MARCH 2018 | VOLUME 29 | ISSUE 2

THERAPY TODAY

"A good supervisor is a necessity and a gift"
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The voice of the counselling and psychotherapy profession

Flying solo

The perils and pitfalls of private practice

Couple counselling – three in the room // Supporting the traumatised therapist
Why are our children so unhappy? // How our own wounds help us heal

It's easy to set up in private practice, isn't it?

There is no expensive equipment to invest in, you just need two chairs and a private space to talk, don't you? To an outsider, it must look like a breeze.

While there are more therapists in private practice than ever before, setting up and making a success of it is far more complicated than it looks. As the thousands of us who do it, or have done it, will testify, there are many practical, financial, psychological and even digital roadblocks to overcome. So, this month we're publishing a special news feature for the thousands of you who will attempt it at some point in the future.

I happen to thrive in the climate of self-reliance that private practice requires, and I value the freedoms and choices it gives me, from when to work to what type of work I'll do. But of course, it doesn't suit everybody.

Is it right for you? Find out on page 8.

Rachel Shattock Dawson
Consultant Editor

CHARLIE BEST

Editor's note

I have had a lot of correspondence in the past couple of weeks with BACP colleagues and with readers about how the magazine could better serve its student readership. After all, as one student reader pointed out to me, with some asperity and a lot of accuracy, students are tomorrow's qualified members and the future of the profession. *Therapy Today* should be reaching out to engage and nurture them, and flag up their concerns, battles and dilemmas (which are, very often, directly related to the future of the profession, since how they are trained affects what kind of therapy future generations will receive). My problem is how to contact trainee therapists for their ideas, as they have no identifiable forum within BACP – at present, at least. So, if you are a student and have ideas about what you would like to read in *Therapy Today* that's specifically for you, and if you would like to contribute, please email me.

Turning to this month's issue, many newly qualified therapists are finding themselves thrown into private practice, whether they feel ready for it or not, because there are so few paid posts out there. So, this month's news feature will be of particular interest. I'd also like to draw readers' attention to the Research Matters pages, which are stuffed with interesting studies – most notably, for me, one that looked at the impact on therapy outcomes of a warm and welcoming reception/ist in counselling services – an overlooked factor in the literature. We also have some thought-provoking responses to the December News Feature, 'Putting gender on the agenda', and John Rowan's Turning Point on 'sacking' clients in the extended Letters pages.

Catherine Jackson
Editor

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

COVER IMAGE: SHUTTERSTOCK – BUNK BUNK

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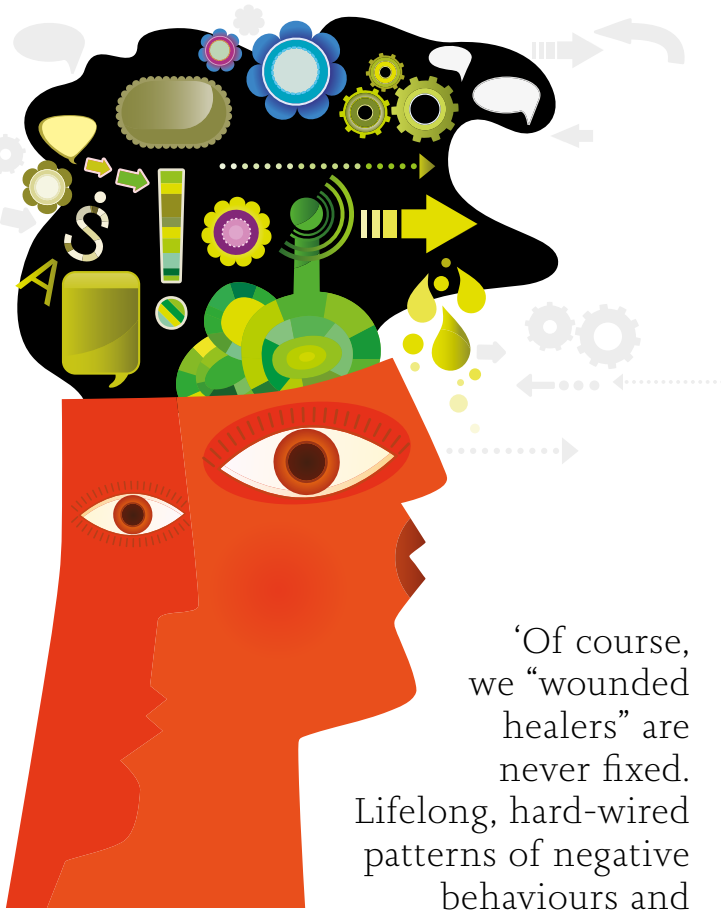

‘Of course, we “wounded healers” are never fixed. Lifelong, hard-wired patterns of negative behaviours and processes do not vanish in a puff of smoke just because you’ve got a string of letters and qualifications after your name.’

(page 20)

On the cover

Private practice

What do you need to know before venturing into private practice?

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Here and now

The big issues

Regulars

Your association

bacp | counselling changes lives

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

In the news

Our monthly digest of news, updates and events

Schools and counselling

Some 57% of counsellors and psychotherapists working in schools say they struggle to do their job because schools don't understand how they can help, and 30% say schools' expectations of them are 'not clear'.

The findings are from a survey on barriers to providing mental health support in schools by Place2Be, with BACP, UKCP and the National Association of Head Teachers (NAHT).

Nearly half (44%) of school leaders said knowing what type of support is needed was a major barrier, and 37% said they didn't feel confident to employ a counsellor or therapist. Lack of funding was the most commonly cited barrier, for schools and counsellors alike.

Most schools (45%) relied on word of mouth to recruit counsellors, or used local authority lists (35%); 26% used lists published by professional bodies.

Dr Andrew Reeves, BACP Chair, said: 'We must enable school leaders with the information and funding to be able to recruit counsellors.' **bit.ly/2EqEmlv**

Prescribed drug addiction review

The Government has ordered a review of prescribed drug addiction, in response to rising concerns about how many people are taking potentially addictive medications.

The review, to be conducted by Public Health England, will cover benzodiazepines and similar insomnia drugs, opioid pain-killers, antidepressants, and drugs used to treat anxiety disorders. It will report early in 2019. Antidepressants are not classed as dependence forming, but are included as coming off them is known to cause severe difficulties for some patients.

According to NHS data, nine per cent of adults were prescribed a drug classed as 'potentially dependence forming' in the past year. Two-thirds of the patients prescribed these drugs are women, many in their 50s and 60s. There has been a 60% increase in how long patients are kept on opiate-based painkillers, which should be only for short-term use.

Public Health Minister Steve Brine said: 'We know this is a huge problem in other countries like the US and we must make sure it doesn't become one here.' Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, said: 'We hope this review's conclusions will include the need for greater provision of, and access to, alternative treatments in the community.' **bit.ly/2Fxhz3G**

Youth happiness plummets

Confidence and happiness have hit their lowest levels among young people in Britain, according to the 2018 Prince's Trust Macquarie Youth Index.

The Index, now in its ninth year, gauges young people's wellbeing across a range of areas, from working life and family relationships to physical health.

The 2018 Index surveyed 2,194 16- to 25-year-olds across the UK. Overall happiness and confidence ratings have dropped to 69 from 73 in 2009. Some 28% of the young people in employment said they felt trapped in a cycle of jobs they didn't want; 29% said they had to take whatever job they could get, rather than develop their career; 44% expected to still have fewer job opportunities in the next three years; 59% were worried about the unpredictable political climate and the future, and 39% (up from 28% in 2017) said they didn't feel in control of their lives.

'The cliff-edge decline in young people not feeling in control of their lives echoes conversations we have every day with young people,' Nick Stace, UK Chief Executive at The Prince's Trust, said. **bit.ly/2GlfNnB**

Mental health in pregnancy

An estimated one in four women experiences mental health problems during pregnancy, higher than was thought, new research suggests.

In the first UK study to measure the prevalence of mental health problems at the point when women are seen by their midwife for pregnancy care, researchers at King's College London found that 11% of pregnant women had depression, 15% anxiety, two per cent had an eating disorder, two per cent obsessive-compulsive disorder, and just under one per cent post-traumatic stress disorder. Smaller percentages had bipolar disorder and other disorders.

The study also found that the two-question depression screen used by midwives, known as the Whooley questions, is as good as the more detailed, 10-item, self-complete Edinburgh Postnatal Depression Scale questionnaire in identifying women with mental health problems, although both are least successful at identifying depression among older women.

Maria Bavetta, co-founder of Maternal OCD, said, 'This study shows how vital it is for pregnant women to be asked the right questions at the right time, with a non-judgmental space to be listened to.' **bit.ly/2Cm9dux**

NICE backs digital CBT

NICE has approved the first digital CBT treatment programme for trial in the NHS, despite the lack of studies comparing it with face-to-face therapy.

NICE has been asked by NHS England to draw up a list of 14 recommended digital psychological therapies for use in IAPT services to treat anxiety and depression.

The programme, Deprexis, is for depression. It is modular and can be accessed online and via smartphone app. It could be offered in IAPT services by psychological wellbeing practitioners (PWPs) as a stage-2, guided self-help intervention. The PWP can monitor the patient's progress and exchange messages with them via a secure messaging system.

