

THERAPY TODAY

The voice of the counselling and psychotherapy profession

“
I'd never just
sit in silence;
silence can be
very persecutory
”
Page 43



Education or entertainment?

The ethics of broadcast therapy

Socio-politics in groupwork // When setting goals can be helpful
Self-harm and healing // Making the Ethical Framework work for you

I always take a special interest when therapy is represented in the media in some way.

I observe the sessions very closely, from what's in the room to what the therapist wears, and everything that is said - and isn't said - and I ask myself if I would work the same way. Fictional therapy can provide wonderful CPD if it's done well.

However, when the client is a real client, talking about their real-life issues and the whole world can listen in, I get twitchy. Broadcast therapy is a fantastic opportunity for the public to see what really happens in therapy sessions and helps to normalise what we do. However, for the client, the repercussions are potentially problematic; inevitably, they waive some of the boundaries that would normally protect them and I worry about where the media are going with it. Our news feature this month offers some interesting perspectives from therapists doing this work, and others who have turned it down (pages 8-11). What's your view?



Rachel Shattock Dawson
Consultant Editor

Editor's note

Incredibly (to me, anyway), it's been a year since we relaunched *Therapy Today*. Our aim then, as I said in my first Editor's note, was 'to build on all that was good and highly valued about the journal... its balance of practice, research, politics and debate', and to 'lighten and brighten it a bit'.

We had a lot of feedback in the early months - positive and negative - and we've tweaked a few details over the year, including reintroducing the much-valued book reviews, but we have broadly maintained the direction we set.

So, 12 months on, it's time to ask you how we've done. I've had the full range of responses from people I've met out and about - understandably, there was a bit of caution initially, but now I hear mostly, 'I read it cover to cover'. Please complete the reader survey we're running this month. You can find it online at bit.ly/TherapyTodaySurvey. We'd love to know in detail what you think (and there's the chance to win £100 in book tokens).

Thank you all, whether you simply read, reflect on and enjoy the magazine, or contribute articles, opinions and ideas yourself. *Therapy Today* should speak for and to its readers. Your letters certainly suggest you are engaging with the content - keep them coming.

And there's an important change - your copy of *Therapy Today* will, from this issue, arrive at the start of the month. It's always been an anomaly that the magazine drifts through your letterboxes sometime mid-month. This means we can be more timely in our coverage of topical issues, and makes it easier to co-ordinate with events.

Catherine Jackson
Editor

Complete
our reader
survey (bit.ly/TherapyTodaySurvey)
and you could win a
£100 book token



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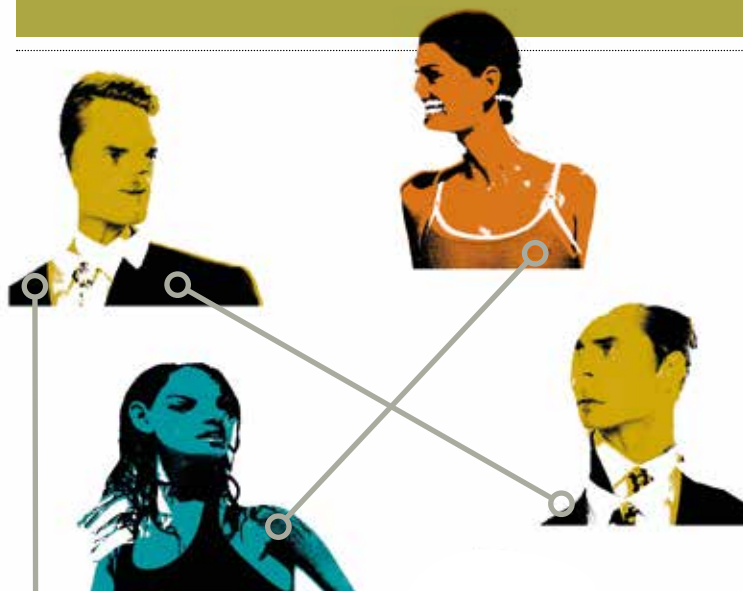
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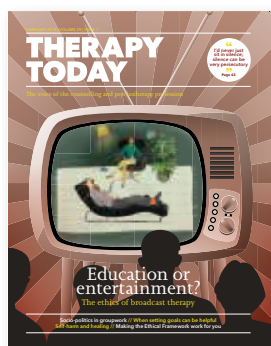
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‘Just as nations... we both guard and reach out beyond our boundaries, finding succour and limitation in sameness and fear, and hope of enrichment in difference, so too does the small group and each member within it.’

Nick Barwick teases out the personal, social and political resonances in group therapy (page 20)



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Strictly therapy?
Is it right to broadcast therapy with real clients on our screens and airwaves?
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This is your journal. We want to hear from you. therapytoday@thinkpublishing.co.uk

In the news

Our monthly digest of news, updates and events

Debt and relationships

Debt advisers and couples counsellors should work together more closely to tackle the rising problem of debt, Relate says in a new report.

Some 16% of UK adults have problem debt and six per cent of children live in households with a persistent debt problem. Nearly one in three Relate users say debt contributed to the breakdown of their relationship, and almost one in five (19%) debt advice clients say debt had a 'considerable' impact on their relationships with their children.

There is also strong evidence that relationships are very important for

people's ability to manage debt and money. The report finds: 'Couples who make decisions together experience fewer financial problems.'

Relate wants relationship support and debt advice providers to develop closer collaboration and the Government to fund free relationship support for low-income, indebted clients.

The report's authors, Anna Darnell Bradley and David Marjoribanks, conclude: 'Recognising the interdependencies between debt and relationships is necessary to provide the most effective support for families.'

bit.ly/2zxbxNI



13,746

sessions about anxiety were delivered by Childline in 2016/17 - up 59% in two years
bit.ly/2zMiX3H

46,000

students in Scotland sought help from their university counselling service over the past five years
bit.ly/2qhJguz

MBE

BACP member Neelam Farzana has been honoured for services to mental health in the community

Improved access to talking therapies

Over one million referrals were made to IAPT talking therapy services in England in 2016/17, according to the latest data from NHS England. Of the 1.4 million new referrals, 965,000 people began treatment, a 32,000 increase on 2015/16.

Waiting times decreased and recovery rates improved, the data show: of the 567,106 referrals who finished a course of treatment (attended at least two sessions), 87.5% waited less than six weeks for treatment, and 98.2% waited less than 18 weeks. Recovery rates improved to 49%, and 65% of other patients showed 'reliable improvement' as a result of treatment.

Claire Murdoch, NHS England's National Director for Mental Health, said: 'Not only are more patients getting help more quickly, but their chances of recovering, thanks to NHS support, are improving significantly.' bit.ly/2EHkl6G

Health and employment

Physical and mental health problems at age seven can determine a person's employability at age 55, two new studies have found.

The studies, published by the International Longevity Centre - UK (ILC-UK), found that children as young as seven whose parents and teachers reported them showing signs of depression, worry or withdrawal, or who were disobedient, aggressive or bullies, are more likely to be unemployed, more likely to be unable to work because of long-term sickness, and more likely to be caring for dependants full-time at home at age 55.

Traumatic events in childhood, such as physical or sexual abuse, or parental absence or divorce, are also associated with reduced likelihood of being employed at 55.

ILC-UK says the Government needs to adopt a life-course approach to health and wellbeing.

David Sinclair, Director of ILC-UK, said: 'Early intervention is key if we are to ensure that people can continue to work into old age.'

bit.ly/2Acicwu

Adversity in Wales

Nearly half of all adults in Wales have experienced trauma in childhood, according to a new *National Population Assessment Report* published by the Welsh Government.

The report also found that 41% of adults in Wales who suffered four or more adverse events in childhood are now living with poor mental wellbeing; 26% of people living in Wales have a limiting long-standing illness or disability – more than in any other region of the UK; one in five young people in Wales report low life satisfaction; 17% of adults report feeling lonely, and 75% of carers are concerned about the impact of caring on their health over the next year.

It also predicts that the number of people aged over 85 living in Wales will increase by an estimated 119% by 2035.

bit.ly/2CKtJpR

Lonely and old in Scotland

Around 120,000 older Scots could be living with undiagnosed mental health conditions caused by loneliness and isolation, two leading charities warn.

The Mental Health Foundation and Age Scotland surveyed 500 people aged over 65. A quarter said that loneliness made them feel depressed and 16% that it made them anxious. Some 80% said increased use of social media had made the problem worse, as they were less likely to see people face to face. Almost a third said they felt they should cope with the problem themselves. Others said they didn't want to bother family or friends or would not feel comfortable talking to their GP about it.

The charities have put together a 12-point campaign to tackle old-age loneliness. They are calling for every older person discharged from hospital to have a 'welcome home box' of advice and information, a four-week follow-up befriending service, and pre-discharge screening for depression. bit.ly/2AbYD7i



What about young women and girls?

The mental health needs of girls and young women are being overlooked, despite evidence of higher and increasing need, the Mental Health Foundation says.

In a new report, *While Your Back Was Turned*, the Foundation cites a litany of evidence that girls and young women are at higher risk of a wide range of common mental disorders, self-harm, post-traumatic stress disorder and bipolar disorder, and that the gap between the mental health of young men and women has grown wider in recent years. According to the latest Adult Psychiatric Morbidity Survey, young women have the highest score of any demographic group for prevalence of common mental disorders, at over 25%. In 2014, common mental disorders were three times more common in women aged 16-24 (26%) than in men (9.1%).

At the same time, the mental health of young women has slipped down the policy agenda, the report says: gender is 'almost entirely unmentioned' in major policies, and the needs of young women and girls are subsumed within policies for children and young people.

The Mental Health Foundation is calling for more attention to gender in children and young people's mental health policies, and for government leadership and action to address young women and girls' mental health.

bit.ly/2BL273p

CYP Green Paper disappoints

The Government will invest over £300 million in a set of proposals that it says will radically transform children and young people's mental health care in England.

But there is no mention of school-based counselling, despite its proven success in Wales in reducing the need for referral on to CAMHS. BACP has called the plans 'a missed opportunity' (see BACP Round-up, page 47).

The consultation Green Paper, published in December last year, proposes that every school and college in England will appoint a designated senior lead for mental health. Their role will be to co-ordinate existing school-based support, help children access specialist therapies and other NHS treatments, and develop a 'whole school approach' to mental health and wellbeing. Alongside, £215 million will be invested in new mental health support teams to work with local schools to support pupils and improve early intervention. The new teams will be trained to offer CBT and other evidence-based treatments in the classroom, the Department of Health says.

Former Education Secretary Justine Greening said: 'There are great examples of schools and colleges across the country already playing a vital role in supporting students' wellbeing and mental health. We want that kind of excellence to become the norm.' The consultation ends on 2 March 2018. bit.ly/2jfjlhl

Strictly therapy?

Sally Brown explores the growing phenomenon of broadcast therapy

A young American couple, both committed Christians, have come to therapy to address their mutual lack of sexual desire. As the session progresses, the woman confesses that she only enjoys sex when her husband pretends to be a roguish, sexually confident Frenchman called Jean-Claude. It is a brave admission from a deeply private couple. But this couple aren't my clients – I was listening in on their therapy, along with thousands of others who tune in regularly to US psychotherapist Esther Perel's podcast series *Where Should We Begin?*¹

Each episode is an edit of a two-hour, real therapy session with the couples and relationship therapist at her private practice in New York. In another episode, we hear a mixed-race couple facing the unspoken challenges that their cultural differences bring to their relationship. In another, a lesbian couple deal with the negative impact on their relationship of finally having their longed-for children.

As a therapist, the chance to be a fly on the wall while a fellow practitioner works, especially one as respected and successful as Perel, is hard to resist. But as I listen, entranced, I also feel

unsettled. Confidentiality is at the heart of what we do, so can it ever be ethical to use real-life sessions as a basis for what is, after all, entertainment? And is the argument valid that it benefits our profession and our clients by demystifying what happens in the therapy room? Is it simply a distorted representation of what we do, edited down for entertainment?

Client confidentiality

Addiction counsellor Mandy Saligari, Director of the Charter Harley Street private rehabilitation centre in London, wrestled with this dilemma before agreeing to be involved in the Channel 5 series, *Celebrities in Therapy*. Each programme is an edit of several therapy sessions conducted by Saligari with celebrities known for their 'troubled' pasts, such as Kerry Katona, Daniella Westbrook and Bobby Davro. The sessions are filmed in single takes with a fixed camera at Saligari's therapy room in central London, then condensed into a 45-minute programme. It often makes for compelling viewing – we see Davro deny and then admit his dependence on alcohol, and Katona talk about encouraging her drug-addicted mother to kill herself.

Saligari admits to having qualms even as she is being filmed. 'A couple of times, I felt protective of the clients, of how much they would give themselves over, not just to the camera but in general, to the media,' she says. 'Kerry Katona was a perfect example of that. I became aware that there was literally a tiny bit of her left that was Kerry, and having spotted that, there was an internal conflict – do I move in to work with it on TV, therefore making it public, or do I shield it? I chose to point it out, but said, "I am not going to go there because you need that." I made her conscious of how much of herself she gave away, which was part of her primary issue: not enough of Kerry belonged to Kerry.'

The production company chose which celebrity clients were interviewed, but Saligari says she had the right to veto their choices, on clinical grounds. 'My criterion was, are they robust enough to do the type of therapy I do on TV?' She also ensured clients had some power over what was included in the final edit: 'At times they would say, "I don't want this filmed," and I would say, "The camera will keep rolling, but you can mark it by saying, 'Don't use this' a few times, as you say it," then it can't be used as they can't edit it out,' she explains.

The ethics of consent

There are ethical concerns even with consent, says Professor Brett Kahr, psychoanalyst, author and former BBC Radio 2 Psychotherapist in Residence. 'I have been approached by a number of television companies over the years for exactly that sort of project and I have always turned them down. I just did

'Kerry Katona was a perfect example of that. I became aware that there was literally a tiny bit of her left that was Kerry... there was an internal conflict – do I move in to work with it on TV, therefore making it public, or do I shield it? I chose to point it out, but said, "I am not going to go there because you need that"'



‘One has to ask how much... informed consent is being provided before people expose those parts of themselves through their own authorisation in a public forum’

of the client in his first attempt, called *Introduction to Psychotherapy*, which he made in 1963, but he wasn't happy with the result, so found a 'real' client for the 1965 project.

Gloria was told it would be an educational series on how therapy works, but the film was shown nationwide throughout the US on mainstream cinema screens, and she found herself the subject of widespread and prurient public interest in her sex life. According to an account written after her death at age 45 by her daughter, Pamela J Burry, taking part in the sessions negatively impacted on Gloria for the rest of her life.²

‘One has to think very carefully about the meaning of informed consent,’ says Kahr. ‘When one invites Ms X from Scunthorpe or Mr Y from Basingstoke to appear on a television programme, one must ask whether anybody has had a thorough conversation with these people beforehand to help them think with consideration about the meaning of such a decision, particularly the meaning of one's mind and body becoming public property. One must be very vigilant as to whether exposing oneself on camera might become a re-enactment of an early sexual trauma.’

Saligari agrees that consent is a complex issue, but says the production company she works with takes the issue seriously. ‘Prior to filming and through the agents, should there be any concerns regarding mental health issues, the production company offers to pay for an independent mental health assessment with an accredited professional. These individuals are

ISTOCKPHOTO / FREESOU PRODUCTION - GETTY IMAGES / SALLY EFORD

not feel sufficiently comfortable with the notion, and sometimes I felt that the researchers and producers from television companies had really not thought through the ethical implications carefully enough and the potential long-term impact, both on the clients and the therapist.

‘One has to ask how much preparation, how much informed consent is being provided before people expose those parts of themselves through their own authorisation in a public forum,’ he says. As there is an element of unknown potential with every broadcast – how many people will view it, will it trigger media interest,

will the press coverage be positive or negative, how will that influence public opinion? – it could be argued that clients are unable to give full consent, as they are unaware of what they are consenting to. Perhaps the most famous example of this is ‘Gloria’, the client who featured in the famous *Three Approaches to Psychotherapy* films made by California psychologist and psychotherapist Everett L Shostrom in 1965. Gloria was filmed in session with three leading proponents of three different models of therapy – Franz Perls (Gestalt), Carl Rogers (person-centred) and Albert Ellis (rational emotive therapy). Shostrom originally cast an actress in the role

already in the public eye and are talking here about issues that they have mainly discussed in the media before. They are well versed in the pitfalls of those issues being public knowledge.'

Fact versus fiction

Without broadcasts of real therapy sessions, prospective clients only have fictionalised accounts on which to base their knowledge of therapy, and these are notoriously unreliable and misleading, argues Dr Otto Wahl, Professor of Clinical Psychology at the University of Hartford. He conducted a systematic review of the portrayal of therapists and therapy in films released between 2000 and 2013,³ and, while he found some changes for the better in terms of accuracy of portrayal, there was, he says, still 'a lot of unethical behaviour'.

'It wasn't the same as in films of the past, when the therapists were usually shown as evil and manipulative, or sleeping with their patients, but in a more insidious way. Therapists would share personal information about their clients without their permission. If I'm a client considering going to psychotherapy, I might think, if I am going to tell someone something really personal, I want to know that it is between me and the therapist,' he says. Such fictional portrayals can easily normalise this kind of practice. 'In the films we looked at, therapy was also seldom helpful. You rarely saw people get better, and for those that did, it tended to be because of a dramatic breakthrough that occurred.'

His biggest concern was over physical touch. 'Seventy per cent of therapists in the films we studied touched their clients in some way, other than shaking hands. It wasn't always overtly sexual, but one of the problems with boundary violations is that they begin gradually. If a client is uncertain about what the boundaries are - what kind of touching is OK and what is not OK - those who tend to trust their therapists can be led into relationships in a gradual fashion. If you are communicating that touching is a common and acceptable part of therapy, you are opening the door to expanded physical contact.'

'We have to show real psychotherapy. To contradict and challenge stereotypes, we need to stimulate discussion about them. We have to say, "What you see in films, it's not... real life"'

Kahr agrees that fictionalised accounts of our profession largely do us a disservice. 'I do not recognise the psychotherapists and counsellors I see in films and TV programmes. *In Treatment* [HBO's drama series that showed 'real-time' client sessions with the fictional psychotherapist Dr Paul Weston] was beyond diabolical in giving so much air time to a mental health practitioner who had an affair with a patient,' he says.

It is for this reason that, while we should take the issue of consent seriously, says Wahl, we cannot let it stop us from finding ways to bring real therapy sessions into the public domain. 'We have to show real psychotherapy. To contradict and challenge stereotypes, we need to stimulate discussion about them. We have to say, "What you see in films, it's not what you see in real life." We have to help people become more critical viewers, to make them ask if this is accurate. But confidentiality belongs to the client. If the client says it's OK, then it's OK for you to show their treatment, as long as there is no coercion or persuasion involved.'

