with mental health issues are likely to have other serious health conditions.

Primary care is as important as ever, but there are changes afoot. Along with change comes acceptance and resistance. We will need to understand the changes, so that we can help and inform our clients. ■

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

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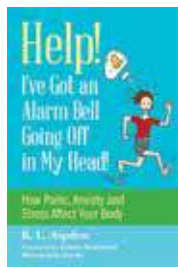


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REVIEWS



BOOKS



HELP! I'VE GOT AN ALARM BELL GOING OFF IN MY HEAD: HOW PANIC, ANXIETY AND STRESS AFFECT YOUR BODY

KL Aspden

Jessica Kingsley Publishers, London

ISBN 1849057044 £7.99 (paperback)

Consisting of just 48 pages in total, this little book only took 15 minutes to read. Designed for children, with illustrations throughout, it offers a good insight into the subjects of panic, anxiety and stress. It is presented in an easy-to-follow format to which children can relate.

The aim is to teach children who suffer from stress, anxiety or panic about the fight or flight response in their body. In chapters one and two, we learn about the triggers (alarms) that may lead to distress or high anxiety levels. In chapter three, various coping strategies are presented, including grounding techniques, self-soothing, and approaches for regulating the emotions and reconnecting to the 'here and now'. Chapter four focuses on looking after the alarm system, and teaches children techniques to work through to control signals that may set off a false alarm.

This is a delightful little book for anyone working therapeutically with children. It enables the therapist to work through panic, anxiety and stress with their clients and is a valuable addition to the therapist's toolbox. The book is fun to read, with clear, child-friendly illustrations and language.

Jo Sansby MBACP (Snr Accred), BACP registered counsellor, psychotherapist and supervisor private practice



BEREAVED PARENTS AND THEIR CONTINUING BONDS: LOVE AFTER DEATH

Catherine Seigal

Jessica Kingsley Publishers

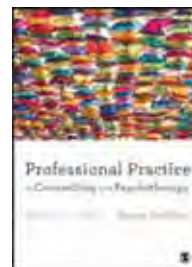
ISBN 978-1-78592-326-5 £12.99 (paperback)

The death of a child is one of the most traumatic, difficult experiences that any of us could imagine. In this book, Catherine Seigal, a retired BACP senior accredited counsellor, writes in a sensitive and knowledgeable way about her first-hand experience of counselling parents of child patients at a London teaching hospital.

Seigal's book concerns itself with the way in which parents can cultivate and nurture an ongoing relationship with a child who has died. She describes how conventional theories of grief may fall short when dealing with clients who have lost a child and focuses instead upon ways of continuing the bond with the child, so that the lost child's life continues to have a meaning.

Seigal is clear that her writings are based on her experiences of listening and talking to grieving parents, rather than empirical research. In my opinion, this strengthens rather than weakens the book, making it more accessible. I found it to be a moving read, which honours the experiences of the many parents with whom Seigal has worked.

Joanna Benfield is a psychosexual and couples' counsellor. She is also editor of this journal.



PROFESSIONAL PRACTICE IN COUNSELLING AND PSYCHOTHERAPY: ETHICS AND THE LAW

Peter Jenkins

Sage

ISBN 978-1-4462-9664-6 £24 (paperback)

This book provides a solid overview of the legal, ethical and organisational frameworks within which we work as a profession. While it is primarily aimed at trainee counsellors and psychotherapists, it can also prove useful to anyone who wants to review the professionalism of their practice. It covers subjects such as safeguarding vulnerable adults, risk assessment and the avoidance of discrimination. The author considers the differing demands of various organisational settings, including the NHS and the third sector. He explores the challenges of working within a multidisciplinary team and within the contexts of evidence-based practice and the stepped care model, all of which are topics of relevance to those working in NHS-funded services.

The book is designed as a textbook and is very straightforward to read. It is firmly grounded in BACP's *Ethical Framework* and accompanying documents. I was left wishing that I had had access to this book while I was still training as a counsellor, as I felt it would have given me a strong foundation in professional practice.

Joanna Benfield is a psychosexual and couples' counsellor. She is also editor of this journal.

BACP HEALTHCARE ROUND-UP

FORTHCOMING BACP EVENTS

Professional development days

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

Integrating artwork into your therapeutic practice

14 February – Norwich
Facilitator: Pauline Andrew

Working with partners of trans-identified people

12 March – Cardiff
Facilitator: Tina Clark

Supervision, relationship, authority and ethics

24 March – Southampton
Facilitator: Steve Page

Working With Days

Working effectively with trauma in healthcare settings

8 March – Manchester
Facilitator: TBC

Working with critical incidents – prepared not scared: are you ready to respond?

17 April – Edinburgh
Facilitator: Nicola Neath

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

Conferences

BACP CYP Conference 'Working with children in their world'

24 February – London

The annual conference of the Children, Young People and Families division of BACP will focus on how counsellors and psychotherapists can connect with children and young people in their own world, in order to achieve better outcomes for them. Presentations will cover a wide range of themes, including children with autism, children who are being looked after and accommodated (LAAC), and children who themselves are carers. The conference is also available as an online webcast.

To register your interest in this event, please email: katy.hobday@bacp.co.uk

Research Conference 'Counselling changes lives: research that impacts practice'

11–12 May – London

This conference is aimed at practitioners, researchers, students and academics, and allows for an exchange of ideas, experience and best practice. The focus of this year's event is on research that has an impact on counselling and psychotherapy in the real world. The event is co-hosted with the University of Roehampton. On Saturday 12 May, there will be a keynote speech by Dr Pim Cuijpers on 'Four decades of research on counselling for depression: directions for the future'.

To register your interest, please email katy.hobday@bacp.co.uk

Aims

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

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

About BACP Healthcare

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

Membership

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

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

Subscription fees

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

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

MEMBERS' AREA

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

BACP divisional journals

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

Private Practice

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



Counselling at Work

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



BACP Children & Young People

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



University & College Counselling

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



Coaching Today

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



Thresholds

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



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

To enquire about joining a BACP division, call 01455 883300. For a free of charge consultation on advertising within these journals, contact Adam Lloyds on 020 3771 7203, or email adam@thinkpublishing.co.uk

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