It costs £270 per person for 90 days' access, less than face-to-face individual cognitive behavioural therapy (CBT), at around £560, but more than a six-month course of antidepressants (£110 per patient). However, it is 'not directly equivalent to face-to-face CBT as it is less tailored to each individual user and so less nuanced', NICE says. Two of three randomised controlled trials found that it is more effective than no treatment or care, as is usual in adults with mild to moderate depression. A third, smaller trial, found that psychotherapy with Deprexis as an adjunct was more effective than psychotherapy alone. **bit.ly/2DQ19mm**

Award for Room to Talk

Eileen Whittaker, co-founder of the voluntary sector Room to Talk counselling service at HMP/YOI Styal, has won the 2017–18 Butler Trust Award for staff, volunteers and partners working in UK prisons, probation and community and youth justice settings. Room to Talk featured in the relaunched February 2017 issue of *Therapy Today*.

Room to Talk's network of volunteer counsellors delivers one-to-one, group and other therapeutic interventions to the women prisoners and prison staff.

Initial CORE-10 data show that counselling with Room to Talk volunteers reduces psychological distress by around half, from 'severe' stress to non-clinical levels.

Congratulations, Eileen.

No to personality disorder label

A coalition of mental health organisations has called for an end to the use of the label 'personality disorder'.

The organisations, including Mind, the British Psychological Society, the Royal College of General Practitioners and the Anna Freud Centre, have signed a consensus statement saying the label is misleading, stigmatising and only 'masks the nature of the problem it is supposed to address', adding to people's difficulties.

One in 16 people worldwide has a diagnosis of personality disorder, rising to 60–70% of people in prison. People with this diagnosis live shortened lives, due to higher risk of suicide, homicide and accidental death, but also because of poor healthcare from the NHS. Most have experienced past trauma, the statement says.

The signatories are calling for services to 'ask the right questions early on' so help can be offered sooner; for better access to a wider range of evidence-based interventions, and for a trauma-informed, formulation-driven, whole-system approach to care.

Former Care and Support Minister Norman Lamb, who has led the campaign with Sue Sibbald, who has a personality disorder diagnosis herself, said: 'It is intolerable that the services we offer do not meet the needs of this group of people, when small changes could make such a difference.' **bit.ly/2mx6cSb**

PHOTOGRAPHS: SHUTTERSTOCK, GETTY IMAGES

Going it alone

For many counsellors, private practice is their only option if they are to earn a living. What do you need to know to do it safely and effectively? **Sally Brown** finds out from those who have made it work

According to the 2017 BACP members survey, half of us work in private practice. For many, it's a positive choice – a chance to control when, how and with whom we work. But for counsellors struggling to find a paid job after qualifying, going into private practice may be their only alternative to taking a voluntary, unpaid role, or leaving the profession altogether. In the same survey, 49% of BACP members said finding paid work was their biggest challenge.

So what do counsellors need to know in order to make a success out of private practice from the start? We asked successful private practitioners what they wished they had known when they first started out.

Specialise to stand out

It's tempting to tick every box on the 'areas of counselling covered' section of your directory listing, in the hope that it will bring you more clients. But many of the most successful practitioners have found that the opposite is true, and that specialising is the key to attracting clients. 'Ninety-five per cent of the work I now do is on anxiety,' says James Rye, who works in private practice in Norfolk and is author of *Setting Up and Running a Therapy Business* (Karnac, 2016). 'Once I recognised the demand, I set out to become as expert as I could in it. If I were starting out now, I would consider specialising in working with children under 11, as that seems to be a growing area of demand.'

Central London- and Surrey-based counsellor Joanne Benfield believes that choosing to specialise as a sex and relationships therapist was the key to her success in private practice. 'After qualifying with an MA in counselling and psychotherapy, I realised there was a huge number of counsellors working in my five-mile radius that I would be competing with. But there weren't many specialising in sex and relationship therapy, and I knew there was a growing demand for it. It was also an area of interest for me, so it seemed to make sense to specialise.'

Birmingham-based counsellor Martin Hogg chose to specialise in anger management, offering workshops and courses, as well as one-to-one sessions.

'A well-intentioned therapist early on in my training told me to forget all my past experience and think about starting as a counsellor with a clean sheet. But I say, draw on what you have experienced in your life to inform your specialism'

'A well-intentioned therapist early on in my training told me to forget all my past experience and think about starting as a counsellor with a clean sheet. But I say, draw on what you have experienced in your life to inform your specialism. When I was doing my counselling placement, I was asked to engage with a group of young men, which involved anger management work. It really clicked with me. Prior to becoming a therapist, I spent 20 years in the hospitality industry, running pubs and clubs, and a lot of that work was about managing behaviour and resolving conflict.'

Keep training

Once you have identified a potential specialism, it's essential to get further training in it. Benfield invested in a post-qualification diploma in psychosexual and relationship therapy, as well as attending relevant talks and workshops. 'Part of my motivation was to meet other practitioners in this field,' she says. A chance meeting at one event with a publisher looking to commission a book on sex and relationships (this became Benfield's book *Three in a Bed: conversations with a sex therapist,* published by HarperCollins) ignited her career. 'It had always been my dream to move to the south of France and write a book. When I was offered the book contract, I did some research, moved to Monaco, and set up a private practice there while I worked on the book.'

Adding specialist training after qualifying was also crucial for Rabina

ISTOCKPHOTO

Akhtar, who works in private practice in Peterborough. 'It's obvious from my profile picture that I am a Muslim, so I assumed I had an automatic specialism and the clients would come to me, but I was wrong. I didn't get a single Muslim client until I invested in specific training, then offered my services for a reduced fee to an organisation that worked with the Muslim community. It's almost as if I needed to grow within myself before the clients came. I also learned a lot about the needs of the community – don't assume you know everything just because you have experience in an area.

'You should look at your three-year general counselling qualification as a base level on which to build, not something that qualifies you to work with everyone who walks through the door, no matter what they present with. And don't mis-sell yourself – you're not only mis-selling yourself, you're mis-selling counselling as a service.'

Portfolio working

To be in a position to be selective about clients, you may need another source of income, and 37% of BACP members in the 2017 survey said they have a portfolio career that includes non-counselling work. Rye says he 'couldn't have survived' without the income from his part-time job as a trainer. 'I don't know anyone who goes straight into earning £25-£35k a year in private practice,' he says. 'I had been in teaching for many years and was fortunate to get a part-time job that was mornings only, which allowed me to build up a counselling practice in the afternoons and evenings and gave me the financial security I needed to allow my practice to grow gradually.'

Starting with one or two days a week of counselling, combined with another role, can help you gain experience in a contained way. 'Having another revenue stream, especially initially, is crucial, as it allows you to take the number of clients that is right for you, rather than how many you need to pay the bills,' says Hilda Burke, a private practitioner in west London. 'There is a tipping point where your caseload impacts on the quality of your work. I realised that a full practice is not the same as a successful one. There was a point when I was taking as many clients as I could, but I also had a high turnover rate – clients didn't stay. Now, I take on fewer clients, but they stay for longer.

'I think it's about the quality of the attention they receive from me. I boost my income with writing and consultancy work for PR companies on mental health issues. I would advise all new practitioners to think about ancillary revenue streams that relate to the work of counselling but are not client-facing, such as training, speaking or writing.'

Money, money, money

As well as establishing what the right number of clients is for you, there is the question of what to charge them. 'When you first start out, it's easy to think ▶

that any low fee is better than working on a voluntary basis, but as I got more experienced, I realised that clients who aren't prepared to invest in themselves financially often aren't prepared to commit to coming regularly,' says Akhtar.

You need to consider what your service is worth, says Rye. 'I started out with this wonderful idea that I would charge people a 1000th of their income, so if you were earning £70,000 a year, you paid £70 a session, or if you earned £10,000, you paid £10. I soon found out that, apparently, everyone earned £10,000 a year. You shouldn't be embarrassed about putting a significant price on the skill you offer. If your work helps one man refrain from taking his life and bereaving his young family, or helps one woman stop abusing alcohol and keeps her with her partner and children, think of the financial and emotional cost you have helped others avoid. Wising up to that was part of my growth.'

Getting your pricing right may be a trial and error process, says Rye. 'The advantage of working in private practice is that you are free to both make and change decisions. You don't have to decide on one figure and then stick with it, regardless of the effect.'

Location, location, location

Your choice of location can also influence what you charge, as Chloe Langan found when she moved her practice from Kent to Inverness. 'I had to do a lot of thinking about pricing when I moved. You can't ignore the local economy,' she says.

The change in geographical location also shaped the way she worked. 'In Kent, I was working in an urban, densely populated environment, and I moved to an area where the population was sparse and very spread out. That meant some of my clients travelled two hours to get to me from Skye or Wick and were at the mercy of the weather. I had to change my thinking about boundaries – I can't be as rigid about sticking to timing as I was in Kent.'

There is also the decision of whether to work from home, or from an external location. Renting a room in a building used by other counsellors can provide contact and informal peer support from more experienced practitioners. It's an added expense, but one that is tax deductible, and it separates your work and personal life. 'If there isn't anything suitable available, consider getting together with a group of local counsellors and renting rooms together,' says Akhtar.

> 'I would be left sitting on my own in an expensive room in central London at night, having travelled an hour to get there. My practice really took off when I moved it into a room in my home'

But for many practitioners, working from home is more convenient. 'When I first started, I thought I would look more "professional" if I also worked from a room off Harley Street, and thought this might be attractive to more clients,' says Surrey-based Rachel Shattock Dawson. 'What I found was that London workers are reluctant to contract to a regular weekly appointment in office hours, and at the same time they were not always in a mindset to come straight from work. Or they would cancel at the last minute because a meeting ran late or whatever, and I would be left sitting on my own in an expensive room in central London at night, having travelled an hour to get there. My practice really took off when I moved it into a room in my home. It seems that for my clients "low key, local and homely" has more appeal than "inner city and sophisticated"!'