Kahr agrees: 'We have a huge responsibility to disseminate useful, admirable, responsible knowledge about our profession to members of the general public. We may think of ourselves as kind, compassionate people, but we are an intimidating profession in that people have all kinds of fantasies about what we are going to say to them, what we are going to say about them, what aspects of their secret lives will be unearthed, and whether we can be trusted to keep their secrets. So, I think we do have a responsibility

to portray ourselves so that people can learn about our work.'

Therapy as entertainment

There is also the issue that good therapy doesn't necessarily make good entertainment. Therapy rarely achieves its results in a cinematically dramatic breakthrough; its 'plot' is rarely linear - generally, changes unfurl very gradually over time. How accurate can 'real-life' portrayals of therapy be, given the impossibility of sustaining dramatic interest in real time? Did Saligari feel a pressure to change the way she worked, to make it more dramatic, I wondered? 'I took responsibility for therapy and the producer took responsibility for TV, so we had our clear roles, and when we disagreed with one another, we would argue it out and hold our corners,' she says. 'If it wasn't interesting TV, it wasn't my problem: they gave me the clients, I worked with them in the same way I work with all clients. That's how we did it, and it worked.'

Her guide was that fundamental principle of therapy: 'I would say, we have to trust the process. With [reality TV star] Nikki Grahame, for instance, for 25 minutes she didn't speak, and in terms of television, that is a long, long time. I pushed her and she went into a shame-based withdrawal, and I knew I had to sit it out. If I went to retrieve her from it, I was rescuing her and reinforcing the victim space. But, in my mind, I wondered how easily the production team were waiting. They were downstairs, and I could almost hear their thoughts through the floor: "This is 25 minutes of television time!" And I'm thinking, "Don't come in the room." Afterwards I said, "I am so grateful that you trusted me to roll with that." They said they had discussed what they should do, but the mutual respect between us meant they held off from coming in.'

This potential for 'good entertainment versus good therapy' conflict was an issue for psychotherapist Susie Orbach in the making of her Radio 4 series, *In Therapy*. 'Therapy is not a good spectator sport, and there can be *longueurs* where nothing happens,' she

says. 'The fact is, you are sitting with somebody and helping them not to feel alone. There isn't very long; each [broadcast session] is 12 and a half minutes, so the BBC had to struggle with allowing silences in that time. More time, two 20-minute sessions for instance, would have been much better but it wouldn't have fit the schedules.'

The series didn't feature live clients. The sessions took place in Orbach's own therapy rooms and were unscripted; the clients were actors, who were given a detailed brief about their character and then freed to improvise. 'I knew I didn't want to script something; that would not show how therapy actually goes,' she says. 'I suggested very little beyond the barest outlines. I said, give me a young couple whose life dilemma may be reflecting their personal histories; give me a 60-year-old trade union person who is facing a difficulty, but I didn't know what that difficulty was. I would be told a paragraph of background, similar to what you would know about any new client before they walked through the door. But then we had to make it sound like I had been seeing them for six months.'

She had no idea what would emerge – that John, the trade union steward, for instance, would confess that he had fallen in love with her. 'The director would put a few "bombs" into each session. Although I did say, you can't put too many bombs in each situation as then I am being thrown about too much, and it's implausible.'

Orbach's motivation was to show how therapy is done. 'There has always been a strong aesthetic for me in therapy – it's

'I wanted to show many different things – how deeply interesting it is, how therapy is a different form of talking, a different form of listening, and a different form of engagement'

Sally Brown About the author

Sally Brown is a counsellor and coach in private practice (therapythatworks.co.uk), a freelance journalist, and Executive Specialist for Communication for BACP Coaching.



a craft,' she says. 'I wanted to show many different things – how deeply interesting it is, how therapy is a different form of talking, a different form of listening, and a different form of engagement. I also wanted to show how people can think differently when exposed to different ways of talking and feeling.'

Demystifying therapy

Orbach also wanted to 'bring people closer to the experience of the consulting room': 'Attitudes to therapy have changed dramatically since I've started working, when it really was a taboo; now, it's not a taboo in the same way, but it's still a mystery, and I had the opportunity, through vignettes with imagined people, to show what I do and what my day is like.'

Saligari similarly says her motivation for being involved in the programme was to 'destigmatise therapy and addiction': 'I saw it as an opportunity to make therapy seem accessible, to teach people to interview their therapists rather than just turn up to be fixed, and to push through an unconscious glass ceiling that therapy doesn't have to come at the end of a long line of changes, like moving house, changing relationships, changing your hair; it could be an earlier option,' she says.

Orbach has always been in the public eye, so the clients she sees in her private practice three days a week were unaffected by the programme, she says, although it did trigger a rise in enquiries from potential clients. Saligari also carried on seeing regular clients during filming of her TV show. 'I preserve two days for client work. My pattern is that I do the intake session, then refer the client to my team or onward for inpatient

treatment. I also have 12 regular clients a week, and I refused to let the filming schedule intrude on those days, so they had their time with me as normal.'

She believes the show has had a positive effect – she sees a spike in enquiries when the series airs; most want to know how to find a therapist near them, and she refers them to the BACP, UKCP and BABCP websites. 'Loads of people have written and said, "I'd never thought I'd have therapy but since watching the programme I am going to give it a shot." One man got in touch and told us he had booked into a hotel to take his own life. He turned the TV on, watched the Bobby Davro programme and was transfixed, and decided to go to AA instead.'

Certainly Channel 5 thinks there is a growing public appetite for real-life therapy. A fourth season of *Celebrities in Therapy* is planned for this year, and Saligari is currently looking for couples to appear in a new programme on couples counselling. Esther Perel's podcast frequently appears in the top 10 of iTunes' 'most-listened to' podcasts,⁴ and Orbach is working with director Ian Rickson at the National Theatre to develop a stage version of *In Therapy*.

These pioneers of the genre are carefully walking the line between education and entertainment. Broadcasts of 'live' or simulated therapy are a way to showcase ethically and responsibly to the general public what therapists and therapy do. So long as principled and accountable practitioners are working with responsible and principled broadcasters, we can be hopeful that they are making it easier, safer and more acceptable for people to seek help, without creating another generation of Glorias. ■

REFERENCES

1. *Where Should We Begin?* is available on iTunes or at audible.co.uk
2. Burry P.J. *Living with the Gloria films: a daughter's memory*. Ross-on-Wye: PCCS Books; 2008.
3. Wahl O, Reiss M, Thompson CA. Film psychotherapy in the 21st century. [Online.] *Health Communication* 2016; 29 December. doi: 10.1080/10410236.2016.1255842
4. bit.ly/2lFJukB

The month

Don't miss



Event

Trauma summit

Looking ahead to the summer, the *International Trauma Recovery Summit* brings to Belfast many of the leading international experts in the fields of trauma, anxiety and stress, on 27-28 June. The impressive line-up of speakers includes Bessel van der Kolk, author of *The Body Keeps the Score*, Judith Herman, author of the classic *Trauma and Recovery*, and Gabor Maté, whose recent book, *In the Realm of Hungry Ghosts*, locates the origins of addiction in trauma and loss. There will be a programme of workshops running alongside the conference, and a parallel conference for the general public, covering issues including suicide and children's mental health. www.trauma-summit.com

Film

LADY BIRD

Catch if you can

The disappointment and bitterness of a mother's unrealised dreams are unleashed on her teenage daughter in a film that has more depth than the run-of-the-mill coming-of-age story. Billed as a comedy-drama, *Lady Bird* drills deep into the heart of the fraught and complex nature of the mother-daughter relationship. Saoirse Ronan, who is tipped for a nomination in March's Oscars, plays the daughter, Lady Bird, who is finding her identity and independence. Laurie Metcalf plays her mother, fighting to keep the family financially afloat after her husband loses his job, while negotiating her knife-edge relationship with her equally strong-willed daughter. *Lady Bird* is on general release from 16 February.

Event

Self-care

Burnout is an occupational hazard for the helping professions. So too is secondary trauma - even the most experienced therapists can find themselves triggered by a particular client or distressing story. How do we develop resilience in relation to the emotional pressures of our work? In this one-day seminar, Anthea Millar, a psychotherapist with a background in trauma, explores the multiple dimensions of 'second-hand shock', including the neuroscience behind the phenomenon. Alongside, Elizabeth Wilde McCormick, founder member of the Association for Cognitive Analytic Therapy, explores the 'human function curve' and the difference between healthy function and arousal and keeping a check on our 'energy bank'. *The Psychotherapist's Self-Care* is in London on 17 March. tinyurl.com/yd75f8bc

Video

Man enough?

Actor Justin Baldoni is known for his macho roles as the charismatic, powerful male, in which he is typecast by the film industry. In this inspiring and heartfelt Ted Talk, *Why I'm done trying to be 'man enough'*, Baldoni challenges the scripts that men adopt in real life in order to feel accepted. His message is that we need to redefine what strength and toughness mean to men, and he draws on his own social media 'experiment', in which his posts about love received responses only from women, and only men responded to those about tough workouts and bodybuilding.

tinyurl.com/y894jh59



Our monthly round-up of film, theatre, the media and events



Theatre

The shape of pain

Can we ever really understand how another person experiences physical pain just through words alone? Director Rachel Bagshaw and writer Chris Thorpe have put together a unique sensory exploration of pain, based on Bagshaw's experience of living with complex regional pain syndrome (chronic pain that persists long after an injury). This one-woman show, performed by Hannah McPake, uses dialogue, video, light and sound in a compelling, if disconcerting, experience that won it a *Scotsman* Fringe First Award at last year's Edinburgh Festival Fringe. *The Shape of Pain* is at the Battersea Arts Centre, London, 20 February to 10 March. tinyurl.com/yc2p6xl5



Radio

BOMBED OUT

'Keep Calm and Carry On' is one of the best-known slogans from the Second World War, and has enjoyed a resurgence in recent years. But what impact does war, and the threat of war, have on the unconscious mind? In this fascinating broadcast, historian and psychoanalyst Daniel Pick explores psychoanalyst Melanie Klein's case notes on 10-year-old 'Richard', to tease out what the boy's drawings reveal about his experience of the Blitz. Pick goes on to consider what living under the threat of a nuclear cataclysm does to the mind. *The Unconscious Life of Bombs* aired on BBC Radio 4 in December and is still available on iPlayer.

Tune in

Video

Depression

Depression is an incredibly isolating experience. The shame, self-contempt and inability to face others can make it impossible to believe that anyone else feels this way or to ask for help. *Bulldoze*, a video by student film-maker Jake Earwaker, picked up an award at the Cornwall Film Festival's Short Film Competition. Surreal and evocative, the film uses puppets, created by artist Jonathan Leach, to tell Jake's story of dealing with his own and his father's depression and how, when he began to break free of its grip, he was able to see he was not alone. tinyurl.com/ycs4ljqp



Television

Male rape

An estimated one in six men are victims of rape, but only 10% of these men report the crime. This BBC documentary follows three men, now breaking their silence, to explore the taboo that surrounds male rape. The men talk about their experiences and the impact on their recovery of the unhelpful responses they received when they disclosed the assault. The film travels with the men as they speak with other survivors and therapists and shows how sharing their experience with others paves the way towards acceptance. *Male Rape: breaking the silence* is available on BBC iPlayer.



Know of an event that would interest *Therapy Today* readers?

Email media@thinkpublishing.co.uk

The month

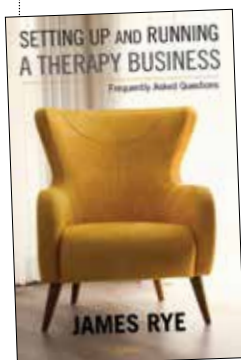


Read a new book worth reviewing? Email reviews@thinkpublishing.co.uk

Reviews

Setting Up and Running a Therapy Business: frequently asked questions

James Rye (Karnac Books, £16.99)



When I started psychotherapy training, I had an image of myself as a qualified therapist with a part-time job in a local NHS service. But, as time marched on, this image began to evaporate like fog on a sunny day. Today, such jobs are rarer

than hen's teeth. I realised I needed to think again, and thus my move into private practice was born. However, having always worked on a PAYE basis, I had no idea about the logistics of running a private practice.

I know I'm not alone in this, and I think James Rye's book should be on the curriculum of all counselling and psychotherapy courses, and should be recommended reading for therapists embarking on private practice. Rye covers areas I knew that I knew (eg how to manage bumping into a client in the street), what I knew I didn't know (eg the difference between a sole trader and a limited company), and things I didn't know I needed to know (eg registering with the Information Commissioner's Office).

As I moved from venturing into the new world of private practice to maintaining and managing a successful practice, my needs changed. I now need help to know how to manage my work/life balance, to think long-term rather than react to short-term offers, to optimise my self-care, and to form networks with colleagues. Perhaps Rye will write a follow-up book for me and others like me. I would certainly buy it, based on the quality of this book.

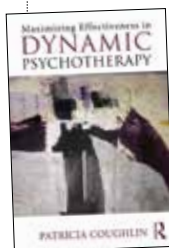
Helen Cordery, attachment-based psychoanalytic psychotherapist

Maximizing Effectiveness in Dynamic Psychotherapy

Patricia Coughlin (Routledge, £24.99)

Coughlin describes a form of Davanloo's intensive short-term dynamic psychotherapy that is delivered in multiple sessions spread over three days. The book is structured around six brain-change factors: focus and repetition; creating and maintaining a collaborative alliance; inducing moderate levels of anxiety; facilitating multiple levels of emotional activation; creating 'profound moments of meeting', and developing a coherent life narrative.

In this approach, the therapist is the expert and therapy is seen as a 'corrective emotional experience', so the book will be most useful for people who understand therapy in these ways. It was fascinating to see how the author condenses what might more usually be a prolonged process into just a few days. However, I found it unrealistic to presume that a lifetime of distress and trauma could be resolved in such a short period.



Liz Jeffries, transactional analysis psychotherapist in advanced clinical training in private practice in south Manchester

A Different Path: an emotional autobiography

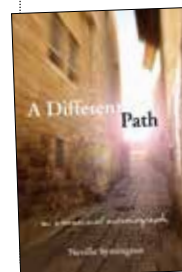
Neville Symington (Karnac Books, £29.99)

Symington takes the reader on an emotional journey from his privileged upbringing in Portugal to his life as a priest in London's East End, and then to his training as a psychoanalyst. The exploration of how this 'timid little shrimp' became a robust man with a caring heart held me captive from the first chapter. Like all great therapists, the concept of the wounded healer enables him to be with the 'other', especially the deeply wounded in society. He has a distrust of dogmatism, which allows him to work with clients who others might find impossible.

He is not afraid to reflect on the inner pain that drove many of his life decisions, and he grounds his esoteric

thoughts within the texture of everyday life. I have been greatly enriched by reading this book, and I await with enthusiasm the next instalments in Symington's life.

Mary Downie, integrative psychotherapist in private practice



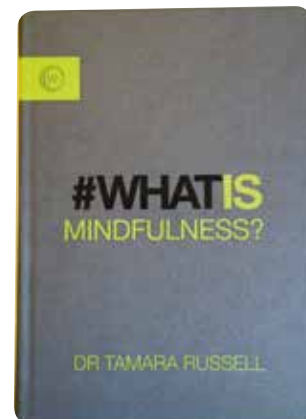
What is Mindfulness?

Tamara Russell (Watkins Publishing, £7.99)

This small book sets out to explain what mindfulness means, where it comes from, how it works, what its benefits are and how we can get the most from it. Russell presents her topic clearly, with diagrams and examples.

I enjoyed the inclusion of the latest research from the US, which has identified three brain networks that turn on and off as we move around the 'mindful moment cycle'. This is like giving our brain a 'workout', and the more we do this, the more we can control and use our brain to respond fully and appropriately in any situation. Given the amount of free resources and the vast array of self-help books on the market that take a mindfulness approach, this book may get a bit lost, which would be a shame, as it offers a concise guide to the practice.

Teresa Raven MBACP (Accred), counsellor in private practice



First lines

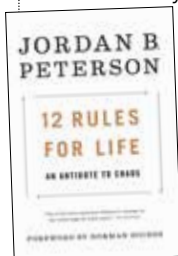
'There are two main consequences of our age of communication, computers, networking and fast-paced technology. On the one hand, the disparity between experts and lay people may have lessened. On the other hand, however, the new trend has produced super specialists who know ever more about so very little.'

From *The Theory and Practice of Balint Group Work: analyzing professional relationships* by Heide Otten (Routledge, £29.99)

Previews

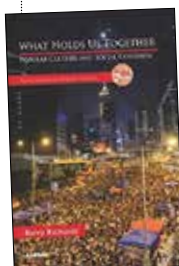
12 Rules for Life: an antidote to chaos **Jordan B Peterson** (Allen Lane, £20)

Drawing on examples from his clinical practice and personal life, cutting-edge psychology and philosophy, and lessons from humanity's oldest myths and stories, Peterson provides 12 practical principles for how to live a meaningful life. Happiness is a pointless goal, he argues. Instead, we must search for meaning, not for its own sake, but as a defence against the suffering that's intrinsic to our existence.



What Hold Us Together: popular culture and social cohesion **Barry Richards** (Karnac Books, £17.99)

Richards draws on psychoanalysis to consider the current malaise of politics in comparison with the vitality of popular culture. In a wide-ranging analysis that links topics as diverse as the rise of counselling and the changing impact of sexual scandal, he concludes that a reconstruction of nationalism could make an important contribution to the renewal of democratic politics.



Transforming Despair to Hope: reflections on the psychotherapeutic process with severely neglected and traumatised children

Monica Lanyado (Routledge, £25.99)

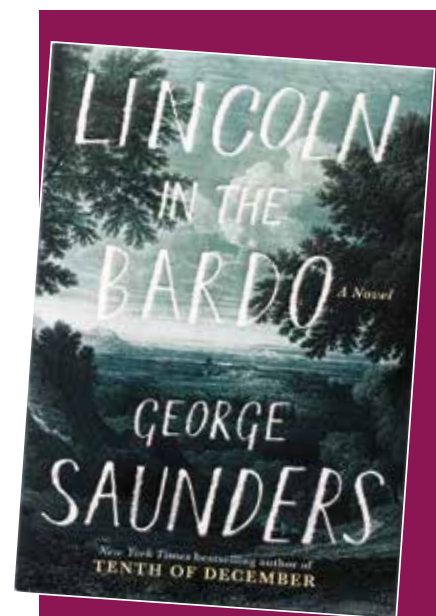
Lanyado offers a historical and social perspective on the problems and rewards of working with severely neglected and traumatised children. Through clinical examples, she describes the consequences of severe neglect and trauma on a child's development, and examines what brings about positive change.



Things Jon Didn't Know About: our life after my husband's suicide **Sue Henderson**

(Jessica Kingsley Publishers, £13.99)

An honest and moving account of the day-to-day practicalities and emotional impact of raising a family as a single parent after her spouse's suicide. Drawing on her experience as a social worker of 25 years, Henderson provides a theoretical framework within which she discusses theories of grief, men's mental health and the rise in male suicide.