Rye has always worked from home, even though it could be tricky when he first started out and his teenage children were at home. 'It meant giving them money to go out at times,' he says. 'But working from home gave me flexibility, especially when I was starting out. If my client appointments were spread out, I wasn't sitting in an empty room waiting for someone who might not turn up, and I could get on with other things between appointments. I have always made it clear that I work from an office at home, so clients know before they turn up. Many clients say they prefer the informality of it.'

Peer power

The downside of working from home, however, is the potential for isolation, which Shattock Dawson staves off through extra peer supervision and support. 'I make a point of regularly meeting other therapists for coffee, lunch or whatever, and I also do three hours of peer supervision every month,' she says. 'There can sometimes be an element of censoring in clinical supervision, but peer supervision tends to be more open and honest. We also discuss the practicalities of private practice, like what marketing works best, and how to adapt the household around client needs.'

An important element of contact with other local practitioners is that you get to know counsellors to refer clients on to, says Bristol-based counsellor and supervisor Els van Ooijen. 'We have a responsibility to work within our capabilities, and that means we should be referring on clients that we are not confident we can work with effectively. The best way to find who to refer to is to meet and talk to local practitioners.'

Doing a few hours of voluntary work can also be a good way to connect with peers, says Rye. 'When I started out, I was managing the counselling for a local charity for a few hours a week on a voluntary basis, which protected me from isolation. It also provided me with free training and CPD. Joining or setting up a monthly counsellors' reading group is another good way of ensuring you have regular contact with other practitioners.'

Supervision and mentoring

Another source of support is supervision. It's essential to find the right supervisor when you start out in private practice, which may not be your training supervisor. 'If people are going to go into private practice, they really need

to have a supervisor who is steeped in private practice, and has a lot of experience,' says van Ooijen. 'If you have never been in private practice, how do you know what it is like, and the kind of things to think about? It's limiting to think supervision is only about talking about clients – it should be everything that a practitioner needs in order to give the best service to the clients. For some of my counsellors, it can mean booking an extra session where we deal with the business side.'

For other practitioners, finding a mentor who can advise on the logistics of building a private practice works well. Burke stumbled across her mentor at a friend's wedding in the Caribbean. 'One of the guests was a very successful analyst running a private practice in New York. We started talking and I told her I was just starting out. She was very straight-talking, and said, "You have to approach it as a business right from the start." I feel lucky that she remains an unofficial mentor.'

An alternative is to identify a successful local practitioner and ask if you can pay for an hour of their time for advice, says Akhtar. 'I find you always pay more attention to advice you have to pay for!'

Smart marketing

Once you feel ready to get going, your challenge is to help the right clients find you. 'The biggest mistake that

counsellors make is that they think they are selling counselling,' says Hogg, who runs one-day marketing courses for counsellors. 'What you are actually marketing is what counselling can do for people. With the exception of trainees, no client is coming for an "experience" of counselling. They are coming because they want to relieve the pain of their bereavement, their anxiety, their depression, or move towards a better relationship with their partner or children. But counsellors will set up a website that says, "My name is John, I am an integrative counsellor and I studied at the Institute of Counselling, and I have a diploma in whatever". A successful website speaks about the client – what they will get from coming to you, in language they can relate to.'

Rye agrees: 'Just because you are qualified and list your qualifications in a directory profile, and say how supportive you are and that you offer a safe space to talk, it doesn't mean that clients will come to you. You have to learn how to market yourself.'

There are a growing number of marketing courses available for counsellors, and you can also learn a lot from looking at the websites and directory entries of successful practitioners. But it can be a trial and error process, says Akhtar. 'I set up in 2011, but it took me until 2012 to get my act together about marketing myself. It is easy to think, "Well, I've done the training and I'm qualified, so now clients will come to me." As a result, my first year was very quiet. And it's only in the last two years that it has really grown, and now I can choose the hours I want to work.'

Treat it like a business

Whether you have ended up in private practice by choice or by default, you can't ignore the fact that you are running a business, and that is not for everybody. 'Would-be private practitioners would do well to be realistic about their personal strengths and weaknesses,' says Rye. 'Apart from the professional difficulties of working with clients in an isolated context, there are the personal qualities that are needed to overcome other difficulties.'

'This really is a business venture that you are embarking on, and you have to regard it as such,' agrees Mervyn Wynne-Jones, Deputy Chair of BACP Private Practice. 'There are expectations of you, not only from your clients and your professional body, but also from external bodies such as HMRC and the Information Commissioner's Office.' Rye recommends considering a business-skills course: 'It was one of the best things I did when I was starting out.'

It undoubtedly pays to do your research, and make use of all available resources, before taking the leap into private practice. Flying solo is not for everyone, and it may take time to get it right, but when you do, it can offer what we all want from our working life – flexibility, autonomy and a sense of purpose. ■

USEFUL RESOURCES

- **Good Practice in Action.** **An ever-expanding library of free resources created by BACP for its members on all aspects of counselling, including confidentiality, record-keeping and contracting, and how to choose a supervisor.**
- **BACP Private Practice.** **Membership includes the quarterly *Private Practice* journal and a UK-wide network of local groups. bit.ly/2HgMcw2**

Sally Brown
About the author

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What worked for you when you set up in private practice? Email **therapytoday@thinkpublishing.co.uk**

The month

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

©THE DANCING BEAR TRILOGY 2018

Theatre

Dancing Bear

People identifying as LGBT+ can find themselves performing a precarious balancing act between personal integrity and social acceptance. This feast of storytelling and music, performed by a multi-talented cast and featuring drag star Divina De Campo (aka Owen Farrow), lays bare the interplay between faith, sexuality and gender identity. The show is produced by theatre/film director Jamie Fletcher with the aim to engage audiences in discussions about LGBT+ issues. We are promised a mix of glamour, hilarity and honesty that reaches to the heart of the matter. *Dancing Bear* runs at the West Yorkshire Playhouse, Leeds, 6–7 April, with discussions after both performances. tinyurl.com/y7y6uuuv

Video

Learning from lobsters

Did you hear the one about the stressed lobster? Rabbi and psychiatrist Abraham Twerski is an engaging storyteller, delivering a succinct and delightful tale about what the lives of lobsters can teach us about managing stress. The message is that we need to embrace the stress signals we receive in life as motivators for change, and that how we tackle personal challenges determines our personal growth. *How to Never Stress Again* is available on YouTube. **tinyurl.com/y9hb867d**

Exhibition

Rape's aftermath

This multi-media art installation created by survivor and camerawoman Elisa Iannacone explores the psychological impact of rape. It tells the stories of 25 rape survivors through a series of surreal visuals, including an underwater tank filled with railway tracks and a vintage car surrounded by 30 film extras. The project as a whole was intended to be part of the healing process for the participants, as well as to open up a dialogue around rape and challenge taboos. *The Spiral of Containment: rape's aftermath* is on show at Bargehouse in London, 8–11 March. tinyurl.com/y7h2efmq

Conference

ATTACHMENT AND ILLNESS

An insecure attachment style has a significant role in medically unexplained symptoms and how people manage chronic medical conditions. This one-day conference maps the association between embodied distress and attachment. Speakers include Gwen Adshead, PTSD expert and consultant psychotherapist at Broadmoor Hospital, Helen Payne, a pioneer of dance movement psychotherapy in the UK, and David Peters, former GP, osteopath and Director of Westminster Centre for Resilience. 'Insecure Attachment and Unexplained Illness' takes place in London on 21 April. **tinyurl.com/y7ccwnd4**

ROH PHOTOGRAPH BY STEPHEN CUMMISKEY

Theatre

Don't miss

4.48 Psychosis

4.48 Psychosis was the final work of the highly acclaimed British playwright Sarah Kane, who took her own life, aged 28, in 1999. The numbers in the title refer to the time in the early morning when 'clarity and bleak despair strike together'. Philip Venables' operatic adaptation of the play brings new resonance to the work, with six female singers and a chamber ensemble. Darkness and despair are leavened with humour and warmth in a powerful production that won the 2016 UK Theatre Award for Achievement in Opera and the 2017 Royal Philharmonic Society Award for Large-Scale Composition. *4.48 Psychosis* runs at the Lyric Hammersmith, London from 24 April until 4 May. **tinyurl.com/y7jtl77d**

Theatre

FINDING NANA

'Nana is nut brown, wrinkled and she has chicken fillets for arms. And she treats me like I'm way more amazing than I actually am.' Set in a seaside hotel of childhood summers, this autobiographical play by award-winning writer Jane Upton explores the specific relationship between a grandchild and her beloved grandmother. The one-woman show tells a story of love, the loss of a particular kind of unconditional love, and the crippling fear of forgetting. Following its debut at the Edinburgh Festival Fringe in 2017, *Finding Nana* is touring the UK until 24 March.
tinyurl.com/ybxpd5mr

TV

Addicted to food

For those working to overcome addiction or compulsive behaviour, every day is a battle. Reaching a place where recovery is possible requires a painful process of dismantling defences. This US documentary series follows eight people with eating disorders taking part in a 12-step recovery programme, over 42 days, at a Texan treatment centre. The documentary shows how a mix of creative therapeutic interventions, strict boundaries and the support of the group can effect change, and also how fierce resistance and relapse are an inescapable part of the process. *Addicted to Food* is available on Netflix.