A book that shaped me

Lincoln in the Bardo **George Saunders** (Bloomsbury Publishing, £8.99)

At the core of the winner of this year's Booker Prize is a reflection on what keeps us stuck and how we change. The tale is told by the voices of souls clinging on, through desire, anger or fear, to a shadow of life. What keeps them attached to this half-life are their stories, which they tell over and over again. It is only when they are supported and challenged by the compassionate relationships they form with each other that they can let go of their denial and self-deceit, tell a different, more truthful story, and are able to move on. I found the book a moving and helpful perspective on what we do as counsellors.

David Goldstein MBACP
(Snr Accred), counsellor
in private practice

Letters

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

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

Gender and relational depth

In a letter to *Therapy Today* in May 2017, I raised the issue of unconscious bias in relation to male counsellors, particularly with regards to expressed views that somehow women are more suited to counselling than men. I am returning to the same point in response to Mick Cooper's statement in his article, 'Meeting at Relational Depth' (November 2017), that, in studies, clients have reported greater relational depth with female counsellors than male, and that 'the deepest levels of connection are between a female therapist and a male client'.

This, of course, is all dependent on the level of critical analysis that has been used in those studies, and whether each study can demonstrate an absence of confirmational bias in its analysis. Confirmational bias 'describes the near-universal human tendency to use new information only to confirm existing beliefs, rather than challenge them', and it is the element of challenge that I believe is needed, not just in relation to unconscious gender bias, but also in the quest to identify, in Cooper's words, 'what happens, and how and why, when therapist meets client at relation depth'.

It interests me that the gender measure comparison is seen as being relevant in those studies, and that gender is dogmatically contained within the male-female perspective. How might the phenomena of relational depth correlate to transgender or non-binary counsellors and clients? Surely, we must assume that any number of possibilities may inform or affect the phenomenon of relational depth for both client and therapist, beyond biological factors such as gender?

In Cooper's article, there is no recognition of what has gone on outside of the room when relational depth is experienced. Perhaps client and therapist might include, and reflect upon, external influences, such as how their respective days have been in

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... we are searching for the key under the street lamp. Instead, we should take a torch into the park and see what we can find beyond the convenient, analytically limited and tiresome gender comparisons

”

the run-up to that experience, and how physically and emotionally available they were at the time? Perhaps a comparison of the influence of environmental elements, such as the room that the relational depth was experienced in, might be helpful? Might temperature, furniture, acoustics, or light contribute to relational depth? What about social, educational and economic influences in relation to the client's and therapist's worlds?

There are so many elements beyond gender that might be compared outside of the claim that being female privileges a therapist in achieving relational depth.

Perhaps the direction might lie in Mick Cooper's amusing tale of the drunk and the lost key. I assert that, by allocating too much value on gender in relation to relational depth, we are searching for the key under the street lamp. Instead, we should take a torch into the park and see what we can find beyond the convenient, analytically limited and tiresome gender comparisons.

Richard Mason MBACP (Accred)
Counsellor at University of Chester

Pathologising terminology

I'm troubled by your question to Graham Music (Analyse Me, November 2017): 'What client presentation do you most dread walking through the door?' I have never seen a 'client presentation... walk through the door'. What objectifying and pathologising terminology. It is

'people' who 'walk through the door'. People defy labelling; we're all complex. How disrespectful to imply that some people are to be 'dreaded'. And how unsurprising that asking the question elicits a response containing the term 'borderline personality disorder'.

Dr Deborah A Lee

Senior lecturer in sociology and psychotherapist-in-training

A good point. We have changed the question to one that is couched in less judgmental terms: 'What, for you, is the most challenging issue that clients bring?' Ed

Embrace empathy

With reference to Sally Brown's news feature 'Burnout... the high cost of caring?' (November 2017), it was good to see an article that focuses on the impact of the work on a therapist. However, as with Lisa Jenner's article in the June 2016 *Therapy Today*, 'The High Price of Empathy', there is a focus on protection and prevention that misses some of the other narratives about this subject. In particular, there is an idea that it is desirable to vary the intensity of empathy – an idea championed by Babette Rothschild, which Jenner acknowledges was not possible for her.

Empathy is one of our major tools, so, rather than placing a barrier between us and our clients, might we not look for other ways to manage the consequences of empathic engagement? A different narrative might start from the work of Pearlman and Saakvitne, who understand the impact on the therapist as inevitable, and therefore look at how we manage and understand the changes this brings.

I find intimate empathic contact with clients constantly challenging; it demands that I seek to understand and manage my own emotional health. Sometimes the work brings me joy, and sometimes it brings me suffering, but to reduce the suffering,

What value counselling?

Tom Livesey's review of *A Question of Worth* (The Month, September 2017) left me with a number of parallel concerns and arising questions in relation to the quantification of human value.

What happens when the individual is a counsellor, working for a provider commissioned to deliver IAPT? What happens when that counsellor is no longer paid per hours worked per month but only at the end of therapy? What happens to this counsellor's sense of worth and what impact does this have on counselling?

Furthermore, what does this mean for clients? What counsellor is going to take on a Step 3 or Step 3+ client (eight to 14 sessions respectively)? What level of invisible subsidy is this counsellor providing, at personal cost, in order to see these clients? As far as I can make out, the counsellor is paying for transport, supervision, insurance, CPD and membership of appropriate institutions for eight to 14 weeks before payment is received. I am assured that this will 'even out', but I am unsure how, when the counsellor has no regular income to count on.

How does the possible resentment built up by the above situation impact on the counselling process?

Returning to the counsellor/client relationship and the question of worth, the counsellor may not be willing to take on more challenging clients because financially this is too difficult; the counsellor walks into the consulting room with little sense of worth herself (she is no longer paid for clients who fail to attend unless they have turned up twice before, and may not be paid anyway for three months or more); the counsellor may feel compromised by all kinds of financial considerations, which may or may not affect the client.

I would suggest that, using the criteria expressed by the book, counsellors working in the context of IAPT, which is more a business than a therapeutic model, are made to feel isolated and worthless, that this can and does mirror clients' experience, and that we need to consider how this situation can promote wellbeing, self-care and good practice.

It is not normally the case that the innocent review of a book connects quite so poignantly with my own and my colleagues' experience. The workings at macro level affect micro functioning through the devaluing of human, ethical and moral values, and, in addition, the entire process is rendered invisible, unspoken and unacknowledged - a good description of abuse.

Name and address supplied

I would also need to mute the joy. I am not arguing against boundaries or sensible self-care, but I am arguing for us to embrace and process positively the suffering we inevitably experience from intimate empathic connection with our clients.

Chris Paul MBACP

Quality of supervision

Reading through the supervision training courses advertised in *Therapy Today*, I am surprised by the low level of their entry requirements.

In the November 2017 issue, there were 12 training organisations offering certificates/diplomas/MAs in supervision. As far as I

can ascertain from their websites and from email enquiries, entry requirements range from BACP or UKCP membership (with no mention of any post-qualification hours), through one year or 350 hours' practice, to four years or 900 hours, plus BACP or UKCP accreditation. In one instance, there is no entry requirement at all.

I recognise that post-qualification experience is no easy guide to the quality of supervision on offer, but I think it is unsatisfactory that the bodies that accredit these courses do not require entrants to have significant levels of experience (five years?), and do not insist they should be members of and accredited by a recognised professional body.

“The cynical part of me suspects that some counsellors choose to become supervisors to increase their revenue”

Early in 2016, I searched for a second supervisor to oversee a specific aspect of my work. The criteria I applied were training, experience of working with trauma and geographical proximity. I drew up a shortlist of those who met these conditions and 'interviewed' three candidates. I chose the one that I felt offered the best fit in terms of knowledge, experience and readiness to support and challenge. Other counsellors may be less demanding and choose a supervisor based on location and price. The danger is that they end up with someone who is both an inexperienced counsellor and an inexperienced supervisor, with minimal training.

The cynical part of me suspects that some counsellors choose to become supervisors to increase their revenue. Caveat emptor.

David Buswell MSc MBACP (Accred)
Counsellor and psychotherapist

Celebrate our professionalism

It is high time for BACP to lead a 60th-anniversary celebration of the non-medical counselling and psychotherapy profession, perhaps joining with other related associations to shout about its existence as a mature profession now, in the 21st century. It has come such a long way from its emerging status in the mid-60s.

The non-medical counselling and psychotherapy profession is so needed in the 21st century, working in parallel with the NHS provision, for ordinary folk with ordinary problems.

Non-medical counselling and psychotherapy offers the public such a richness of provision, with therapists using so many different approaches. Should we not be celebrating this richness and shouting our professionalism, with our registrations/accreditations and codes of ethics, from the rooftops? Let us stand up and be counted, advertising the sheer number of ready-made (achieved mostly at the therapist's own expense), qualified, non-medical counsellors ►

“
**Are we paying too much
 attention to our narcissistic
 wounds, based on not being
 able to reach someone?**
 ”

and psychotherapists in order that the public and Government cannot but be aware of our existence, and the Government cannot sideline us by funding just the NHS cohort, but must be compelled, with public pressure, to fund non-medical therapists in parallel with the NHS provision.

Such action could lead to more help for the people of our nation, the alleviation of suffering and more paid work for our therapists. Is this not the action BACP members have a right to expect of this lead professional association? Would it not increase BACP's standing to lead such a celebration?

Dr Penny Rawson MBACP (Accred)

In praise of peer supervision

With reference to the descriptions of contributors' ideal supervisors in the November Talking Point, I was interested to note that group and peer supervision were not mentioned. Two of the contributors mentioned that they had more than one supervisor to reflect different aspects of their practice, and all seemed to feel that a wide-ranging and comprehensive approach was the most beneficial.

Over 20 years ago, I chose the subject of peer supervision for my thesis, and for most of my working life this is the type of supervision I have participated in. When I first qualified, individual supervisors were recommended to me, and I believe that, in the early stages of practice, a one-on-one relationship is probably the most appropriate. However, with more experience behind me, I have found the benefits of peer supervision to be immeasurable, as the work with clients can be approached from a wide variety of disciplines, and, perhaps even more importantly, the feedback on my part in the process comes from different perspectives.

I have found it extraordinarily enlightening to hear the responses from those who practise in other therapeutic paradigms,

be they medical or mindful; the mutual respect experienced in a well-run peer group provides, I believe, a good model for the client/therapist relationship, as the dynamic remains one of equality, not of superiority of knowledge. I have also found that peer and group supervision both provide a stimulating yet challenging atmosphere that is difficult to replicate with a single supervisor, however accomplished that person might be.

**Sue Sutcliffe BA (Hons),
 MBACP (Snr Accred)**

Harsh words

I felt disturbed - both professionally and emotionally - after reading John Rowan's Turning Point article (December 2017). Both the content and the manner of expression were quite upsetting.

Why did Rowan wish to stop working with a client because, after a two-year period of therapy, the client had almost no emotional response to his girlfriend leaving him? Perhaps the client was 'immune to therapy', as John says, but it is difficult to see the evidence for this. Rowan asks if it is OK to sack a client, and says that he does not know the answer. He says that he 'now thinks that, as soon as we think we have the answer and the client does not agree, the therapy is doomed'. Why is therapy 'doomed' when the client thinks differently from their therapist? Perhaps connection and discussion together in an empathic therapeutic relationship could be a way of resolving differences of opinion. He invites us to discuss this issue. I would be OK with discussing it if the language used were more respectful and more sensitive. I feel disturbed by the writer's use of terms such as 'sacking a client', 'telling a client to leave' and 'giving a client the boot' - these terms suggest the therapist's needs, with little thought to those of the client.

In my view, most therapists have, on occasion, suggested working towards an ending with a client who has not engaged

with them or who appears to lack sufficient motivation to make therapeutic change. It is hoped that the process of ending therapy is one of collaborative working between therapist and client - it is also to be hoped that a therapist would respect the client's views and emotions, and that a therapist would be mindful of the necessity for ending all episodes of therapy in a considered and sensitive way.

Elaine Brown MBACP (Accred)
 Counsellor and CBT therapist in private practice and clinical supervisor

Straight talking

John Rowan raises an interesting question in the December 2017 Turning Point ('Is it OK to sack a client?'). He's right that there's not much (any?) discussion of this in the literature, and it's never come up with any of my supervisors or trainers over the years.

On the one hand, could it damage clients permanently if we dismiss them? Are we paying too much attention to our narcissistic wounds, based on not being able to reach someone? Should we not persevere patiently, as it can sometimes take many years for a client to be ready for change? And what are the implications for ethical practice of 'sacking' a client?

On the other hand, are some clients attending therapy as a substitute for genuine engagement, to convince themselves they're doing something apparently constructive about their difficulties? Unethical, but in these times of competitive private practice, could some practitioners not continue with someone like this for financial reasons? By not challenging clients on their preparedness to release rigid and long-standing patterns, could we be colluding with their self-deception?

An interesting question indeed, and one that would benefit from some professional attention and exploration.

Roslyn Byfield MBACP (Accred)
 Counsellor in private practice

MAKING CONNECTIONS IN GROUPS

Nick Barwick finds echoes of the wider political context in the psychological workings of group-analytic psychotherapy

Few therapists can be unaware of the current socio-political climate, with the dramatic resurgence of nationalism at a time when the general trend has been towards internationalism, its polar opposite. A core principle of internationalism, and one shared with group analysis (or group-analytic psychotherapy), is that of interconnectedness.

To me, the 17th-century English poet John Donne poignantly captures the 'internationalist' perspective, albeit in a spiritual context, and using a geographical metaphor: 'No man is an island, entire in itself; every man is a piece of a continent, a part of the main... any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.'³

In stark contrast, 'Britain First' (a far-right UK political party and the words of Thomas Mair as he murdered the MP Jo Cox in the run-up to the EU referendum), and 'America First' (the election slogan and now political policy of the US Trump administration), express a very different creed. This phenomenon is not confined to the UK and US - throughout western Europe, we are seeing a new

nationalism emerging. As *The Economist* observed, '... new nationalists are riding high on promises to close borders and restore societies to a past homogeneity'.⁴

Although economic insecurities experienced by some sections of society have been offered as the rationale for this resurgence - the revenge of the 'have-nots' - Inglehart and Norris⁵ argue that of greater import are psychological factors, which have prompted a powerful cultural backlash. The spread of 'progressive values', multiculturalism and, most recently, mass migration, have marked the growing dissolution of many traditional boundaries: mental, physical and moral. Fears provoked by this sweep of 'progress' - fears that are, at heart, about loss of identity - have led to an intensified nostalgia - a yearning, in the face of a growing sense of impotence, irrelevance and invisibility, for a return to more solid boundaries (borders, barriers, walls indeed), and a longing for one's tribe to be 'great again'. Accompanying this nostalgia has been a revolt against the perceived establishment - those mainstream parties who, because they appear to be at ease with a broadly progressive international agenda, have come to be viewed by the disgruntled and disaffected as led by a morally corrupt elite.

Psychological isolationism

What relevance can this wider socio-political context have to the intimate, psychological explorations of a psychotherapy group? For SH Foulkes (the founder of group-analytic psychotherapy), the therapy group is a microcosm of society. Just as nations, or

'We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one destiny, affects all indirectly'

(Martin Luther King)¹

as a species indeed, in struggling to survive and grow, we both guard and reach out beyond our boundaries, finding succour and limitation in sameness, and fear and hope of enrichment in difference, so too does the small group, and each member within it, struggle with these very same paradoxes and challenges - challenges that are at once profoundly and inextricably personal, social and political. Failure to meet these challenges and, instead of articulating our experience of them, retreating into the seeming safety of isolationism are, from a group-analytic perspective, signs of psychological disturbance and distress.

Group analysts view individual psychological disturbance and distress as symptomatic of disturbance and distress in the wider social network. This speaks again of an appreciation of the permeability of boundaries. There are no psychological islands. We are all 'part of the main'. However, although a group-analytic perspective is rooted in the principle of

'Mit unsichtbaren Fäden wird man am festesten gebunden [Invisible threads are the strongest ties]'

(Friedrich Nietzsche)²

Counselling changes lives



interconnectedness and in a belief that our lives can be immeasurably enriched by the accommodation of difference - a 'fusion of horizons'⁶ - if this is to happen without precipitating, at worst, breakdown, at best, defensive regression, then we also need to pay due heed to what the psychoanalyst Ferenczi called 'timing' and 'tact';⁷ that is, the pace of change must be tolerable and our explorations must take us no further from our secure base than psychic stability allows. Further, from a group-analytic perspective, when some of us find it difficult to manage either the pace and/or intensity of change, there is a sense in which all of us do.

Half of Britain voted for Brexit. Half of the US voted for Trump. Politics is always, of course, an arena of antagonisms, but something about the stark intensity of these divisions, of the difficulty we are having in finding common ground across the deep divide, seems to me to speak of 'malignant mirroring'⁸ - of splitting, and of projective mechanisms at work. To heal the split does not mean that those who believe in the principle of interconnectedness need to ditch their values. But we do need to facilitate a process of communication in which real fears can be aired and feelings of shame, invisibility and impotence can be safely explored - fears and feelings that, at some level, according to group-analytic principles, are likely to be common to all.

Immigration and the group

Lately, Brexit has been a topic frequently raised and occasionally dwelt upon in the groups with which I have worked. This is not surprising; the subject can provoke strong passions. Perhaps because the people with whom I work tend to be youngish and London-based, for the most part the discussions reveal unifying attitudinal characteristics, such as abhorrence of narrow-mindedness and scorn of those believed to be 'foreign-phobic'. Clearly, this does not do justice to potentially silenced minority undercurrents. Indeed, in the vignette that follows, seeming political homogeneity - support, for example, for open borders - also belies a deeper ambivalence. I have anonymised the material, and condensed several sessions into one, for brevity.

The group I describe was small at the time: two women, two men. Three had left in recent months and I'd raised the prospect of the

arrival of three more to replace them. Despite its small size - perhaps in part because of it - the group had developed a deep intimacy, encouraged by a series of particularly sensitive disclosures, although these had also brought with them renewed anxieties about trust.

I began the session by reading aloud an email received from a recent 'leaver', Daniel, who had given a quite detailed account of the difficult time he was having. I'd been unsure whether to do so since, strictly speaking, it was a communication from beyond the boundary of the group. Further, like most analytically oriented therapists, I'm wary of interrupting with my own agenda the organic emergence of material. However, it was clear to me that Daniel hoped I would speak on his behalf, wanting perhaps the comfort gained from knowing people important to him bore him in mind. I also thought, given the genuine affection in which he had been held, that most group members would be interested in having some news. However, as I was reading, I experienced from the group not interest but restlessness, impatience even. Further, once finished, the group commented little, except to note that the email was typically long-winded; one member, Sophie, wondered why I had read it out at all. The group then simply got on with the business of 'checking in'.