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BBC

Tune in

TV

A Game of Soldiers

A yearning to belong and to feel valued and special can often be an unconscious motivation for people signing up to join the army. The army becomes a substitute family, but the safety and security it appears to offer can be brutally shattered by the reality of the requirements of the job. First transmitted in 1990, but no less relevant today, this documentary explores the psychology of warfare and killing and their impact, through interviews with soldiers who have fought in the Falklands and other wars. Alongside, a specialist psychologist reflects on the consequences of the training for both the soldiers themselves and society. *A Game of Soldiers* is available on BBC iPlayer.

The month

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Reviews

Bereaved Parents and their Continuing Bonds: love after death

Catherine Seigal
(Jessica Kingsley Publishing, £12.99)

This is an intensely emotional read about parents' experiences of their children's death and the ensuing grief. Almost every page tells a unique story of loss that illustrates how continuing bonds are formed, what facilitates and sustains them, and what can stop them developing. These are intertwined with advice, guidance and useful information on how professionals can encourage and support the continuing bonds process.

These grieving parents' stories are a testimony to all those Seigal met and learned from during her five years' counselling in a children's hospice (after 15 years of counselling elsewhere). Her writing is based on individual narratives, not empirical research, but this in no way undermines their importance.

Seigal asserts that conventional models of grief are 'inadequate' for bereaved parents. Her experience and observations have taught her that 'grieving parents have a considerable investment in continuing to grieve'. If that is so – and I very much believe her after reading the book twice – this should influence counsellor training and our understanding of bereaved and grieving parents.

My one criticism is the density of the highly emotional case studies. They tend to eclipse the useful guidance and advice and, consequently, the practical steps can be lost. I found myself rereading the chapters and skimming the case studies, and would have welcomed end-of-chapter summary review points.

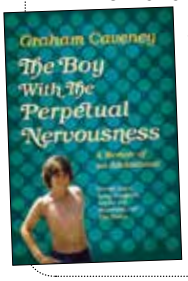
Augene Nanning, Manager of Caris Islington Bereavement Service and supervisor in private practice in north London

The Boy with the Perpetual Nervousness: a memoir of adolescence

Graham Caveney (Picador, £14.99)

Caveney's autobiography dissects in painful detail the process of grooming and abuse, and its legacy of damage to his sense of self, relationships and life hopes. A Catholic story with little redemption, this is a surprisingly funny book. With acerbic wit, the author relentlessly uncovers hypocrisy and posturing, both in himself and others, but also gives space to instances of care and kindness.

Caveney is particularly good at analysing the process of grooming, showing how the victim is initially drawn in by the special attention and later finds they are powerless to expose it. Because of the perpetrator's social standing, Caveney's parents trusted him, and this both damaged Caveney's relationship with them and made it impossible for him to reveal the abuse. This autobiography puts flesh on the bones of any training that therapists may have on safeguarding/sexual abuse issues. It demands to be read.



Gina Crowley MBACP, counsellor in Newcastle

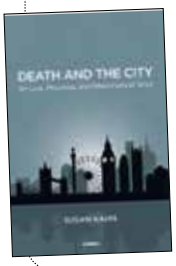
Death and the City: on loss, mourning and melancholia at work

Susan Kahn (Karnac Books, £26.99)

Over the last few decades, the idea of a 'job for life' has disappeared and been replaced with a need to demonstrate to a potential employer your ability to be adaptable, flexible and resilient. But what is the psychological cost to the individual of this adaptation?

Kahn has put together a moving and comprehensive piece of research on endings, loss and mourning in the workplace. She worked as a researcher inside a bank as it imploded during the financial crisis of 2008, and gives a first-hand account of what it was like for the leaders and employees, and shines a light on the personal impact.

As an integrative counsellor, I found Kahn's psychoanalytical approach a bit off-putting, but the book comes alive after the first section, and is full of fascinating insights of real value to therapeutic work. It has wide-ranging relevance to coaches and counsellors working with organisations and in workplace roles.

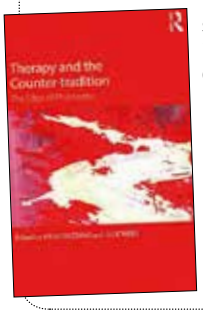


Alex Pledger MBACP (Snr Accred), counsellor in private practice

Therapy and the Counter-Tradition: the edge of philosophy

Manu Bazzano, Julie Webb (eds) (Routledge, £31.99)

This collection of fascinating chapters is not an easy read, but worth persevering with. Its basic assumption is that therapy and philosophy have much to offer each other, and that current therapy training is the poorer for not including basic philosophical education. This deficiency is explored by the contributors, who present a wide spread of Western philosophers and writers who have influenced them in their work, ranging from Nietzsche, Kierkegaard, Keats, Butler and Camus, through to Merleau-Ponty, Schopenhauer and Wittgenstein. The overarching challenge for both therapy and philosophy, in the editors' view, is how they work towards human 'wholeness' in a context where rationality, regulation and diagnosis rule. As Bazzano and Webb note, this presents considerable challenges to psychotherapy, which is fast turning to prescriptive technique instead of descriptive methodology.



Keith Silvester MBACP (Snr Accred) is a psychosynthesis psychotherapist, supervisor and trainer and Alexander teacher working in London

First lines

‘Passion is a fire from within, to use the idea of the poet Pablo Neruda... It can be captured and transformed into moving works of art, or it can be deadly. It may be fulfilling, or cruel and ambitious. Whether to embrace it fully or to rein it in has been a dilemma since the beginning of time.’

From *Psychoanalytic Perspectives on Passion: meanings and manifestations in the clinical setting and beyond*, edited by Brent Willock, Rebecca Coleman Curtis and Lori C Bohm (Routledge, £26.99)

Previews

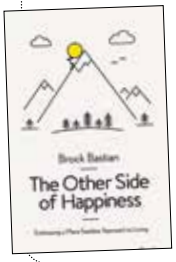
Death of a Psychotherapist and Other Poems

John Woods (Karnac Books, £8.99)

The title piece of this collection of poems expresses the mental fragmentation of a period of illness and near-death that interrupted the author’s final few months working as a psychotherapist in an NHS clinic – as well as the search for meaning and wholeness. Other, shorter poems describe illness as a challenge to be met, rather than an overwhelming immersion.

The Other Side of Happiness: embracing a more fearless approach to living

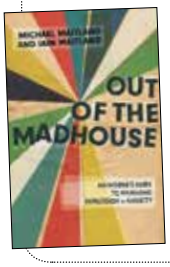
Brock Bastian (Allen Lane, £20)



Renowned social psychologist Dr Brock Bastian argues that suffering and sadness are neither antithetical to happiness nor incidental to it: they are a necessary ingredient for emotional wellbeing. Drawing on psychology, neuroscience and findings from Bastian’s own researches, the author encourages a more fearless approach to living.

Out of the Madhouse: an insider’s guide to managing depression and anxiety

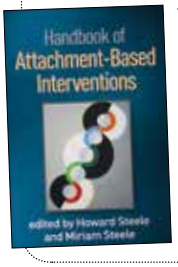
Michael Maitland, Iain Maitland (Jessica Kingsley Publishers, £12.99)



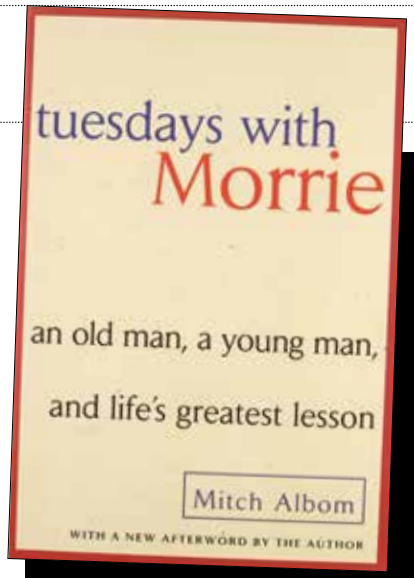
Told with humour and frankness, this book of diary entries charts a son’s journey to recovery from entering psychiatric hospital to becoming a mental health ambassador for young people, and a father’s reflections on the experience. Michael and Iain Maitland share tips and techniques that have helped them and others manage depression, anxiety, anorexia, OCD and other distress.

Handbook of Attachment-Based Interventions

Howard Steele, Miriam Steele (eds) (Guilford Press, £48.99)



Leading proponents describe how their respective approaches are informed by attachment theory and research, from how sessions are structured and the techniques used to the empirical evidence base and training requirements. The book encompasses interventions for school-age children, adolescents and couples, with a focus on strengthening caregiving relationships in early childhood.



A book that shaped me

Tuesdays with Morrie: an old man, a young man, and life’s greatest lesson
Mitch Albom (Sphere, £8.99)

A friend recommended this book to me when I was at university. When I eventually got around to reading it, I couldn’t put it down. It is a beautifully written, life-affirming memoir. It helped me to re-evaluate my life and played a part in the journey that led me to a career in counselling. Morrie’s message in the face of a debilitating terminal illness is clear: embrace life. I find it deeply therapeutic to reflect back on this particular quote: ‘The most important thing in life is to learn how to give out love, and to let it come in.’