Sophie spoke excitedly about a new venture, a psychology course she'd embarked on. Paul asked a question that drew the conversation elsewhere, leaving her story hanging. An excited discussion ensued, dominated by the men, Paul and Marcus.

'Half of Britain voted for Brexit. Half of the US voted for Trump. Politics is always, of course, an arena of antagonisms, but something about the stark intensity of these divisions... seems to me to speak of "malignant mirroring"'

After a while, I mentioned this shift in conversational thread and the apparent gender dynamic. In response, Paul confessed, 'That's what I do. I interrupt,' and went on to relate how he'd responded angrily to a female friend on Facebook for dominating recent messaging exchanges with her endless, detailed accounts of her travels. Although Marcus suggested Paul was being hard on himself, Sophie wondered whether his difficulty with his Facebook friend linked with his difficulty with her - a long-standing tension that, although it had improved enormously over the year, emerged at times for further work and bore some relation, as they'd both come to understand, to his rivalrous relationship with his sister.

Silently (and approvingly), I agreed. As I did so, I wondered whether Sophie's own desire to capture my approval - which her analytic insights often did - paralleled her painful efforts to gain her distant father's love. I said nothing of this, however, as I suspected the wider context also called for attention, offering a potential broadening of understanding, as well as a deepening of it. Instead I said: 'Paul's insight into how he interrupts reminds me of how I began today. A bit unusual, reading something out, perhaps interrupting conversations that otherwise might have been. And come to think of it, although no one interrupted me, I wondered whether some might have wanted to. Sophie, for example, wondered why I even read out Daniel's email.'

What followed was considerable irritation with Daniel's way of speaking (and writing); his neediness, his tendency to take up time, whether in the group or not, and his difficulty in developing independence. 'It wouldn't be good for him to come back to the group,' someone said (as if he'd asked to do so). 'He needs to stand on his own two feet,' said another. Finally, with an edge of anger, Marcus asked, 'So why did you read it out?'

I paused a moment - I tend not to disclose my thinking too readily - then decided to be transparent. I simply explained that I believed the group was significant to Daniel and that Daniel had been significant to the group; that I thought the group might like, at this early stage of separation, to hear that he was thinking of them, as well as simply how he was.

'It is, in the end, our "groupishness" that, on balance, although able to threaten us and other life forms with extinction, enables us to develop, prosper and thrive'

A quiet reflectiveness ensued. After a while I added, 'And I still think this is the case. So, it's interesting that the email doesn't seem to have been welcomed and that Daniel has come in for a bit of a rough ride today. In fact, it makes me wonder if this isn't all about Daniel but also about the fact that there's a lot pressing at the boundary of the group just now: Daniel's email, yes, but also the imminent return of one member and two more after that - and all when there's immense vulnerability in the group, and, in equal measure, I suspect, trust and mistrust.'

Following what seemed to me a collective sigh of relief, Andrea, who recently, and for the first time, had disclosed a particularly shocking experience of parental abuse, said, 'I don't want anyone else in the group.' Appreciative of her wariness, the group shared further concerns about how depressed new members might be. What would that do to the group? Would it be 'swamped'? Would it be worn down by the level of need? Did they have sufficient resources to cope? It was at this point, after a long pause, that Marcus, who had identified himself as a staunch 'Remainer' in earlier Brexit discussions, added: 'It's so bloody difficult - this immigration thing.'

Connection

Neuroscientific research demonstrates that we are hardwired to connect deeply with others and that these connections, in turn, mould who and how we are. Simply put, we are made, through literal and metaphorical intercourse, to create. Although our long and chequered history as a species shows all too well how capable we are of committing the most horrendous atrocities in unthinking groups, we are capable too, together, of

great compassion, immense generosity and laudable, civilised co-operation. It is, in the end, our 'groupishness' that, on balance, although able to threaten us and other life forms with extinction, enables us to develop, prosper and thrive. That the group, with all its psycho-social intricacies, can be both so dangerous and so life-enhancing is a clear indication that to ignore its complexities, to ignore how we both contribute to and are made from them, is to ignore the principle of interconnectedness at our peril.

I would like to finish with an apocryphal story, told to me when I was 10. I am grateful to John Schlapobersky⁹ for reminding me of it, albeit in a slightly different form.

One night, a wise man dreamt that a messenger of God visited him and offered to show him both heaven and hell. The messenger took him first to visit the damned. The wise man was surprised to be shown a beautiful banqueting hall in which, at its centre, stood a huge table, laden with the most delicious food. On the table were many pairs of chopsticks, each six feet long. The damned, who were seated around the table, were allowed, said the messenger, to eat as much as they wanted whenever they wanted, but they could only do so if they used the long chopsticks. The wise man noticed how all those who sat at the table were groaning in the most terrible agony, emaciated and starving, because they could not feed themselves with these unwieldy utensils. And so it would be, for eternity.

Overwhelmed by this horror, the wise man pleaded to be taken from this terrible place and instead to be shown heaven. In an instant, he found himself transported to another, equally beautiful banqueting hall, in which, as in hell, a huge table stood, laden with delicious food. Again, on the table were many pairs of chopsticks, six feet long, and the wise man was told that here, as in hell, the same rules of feeding applied. Yet here all were well-nourished, cheerful and content. 'How can this be?' he asked. 'The same hall, the same table, the same food, the same chopsticks and the same rules. And yet here in heaven all thrive. What then makes the difference between heaven and hell?'

'Ah!' replied the messenger. 'In heaven, people feed each other.'

Group-analytic therapy is a therapy whose primary aim is to enable the individuals who

engage in it to lead less pain-wrought, more creative, more productive lives. But it believes it must do more than this if it is to help the individual fully thrive. It aspires to engage its members in a complex psycho-social-educational experience. The process of such engagement is inextricably both personal and social, both psychological and political, since the future it seeks to enable for each person - one that is more hopeful than despairing, more creative than destructive - is a future which, as Donne well understood, involves all humankind. ■

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REFERENCES

1. King ML, Jnr. Letter from Birmingham City Jail, 16 April, 1963. bit.ly/1PzYolh (accessed 1 December 2017).
2. Nietzsche F. *Nachgelassene fragment*. Berlin: De Gruyter; 1882-84/1977.
3. Donne J. Meditation XVII. In: Hayward J (ed). *Donne: complete verse and selected prose*. London: The Nonesuch Press; 1624/1929.
4. The Economist. League of nationalists. [Online.] The Economist 2016; 19 November. econ.st/2jAn6x9 (accessed 1 December 2017).
5. Inglehart RF, Norris P. Trump, Brexit and the rise of populism. Faculty research working paper RWP16-026. Cambridge, MA: John F Kennedy School of Government, Harvard University; 2016. bit.ly/2njX4Df (accessed 5 December 2016).
6. Gadamer HG. *Truth and method* (trans Weisheimer J, Marshall D). London: Sheed & Ward; 1975.
7. Ferenczi S. The elasticity of the psycho-analytic technique. In: Ferenczi S. *Final contributions to the problems and methods of psycho-analysis* (Balint M ed). London: Karnac; 1928/1980 (pp87-101).
8. Zinkin L. Malignant mirroring. *Group Analysis* 1983; 16: 113-126.
9. Schlapobersky J. *From the couch to the circle: group-analytic psychotherapy in practice*. London: Routledge; 2016.

What's the harm?

It's vital to understand self-harm as a way of coping, not as a suicide bid,
writes **Jeanine Connor**

When was the last time you knowingly did something harmful to yourself - smoked a cigarette or nicotine substitute; drank a glass of wine over the recommended allowance; swallowed a couple of paracetamol above the prescribed amount; took a recreational drug; skipped a meal or binge ate? Usually we do these kinds of things because we think they'll change our mood in some way by helping us to unwind, de-stress or relieve psychological pain. On occasion, we might do things we know are harmful in order to manage our emotions or dissociate from them. Is this self-harm?

Most people think of self-harm in terms of cutting or burning, and associate it with adolescent girls using it to 'act out' or follow a 'copycat' trend. All too often it's labelled as 'attention-seeking behaviour' and is misunderstood or dismissed. Self-harm is far more complex than these simplistic stereotypes suggest, as I hope this article will illustrate, and it is prevalent across all genders, cultures and age groups. If we are to work with it, it is important that we counsellors and therapists are clear in our own minds about what we understand self-harm to be, as this will influence our clinical work, from contracting to discharge, as well as inform our decision-making around safeguarding and disclosure throughout the period of therapeutic engagement.

In this article I draw on a number of definitions of self-harm, mostly expressing or derived from a medical, diagnostic model, even if they are written in lay language. While I do not necessarily endorse these definitions, they provide a valid starting point for a critical exploration of self-harm and how we can work with it safely, appropriately and therapeutically. They also remind us how our colleagues in mental health and medical settings may view it. As I work almost exclusively with children and young people, the clinical examples I include are from the adolescent age group, although similar models of working can be applied whatever the client's

age. These examples are amalgamations of multiple client experiences rather than identifiable individuals.

Motivation

NHS Choices, the public-facing health information website, defines self-harm as '... when somebody intentionally damages or injures their body... usually as a way of coping with or expressing overwhelming emotional distress'.¹ This is uncontentious but restricted, and does little to inform our understanding or treatment of self-harming clients.

The online Medical Dictionary is more nuanced, defining self-harm as: 'The deliberate infliction of damage or alteration to oneself without suicidal intent, in particular by those with eating disorders, mental illness, a history of trauma and abuse: eg emotional or sexual abuse - or mental traits such as low self-esteem or perfectionism.'²

Both these definitions lay stress on 'intentional' or 'deliberate', which, for many, have judgmental resonances. While there has been a welcome shift away from use of 'deliberate self-harm' (DSH) in some settings, the new language of 'non-suicidal self-injury' (NSSI), which feels less condemnatory, is taking a while to become fully embedded.

I contest the use of the word 'alteration' in the Medical Dictionary definition, as would most of my clients. I have debated with counselling and psychotherapy colleagues whether tattooing, piercing, ear stretching or cosmetic surgery are forms of self-harm. To me, even people who go to seemingly extreme lengths of piercing and stretching to alter their body and/or face are not demonstrating self-injury. The crucial difference is the motivation, which for these individuals is to enhance and embellish their bodies rather than harm them, however extreme their methods might seem.

I also find problematic the suggestion that self-harm often accompanies eating disorders (although, confusingly, eating disorders are sometimes described as a form of self-harm),³ mental illness, or a history of trauma and abuse. I think that this definition perpetuates an increasing trend towards pathologising behaviours that, seen from the individual's perspective, may be regarded as an understandable response to an unbearable situation. Pathologising suggests that someone who self-harms is ill. Some people with a diagnosed eating disorder or mental illness might self-harm, and the behaviour could be an

'If we are to work with it, it is important that we counsellors are clear in our own minds about what we understand self-harm to be'



expression of trauma, but that is not the place from which to start the conversation. It is helpful to note that the National Institute for Health and Care Excellence (NICE) states explicitly that: 'Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.'⁴

I considered this definition useful in my work with Dan, a 19-year-old student who came to me for psychotherapy because of problems with intimacy. He was an unconfident, shy young man with lots of visible tattoos and enlarged earlobes through stretching. A couple of sessions into therapy, he arrived with deep scratches on his face, and told me he got them when he was drunk but couldn't remember how. Later, he admitted that the scratches were self-inflicted, and over the following weeks his visible injuries became more extreme. He arrived at one session with a deep wound on his cheek having intentionally cut himself with a razor blade. Over several months of therapy, we worked through Dan's hatred of his appearance and ambivalence about his sexuality. We disentangled the 'alteration' - tattoos and ear-stretching - from the 'self-injury'. We explored the meaning of Dan's behaviour in establishing his identity, and I tried to encourage him to self-harm safely and helped him to find healthier and non-violent ways to express his emotions.

Ask the question

The Mental Health Foundation defines self-harm as: '... a wide range of things that people do to themselves in a deliberate and often hidden way'.⁵ I think it is a mistake to think of self-harm as often hidden - in my experience it may be selectively hidden, in that it may be concealed from parents, peers, partners or professionals, or the individual might self-injure on a part of their body that isn't readily visible to others, for a multitude of reasons.

This definition also states that, 'in the vast majority of cases, self-harm remains a secretive behaviour that can go on for a long time without being discovered'. The chances are then that some of our clients may be self-harming and we don't even know it. Whether they disclose or not is up to them, but I think it is also up to us. As with any subject that is remotely taboo, clients pick up on cues from us about what is OK to talk about. When I'm working with someone who presents with low mood or anxiety - which is almost every young person who comes to me for therapy - I always ask about self-injury. Most tell me they are hurting themselves, or have done so at some point in the past. If you don't ask the question, you might be sending a message that you are uncomfortable talking about it, and therefore your client will be too, thus perpetuating the secrecy.

When I asked, 12-year-old Shaila told me that she had been self-harming since she was nine. I asked if she could tell me what she did, in as much detail as she felt comfortable to share. She was embarrassed, and said she had never told or shown anyone before because she didn't want to be accused of attention-seeking. I hear this a lot. I said I didn't need to see unless she wanted to show me, which she didn't. She explained that she used the flat side of a scissor blade to graze the upper parts of her thighs. She had never broken the skin or caused bleeding.

As we talked further, I began to understand that Shaila had been struggling in silence with overwhelming emotional distress that she felt powerless to control. She was academically successful and popular at school, but had buried the pain of her parents' separation and become isolated and depressed. Her mother was dealing with her own grief following the end of her marriage and the death of her father. Shaila did not want to add to her mother's distress or make her feel responsible for her unhappiness, and so she kept her feelings hidden. For some people, the act of self-injury is what helps; they replace emotional pain with physical pain. Over time, we worked out that the important thing for Shaila was not hurting herself physically per se, but that she had the power to stop the pain. She couldn't stop the emotional distress, but it helped her that she could stop the physical pain, and to be able to do that, she had to inflict it.

I meet so many girls like Shaila who have concealed their psychological pain and the physical harm they have relied on to manage it. They are the antithesis of the 'attention-seeking' adolescent. I helped Shaila to uncover the distress and put her feelings into words - a painful process, but with it came relief from no longer having to hide a secret that felt shameful, and, in time, Shaila no longer felt the need to rely on self-injury as a way of managing her emotions.

Self-poisoning

The NICE definition of self-harm includes '... any act of self-poisoning',⁴ and I think this inclusion is useful. I have worked with young people who self-poison by inhaling ►

gas or aerosols or swallowing toxic substances. Their motivations are different from those of young people who take recreational drugs, and it is important, therefore, to establish the meaning behind the act of self-poisoning – to cause harm or to get high – in the same way that it is important to distinguish alteration of the body from self-injury.

Robert was 14 and had just been excluded from school for the third time when he was referred to me for psychotherapy. He found it difficult to settle physically or mentally. His mother was emotionally distant and was self-medicating for depression with alcohol. Robert had low self-worth and had internalised the script that he was 'useless like his father', who was serving a prison sentence for aggravated burglary. Robert was aggravated too, and had a tendency to aggravate people around him.

Over six initial assessment sessions, I discovered that Robert had worked hard to keep his family narrative a secret and that he felt enormous shame when people found out. He had presented as angry and aggressive throughout primary school and had now turned that aggression on himself. When I asked about self-injury, Robert told me he had, in the past, used aerosols to burn his skin. This started out as a dare but had developed into something more like self-punishment. He then began inhaling aerosols, in order, he said, to 'feel dead'. We began to understand this as a means of temporary escape: Robert didn't want to die; he wanted some relief from the emotional pain of his experiences. Self-poisoning was a way to numb that pain by replacing it with another.

Non-suicidal self-injury is not, and never has been, listed as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the guide developed in the US and routinely referred to by medical professionals throughout the UK. It is, however, included in a new category in the latest edition, *DSM-5*,⁶ called V-codes, which describe 'other conditions or problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder'. (Of note, V-codes also include parent-child relational problems, relationship distress and academic/educational problems.) The new V-code categorisation explicitly recognises that NSSI (and other V-codes) are 'relational problems requiring relational solutions', rather than mental disorders, with the stigma



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this implies.⁷ While a primary function of inclusion in the *DSM* in the US is that it gives access to insurance funding for medical treatment, the new coding system provides a welcome shift away from medicalising behaviour and encourages professionals to think differently.

DSM-5 defines NSSI as 'the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned, including behaviors such as cutting, burning, biting and scratching skin as a way of coping with difficult emotions'. This is the most inclusive of all the definitions I have found, as it addresses the what, how and why of self-harm, as well as what it is not. I think the 'socially sanctioned' part helps distinguish piercing, tattooing, etc from self-harm, as does the NICE definition, and *DSM-5* also highlights the distinction between self-harm and suicidal intent. Self-injury is often a means of staying alive, a bid for survival, not death, although it may be accompanied by suicidal thoughts, and persistent self-harm can be a risk factor for suicide.

Lucy was 13 and had a history of risky behaviour, including serious self-injury, sexual promiscuity and absconding, when she was referred to me for psychotherapy. She was small, heavily made-up and fragile looking. To me, she seemed empty inside, like a china doll. She said she hated her 'no-good' mother and described her father as a relentless bully who 'doesn't know when to stop'. Shortly after we started to work together, her self-injury escalated. When her mother tried to make the home safe by removing any sharp implements, as I had insisted, Lucy smashed a window and used the glass to cut herself so deeply that she had to have stitches. She pierced her face with a compass point and the wound became infected. She refused to eat or wash. She dyed her hair blue. She had unprotected sex with older men 'because they wanted to'. She constantly said she'd be better off dead, although she had no suicide plan or intention to kill herself.

I wondered about the escalation in Lucy's self-harm and what the attacks on her body might be about. I understood the uninhibited flaunting of her physical injuries as an attempt to draw attention to her distress. It felt important to show her that I understood that these visible displays were communicating pain that she was, as yet, unable to verbalise. I didn't want her to perceive me as either an intrusive father or useless mother; I needed to 'hold' Lucy (psychologically) and proceed at her pace. My being able to bear her behaviour allowed Lucy to finally disclose that her father was sexually abusing her. We later came to understand her attacks on her own body as symbolic attempts to eradicate the intolerable memories of the trauma she had endured. They might also have illustrated her attempt to control her feelings of murderous guilt and rage towards both her abusive father and her mother, who failed to protect her, by displacing them onto herself.⁸ My work with Lucy came to an abrupt end when she was removed from her family for her own safety.