Nathan Walker MBACP, integrative counsellor working in IAPT

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

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

Letters

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

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

Confidentiality and the law

I was interested by the dilemma 'The police have requested access to my case notes' (November 2017). Recently, a client was referred to me because they were the victim of a crime. During our therapeutic work, the case went to court. The police contacted me to request my counselling notes. My main concern was my client and, before I responded, I wanted to feel confident and equipped with the relevant knowledge.

First, I contacted the BACP ethics team. They were able to reinforce areas I was familiar with in the Ethical Framework and gave me some important advice about the case. I then contacted my indemnity insurance company, from whom, for many years, I had never needed support until now. They provided me with a thorough knowledge of my legal obligations to the court and to my client.

The police presented me with a medical disclosure form and a data request form but I was not prepared to disclose any material without a data disclosure form signed by the client. The police told me I would receive a summons to court that day/evening. I felt intimidated by the tactics they were using. However, I felt more confident with my small army of professional advisers supporting me.

I spoke with my client at the first opportunity and informed them of the events that had taken place and the requests made of me. After sharing with them my notes from our therapeutic work, I asked if they would sign a disclosure form that would allow me to share the notes with other professionals involved in the case, which they did.

When I did go to court the following week, I felt confident that all I had done had kept my client's best interests as the priority. I may be wiser now, but there is still part of me that would like a clear checklist of how the system works from the very start of the therapy work. However, this situation has highlighted to me the importance of being covered by indemnity insurance, because I now appreciate such situations could happen to any therapist at any time.

Kathy Jaloussis MBACP (Accred), BSc
Counsellor and psychotherapist

> **"... having a brain with sex hormones that do not match your body, and therefore your gender assigned at birth, is not a choice, nor a mental health issue – it is a serious condition that needs responding to"**

Gender dysphoria and acceptance

Thank you for 'putting gender on the agenda' (News Feature, December 2017). However, I was shocked and distressed to see the approach suggested for use with children. Comparing a child bravely expressing their true gender self to a therapist with a child saying 'I am a panda' is crass, grossly insulting and misguided. An expression of a child's gender identity should be met with genuine openness, not pretending to be open while seeing this expression as comparable to a fantasy – which, if it continued, would signify a serious delusional mental health condition. This has nothing in common with someone's gender identity journey.

Gender dysphoria is not a mental health condition. We know now that gender identity begins to be formed in the womb; we know that, if the development of sex hormones in utero is interfered with, this can create gender dysphoria. We know that all children between the ages of three and six explore and affirm (if allowed) their gender. Actually having a brain with sex hormones that do not match your body, and therefore your gender assigned at birth, is not a choice, nor a mental health issue – it is a serious condition that needs responding to. But professionals who are approaching it with an agenda/hidden agenda attitude can actually create or exacerbate the mental distress associated with the lack of acceptance that trans and gender-questioning young adults already experience from society.

When Pamela says a girl wants to be a boy because she wants to be a soldier, she is talking about representations of gender socially. This is not the same as being transgender. When Michelle says, 'Young women think that what it means to be a woman is to wear high heels,' she is underestimating the emotional insight and intelligence of young people. I know trans girls that play football and like rough play and sword fighting. I know a trans woman who is a sergeant major in the army. Maybe gender identity actually is less linked to societal norms and parenting attitudes than cis-gender people would like to imagine.

The Tavistock takes a controversial and extremely conservative line, unlike many other parts of the world. Following their agenda of 'never' giving up hope that the depressed, anxious, self-harming, suicidal trans person in front of you might not actually be trans is the opposite of what those vulnerable young people need from a therapist. They need total, unconditional acceptance of their true, emerging self, without your holding out any hope that they might not actually be who they really are.

Lesley Pender MBACP

Consequences of transition

I welcome the general move among the therapy and counselling professions to embrace diversity and accept difference when it comes to expressions of gender and sexuality. The intentions driving the recent Memorandum of Understanding (MoU) are therefore to be applauded. The News Feature ('Putting gender on the agenda') in the

Meeting at breadth

We would like to take issue with Mick Cooper's comment that 'the shallowest connection [is] between a male therapist and a male client' ('Meeting at relational depth', November 2017).

As two male counsellors who regularly work with male clients, and who have also recently conducted research on relational depth between male counsellors and clients, we feel that 'shallowness' is not an appropriate or helpful adjective to use in this context: it feels hurtful and belittling.

Our research used a narrative inquiry methodology, and revealed some useful pointers about working with male clients, highlighting the way men are socialised and how to work in a relational way with this in therapy.

We questioned how 'relational depth' is defined and whether thinking about it as a 'phenomenon' is helpful, as it is perceived so differently by people, especially when considering gender. Of particular note to person-centred practitioners is whether relational depth sits within or outside Rogers' six conditions.

The best understanding we've come up with is that it is synonymous with working with emotional intensity. This is important, given the dominant narratives in society of how men and women are socialised: broadly, men express emotions at a lower level of intensity than women, particularly in therapy. Might that explain Mick's reported 'relational shallowness' when men counsel men? Just because male clients don't necessarily present emotional intensity, that doesn't mean that effective work isn't being done.

Men may often need different approaches, but trust, rapport, understanding, connection and humour all happen when working with men – perhaps these are more 'relational breadth'? Maybe what works with the goose doesn't always suit the gander?

Working at relational depth is sometimes presented as a gold standard for trainees to aim for, but we would question whether it deserves such an accolade; in particular, it could effectively be setting up new 'conditions of worth' for the trainees. Not expressing emotions at 'high' intensity can be marginalising for men in training (see, for example, Nick Tarrant's letter, 'Closed to men?', May 2017).

If anyone is interested in discussing effective ways of counselling and working with men, please contact us.

Andrew Cranham MSc
Student MBACP currently looking for employment, andi.cranham@googlemail.com

Mike Trier MBACP (Accred)
Private practitioner in Sheffield, mike_trieruk@yahoo.co.uk

December 2017 issue raised the danger of 'straight, cis-gendered therapists' practising conversion therapy. However, it totally omitted to mention the very real opposite danger. Fears of being accused of practising conversion therapy (along with appeals to a fictitious innate gender essence and fears of being perceived as transphobic) seem to have almost totally closed down responsible psychological thinking about gender dysphoria. This has effectively left medicalisation with hormones and surgery as its default treatment, despite the fact that there is currently no credible medical explanation for the condition. Furthermore, such treatment has serious long-term consequences that may include infertility and a life-long dependency on synthetic hormones.

The situation is particularly worrying given the recent surge in children and adolescents identifying as trans. In the West, a secure adult sense of identity is not normally established until well into the 20s. Additionally, many young people struggle with a variety of issues related to their emerging sexuality, family break-up, social isolation, autistic traits, self-harming behaviour and/or traumatic memories held unconsciously in their bodies. All these problems can contribute to gender dysphoria. Self-identification as trans may seem to offer a magical solution to such issues. But, if trans-identification is simply affirmed, the number of unnecessary medical transitions is bound to increase. It seems all too plausible that future generations will come to regard us as having presided over a profound failure to think and work psychotherapeutically with gender dysphoria. There is a real danger that, in the name of protecting vulnerable young people, the MoU will have unintentionally contributed to that failure.

"... if trans-identification is simply affirmed, the number of unnecessary medical transitions is bound to increase"

Robert Withers BPC, UKCP
Jungian analyst, visiting senior lecturer in mind-body medicine, Inter-University College Graz

I sacked my therapist

I read with interest John Rowan's piece on 'sacking' three of his clients ('Turning Point', December 2017). In my own case, I sacked my therapist.

A long time ago, I went into therapy to try to deal with some issues that were causing me a lot of distress. It was agreed at the beginning of the therapy that 'we needed to work on' these issues. But a very few sessions in, the therapist seized on another matter, which was not relevant to my issues and which he knew was not particularly important to me. To me the 'answer' he then tried to impose was irrelevant to my pressing concerns, and it was alien to my personal values. It also proved to be non-negotiable; I spent a number of unproductive sessions trying to get him to relate to my feelings on the subject. He dismissed these feelings without consideration, and occasionally with contempt, and just continued to, as he put it himself, 'make his case'.

I did not feel I was in therapy to answer his 'case', but to get consideration for my own; finding his treatment not just useless but painful, I abandoned, rather later than I should have done, any attempt to get recognition for any feeling of mine, and gave him the sack.

So, as a client, I would say that, when the therapist becomes so engaged with their own objectives that they can't or won't relate to the client's feelings, or consider that they might be mistaken about the adequacy or appropriateness of their 'answer', then the therapy is doomed – and the client had better get out before they get hurt.

That risk seems to be a recognisable one, since the transactions described were the subject of a complaint that was upheld by the therapist's professional association.

Name and email supplied

> **"Clients who tend to disagree with our answers tend not to take responsibility for themselves while continuing with their repetitive behaviour... so I have no qualms about bringing the sessions to an end"**

Calling time

I read John Rowan's Turning Point article about sacking a client (December 2017) with great interest. I am a bereavement counsellor and have had to come to this conclusion with a few of my own clients over the years.

At first, I took this issue to supervision and was reassured that this was OK as some clients will never let go of their issues, no matter how far they go into therapy, and that this is a conscious decision on their part – after all, when their issues are resolved, then what? Some clients feel guilty for letting go of their issues and need to hang onto something that will show they still care, love, etc (certainly in bereavement counselling).