'It felt important to show her that I understood that these visible displays were communicating pain that she was, as yet, unable to verbalise'

'I tell them... my role is to understand what they are doing and why, and to work with them, and their family if it's appropriate, to keep them safe'

Disclosure

With Lucy, I had no reservations about sharing information with the statutory authorities about her self-harm and her disclosure of abuse. But it is rare that I need to raise self-harm as a safeguarding concern, even though most of my clients self-injure. When I contract with new clients, I tell them that, if I am worried about their safety, I might need to talk to someone else about it, but that I will always talk to them first. If a client tells me they are self-harming, I keep in mind the *DSM-5* definition - that the behaviour is 'a way of coping with difficult emotions', and that it is different from suicidal intent.⁹ I explore their means and motivation by asking what, how and how often they injure themselves. I tell them that it is not for me to either condemn or condone their behaviour, but that my role is to understand what they are doing and why, and to work with them, and their family if it's appropriate, to keep them safe. I usually

say that I have met lots of young people who self-harm, to demonstrate that I can bear it, but I always emphasise that I know it means something different for each of them. I tell them that I want to understand what it means for them, to reassure them that I am making no assumptions.

For me, risk assessment is not a one-off event; it is entrenched in every session of psychotherapy. It includes an appraisal of each client against what might be ordinary, age-appropriate behaviour within their family and social context. Assessment is also informed by organisational protocols and procedures, and professional ethical guidelines, as well as by my own clinical experience and instinct. The NICE guideline on self-harm provides a helpful framework for working with clients safely. For clients who repeatedly self-harm, NICE recommends offering advice on how to treat their own superficial injuries and on harm-minimisation, for example by using clean blades and antiseptic products, rather than trying to stop them from doing it, which is seldom effective.⁴

In my work with both Dan and Robert, I understood their self-injury as an expression of distress rather than suicidal intent, and embedded in our sessions suggestions for ways they could self-harm more safely. With Shaila, I didn't share with the statutory authorities or with her family her disclosure of self-injury, despite her young age, but nor did I collude with her secrecy. I encouraged her mother to acknowledge and 'bear' her daughter's feelings of grief as separate from her own.

If we continue to monitor the level of risk, we should be able to hold our clients' distress. Putting words to their pain, in my experience, leads to a reduction in the reliance on self-injury, whatever the client's age. ■

HARM-MINIMISATION

Harm-minimisation is based on the understanding of self-harm as a coping mechanism - one that has an important purpose and meaning for the individual, but carries potentially serious physical health risks. The aim of harm-minimisation is to reduce those risks as far as possible, so the person can stay safe and avoid doing severe, potentially life-threatening, unintended and irreversible harm to themselves. It accepts that someone is self-harming, and looks for ways to enable them to stay safe, rather than trying to stop them (which generally doesn't work or help).

A helpful guide to harm-minimisation is Kay Inckle's book, *Safe with self-injury*.¹ The book sees self-harm through the lens of a social model of distress. It explains harm-minimisation in the context of an exploration of the meanings of, and reasons for, self-injury, drawing on the words and experiences of people who self-injure. It includes a section on 'staying safe', covering harm-reduction practices, self-care and alternatives to self-injury.

1. Inckle K (2017). *Safe with self-injury: a practical guide to understanding, responding and harm-reduction*. Monmouth: PCCS Books.

REFERENCES

1. See <https://www.nhs.uk/Search/?query=-self+harm>
2. See <https://medical-dictionary.thefreedictionary.com/Self+harm>
3. See www.rcpsych.ac.uk/healthadvice/problemsdisorders/self-harm.aspx
4. NICE. Self-harm. QS34. London: NICE; 2013. www.nice.org.uk/guidance/qs34/chapter/Introduction-and-overview
5. Mental Health Foundation. A to Z: self-harm. London: Mental Health Foundation. www.mentalhealth.org.uk/a-to-z/s
6. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th edition) (DSM-5). Arlington, VA: APA; 2013.
7. Self-Injury Institute. The surprising place for self-injury in the new DSM-5. [Online.] Los Angeles, CA: Self-Injury Institute. <https://selfinjuryinstitute.com/the-surprising-place-for-self-injury-in-dsm-5>
8. Fonagy P, Target M. Towards understanding violence: the use of the body and the role of the father. In: Perelberg RJ (ed). *Psychoanalytic understanding of violence and suicide*. London: Routledge; 1999 (pp51-72).
9. Zetaqvist M. The DSM-5 diagnosis of nonsuicidal self-injury disorder: a review of the empirical literature. *Child & Adolescent Psychiatry & Mental Health* 2015; 9: 31. www.ncbi.nlm.nih.gov/pmc/articles/PMC4584484/ PMID: PMC4584484

What do you want to change?

Mick Cooper and **Duncan Law**
explore the benefits and challenges
of goal-oriented practice

Gita has come to a local community counselling service for therapy. She is 42 and got divorced three years ago. In her first meeting with her therapist, she speaks of how she has felt since then: 'I just can't live with the despair, anxiety, guilt and shame. I feel like they're ripping me to shreds.' Her therapist listens. After a few sessions, she gently enquires about Gita's hopes from therapy. Gita is unsure - she knows she does not want to go on feeling as she does, but cannot see beyond the emotions; she just wants them gone. Over the next two sessions, they tentatively start to shape ideas about what might be helpful to focus on in the therapy. Gita would like to find a way of moving on. 'What I want is to not feel that intense shame. I want things to settle so I can be more myself again - and I'd like to start thinking about new relationships.'

This shaping moves the narrative from what has been to what could be, from the unbearable past to the hoped-for future. Towards the end of this session, Gita and her therapist write down the tentatively agreed goals: 'Not feel deep shame', 'Feel more settled and secure', and 'Develop the confidence to start a new relationship'. The therapist explains that at the start of each session she will invite Gita to indicate how much she feels she has moved towards achieving these goals.

In the next few sessions, Gita goes deeper into her lack of self-confidence and its roots: how her parents teased her for being overweight, how her husband dismissed her feelings, and her sense of injustice. At the start of each session, Gita rates her progress towards her goals, and can see that, in a small way, she is starting to develop more self-confidence, and that her unbearable feelings of shame have also started to

subside. At session 16, Gita tells her therapist that therapy has helped enough for her to continue to make progress on her own, for now. Her goals have given her hope and a sense of direction and purpose for the future. When things get difficult and the feelings re-emerge, she is able to think back to the therapy and remember the progress she made.

What are therapeutic goals?

This is an example of goal-setting in counselling and psychotherapy. Goals can be defined as a 'subjectively desirable state of affairs that the individual intends to attain through action' or, more simply, 'what I want to change'.¹ Goals have a number of features. First, they are a thought or cognition, rather than a behaviour. Second, they are always oriented towards an object: the goal object. This may be a behaviour, a state of affairs, an entity, an event, an experience or a particular characteristic; it does not need to be a fixed and definite endpoint, it could just be a diffuse sense of where the person wants to go. Third, goals have a motivational element: they are a distinctively emotional form of cognition; they matter to the person; they are affect-laden. Fourth, goals are about the future: they describe what the person wants to happen in the coming hours, days or years. Finally, goals are aspirations that the person sets for themselves. This distinguishes them from, for instance, 'wishes' or 'expectations' that a person might hope will be achieved through the actions of others.

Development of goal-oriented practices

Goal-oriented practice is a complex, subtle and dialogical process, in which collaboratively agreed goals are used to provide ongoing focus and direction to the therapeutic work. Early psychoanalysts believed that behaviours were driven by instincts that were unknown (and, to an extent, unknowable) to the client, so direct enquiry into the client's goals had little value. Charlotte Buhler is credited with being the first to argue for a more explicit link between the life-goals of the client and the goals of therapy.² This legitimised the therapist enquiring about a client's goals, but goal-setting was still led by the therapist.

There followed a period of growing interest in hearing what clients wanted to get from therapy, as part of the focus of the work itself. This interest was incorporated into a range of emerging modalities, most notably cognitive therapy. Arguably, however, it was not until the latter part of the 20th century, when brief solution-focused therapy

emerged, with its interest in helping clients reach their 'preferred futures', that clients' goals took centre stage and were endorsed as the primary focus of therapeutic work. Goals now have a prominent role in other psychological practices that seek to facilitate individual development, such as coaching and consultancy.

In England, recent policy has supported the use of goals in therapy. Implicitly, this has been through the 'recovery' and 'choice' agendas enshrined in NHS England's *Five Year Forward View*,³ which call for interventions to be 'safe, effective and personal'. The personalisation of care requires all those who work with people with mental health difficulties to ensure they focus on what the client wants from services, on their personal goals. In children's services, support for the use and monitoring of goals is set out in *Future in Mind*,⁴ which recommends goal-based outcomes tools as one of the standard metrics for measuring therapeutic change.

Goal-oriented practice

Goal-oriented practice is a therapeutic stance rather than a therapeutic model. Once a therapy goal has been collaboratively agreed between therapist and client, it is possible to use any suitable intervention to reach it. Goal-oriented practice provides a focus, or a direction of travel, that the therapist and client have agreed to work together to reach. It operates on the pluralistic principle that many potential vehicles can take you towards the same destination.⁵

Goals may be agreed in the first therapy session or, as with Gita, later on in the process. Either way, it is important that they are allowed to evolve and change over time. ►

'Goal-oriented practice is a complex, subtle and dialogical process, in which collaboratively agreed goals are used to provide ongoing focus and direction to the therapeutic work'

‘...goal-setting invites clients to take an active role in determining the therapeutic agenda, it doesn’t mean that the therapist simply hands them this responsibility’

Goals may be recorded on a particular instrument – such as the Goals Form⁶ or the Goal-Based Outcome (GBO) Tool (for children and young people)⁷ – but they can also be written down more informally and used as a general guide for the therapeutic work and a measure against which the client can regularly rate their progress. Clients may also prefer just to keep their goals ‘in their head’, and, of course, some clients may not want to focus on goals at all – they may feel that it makes them more anxious about being judged, for example – and it is essential that their preferences are respected.

Although goal-setting invites clients to take an active role in determining the therapeutic agenda, it doesn’t mean that the therapist simply hands them this responsibility. Rather, the essence of this work is a dialogical process of shared decision-making between therapist and client. Here, therapists have a key role in helping clients to identify and clarify goals that will genuinely support their psychological wellbeing.

Jo, aged 13, was referred to a child mental health service with concerns about her low weight. Her parents reported that she had been losing weight over the past six months, she was restricting what she ate, her periods had stopped, and, in their view, she was exercising too much. In the first part of the session, Jo’s parents shared their worries and discussed their goals: ‘To get our little girl back and to see her happy and eating again.’ In the second part, the therapist met Jo on her own to give her a chance to talk about her concerns, away from the understandable anxiety of her parents. Initially, as they tentatively explored what Jo wanted, she said her aim was ‘to lose weight – another half a stone’. This goal was clearly not safe, given her physical health. The therapist’s task was to find some overlap between Jo’s goal and goals that would be safe to agree to work on together.

Therapist: So, Jo, you have been really clear that what you would really like is to lose more weight – half a stone? Is that right?

Jo: *Yes – I feel fat. People stare at me because of that, particularly in PE... I feel fat, and unhappy, I don’t have any friends...*

Therapist: That sounds really uncomfortable, feeling that people are staring at you. Let’s just think for a moment about what you hope life would be like if you lost half a stone? How do you think things would be different?

Jo: *I wouldn’t be fat.*

Therapist: OK. What else would be different?

Jo: *If I wasn’t so fat, I’d feel happier and more confident.*

Therapist: And what if you were feeling happier and more confident?

Jo: *I’d probably have more friends too.*

Therapist: So, if you lost half a stone, you might feel more confident, feel happier and start to have more friends?

Jo: *Yes, I think so...*

At this point the therapist is starting to get a glimpse of safer goals behind Jo’s unsafe one of losing half a stone: ‘To feel happier, more confident and have more friends.’ These higher-order goals might, over time, form goals that the therapist, Jo and her parents can agree to work on. In Jo’s case this took another few sessions, partly due to her firm belief that the only thing that could help would be to lose more weight, and partly because it was necessary to attend urgently to her extreme low weight through a refeeding plan. Both of these factors had a big negative impact on the therapeutic relationship. However, over time, Jo slowly progressed towards achieving the self-confidence, happiness and ability to form friendships that she, at a deep level, wanted.

Why goals?

So why should therapists work with goals in counselling and psychotherapy? Clinically, as we saw with Gita and Jo, goals can help focus and direct clients’ and therapists’ attention in the therapeutic work. This may be particularly important in short-term work, where interventions have to be tightly focused to achieve ‘results’ within the time limits. Setting goals for therapy may also give hope, energise clients towards their goals, boost persistence and help them find more effective strategies for achieving their goals. Through discussing and setting goals, clients may also develop a deeper insight into what they really want in life – a crucial first step towards being able to achieve it. These potential benefits are supported by research from the psychology field that suggests people are more likely to achieve what they want if they set explicit goals.⁸ In addition, research shows that better clinical outcomes are associated with therapist and client agreement on the therapy goals.⁹

There are also ethical arguments for working with goals in counselling and psychotherapy. Therapists, however ‘client-centred’ they are, will always have particular wants, hopes or expectations in the therapeutic work. A goal-oriented approach puts the client’s explicitly stated agenda at the heart of the therapeutic process. Orienting the work around the client’s goals also means that their priorities take precedence over any diagnosis-based treatment plan. This is important because, as the research shows, clients

with similar diagnoses can have very different objectives for therapy.¹⁰ Clients who are depressed, for instance, may want to improve their interpersonal relationships, or develop strategies for becoming more active, or come to terms with childhood events.

A goal-oriented approach may also be empowering to clients because it 'constructs' them as choice-making beings who are active and effective agents in shaping their own world. They are not victims of their circumstances, or passive 'sponges', but people who have the potential to act towards and achieve their desired futures. By asking clients about their goals for therapy, counsellors and psychotherapists are implicitly communicating that they respect their opinions and understandings.

Setting and discussing goals for therapy may also be empowering to clients because it can make the therapeutic agenda more transparent. As suggested above, therapists too will have goals that they want from the therapeutic work, whether these are consciously or unconsciously held. For instance, a therapist may want a client to 'feel more accepting of who he or she is', while a client may just want 'the pain to disappear'. Ignoring these differences does not make them go away. Rather, it means that they can lie, unacknowledged, in the therapeutic work and potentially lead to ruptures in the therapeutic alliance. Explicit discussion about goals can bring these wants to the surface, and help to establish a more open, trusting and honest relationship.

Another strong argument for using goals in therapy is that this is what many clients want. Research suggests that around 60% of clients would like specific goals to be set in therapy, while 20% do not want this, and 20% say they don't mind either way.¹¹ However, mental health practitioners, asked for their preferences as clients, are significantly less likely to want goals (just 40% say they would like them). This suggests that therapists should be particularly wary of assuming that their clients will have the same preferences as them regarding goal-oriented practice.

Why not goals?

What about the counter-arguments? From a 'depth-psychology' perspective (which holds that the principal determinants of human experiencing exist beneath the threshold of consciousness), perhaps the greatest objection to a goal-oriented approach is that it may focus only on the most superficial needs and wants of the client. What clients are consciously aware of wanting, particularly at the start of therapy (for instance, 'to be thinner and happier'), may have little to do with their actual, unconscious needs and desires (for instance, 'to punish my parents for making me grow up'), and there is evidence to support this viewpoint.⁸ Closely related to this, it can be argued that clients may censor the goals they are willing to share with their therapists at the start of therapy, and these goals may not reflect their more destructive, 'unacceptable' impulses. In addition, from

many therapeutic perspectives, what clients want, even at the most unconscious level, is not necessarily what they need. As we saw with Jo, for instance, if the therapist simply went with what Jo initially wanted - to lose more weight - she could have ended up in a much worse physical and psychological state. From these perspectives, a goal-oriented therapy may not only miss clients' most significant therapeutic needs, but may also actively undermine their attempts to meet them.

In therapies that emphasise the healing potential of non-judgmental acceptance, there can also be a concern that goal-oriented practices reinforce the processes of self-evaluation and self-judgment.¹² These therapies seek to help clients accept all the different aspects of themselves; goals (and their tracking/rating) may be seen as valorising concepts of success and failure, and leading clients to feel that they must be a certain way. Goals can be seen as emphasising attainment, striving and doing, at the expense of a more 'authentic' state of being. Indeed, to the extent that goal-striving may be seen as the core sickness of a contemporary, western, neoliberal society - and meditative, eastern *wu wei* ('non-doing') as its remedy - a goal-oriented approach may be seen as the very antithesis of therapeutic practice.

There are also practical challenges to working with goals in therapy. What if, as often happens, clients don't know what their goals are? What is the point of asking them? Clients' goals may change and evolve through the therapeutic process, particularly as they become more aware of their deeper needs. So, goals that are set early on in therapy may become barriers to, rather than facilitators of, therapeutic growth. ►

TERMINOLOGY

GOAL-SETTING is the process of identifying and establishing goals, generally at the start of therapy, although they may be reset further on in the process.

GOAL-TRACKING (or goal-monitoring) is the evaluation of a client's progress towards their goals, generally through some kind of individualised outcome measure.

GOAL DISCUSSION, or meta-therapeutic communication about goals, refers to any

process in which client and therapist collaboratively talk about their goals for therapy.

GOAL-ORIENTED THERAPY refers to a therapeutic approach in which the setting, tracking and discussion of clients' goals form a central element of the therapeutic work.

GOAL AGREEMENT is the extent to which therapists and clients are matched in their understandings of the objectives for therapy.

‘The therapist is not treating the client’s goals as fixed and definitive endpoints that must be achieved at any cost, but as fluid, malleable and approximate indicators of the client’s preferred “direction of travel”’

Moving forward

To some extent, these differences in attitudes towards goal-oriented practice emerge from differing psychological and philosophical assumptions. In particular, therapies that emphasise unconscious processes are less likely to prioritise clients’ verbally articulated goals than are therapies that value clients’ conscious insights. Therapies that consider reflective ‘being’ to be a healthier state than striving and ‘doing’ may also be less likely to adopt a goal-oriented approach.

In some instances, however, the challenges to a goal-oriented approach may be based on a one-dimensional caricature of the practice. Goal-oriented therapy, at its best, is a complex, multifaceted, dialogical and nuanced endeavour, in which the therapeutic goals may be articulated and re-articulated many times. The therapist is not treating the client’s goals as fixed and definitive endpoints that must be achieved at any cost, but as fluid, malleable and approximate indicators of the client’s preferred ‘direction of travel’. In this respect, a client’s goals are less the final destination of the voyage, and more like lighted buoys along the way, providing orientation, guidance and illumination to the therapeutic work.

So, should therapists incorporate goal-oriented practices into their therapeutic work? From a pluralistic standpoint,⁴ this is the wrong question to be asking. From this perspective, as our research shows, goal-oriented practices are likely to be helpful for some clients some of the time, and unhelpful to others at other times. A more helpful question may be, ‘At which points in time, and with which clients, are goal-oriented practices likely to be helpful or not helpful?’ This is a question that needs much more research and inquiry. However, it is important to note that there is no ‘neutral’ position here. A therapist who never offers clients the opportunity to explicitly set goals is likely to disadvantage some clients and benefit others, and a therapist who always expects his or her clients to set goals may do the same.

In recent years, there has been a shift in the focus of mental health work away from the medical, diagnostic question, ‘What’s wrong with you?’ to the more collaborative, formulation-driven question,

‘What happened to you?’ This article proposes a further shift: that, in many instances, the starting point of an intervention should be, ‘What do you want to change?’ This question invites clients to share their hopes and wishes for the outcome of therapy: what they want to be different as a result of the therapy, and what resources they will need to invest to achieve this. In short, it asks for the client to articulate their goals. ■

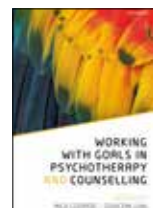
REFERENCES

1. Kruglanski AW, Kopetz C. What is so special (and nonspecial) about goals? A view from the cognitive perspective. In: Moskowitz GB, Grant H (eds). New York, NY: Guilford Press; 2009 (pp27-55).
2. Michalak J, Holtforth MG. Where do we go from here? The goal perspective in psychotherapy. *Clinical Psychology: Science and Practice* 2006; 13: 346-365.
3. NHS England. Five year forward view. London: NHS England; 2014.
4. NHS England. Future in mind. London: NHS England/Department of Health; 2015.
5. Cooper M, McLeod J. Pluralistic counselling and psychotherapy. London: Sage; 2011.
6. Cooper M. The goals form. London: University of Roehampton; 2015. Download from mick-cooper.co.uk (Training/Goals in therapy)
7. Law D, Jacob J. Goals and goal-based outcomes (GBOs): some useful information. London: CAMHS Press at EBPU; 2015.
8. Cooper M. The psychology of goals: a practice-friendly review. In: Cooper M, Law D (eds). *Working with goals in psychotherapy and counselling*. Oxford: Oxford University Press; 2018.
9. Tryon GS. Goals and psychotherapy research. In: Cooper M, Law D (eds). *Working with goals in psychotherapy and counselling*. Oxford: Oxford University Press; 2018.
10. Holtforth MG, Grawe K. Bern inventory of treatment goals: Part 1. Development and first application of a taxonomy of treatment goal themes. *Psychotherapy Research* 2002; 12(1): 79-99.
11. Cooper M, Norcross JC. Mental health professionals and service users’ preferences for therapy. Unpublished dataset; 2015.
12. Rowan J. Personal communication, 2016.

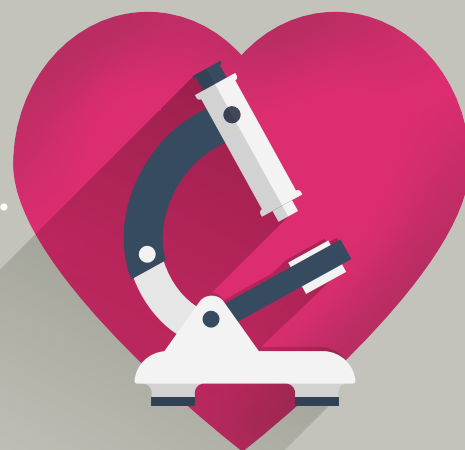


Duncan Law (top)
and **Mick Cooper**
About the authors

Duncan Law and Mick Cooper are co-editors of *Working with Goals in Psychotherapy and Counselling*, published this January by Oxford University Press, on which this article is based. Duncan Law is a clinical psychologist and originator of the Goal-Based Outcome Tool for children and young people. Mick Cooper is a Professor of Counselling Psychology at the University of Roehampton, a practising counselling psychologist, and author of a range of texts on person-centred, existential and relational approaches to therapy.



‘... she said something that would change my whole sense of what science is about. “Try to relax,” she said. “Let it come to you. You will never see it if you don’t love it”’



I was 23 and doing my doctoral

research in botany at Leeds University. I was new to electron microscopy, trying to make out the image of a tiny, single-celled green alga, and I was having a hard time of it. This was the first time this particular species had been examined, so I had no map to which I could refer. My frustration was spotted by my professor, Dr Irene Manton, one of the few women Fellows of the Royal Society at the time, who was showing me how to use the state-of-the-art instrument, and taking pains to help her female students succeed in a male-dominated scientific world.

Neither of us were to know that, a few years later, I would abandon biology for psychology. That day, as I struggled to decipher the image and expressed out loud my irritation at the impossibility of being certain about what I was looking at, she said something that would change my whole sense of what science is about. ‘Try to relax,’ she said. ‘Let it come to you. You will never see it if you don’t love it.’

She explained how science was not a set of fixed certainties but about seeing the world more completely. She went on to show me how to look at something on its own terms - not to look for what I anticipated it should be. She shared her scientific philosophy, influenced by the great science philosopher Michael Polanyi, that knowledge is always on the move and emerges in the dynamic relationship between knower and known. It is personal, and it requires faith that the universe is not random and chaotic, but ultimately makes sense. She understood that seeing is not objective: we can never

be sure, we can always be wrong, and alternative interpretations may bring us closer to the truth.

Irene was well known for her collection of 19th- and 20th-century art, including works by western and Asian artists. Many of her pieces hung in Botany House. She urged graduate students to spend time with the collection, which included works by Miro, Matisse, Mondrian, Picasso, Klee, Kandinsky, Hokusai and Hiroshige, alongside her own, stunning micrographs. She wanted us to learn how to see from multiple perspectives. Manton viewed her collection as a tool that would help us learn to see and interpret nature more fully, unconstrained by the need for certainty imposed by science’s false ideal of objectivity.

Three years later, having emigrated to the US and switched my field to psychology, I had the amazing good fortune to be taken on as a doctoral student by Carl Rogers. As Irene had taught me to see, Carl taught me to listen. He too had been influenced by Michael Polanyi and other post-positivists, and he urged me to ‘let [myself] go into the immediacy of the relationship’, and to surrender to the total organismic response to the other. Sometimes, in our shared work exploring large group encounters, we would arrive at an impasse where the process was indecipherable, bewildering and even threatening. The temptation to take control was great. At these times, I would remember Irene’s counsel: ‘You won’t see it if you don’t love it.’ It reminded me to soften my grip and trust the process. It usually turned out to be the best path. ■



About Maureen

Maureen O’Hara is Professor of Psychology at the National University, US, a psychotherapist and futurist, and worked with Carl Rogers for over 18 years. Her book (with Graham Leicester), *Dancing at the Edge: competence, culture and organization in the 21st century*, addresses the psychological dimensions of our current cultural crises.



The BACP Ethical Framework for the Counselling Professions (EFfCP)¹ has always been intended as a living document that adapts as the work of the counselling professions changes. Following the implementation of the current version, which came into effect from July 2016, BACP wanted to know what was working well, and whether the changes from earlier versions had posed unexpected problems for members or their clients.

To understand better how it was working in practice, BACP undertook extensive research:

- a survey of members' views on the EFfCP and the Good Practice in Action resources that provide additional guidance and information - 1,600 members responded
- an evaluation of all feedback to the dedicated EFfCP mailbox, linked to the BACP website, and any associated issues raised with BACP staff on the Ethical Framework Implementation Group
- an analysis of all enquiries to the BACP Ethics in Action service from members and the public
- a review of the annual monitoring reports from BACP-accredited courses.

We also considered the issues raised in an online conference about the EFfCP, organised independently of BACP, to obtain an external viewpoint.

This research generated a vast amount of data and provided a very informative overview of the current ethical challenges faced by practitioners. From this, we identified the most challenging areas of practice that require difficult ethical decisions by practitioners, as follows:

- confidentiality and disclosure of client confidences
- notes and record-keeping
- supervision-related issues
- dual roles/relationships.

These challenges appear to be intrinsic to the role, as there is no evidence that the introduction of the latest version of the EFfCP made these areas of practice any more or less difficult.

The overall tone of the feedback from all sources was positive. The introduction of the new 'Our Commitment to Clients' section has been generally welcomed as supportive of good practice and an acceptable alternative to the use of lists of 'duties', typical of most codes of practice in health and social care. Overall, very few difficulties were raised and most of the EFfCP appears to be informing and supporting good practice.

Nonetheless, there are a few issues arising from the changes in the 2016 version:

- the introduction of a new duty for members to 'promptly notify' BACP 'where we are in sufficient difficulty to be declared bankrupt or have entered into other types of debt relief or insolvency arrangements' (Good Practice point 43)
- contracting and whether clear contracting ought to be a stricter requirement
- the extent of the supervisor's responsibility for the standards of work undertaken by practitioners, especially trainees.

The monitoring of BACP-accredited courses also highlighted the absence of specific guidance for trainees, which seems surprising, given that they make high use of the EFfCP during training.

This article presents some of the issues that have emerged and how BACP proposes to respond to them.

Financial difficulty

Good Practice point 43 requires members to 'promptly notify' BACP 'where we are in sufficient difficulty to be declared bankrupt or have entered into other types of debt relief or insolvency arrangements'. This requirement has created a number of problems, as is evident from the feedback.

1. Members were uncertain about when to self-report and the scale of financial difficulty that would trigger the duty to self-report. They were also uncertain about what happens when someone self-reports and what the consequences will be.

2. Some members felt this requirement was unduly oppressive to those affected. It sits alongside a duty to report 'any criminal charges' or 'disciplinary procedures', creating the impression that all the matters covered in point 43 involved an element of wrongdoing, which is not usually the case where financial difficulties are concerned. Some members suggested it is shameful and painful enough to be in financial difficulties without being treated like a criminal.

3. There have been unavoidable delays in developing a supportive and informative process to help members manage any implications of their financial difficulties for their practice.

We have considered a variety of options, including redrafting the requirement to remove the implied association with wrongdoing, providing supplementary ►

Making the Ethical Framework work for you

Tim Bond explains some changes to the BACP Ethical Framework in response to feedback from members

guidance, or reconsidering the requirement. It is more obvious now than at the time the requirement was drafted that financial difficulties are affecting an increasing proportion of the population and are a growing source of potential stress for clients and practitioners alike. Some practitioners reported being able to use their own experience of surviving and managing severe financial difficulty as a resource to help their clients. They were able to turn a challenging personal situation into a force for good.

For all these reasons, it seems better to remove the issue of financial difficulty from the 'Integrity' section, where it now sits. There would no longer be any obligation to self-report. Instead we would treat financial difficulty as a matter of self-care and encourage members to seek professional help and discuss any implications for practice in supervision.

Contracting

There are two aspects to contracting that are causing concern.

First, poor contracting is a recurrent issue in professional conduct hearings and a major cause of client complaints at this level. Clear contracting would have helped to avoid many difficulties that resulted in practitioners facing the demands of a conduct hearing and, in some cases, sanctions. The absence of a contract also complicates the task of the adjudicators, as it often requires them to decide between the parties' conflicting memories of what was agreed, with little factual evidence to assist them.

'... we would treat financial difficulty as a matter of self-care and encourage members to seek professional help and discuss [it] in supervision'

The current Good Practice point 32 commits members to give 'careful consideration to how we reach agreement with clients and contract with them', and gives a list of five factors that will be paid attention. The reason for not simply stating 'We will contract with our clients...' is the diversity of practice and the circumstances in which the counselling professions provide their services. Written contracts work well in formally organised services provided by appointment. It is much more challenging if a practitioner is providing emergency services to significantly disturbed or distressed clients who find it hard to engage with formal contracts. Similarly, formal contracts are less suited to drop-in sessions, as they may conflict with other ethical priorities such as accessibility to people with literacy or language difficulties, or providing a culturally appropriate welcome to the service.

Nonetheless, the wording could be more focused on the actions to be taken without losing the flexibility required for different types of services. A revision of point 32 is being considered that states: 'We will work with our clients on the basis of mutual agreement. Attention will be given to:

- a.** communicating terms and conditions of the agreement or contract in ways easily understood by the client and appropriate to the service
- b.** stating any reasonably foreseeable limitations to client confidentiality or privacy
- c.** providing the client with a record, or easy access to a record, of what has been agreed
- d.** keeping a record of what has been agreed and of any changes or clarifications when they occur.'

The second major issue facing practitioners concerning contracting is ensuring compatibility between multiple contracts that affect their work. For example, practitioners may be working within a contract with their clients while employed under a contract with an employing agency that may itself be subject to contractual requirements by funding agencies or subject to inspection and auditing under different regulatory or contractual regimes. The situation can become even more complex for trainees who have contractual arrangements with their training provider that may, or may not, be compatible with the contractual arrangements in operation in their placements.

Again, creating a simple commitment to ensure that all the contractual terms are compatible would not address the scale of the problem and could be unfair to conscientious practitioners. A significant minority of the difficulties experienced by practitioners arise in situations where they are powerless to resolve them themselves. The conflicts may have arisen due to mergers between organisations, or the closure of services due to withdrawal of funding, which can impose new conditions on how services are organised or how records are kept or transferred, or may involve practitioners in contractual disagreements between powerful stakeholders. Further complications can arise for trainees, who often feel powerless to resolve contractual differences because their placement is dependent on the goodwill of a provider, or they are having to try to influence contracts entered into by the training organisation that assesses them. The more complex conflicts between contractual terms often require legal advice and services.

We are considering introducing an additional Good Practice point stating that: 'We will take reasonable steps to ensure all contracts that impact on our work with clients are compatible with each other.'

Supervisors' responsibilities

Single words in the points relating to supervision have caused significant concern.

Good Practice point 59 concerning the role of supervisors states: 'The application of this Ethical Framework will be reviewed in supervision regularly and not less than once a year.' The word 'reviewed' has suggested to some that this is a substantial task in which all aspects of the EFfCP are discussed in detail. This was never the intention. A discussion about which parts of the EFfCP are particularly helpful and which are problematic would be sufficient. Some supervisors prefer to consider specific parts of the EFfCP that are relevant to the issues faced by the practitioner as and when they arise during supervision sessions. Both these approaches would satisfy point 59. How the review is undertaken is a matter for the professional judgment of the supervisor and supervisee. We will substitute 'considered' for 'reviewed' to reduce misunderstandings about the scale of the task involved.

Concerns about Good Practice point 56 are less easily resolved. This states: 'Trainee

'... one of the functions of a supervisor is to protect standards, but they are not solely responsible for this'

supervision will require the supervisor to ensure that the work satisfies professional standards.' It is the word 'ensure' that raises concerns about whether this is a reasonable expectation when the supervisor is generally working from their supervisees' accounts of their work, with no opportunity to directly observe the work themselves.

These concerns could be resolved by inserting a qualification, such as 'take reasonable steps to', thus limiting the supervisor's responsibility. However, closer examination of the monitoring reports of accredited courses suggests that the situation is considerably more complex than envisaged by the current point 56. It is both a legal and ethical requirement that the work of trainees with their clients satisfies at least the basic, fundamental professional standards - in other words, it is undertaken with a reasonable level of care and skill. This may be achieved through additional support for trainees. Trainees are not required to be fully competent and self-sufficient to reach this standard. In practice, this support can come from multiple sources: the trainers, the placement providers, a more experienced colleague, fellow trainees and/or the supervisor. In the counselling professions, one of the functions of a supervisor is to protect standards, but they are not solely responsible for this. For example, it is typically the training organisation that determines whether a trainee passes or fails. Ultimately, the protection of standards of the work of trainees depends on collaboration between supervisors, placement providers and trainers.

Point 56 will be revised to reflect this reality, with a reciprocal commitment for

trainees to collaborate with their supervisors, placement providers and trainers to ensure that their work with clients meets the required standards (see also below).

Trainees

A first draft of the new section for trainees is being prepared for consultation with training courses - especially BACP-accredited courses. The new section will include the following requirements of trainees to:

- relate respectfully to each other, endeavour to support each other's learning and follow good ethical practice when learning new techniques and developing new insights
- inform clients in the interests of openness and transparency if they are training for a first or basic qualification as a practitioner - disclosure of trainee status is not required when undertaking additional training post-qualification as a practitioner
- seek clients' permission to use work with them for training purposes, for example in presentations and case studies
- work collaboratively with their trainers, placement providers and supervisors to provide services to clients that meet professional standards
- be open and honest with training providers.

Yet to be decided

We have still to come to a decision on requests from members for some additional points. One concerns taking responsibility for arrangements in case of unplanned endings or disruptions due to the practitioner's illness, death or other causes. We are considering what would be an appropriate and practicable level of commitment. The other is the suggestion that we reinstate a number of points from the 2010 BACP Ethical Framework:² on working in teams (points 51-55) and making or receiving referrals (points 57-58). These were thought to be particularly useful for trainees.

Next steps

This article was written in early December 2017. The revisions to the text of the EFCP will have been finalised during December, and legal and BACP's scrutiny and approval processes will have been completed early in 2018.

The revised EFCP will be launched in March 2018, to take effect from 1 July 2018. ■



Tim Bond
About the author

Tim Bond is Emeritus Professor, University of Bristol, and Visiting Professor, University of Malta. He is consultant to the BACP Ethical Framework for the Counselling Professions and author of *Standards and Ethics for Counselling in Action* (4th edition) (Sage, 2015).



REFERENCES

1. BACP. Ethical framework for the counselling professions. Lutterworth: BACP; 2016. www.bacp.co.uk/ethical_framework
2. BACP. Ethical framework for good practice in counselling and psychotherapy. Lutterworth: BACP; 2010.

ACKNOWLEDGEMENT

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RESEARCH MATTERS



John McLeod opens his new monthly column by looking at the implications of recent research findings on the personal and social impact of therapy and what it means to be a therapist or client

Bereavement counselling benefits

Many counselling and psychotherapy organisations collect outcome data from clients that are never fully analysed or disseminated, due to lack of time and resources. This results in an apparent lack of evidence for the effectiveness of counselling and psychotherapy delivered by routine, front-line services.

A research initiative by Cruse Bereavement Care Scotland (CBCS) shows what can be achieved when a voluntary-sector counselling agency teams up with an academic partner – in this case, Utrecht University in the Netherlands. The model of counselling used by CBCS, informed by previous research, is based on use of a screening procedure. Clients with low grief scores are assigned to a watchful-waiting group, and those with higher scores are allocated to a trained counsellor, who uses an integrative model of short-term bereavement counselling, drawing on person-centred, CBT and psychodynamic methods.

In their most recent study,¹ counselling clients were asked to complete grief measures (sent by post) before they started therapy, then 12 and 18 months later. Around half of those eligible for counselling entered therapy (the other half were unable to attend for a variety of reasons, such as scheduling or travel difficulties). This made it possible to compare those who had received counselling (on average, six sessions) with those who had sought help, had equivalent levels of distress, but had not been able to take up the offer of professional help.

CBCS found that, while both groups recorded equivalent levels of alleviation of grief symptoms at 12 months, those who had received counselling continued to improve, and at 18 months were in a significantly better place than those who did not.