Also, according to transactional theory, these are games that the client plays and a counsellor needs to recognise this and be congruent to their self, as well as to the client; there is nothing wrong in agreeing to disagree. Clients who tend to disagree with our answers tend not to take responsibility for themselves while continuing with their repetitive behaviour, in my experience, and so I have no qualms about bringing the sessions to an end as further work will not benefit either of us.

Agnes Murria MBACP (Accred)

My therapist 'sacked' me

As a 'sacked' client myself, I was interested to read John Rowan's Turning Point in the December issue of *Therapy Today*. I had gone into therapy for a very specific reason and I had been extremely clear about that. When I was 'sacked', it served to reinforce the pattern I had been trying so hard to grapple with. My process had been deep; I knew I had been taking myself to some very primal places, and I had trusted my therapist's capacity to meet me there.

I absolutely appreciated the 'endless patience' and considerable support my therapist had offered me, over approximately 18 months, and when she 'gave me the boot' (by email), I was shocked and incredibly hurt. I pleaded for an ending session, which she refused. I was then plunged into a profound

> I am always fascinated by how... the brain has everything available to it, given the right conditions

experience of grief and pain and (inevitably, perhaps) self-blame.

I assume John was in supervision when he 'sacked' his first client, although he speaks of feeling 'very alone' in the experience. As a client, I am not sure I had ever felt so alone. I felt punished, blamed, humiliated and incredibly lost. My therapist referred to the support and guidance of her supervisor when telling me why she had made her decision, and I felt somewhat 'ganged up on'. She had somewhere to go with her feelings - I did not.

While I agree that it is not ethically appropriate to continue with therapy 'regardless', I do believe that endings need to be extremely carefully and sensitively navigated if we are not to perpetuate damaging relational/attachment patterns and potentially undermine any work that has already been done. I also believe that, as therapists, we need to look at ourselves very carefully too.

(Name and email supplied) MBACP
Counsellor and trainer

Don't diss person-centred therapy

I was slightly surprised by Sarah-Jane Butler's statement ('Informed choice', Letters, December 2017) that the likelihood of a PTSD sufferer 'getting better' through person-centred therapy 'is small'. I have worked with many clients with PTSD, including ex-service personnel, and there is no doubt in my mind, or theirs, that they have 'got better' (or, as I'd prefer to put it, their flashbacks, nightmares, obsessions and anxieties either lessened or disappeared).

Person-centred therapy does not consist of sitting with a client, passively empathising and reflecting and providing minimal encouragers. Person-centred therapy is about building a relationship, discovering what it feels like to be your client, and, insofar as it's possible, entering their world. From their viewpoint, then, you can understand what it is that they need, and, if that's psycho-education, thought experiments, mindfulness, focusing, or even tailored and intelligent CBT, then that's what they get from you.

Gene Gendlin wrote this: 'When I sit down with someone, I take my troubles and feelings and I put them over here, on one side, close, because I might need them. I might want to go in there and see something. And I take all the things that I have learnt - client-centred therapy, reflection, focusing, Gestalt, psychoanalytic concepts and everything else (I wish I had even more) - and I put them over here, on my other side, close. Then I am just here, with my eyes, and there is this other being.'[1] I echo that, and I think any person-centred therapist worthy of the name would do the same.

I understand the current trend for ever-smaller specialisms, but I do see it as a trend. There is no 'one' therapy for 'one' issue. Research quite clearly suggests that the crucial factor is the relationship in the room, and that the modality comes second.

Max Marnau MBACP (Accred)
Selkirk

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> I understand the current trend for ever-smaller specialisms, but I do see it as a trend. There is no 'one' therapy for 'one' issue. Research quite clearly suggests that the crucial factor is the relationship in the room

Where left and right meet

I was inspired by Robin Shohet's article on left/right brain split ('We are in this together', December 2017), as both elements are present in eye movement desensitisation and reprocessing (EMDR). There seems to be quite a lot of mystique surrounding EMDR, and it still continues to divide opinion, even though there is extensive evidence of its effectiveness. I just want to illustrate how it can be used to facilitate change that is right-brain and clearly therapeutic - it may also help to demonstrate what EMDR is about.

The EMDR process itself is quite structured (left brain), with a set of stages that guide the therapist and client to the point where eye movements akin to rapid eye movement sleep are induced, alongside the activation of a traumatic memory. This part of the process is where the right brain takes over - eye movements seem to stimulate the brain in a highly creative way, with new 'information' emerging from within the client in the form of pictures, thoughts, feelings or body sensations. This was something I observed recently during the processing part of EMDR: a client who was dealing with childhood sexual abuse suddenly saw themselves as 20 feet tall, which rapidly dissolved fear and powerlessness and became a turning point in the therapy.

I, as therapist, could have suggested imagining this, but it has far less power than the client 'realising', or seeing this generated from within. This outcome could have been achieved through many other modalities of therapy, given time, but I am always fascinated by how this level of change can happen within a few sessions with EMDR, and how the brain has everything available to it, given the right conditions - Maslow's 'self-actualisation' in full view. May our right and left side of our brains continue to work in harmony and may we remain curious about ourselves.

Justin Havens MBACP (Accred)
Cheltenham

Experts by experience

Steph Jones argues that personal experience of mental health problems can add to a counsellor's skills

I was recently thumbing through a back issue of a psychology magazine and came across one of those 'short interview with a therapist' articles. The therapist in question had only decided to retrain after he reached retirement age; his motivation was, he said, to 'give back to society'. As I continued reading, I felt more and more unsettled. The interviewer asked, 'Have you ever been in therapy?', to which he replied, 'No, I've never needed to be.'

This spun me back to a lecture on my own counselling training course, where our professor uttered these words, now permanently etched on my brain: 'Never trust a therapist who hasn't had therapy.'

In my late teens and early 20s, I struggled like hell. I grew up in a single-parent household, and my mother battled (although mostly in complete denial) with alcohol. Sofa-surfing and jobless by 17, I found drugs, boys and alcohol were fun alternatives to escape the crushing pain of abandonment and rejection (Mum left me for a violent and abusive man who shared her passion for alcohol. Both are now dead, due to their addictions.)

I remember my early childhood as being a very confusing time. Mum would lavish me with love and attention, but fly off the handle for no particular reason. She would talk to me like an adult friend, after she'd downed a bottle of wine. I had absolutely no boundaries. I was obsessively washing my 'contaminated' hands by age seven, a latch-key kid by nine, and hauled into the GP's surgery aged 10 by my hysterical mother demanding to know what was wrong with me. She later gave me hell for not showing the GP my 'real behaviour'.

I first went for counselling when I was 25 and had accepted that, although my life was by then relatively stable, something didn't feel quite right. My counsellor (a trainee CBT practitioner) didn't seem all that interested in my journey of abuse and neglect, my presentation of emotional instability, attachment issues, no confidence or self-worth, major depression, anxiety, frequent panic attacks, dissociative states, some self-harm, impulsivity, maladaptive ▶

'This spun me back to a lecture on my own counselling training course, where our professor uttered these words, now permanently etched on my brain: "Never trust a therapist who hasn't had therapy"'

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behaviours and evidence of substance abuse. Instead, we focused on what he deemed to be the main problem: why I didn't have the confidence to talk to a guy I had a crush on.

It wasn't until several years later that I had 21 sessions of cognitive analytic therapy, through an IAPT service, with a kind, funny, attentive and authentic male counsellor. Each week I would pour my heart out as we did 'the work'. Together, we painstakingly collaborated in trying to make sense of my life and helping me learn the art of self-acceptance. I screamed, I got angry at him, I wept in grief and anguish; I projected all the unresolved dysfunctional toxic material from my relationship with my mother into our dyad, and he held it securely, compassionately and patiently. He made me realise (much to my initial resistance) that I was in a relationship with an abusive narcissist (I was), and that I was making excuses for his terrible behaviour because I could understand where his pain came from: 'Jones knows her onions,' my therapist said.

One afternoon he remarked that he thought I'd make a good counsellor, and I admitted that I'd previously looked into it but hadn't pursued it, 'because... reasons'. At that moment, I realised all my 'reasons' were, in fact, fear-based excuses, and within the next few years I had qualified with a postgraduate diploma in counselling and psychotherapy on a BACP-accredited university course. I worked 60 hours a week to achieve my goal, and burned out on several occasions, collapsing under the strain of the essays, and feeling incredibly alone. But I stuck with it. All we trainees did.

Walk the walk

Over the years, I have had around 70 sessions of counselling of different types with different practitioners: some good, some bad, some bloody awful (one therapist told me that he communicated with aliens to help him in his practice).

It may seem like a gross over-generalisation, and I know many skilled counsellors who have travelled the academic route, but, in my experience, those that were bang on the money in terms of their awareness, observations, communication style, interventions, empathy and guidance had all been through the mill - they had lived the syllabus; they spoke from a place of core wounding and subsequent healing.

What is that about? How does my own mental health experience shape me as a professional? What exactly is the special 'thing' that I bring into the counselling relationship to help the work? When I attempt to solve this riddle, I realise just how difficult it is to quantify. But maybe that's the point - it is almost impossible to capture in words an intuitive skill that extends beyond the five recognised senses and is, therefore, in the eyes of science, situated somewhere in the realm of Woo-Woo. Isn't this part of the problem - that, in our Western culture, we seek to dissect and label all we see in order to 'understand'

'What exactly is the special 'thing' that I bring into the counselling relationship to help the work? When I attempt to solve this riddle, I realise just how difficult it is to quantify. But maybe that's the point'

though our limited senses? A shamanic culture, by contrast, would take interconnectivity and acute empathy as a given, without the need for any scientific research to make it 'real' or true.

This is my humbly offered attempt at an answer. I believe pain and suffering allow us a glimpse of the truth. I'm suggesting that, when you've experienced a high degree of pain and suffering in your life, you naturally cultivate a wider emotional spectrum.

Perhaps, at a biological level, this is about having an over-stimulated sympathetic nervous system, and learning to manage this effectively enough (adapting) so the world is no longer perceived as a constant threat. I sometimes visualise this as a variation on the window of tolerance - that, when you've done enough work on yourself, a hyper-aroused state can be cultivated so that your senses become cat-like, useful, and not just unpleasant.

Could it have something to do with the brain's mirror neurons - could therapists who have personally experienced mental health issues simply be picking up on strong and familiar subliminal clues, even before the client has verbalised their concerns? By this same token, having been to the depths of despair yourself might suggest that your transference receiver is already finely attuned to the suffering experience - a bit like a sniffer dog checking for explosives in an airport check-in queue.

This exquisite sensitivity used to frighten me - I used to consider it a 'weirdness' and would try to hide it away from others, but I now regard it as a magical power in my counselling toolkit. To put it another way, therapy is hard work, my experience of mental health issues has given me the tools to be an empathic badass, and you don't learn that in class.

Two-way street

My decision to write this article was met with some concern by one of my peers. 'I'd feel really uncomfortable disclosing that, Steph. What if a client read it?' Their comment (although well-meaning) highlights something that I think lurks in the background of our profession. Many of us come to the work as a 'wounded healer', yet there seems to be a tangible undercurrent of shame and embarrassment at the mere suggestion that we were (or are) not '100% mentally healthy'. I know countless practitioners in the caring profession who pour themselves into helping their clients but secretly cry their

eyes out in the bathroom over lunch. But we're fine, aren't we? Nothing to see here, people - just a bit of dust in my eye.

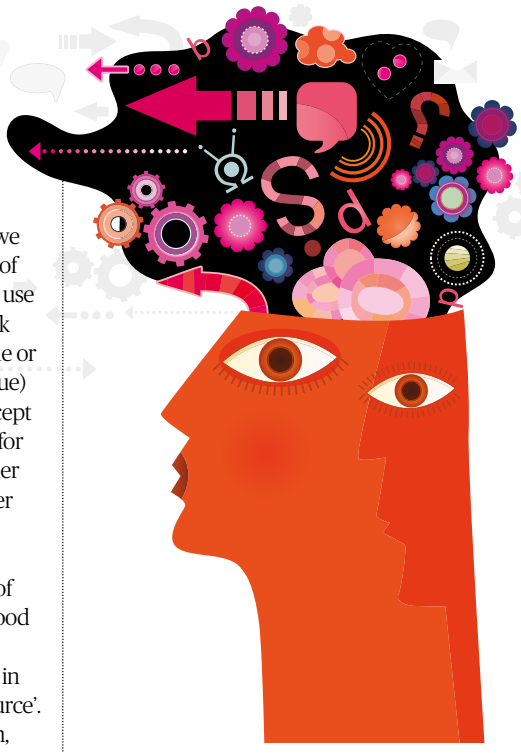
I'm not suggesting for one moment that we 'reveal' ourselves, 'warts and all', to a client (of course, boundaries are critical), but that we use appropriate self-disclosure, and that we seek support to understand our feelings of shame or inadequacy when anyone (client or colleague) 'finds out'. The more we dismantle the concept of the 'expert therapist', the easier it will be for our clients to trust us. In the words of another peer, 'Vulnerability helps even out the power imbalance a bit more.'

I once worked with a highly regarded doctor who had been through a great deal of psychoanalysis to deal with his own childhood issues. He talked about how his experience enabled him to 'feel' the psychological pain in another person, and really 'lock into the source'. He believed this made him a better clinician, and we often talked about how what happens in the patient-professional transaction does so at a level of meta-cognition - an unspoken communication that says: 'I can see you've been there too.'

But it's not pain by proxy, that's for certain. I am deeply and consciously aware of whose material is whose, and have a passionate and curious supervisor who works with me to help 'sift out the lumps'. Nor is it about personally identifying with the client's experience (the all-unhelpful, 'Hey, I know how you *feel*'), or an unprocessed desire to heal vicariously through the work.

For someone who is lost in the dark, perhaps it provides comfort that their therapist has not only been into the darkness, but has come out the other side. There's a famous quote from the film *Good Will Hunting* that seems to encapsulate my point. During an intense therapy session, Sean, the therapist, says to Will, his client: 'So, if I asked you about art, you'd probably give me the skinny on every art book ever written. Michelangelo - you know a lot about him. Life's work, political aspirations, him and the Pope, sexual orientation, the whole works, right? But I'll bet you can't tell me what it smells like in the Sistine Chapel. You've never actually stood there and looked up at that beautiful ceiling, seen that.'

High empathy is beyond the observed, assumed or inferred. It is beyond cognition - it is existential, intuitive and instinctual.



'Of course, we "wounded healers" are never fixed. Lifelong, hard-wired patterns of negative behaviours and processes do not vanish in a puff of smoke just because you've got a string of letters and qualifications after your name'

No shame

When a client walks into my office I am not assuming the role of a perfect professional. I am flawed, just like everyone else, and I am honest about that. In retrospect, every 'Eureka!' moment in my own personal therapy arose from the therapist spontaneously disclosing their own private pain, and so demonstrating to me that this pain could be overcome through blood, sweat and tears. They were the proof, and now I am. Of course, we 'wounded healers' are never fixed. Lifelong, hard-wired patterns of negative behaviours and processes do not vanish in a puff of smoke just because you've got a string of letters and qualifications after your name. In times of stress, my Pure-O OCD will make itself more apparent. I like to nip this in the bud by visualising a bloody big red stamp smashing out the thought, and then making myself a cup of tea. These days, my anxiety has become a manageable and endearing shyness (even though I'm viewed by others as a fun-loving extrovert), and my severe, numbing depression has become occasional low days (I self-care the shit out of low days).

I have learned to accept my past, overcome the stigma and shame, and not let it define me or my future. I am now a very happy 38-year-old, with an incredible partner and a fluffy feline familiar. I let go of what doesn't serve me (jobs, friends, situations), and I practise what I preach.

I would personally be extremely cautious about any counsellor who hadn't sat in the client seat at one time or another. It offers a world of valuable insight to integrate into practice. A client whose therapist claims 'I've never needed therapy' should perhaps have a good, long think about whether they're the right person for them. For me, that comment smacked of 'them and us', which certainly does nothing to equalise the power imbalance in the therapeutic relationship or help reduce the stigma around mental ill health. I guess that is the whole point of sharing this piece - to proudly shout that I'm human, imperfect, messy and authentic, and I'm bloody good enough. ■

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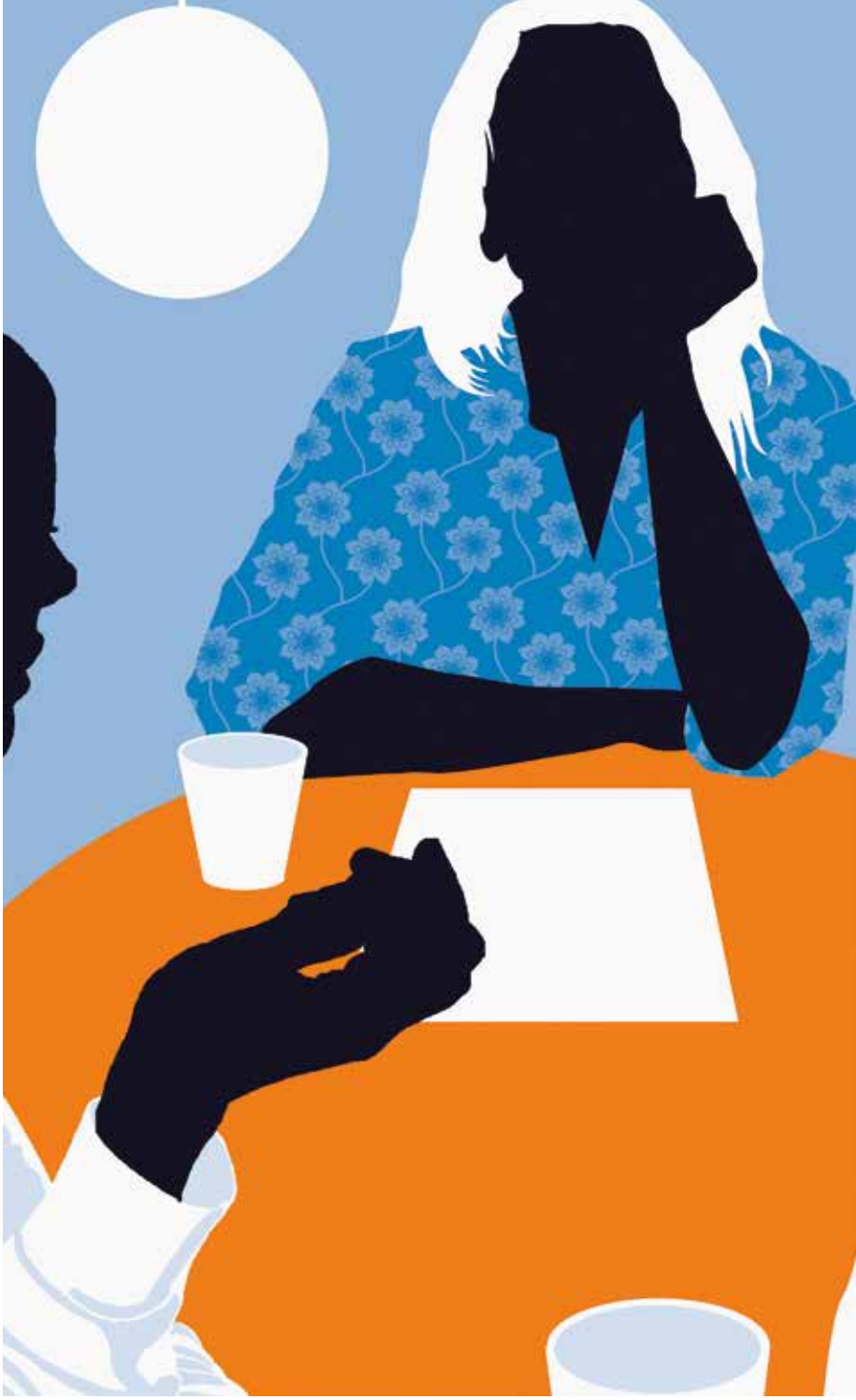
Three *in the* room