A further analysis looked specifically at outcomes associated with clients in households living in poverty (36% of those who contacted CBCS – more than twice the rate in the general population).² Here, it was found that, although clients in the lowest income group were substantially more distressed at the point of contacting CBCS, and were less able to take up the offer of counselling, once they began counselling, they benefited just as much as those in higher income groups.

It is important to acknowledge the limitations of this kind of practice-based research. Less than half of those who began counselling (or became part of the comparison group) filled in questionnaires at the final 18-month data collection point. The research team were able to show that there were no differences in terms of age, gender, initial levels

‘... a service that is embedded in the community... is perhaps particularly well suited to meet the needs of older, less affluent clients’

of severity and other factors between those who contributed data all the way through and those who dropped out of the study. Nevertheless, they were not able to eliminate the possibility that, faced with a questionnaire pack delivered through their letterbox, those most affected by their loss might have found it harder to complete and return it.

Despite this limitation, the CBCS study provides strong evidence for the effectiveness of short-term bereavement counselling based on an integrative, pluralistic model. When compared with similar studies of bereavement counselling in other countries, it also suggests that a service that is embedded in the community, and available in multiple local centres, is perhaps particularly well suited to meet the needs of older, less affluent clients.

Therapy is hard work

A welcome development in the field of counselling and psychotherapy research is the increasing number of studies that use qualitative methods to capture the experiences and stories of clients.

One of the themes that commonly emerges from this body of work is that therapy is hard work for the client. Clients say what matters is not so much the therapy approach used but that it is implemented thoroughly and rigorously by a therapist who seems to genuinely care.

A compelling example of this can be found in an autoethnographic study by a young woman battling with obsessive compulsive disorder (OCD).³ Although this study is not recent, it was not published in a therapy journal, and seems to have passed under the therapy research radar.

There are many fascinating aspects of this study – not least, its vivid account of the secrecy and desperation associated with living with OCD. Another striking aspect is the way the client, although she finds meaning in the explanatory models offered to her (medical and CBT), at the end of the day arrives at her own understanding of her problem. Also notable is her acknowledgement that therapy, although helpful, did not provide a cure, but merely made it possible for her to live with the condition.

The most powerful part of this paper, however, is its description of the remorseless pushiness and thoroughness of the CBT therapist, and the capacity of the client to

‘... that they were more distressed after therapy than they had been previously is unexpected, and, from a therapy perspective, rather troubling’

tolerate what were, for her, massively frightening exposure activities. This study powerfully demonstrates the capacity of autoethnography when it is written by someone who has a story to tell and is brave enough to go to places that are beyond the reach of most interviews and case studies.

Sometimes therapists do well...

There are a lot of similarities between having an interest in research and appreciating music or art. It is impossible to keep up to date with everything, so we become fans of particular bands and artists - or researchers. A researcher worth following is Andrzej Werbart, and his team, based in Stockholm. They are psychoanalysts, and their research mainly involves interviewing clients and therapists and then attempting to drill into the heart of what their informants are telling them.

Their most recent study is a qualitative analysis of the experiences of therapists in relation to achieving good outcomes from long-term psychoanalytic treatment (lasting on average, two years) of young adult clients.⁴

There are two main findings from this study. The first is (again) that therapy is hard work. These therapists described themselves as having to be persistent, patient, courageous and challenging. This theme sits alongside client accounts of their same experience of counselling being hard work. The other main theme is that these therapists saw themselves as particularly motivated to work with these clients. They were drawn to and felt compassion for the clients. They believed in the clients' potential to grow, and felt that there was a mutual connection between them.

The authors of this study comment that there has been a lot of attention given in the psychotherapy research literature to the qualities of effective therapists, stimulated

by the discovery that some therapists, across a series of clients, achieve much better results than others. They point out that most therapists do well, and are the 'right' or 'best' therapist for at least some of their clients. Their study makes a valuable contribution to beginning to understand how and why this happens.

... but perhaps not often enough

Research into counselling and psychotherapy almost always collects information during the period when the client is actually in therapy. As a consequence, findings tend to be influenced, to a greater or lesser extent, by the attitudes and assumptions of the person or organisation collecting the data - typically a therapist or researcher with a therapy background. This makes it particularly important to take account of evidence that is gathered in other ways.

A recent study used information from routine health surveys administered to large panels of members of the public in Germany and the US on a regular four-year cycle.⁵ In the most recent cycle, participants were asked if they had been in therapy since the previous survey.

This question revealed that those who had received therapy during the past four years had higher levels of anxiety, depression, low self-esteem and other negative factors than they had reported in the previous survey cycle.

The results from the US arm of the survey are less conclusive, because the therapy question was framed in a way that was likely to have picked up mainly people who were still in therapy at the time of completing the survey - it is not surprising that people in the midst of an episode of therapy might have higher symptoms. However, the German survey collected data from people who had received therapy during the last four years but had completed the course of treatment. The fact that they were more distressed after therapy than they had been previously is unexpected, and, from a therapy perspective, rather troubling.

The authors of the study acknowledge that further research is needed to replicate these findings, and that the results can be interpreted in different ways. Their preferred explanation is that the majority of therapy research studies tend to use highly qualified, expert therapists, working in optimal conditions, and that most of the therapy on offer to the public is of lower quality, and therefore likely to result in poorer outcomes. ■



John McLeod
About the author

John works at the University of Oslo and the Institute for Integrative Counselling and Psychotherapy, Dublin, and is the author of books and articles on a wide range of topics in counselling and psychotherapy.



Get in touch

If you have comments or questions about any of these studies, or would like to suggest studies for inclusion in these pages, contact John McLeod at research@thinkpublishing.co.uk

REFERENCES

1. Newsom C, Schut H, Stroebe M, Wilson S, Birrell J, Moerbeek M, Eisma M. Effectiveness of bereavement counselling through a community-based organization: a naturalistic, controlled trial. *Clinical Psychology & Psychotherapy* 2017; doi: 10.1002/cpp.2113.
2. Newsom C, Stroebe M, Schut H, Wilson S, Birrell J, Moerbeek M, Eisma M. Community-based counseling reaches and helps bereaved people living in low-income households. *Psychotherapy Research* 2017; doi: 10.1080/10503307.2017.1377359.
3. Brooks C. Social performance and secret ritual: battling against obsessive-compulsive disorder. *Qualitative Health Research* 2011; 21(2): 249-261.
4. Werbart A, Missios P, Waldenström F, Lilliengren P. 'It was hard work every session': therapists' view of successful psychoanalytic treatments. *Psychotherapy Research* 2017; doi: 10.1080/10503307.2017.1349353.
5. Chow PI, Wagner J, Lüdtke O, Trautwein U, Roberts BW. Therapy experience in naturalistic observational studies is associated with negative changes in personality. *Journal of Research in Personality* 2017; 68: 88-95.

THIS MONTH'S DILEMMA:

My client is dating my ex-partner

Uri has been seeing Luka for therapy since the death of Luka's partner six years ago in a car accident. Luka was driving, and blames himself for his partner's death. Uri has focused on supporting him to process his complicated grief, a key feature of which has been Luka's social isolation and suicidal ideation.

On Uri's suggestion, to help him form new friendships, Luka has attended a personal development workshop for gay and bi men. He returns

excited to have formed a connection with one of the participants. When he tells Uri about this man, Uri feels uneasy, as he shares the same name and country of origin as one of his own ex-partners. This triggers painful feelings relating to the sudden ending of that relationship - the result of his then partner's escalating drug use.

Uri attempts to bracket his feelings and to reassure himself that Luka can't possibly have met, and

started dating, his ex-partner. However, he is unable to contain his anxiety and asks Luka about his boyfriend, to put his mind at rest.

The more Luka describes this man, the more certain Uri becomes that he is his former partner.

As Uri has had no contact with him since their relationship ended, he says nothing, in the hope that Luka's relationship with him will fizzle out. But, after some months, it becomes clear it is not going to.

In all these circumstances, Uri should have considered, and must now consider, whether he can continue to work with Luka. Luka must also be given the opportunity to decide whether to continue therapy with Uri, and can only do so once Uri has been completely honest with him.

Unprocessed, painful feelings

Jonathan Harris UKCP (Reg) Psychotherapist, Combe Martin, Devon

Uri's unprocessed, painful feelings about his relationship ending have perhaps prevented him from really helping Luka with his grief at his beloved's death. And so they are pricked by Luka choosing none other than Uri's ex-partner as his new boyfriend. Again, Uri avoids confronting this, so putting himself in 'bad faith' - ie his inner incongruity is outed into an expanded incongruity with his client. So many bracketed feelings, when what was needed was simple honesty. Authenticity and congruence have fled the nest, perhaps because Uri could not empathise deeply enough with Luka without first facing his own pain.

Can Uri fall back on his unconditional positive regard for Luka? If he can, and is able to open up, he could start by levelling with his client and admit that he thinks he may know Luka's new boyfriend, and that he has been withholding this from Luka in the hope that it might turn out to be someone else. He needs to do this first, if Luka is to be able to allow himself to truly feel his guilt and the loss of his previous love.

They say we get the clients we need, and this seems especially so in this poignant tale of entanglement in loss and love, which also offers the possibility of redemption through telling the truth, for both Luka and Uri.

WHAT SHOULD URI DO?

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

Time to be honest

Kate Wolfsohn MBACP Psychotherapist

Uri has dug himself into a deep hole. By concealing from Luka his past relationship with Luka's new partner, Uri has damaged - in all probability, fatally - the working alliance he has built with Luka.

Uri has no choice but to tell Luka honestly about his past relationship with Luka's partner, notwithstanding that Uri may have some difficult questions to answer about his delay in saying this. Uri needs first to reflect honestly, with his supervisor's support, about his reasons for not telling Luka. Was he in denial that his former lover had been able to move on to a new relationship? Or was he perhaps unconsciously

curious to hear about a former partner for whom he may still have feelings?

Although it would generally be my practice to avoid sharing personal information with a client, the circumstances here override any such guideline. Uri's concealment represents dishonesty and dissonance in relation to Luka that are incompatible with there being a functioning therapeutic relationship. For Uri to secretly

know a person Luka is talking intimately about in sessions also seems an invasion of Luka's privacy.

Further, the feelings Uri has for Luka's partner, whatever their nature, will inevitably intrude into his work with Luka, seriously impairing his judgment as Luka's therapist. The conflict also creates other dilemmas: for example, how to deal with Uri's knowledge of his former partner's drug use and how this may affect Luka.

"They say we get the clients we need, and this seems especially so in this poignant tale of entanglement in loss and love that also offers the possibility of redemption through telling the truth"



‘My guess is that if Uri doesn’t talk to Luka about the proverbial elephant in the room, it will play out between them in unhelpful ways’

Avoidance in the room

Victoria Owen MBACP Student

I’m curious to know why Uri has not brought this into the counselling room before. Was it for Luka’s benefit or his own? Uri asked Luka questions about his new partner ‘to put his mind at rest’, indicating that his own thoughts and feelings are taking priority over Luka’s.

My guess is that if Uri doesn’t talk to Luka about the proverbial elephant in the room, it will play out between them in unhelpful ways. For example, Luka may be feeling anxious about talking about his new partner to Uri and have no idea why. Or Uri may be avoiding helping Luka to come to a deeper understanding of his feelings about the relationship because of his own ‘painful feelings’ about it. There’s no mention of supervision, and I wonder if Uri is avoiding the issue there as well.

I would suggest that Uri examines his motivations for not bringing his concerns into the room, and if it is about his own agenda, rather than Luka’s, he should reassess his intervention. This may mean he has to discuss the dilemma more openly with Luka, if he is able to do so without his own feelings taking priority. Or, if he cannot do that, he needs to end the counselling relationship with Luka and be honest about why he is doing so.

Triangulation, grief and loss

Genevieve Buee MBACP Counsellor, University of Sunderland

Triangulation, grief and loss seem like the underpinning themes for both Luka and Uri. Respecting and maintaining boundaries are part of being an ethical practitioner. Therefore, in this instance, Uri has to draw a line and acknowledge

that he cannot continue to offer counselling to a client who is in a relationship with his ex-partner.

Exploring the triangulation in supervision will help Uri address any attachment, grief or loss that he feels, both for his client and his ex-partner. It appears that Uri was holding on to the therapeutic relationship past the point at which he became aware of Luka’s relationship, and it would be unethical to pretend that he is respecting Luka’s autonomy if he is secretly hoping this new relationship will break down.

Exploring Uri’s anxiety through Karpman’s drama triangle might be helpful to provide a perspective

on any feelings resonating with the roles of rescuer, victim or persecutor. It may be that Uri’s ex-partner has overcome his addiction and is leading a different life now. Uri could also explore how vulnerable he perceives Luka and his ex-partner to be, in addition to his own experience of feeling vulnerable in these relationships.

Being honest and congruent about the limitations of the therapeutic relationship may feel impossible. However, with some thought and supervisory support, Uri will be able to find an ending that best meets Luka’s needs and honours the basis of the therapeutic relationship. ■

May’s dilemma:

Kareem is approaching the end of his counselling training and plans to set up in private practice as a specialist drug and alcohol addiction counsellor when he qualifies. His journey into counselling came out of his own struggle with addiction and, in addition to his own personal therapy, a major component in his recovery has been the 12-step programme. He attends a minimum of three meetings a week, sometimes more. In the four years since he went into recovery, he has relapsed periodically, but currently has had six months of clean time.

Kareem attends meetings at different locations in the city where he lives, depending on

his availability. He is aware it is highly likely that prospective clients will attend these meetings, and he may run into them there. He is also likely to want to recommend clients attend meetings if they aren’t already in the programme.

He is currently considering how he will contract with clients around confidentiality, how he will maintain professional boundaries, and the challenges of being a counsellor in recovery and attending meetings that his clients, past, present or future, may also attend. He is particularly wondering about the ethics of working with recovering addicts when his own addiction is active.

WHAT WOULD YOU ADVISE KAREEM?

Please email your responses (300 words maximum) to John Daniel at dilemmas@thinkpublishing.co.uk by 1 March. The editor reserves the right to cut and edit contributions. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but they will not be answered personally.

Where shall we begin?

How do you start sessions with clients?

Sonia Khan

Psychotherapist in private practice in London, and a volunteer counsellor at a hospice

For me, the session starts from the moment we meet in the reception area. People who come to therapy are usually distressed and anxious, so how I present at that point is critical. It's important to convey a sense of warmth and compassion in how I greet them. I always ensure I have time to re-centre myself from the last client. At the hospice, it's a long walk from the reception area to the counselling room and we usually chat about the weather, the buses or whatever. For a lot of clients, what happens once we are in the counselling room just evolves from there. I always go out of my room to meet clients; even in my private practice, there's a reception area. I think it creates a bond when you greet someone in a public space and then the two of you walk away together into a private space – that's quite a special feeling. During that time, a client's body language, how they walk, their voice and facial expression will tell me a lot about their mental state. I often use that to gauge whether I need to stay silent. If a client stays silent for a long time, I might say something very general like, 'You look like you are thinking very hard about something.' When someone has made a point of coming to see me, I'd want to explore what saying nothing is about, so I don't have a standard procedure for opening sessions; I try to understand what my client needs.



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



Kayley Roberts

Counsellor working in NHS primary care in Llandudno

I always collect clients from the waiting area, so I can manage the appointments. Otherwise, some people will just walk into the room, even if they're early and I'm with another client. It's a short walk from reception and I usually ask about the weather, as my room has no windows. I let the client go in first and choose where to sit. I've noticed clients always take the same seat they chose in the first session. I have a few clients with memory loss, due to trauma or medical issues, and they won't remember what we talked about in previous sessions, so I will ask them if they want to recap on last week. Otherwise there's a risk we'll just keep going over the same ground. Or I'll say, 'Where shall we begin?' and take it from there. Others will have something they really want to say and off they go. I don't leave them in silence; it's a lot of pressure on a client.

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Steve Delaney

Psychoanalytic psychotherapist
and group analyst in private practice

How people start a session is always very interesting. A lot of people want to be asked how they are; they want to be given an invitation to speak. That is telling me they've had experience in the past of people not being interested in them; they are looking for cues that show you want to listen. People who start off talking straight away are harder to get hold of. In a way, they are doing what they are supposed to be doing. I might think about their capacity to reflect and take things in from me. Do they deal with feelings by rushing through them? Some people pick up from the previous week as if there hasn't been a break. Are they wanting to deny the fact that I haven't been available to them during the past seven days? I'd never just sit in silence; silence can be very persecutory. I'd say something after 5-10 minutes. With groups, I always allow someone in the group to say something first. Silences are an important part of group therapy and will have many different resonances for the people in the room.

Alistair McBeath

Psychotherapist and chartered psychologist in private practice in Edinburgh

I work from home and in a consultancy, and in both you have to use a lift to get to my office. I always meet the client at the door and accompany them up and down. Going up, we'll have an exchange of information about the weather or their journey here, and I'll pick up immediately if there's something important going on. I learn so much from those lift conversations. Once in the room, I will wait for the client to begin; if I say something, it may not be what they want to talk about and it may disturb their train of thought. If the silence goes on for a long time, I will say something like, 'Well then...' – no more than that. I'll offer them an invitation. Generally, I'm going to follow the client, not lead them. But if someone has just walked through your door and you're going to charge them £50 and you don't say a word, you have to be conscious that they may be playing out some sort of script that you are a bad therapist.

Lucy Garner

Recently qualified counsellor
currently working with young
people in crisis at 42nd Street
in Manchester

Once a client has been buzzed into the building, I come down and take them into one of the counselling rooms. I don't do casual chat as we are walking. I think it's important to have that distinction – I'm not their friend. With some young people, it all comes streaming out the minute they get in the room. With others, I'll do a quick check-in – I'll ask how their week has been, or how they felt about the last session, what was helpful and what was unhelpful. That is about giving them back control. Children and young people have a lot of people telling them what to do; they've been given a lot of labels and had a lot of decisions made for them. Many have never experienced someone actually listening to them. You need to allow them to be something other than a diagnosis.

HOW DO YOU TAKE CARE OF YOURSELF?

Mig Bennett finds (and loses) herself in tennis

I play tennis - a lot of doubles tennis

- outdoors, all year round, in all weathers, including snow flurries. I have at least two regular midweek slots on the courts; I play matches many Sundays, and some evenings, including away fixtures, and I squeeze 'club divisions' into my counselling days.

I love the physical exhaustion and mental battle of three or four hours of tightly fought rubbers, alongside the elation or frustration at the outcome. It's good for my mind and my body.

I started tennis aged about 11. The club was the mainstay of my adolescence. As with a lot of players, my tennis days ended when I started work. I went back to it in my early 40s, mainly to try to replicate for my 11-year-old son the fun I'd had at his age. He preferred football and cricket, but I formed a renewed passion for the game.

Tennis is a game of the mind. I can go onto the court and have to deal with the most appalling player (me), who has no capacity for concentration, can't shut out extraneous

thoughts, whose 'muscle memory' has deserted her, and who has no self-confidence at all. On another day, or even in a later match, I am an astoundingly confident and focused player, who can feel the way the next stroke will be taken before it is hit, and who is overwhelmingly positive about herself and how others perceive her. Huge self-esteem and a feeling of great happiness ensue.

I have used the tennis stroke analogy with clients - the struggle to learn a new stroke, then to use it, consciously thinking through the new technique each time until muscle memory takes over and it becomes automatic. Those struggling to change their negative communication patterns embark on a similar process. First, they practise a new tone or use a new word and it feels unnatural, ungainly. Then, the new pattern has to be thought about and concentrated on each time they interact with their partner. Finally, it becomes embedded in their muscle (brain) memory, and they play out the conversation in a new and better way. ■



'I have used the tennis stroke analogy with clients... Those struggling to change their negative communication patterns embark on a similar process'



About Mig

Mig Bennett is a relationship and specialist couples therapist in private practice in East Sussex/west Kent, and a certified couples counsellor with Relate in Tunbridge Wells. www.migbennettrelationshipcounselling.co.uk



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

From the Chair

‘We have extensive evidence for the efficacy of school-based counselling, and that young people are willing to access counselling services in schools, yet counselling has – again – been excluded from the proposed mainstream provision’

As a mental health social worker who worked for many years in secondary care mental health services, I absolutely agree that we need the full range of services and professionals to deliver the highest standards in mental health care. Indeed, it is my view that a multidisciplinary approach can be invaluable in ensuring people's needs are fully identified and responded to, at all ages. I have spent my entire career working successfully alongside psychiatrists, nurses, mental health support workers, therapists and others – both as a social worker and counsellor.

However, when the Government published its Green Paper on children and young people's mental health in the closing weeks of last year (see News page 6, and BACP round-up page 46), I must confess my heart sank. We have extensive evidence for the efficacy of school-based counselling, and that young people are willing to access counselling services in schools, yet counselling has – again – been excluded from the proposed mainstream provision. Instead, the plan is to burden teaching staff with even more responsibilities around mental health (I chair a safeguarding committee in a secondary school,

and know what a fabulous job teachers already do to support pupils' mental health, but they are seriously overstretched and stressed), and to introduce fast-track access to child and adolescent mental health services (CAMHS) and what are dubbed 'mental health teams' – although not until the mid-2020s.

Looking at this from one end of the spectrum, teachers are not mental health specialists; from the other end, the intention seems to be to pathologise young people's mental health by throwing NHS secondary care services at them all. There is no doubt that some young people require the specialist input of CAMHS.

For many, however, their distress is an understandable and appropriate response to their social, familial and cultural environment. In this context, a counselling intervention can be profoundly life-changing, and does not pathologise human experience.

BACP has responded fully to this consultation and has vehemently argued the case for improving access to counselling for children and young people. Quite simply, it can work, and should be the first port of call for many, rather than pushed yet again to the sidelines in favour of the dominant medical model.



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BACP round-up

Our monthly digest of BACP news, updates and events



Counselling & psychotherapy training focus

Counselling & Psychotherapy Research (CPR) journal is calling for papers for a special edition focusing on counselling and psychotherapy training.

There have been important changes in training over the last few decades relating to standards of proficiency, accreditation and regulation, and also advances in online learning. Your submission can focus on any aspect and we welcome empirical papers from a range of methodological and theoretical backgrounds.

The deadline to submit an article is 1 March 2018. You'll find suggested topics and information on how to submit your paper on the CPR website at www.cprjournal.com

Accreditation facts at your fingertips

Keeping up to date with the accreditation status of BACP members, services and courses has never been easier. To find out if a member is accredited, search for them by name, registration number or location on the 'Search the Register' page of our website. Being able to search using several criteria means you can be sure that you've found the right person. If a member also has a listing in our therapist directory, you can click through to it for additional information about their work. You'll also find accredited service and course directories on our website, within the 'Accreditation' pages.

We frequently update the accreditation status of our members, services and courses on our website so that accurate information is always available to you, your clients and employers. We're also exploring how we can better recognise and celebrate our accredited and senior accredited members on our new website in 2018. With our up-to-date online records easy to access and publicly available, you'll soon stop seeing the 'BACP accreditation' section in *Therapy Today*. We're excited to be able to use this space in future to bring you more news and topical insight from your Association.

Master the GDPR

To help you deal with the important changes in data protection that come into effect on 25 May 2018, we've written a new *Good Practice in Action* resource about the General Data Protection Regulation (GDPR).

GDPR will replace the Data Protection Act. The new regulations are broader in scope and aim to address the increasing use of digital technology to store data and communicate. The guide will help you check that your client records, appointment systems and contracts are compliant before the law changes.

You can download a free copy of the resource from our website.



BACP website

We are still finalising the new website, so forgive us if we don't provide direct

weblinks in this issue. Where advised, please go to www.bacp.co.uk and find your way to the right page via the search function.



Working with young people

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If you're unable to join us at our children and young people conference, 'Working with young people in their world', on 24 February 2018, you can view selected content live online via webcast, and access the recordings on our website for a limited time after.

The conference explores ways to connect with children and young people within their own world, in their family context and other environments, leading to better outcomes.

The recordings will be available from Friday 2 March 2018 for a

limited time and will include two keynote presentations, two workshop presentations, studio discussions and an exhibition walkthrough.

As a BACP member, you'll pay just £25, including VAT. You can find out more about the event on our website.

Children and Young People consultation

The UK Government has published its Green Paper on supporting children and young people with their mental health.

The paper, *Transforming Children and Young People's Mental Health Provision*, prioritises linking schools, colleges and health services together to improve services and reduce waiting times.

While we commend the Government on its focus and commitment to children and young people's mental health, we believe the Green Paper is a missed opportunity to deliver the most effective mental health support in our schools and colleges.

Dr Andrew Reeves, Chair of the Association, said: 'This Green Paper should have been used to finally make that expectation a reality. It's such a missed opportunity. BACP will be engaging fully in the consultation process and our thorough and robust response will urge the Government to be more ambitious in its proposals, ensuring children and young people can access the most effective psychological therapy services.'

The Green Paper consultation closes on 2 March 2018, and we will be engaging politicians and other charities around how to improve the proposals, as well as submitting our own response. You can keep up to date with the latest news through these pages, our e-bulletin and our website.

Counselling children and young people in Wales

There's been a 42% increase in the number of children and young people waiting over a month for mental health support in Wales.

We've been working closely with the Welsh Government on this issue. In September 2017, we supported an enquiry by the Children, Young People and Education Committee about children's mental and emotional health by providing a written report based on our research into the positive impact of school-based counselling. The recommendations from the enquiry will be published in the spring.

We're also working with the Cross-Party Group for Children and Young People in Wales to challenge

the Welsh Government to improve outcomes for vulnerable children and young people in Wales. Later this year we'll jointly deliver a debate in the National Assembly for Wales about improving outcomes through better access to psychological therapies.

We'll keep you updated on our work in this area in future issues of *Therapy Today* and in the monthly e-bulletin.



BACP round-up

BACP accreditation

Newly accredited members, services and courses

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

Counsellor/psychotherapist

Ruth Anderson
Elsa Artur
Stephanie Ashman
Katheryn Austin
Paul Bacon
Sophie Barrett
Janetta Bellamy
Jane Casey
Marcella Celli
Chloe Charles
Sarah Child
Laura Cook
Ashleigh Cormack
Philip Crawley
Leanne Culson
Alistair Dickson
Candida Edwards
Maria Emmanuel
Mabrouka Evans
Frances Ferson
Emily Fiddian
Anne Flanagan
Jude Gaddes
Fiona Geary
Debra Gee
Daniel Glass
Victoria Green
Maria Grimley
Rachel Guy
Julia Haygreen
Michelle Higgins
Elizabeth Hill
Paul Howell
Peter Ireland
Marieclare Keenan
Annabel Knight-Djalili
Billy Lansdell
Chloe Lefroy
Becky Lindsay
David Linford
Karen Little
Joyce Macleod
Andrew Mahoney

Karen Mak
James Makin
Joanne Makin
Karlene Malin
Lynne Martin
Raikha Masih
Susan McCamley
Graham Mortimer
Tanmayo Murray-Clark
Tracey Neale
Daniela Nova
Marie O'Sullivan
Bernadette Owen
Emma Paterson
Dominique Pitman
Marie Plose
Lesley Pollard
Eleanor Port-Burke
Richard Prasad
Amanda Puckett
Shanthini Ramanan
Scott Reeve
Omei Riches
Emma Roberts
Christine Rogers
Chris Sansom
Rachael Scrafton
Maresa Segura
Evelyn Sharp
Anna Shepherd
Melissa Shepherd
Paula Sheridan
Cathie Shore
Charlotte Sjostrom
Caroline Stacey
Carolyn Stafford Bell
Joanne Strong
Louise Sutton
Joanne Temple
Stephen Thomas
Catherine Tiler
Laura Timms
Heather Towers
Joanna Traynor

Julie Tree
Katharina Unverricht
Guy Van de Walle
Andria Vasiliou
Sally Wambold
Amal Wartalska
Penny West
Tina Westmoreland
Jane Wheller
Roger Williams
Roxana Woods
Tracey Wright

Senior accredited counsellor/psychotherapist

Sharon Andrews
Adam Hussein
Dee Johnson
Gaynor Smith

Senior accredited supervisor of individuals

Victoria Abram
Jill Brennan
Mary Connolly
Ian Gowland
Julie Henderson
Lucy Machin
Annette Whitehall

Members not renewing accreditation Counsellor/psychotherapist

Brian Andrews
Anne Barker
Jacqueline Clifford
Angela Dixon
Deborah Duggan
Catherine Elliot
Catherine Evans
Rhona Fear
Patricia Fotheringham
Joyce Gillam
Jane Goddard

Helen Hart
Inger Hatloy
Zsuzsanna Hutchinson
Shirley Jolley
Carol Jordan
Angela Kirkup
Stephan Lee
Heather Mackay
Barbara MacKenzie
Vesna Mandic-Bozic
Jackie Marsh
Jane McCallum
John McCormack
Gill Ormerod
Pamela Phelan
Angela Reynolds
Louise Reynolds
Catherine Rhodes
Jean Selmes
Sue Sprent
Katrina Tae
Mary Turner
Ronald Turrell
Sara Von Sommaruga
Lynne Walker
Esther Zahniser

New and renewed accredited services

We would like to congratulate the following organisational members on achieving and/or renewing their BACP accredited counselling/psychotherapy service:
Relatives for Justice
Washington Mind

All the details listed are correct at time of going to print.

Disclaimer: Please be aware that BACP may have more than one member with the same name. To check whether someone is a registered accredited member, please visit the BACP Register at www.bacpregister.org.uk/check_register



Critical incident responses

Serious, life-changing events, such as terror attacks and natural disasters, devastate lives and leave us searching for ways to help the people who have been most seriously affected. Being prepared and understanding how best we can help puts us in the best position to respond effectively when these tragic and traumatic events happen. As a counselling professional, how prepared are you for the crucial role that you could play? Join us in Edinburgh on 17 April 2018 to explore how counsellors and psychotherapists can contribute before, during and after serious incidents.

You'll develop your knowledge and skills so that you can help those around you, and self-care skills to aid your own recovery and resilience. For more information and details of how to book your place, visit our website.

Book your place at the BACP Research Conference

The 2018 BACP Annual Research Conference, 'Counselling changes lives: research that impacts practice', will take place in London on 11 and 12 May.

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

We're excited to announce that Professor Dr Pim Cuijpers will give the first keynote address, on 11 May,

entitled 'Four decades of research on counselling for depression: directions for the future'.

You'll be involved in discussions about how research embedded in routine practice can provide new insight into the therapeutic process, and how research informs practice and benefits both clients and practitioners.

You can find out more and book your place on our website.



NHS children's mental health services survey

In March 2017, we launched a joint survey with the Association of Child Psychotherapists, the British Psychoanalytic Council and the UK Council for Psychotherapy to explore the experiences of the members of our organisations who are, or have been, working in NHS services in the past five years.

Drawing on responses from members who identified a children's service as their main workplace, we've prepared the report *Working in the NHS: the state of children's services*. The report highlights some concerns about staffing and resources, with 67% of respondents saying waiting times for children's mental health services have increased in the past five years, and 76% that the number of staff in post is inadequate to meet children's needs.

Chair of BACP Andrew Reeves said: 'We know that school-based counselling is a proven early intervention which improves children and young people's mental health and emotional wellbeing. We repeat our plea for politicians to properly resource NHS mental health services; as well as funding for support in schools and communities, to provide greater access, shorter waiting times, and a wider range of interventions that children, young people and their families need and deserve.'

Read the full report on our website.



30% off Sage books

We've arranged a 30% discount for BACP members with Sage Publications. This offer will be open from 1 February to 31 May 2018. Use the code UKBACP18 at the checkout to get your discount.

Visit the Sage website at <https://uk.sagepub.com/bacp-offer> to see what counselling and psychotherapy books are included in the offer.

BACP round-up

PROFESSIONAL CONDUCT NOTICES

Hearing findings, decision and sanction

Sarah Ruth Oliver

Reference No: 717778
IP1 Suffolk

The complaint against the above individual member/registrant was heard under BACP's Professional Conduct Procedure and the Professional Conduct Panel considered the alleged breaches of the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy.

The Panel made a number of findings and it was unanimous in its decision that these findings amounted to professional malpractice, in that the services for which Ms Oliver was responsible fell below the standards that would be reasonably expected of a practitioner exercising reasonable care and skill.

The Panel found evidence of mitigation and did not consider it appropriate to impose a sanction.

Elizabeth Ann Farrow

Reference No: 547946
WA15 Cheshire

The complaint against the above individual member/registrant was heard under BACP's Professional Conduct Procedure and the Professional Conduct Panel considered the alleged breaches of the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy.

The Panel made a number of findings and it was unanimous in its decision that these amounted to professional malpractice, in that the services for which the Member was responsible fell below the standards that would be reasonably expected of a practitioner exercising reasonable care and skill.

The Panel found evidence of mitigation and imposed a sanction.

Sanction compliance

Angela Ashton

Reference No: 552692
B62 West Midlands

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the March 2017 edition of the journal has been lifted. The case is now closed.

This report is made under clause 5.2 of the Professional Conduct Procedure.

Julie Jeffries

Reference No: 627275
PE13 Cambridgeshire

BACP was satisfied that the requirements of the sanction have been met. As such, the sanction reported in the July 2017 edition of the journal has been lifted. The case is now closed.

This report is made under clause 5.2 of the Professional Conduct Procedure.

Full details of the decisions can be found on the BACP website

Challenges in student counselling services

Research from our BACP-funded PhD student, Emma Broglia, highlights the challenges faced by student counselling services in higher education institutions.

Emma collected data from 113 heads of service to identify service similarities, factors affecting counselling services, use of therapeutic technology, and factors characterising service users. The

findings show an increased demand on services between 2011 and 2014, with the majority of students referred for high-intensity counselling support. There was also evidence of services increasingly introducing new roles to support students' mental health, in the form of mental health advisors. You can read the full research paper at bit.ly/2BtmJzu

EVENTS CALENDAR

14 February

Professional development day

Integrating artwork into your counselling practice
With Pauline Andrew
Norwich

24 February

CYP Conference

Working with children in their world
London

8 March

Professional development day

Working effectively with trauma in healthcare settings
Manchester

12 March

Professional development day

Working with partners of trans-identified people
With Tina Clark
Cardiff

24 March

Professional development day

Supervision: relationship, authority and ethics
With Steve Page
Southampton

17 April

Working with... critical incidents

Prepared, not scared: are you ready to respond?
Edinburgh

11-12 May

BACP Research Conference

Counselling changes lives: research that impacts practice
London

Analyse me



What gives your life meaning?

All the usual suspects – my wife, my friends, my cats, films, music, walks, etc. But meanings come and go. A blackbird whistling on a tree branch as I stroll by can fill my life to the brim with meaning.

Ernesto Spinelli speaks for himself

Why did you become a therapist/counsellor? I've always liked films, books and plays that are mainly dialogue-focused and wander about without any obvious direction. Existential therapy is the closest to that I could find.

Where do you work?

In London, usually. Two offices – one north of the river, the other south. I usually write books and such from home, but I could be anywhere. I go to different parts of the world to give seminars and workshops.

How do you work?

I'm an existential therapist. A couple of years ago, a whole bunch of existential therapists came up with a definition that we can all sort of live with. If you're interested to read what that is, go to www.existentialpsychotherapy.net/definition-of-existential-psychotherapy

What's your special interest?

People.

Where is your happy place?

It's a tie between Italy and Greece. For different reasons.

Why do you think therapy works?

I don't think anybody really knows. Probably for the same reasons that any open, truthful, challenging

encounter 'works', in that it confronts us with 'what is there' for us and we agree to accept it.

A client offers you a small gift – do you accept or not?

It depends on when it's given. If it's at the end of our encounters, I feel it would be churlish to reject it.

What, for you, is the most challenging issue that clients bring?

That they want to both change and also remain the same. The tension that this divided desire provokes can be overwhelmingly painful.

What advice would you give to someone entering the profession today?

If you start in this profession already feeling like you've compromised your connection with it, I suspect that you're unlikely to survive in it for very long. Choose what really matters to you, rather than what you think might make most logical sense. Aspire to breathe in that revolutionary spirit that infused the profession in its origins (and still does, if you look hard enough). If you can't challenge yourself and be willing to take those risks that make you leap into the unknown and uncertain, how are you ever going to convince anyone else to do so? And maybe, don't follow leaders. As Nietzsche, in the guise of Zarathustra, told his would-be followers: "Take all of the 'truths' I offer you and do everything you can to destroy them. That way,

what "truths" emerge or remain will be your own flesh-and-blood truths.' That would be my advice.

What is the future for counselling and psychotherapy?

Understandably, lots of people entering the profession these days are looking into the likely future in terms of jobs, and when they do, they see something very limited, something that maybe looks like therapy but doesn't always touch their heart, guts and lifeblood. I'm sorry to say that, as I see it, therapy is becoming so standardised and regulated that its very heart and creativity is being squeezed out of it. Never mind. Something calling itself something else will arise out of the ashes.

What do you think happens when we die?

We die. Life goes on.

Cats or dogs or horses?

Definitely cats. There's never any doubt as to where you stand with a cat.

What is your favourite piece of music, and why?

An impossible question to answer. But the one I play most often, I'd guess, is Bob Dylan's *Highway 61 Revisited*. Everything you need to know is on that album.

When will you retire?

Probably when people stop wanting to come see me. ■



About Ernesto

Now: Existential therapist/counselling psychologist, coach and supervisor. I've taken up novel writing of late, mainly very low-brow, private-eye thrillers.
Formerly: Academic Dean, School of Psychotherapy and Counselling, Regent's College, London.
First paid job: Babysitter.



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