Catriona Wrottesley describes the all-important 'third position' held by the therapist in couple therapy



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Tony and Clare, both now in their 50s, had been married for 10 years (it was a second marriage for both). Between them, they had four children, who had all left home. They came for therapy because Tony had met another woman, and he wanted a divorce. He said he could no longer live with what he called Clare's 'aggression'. She was, he said, dismissive, critical and angry; nothing he did for her was ever right. He had done his duty by staying until the children left home, but now he had found a woman who made him feel good about himself again, and he wanted out.

Clare was devastated by his decision, but acknowledged that she often felt frustrated in the relationship. When difficulties arose, Tony would refuse to discuss them, she said; he'd tell her to 'stop going on and on' and accuse her of 'always finding fault'. She needed to talk about how she felt, and he experienced talking as an attack. His parents used to fight, and he was determined not to replicate their relationship. Hers never fought, and retreated into cold silences; she was equally determined not to be like them.

Tony told me about a row they'd had about a painting he put up in the living room. Clare objected to it. It was a painting of a place where he had spent many holidays as a boy, and he felt Clare was being unreasonable: why shouldn't he be allowed to put up a picture in his own living room?

Clare explained that she wasn't angry because she didn't like the painting, but because she hadn't been consulted. Tony had previously bought a set of second-hand dining room furniture and installed it without asking her. The final straw was when he bought a sofa and brought it home, when she had specifically asked if they could choose one together. He blew up, and accused her of never being satisfied: 'You said you wanted one, didn't you? It was a bargain.'

Tony couldn't continue in the relationship, he said, because he was frightened of her anger. Clare had found a way of 'being herself' outside of the relationship, seeking emotional closeness with friends and family, and satisfaction at work, which compensated for what she felt was lacking at home with Tony. She experienced him as controlling, and said she was equally afraid of his sudden eruptions of anger, interspersed with the periods of ignoring her. She had resigned herself to 'This is as good as it gets'. Then Tony announced he wanted the divorce.

In the room

Tony and Clare are, of course, fictional people, although their problems are typical of those brought to us by clients seeking help. The most obvious difference between couple therapy and individual therapy is that, in couple therapy, three rather than two people are present. Most importantly, the relationship for which help is sought is in the room, so the couple therapist is able to see, feel and hear for herself what is going on, and has a first-hand emotional experience of how the couple relate to one another.

The immediacy and impact of this experience of the couple's relationship and the access to their shared unconscious phantasies are not available in individual therapy, where only one half of the couple and the couple's projective system are in the room, and the absent partner's behaviour, feelings and intentions are described through the distorting lens of the client's own perceptions, projections and internal world.

The interaction between the two partners is the principal focus for the couple therapist,[1] as the couple enact their relationship and projective system in front of her, intimately involving her in their struggles through the transference and countertransference dynamics of the therapy. In individual therapy, the therapist works with the transference to herself, whereas in couple therapy there is the transference between the couple, their individual transference, and their transference as a couple to the therapist. The therapist's countertransference helps her understand and work with the couple's difficulties.

This view of couple interaction as a dynamic to which both partners contribute and one that is shared is something special offered by the model of couple psychoanalytic and psychodynamic psychotherapy, developed by Tavistock Relationships over the past almost 70 years. Fundamental to this model is the view that 'the relationship is the patient',[1] and that couple therapy is not about 'offering two individual therapies in parallel'.[2] The couple therapist seeks to have and maintain what Morgan calls 'a couple state of mind'.[3] She defines this as the therapist's capacity to take a 'third position'[4] in relation to the couple: 'that is, being able to be subjectively involved with both individuals, but also, at the same time, being able to stand outside the relationship and observe the couple'. This, Morgan maintains, is 'a primary factor in containment of the couple'. A 'couple state of mind' is not simply 'holding both partners in mind, though that is part of it... It is about keeping the relationship in mind'.[3]

In individual therapy, the therapist hears their patient's version of their relationships, and, in effect, listens to one half of the story. The couple, however, represent two halves of a projective system that together form what Cleavely refers to as the couple's 'joint personality'[5] (a term originally coined by Dicks when he did his seminal work on marital tensions and dynamics[6]). In this system, 'frightening aspects of their "joint personality" are located in the partner who, both unconsciously agree, will best keep them safe and controlled'.[5] These dynamics, as with many repeating patterns of relating, will be unconscious before the couple enters therapy, as will be the 'marital fit' that attracted the partners to one another, whether for defensive or developmental purposes.[1]

When working with couples, therapists have in mind the idea of a shared unconscious phantasy.[7] Couples share a way of relating to others and situations through unconscious phantasies: for instance, that love, anger, or conflict is dangerous, or that talking about difficulties will lead to catastrophe. This then leads to the establishment of shared defences to cope with these phantasies, resulting in relationships in which sharing feelings is avoided. These couples, in coming for therapy, may present with a difficulty with intimacy or sex, or with feelings of distance and loneliness in the relationship.

Triangular dynamic

The three-person constellation of couple therapy offers hope, but it can also stir anxieties. It recreates the original triangular Oedipal situation of parental couple and child, with all the feelings relating to inclusion, exclusion and envy that this arouses. Warring and unhappy partners may each enter therapy anxious that the therapist will join with the other in identifying them as 'the problem', that one will be preferred to the other or get more of the therapist's attention, understanding or sympathy. The desire to get the therapist to declare who is 'right' and who is 'wrong' can be powerfully enacted in the therapy in a way that puts the therapist under pressure to act as judge and jury.

The much-needed 'third position'[8] is adopted by the couple therapist, who can then empathically connect with each partner's experience, and validate and hold it without taking sides. The therapist also has the task of taking a meta-position, or overview (in effect, a couple state of mind[3]) in relation to the couple's interaction - one that is not identical with either partner's viewpoint - in order to understand and, over time, communicate to the couple the nature of the shared unconscious phantasies, anxieties and defences that are preventing them from having a mutually satisfying relationship. This meta-position is a forerunner, it is hoped, for the development of the capacity in the couple, over the course of the therapy, to take such a 'third position' themselves, in relation to their own relationship. ▶

'Warring and unhappy partners may each enter therapy anxious that the therapist will join with the other in identifying them as "the problem", that one will be preferred to the other'

'Sharing psychic space' without feeling taken over or psychically annihilated may also be a profound difficulty for the warring couple.[2,4] This can be seen when each partner has a different viewpoint, and a fear arises that one will invalidate or obliterate the other. These couples may have become trapped in an 'either/or' struggle between 'my way' and 'your way', where there has to be a winner and a loser, with inevitable damage to the relationship. In seeking therapy, the couple has, consciously at least, agreed to try to find another way, and the involvement of a couple therapist, who is temporarily allowed into their relationship, offers the possibility of a third perspective.

This difficulty in sharing psychic space presents a challenge to the couple therapist. If they offer a different perspective that is not in accord with one or both partners, it may be experienced as an attack, or as refusal of one or the other's reality. When couples seek help, it is generally when the projective system has got stuck, or, as Morgan calls it, 'gridlocked'.[9] This is characterised by a quality of certainty in each partner that they 'know' what the other thinks and feels, and also what they intend, which is generally construed as in some way malignant, harmful, or rejecting of them. Each may be trying very hard to 'get through to' the other and to be understood through increasing levels of projective identification, while the other is trying desperately to defend against this unwelcome intrusion and to force the other to take in their understanding of the situation, and so the cycle goes on. In the therapy room, this can manifest as a very stuck pattern of attack, defence and counter-attack, in which neither is heard and neither is able to listen, while the levels of frustration and distress escalate. This is where the presence of the couple therapist, who witnesses and can feel what it is like to be in the presence of this interaction and not a participant, can be very helpful.

Keeping the relationship in mind

There can, of course, be many pressures that make it difficult to keep the relationship in mind, including each partner's sense, sometimes amounting to a conviction, that the other is the problem and, if only they would change, all might be well. With that in mind, many couples enter therapy with a wish for the therapist to 'sort out' the other partner. Other challenges include that of one partner communicating with the therapist by email, letter or text between sessions, and excluding the other from the communication.

Within the session, the couple therapist may become conscious that they are engaging for a while with one partner and leaving the other on the sidelines, so to speak. When that happens, it is important that the therapist remains mindful of the partner who is not for the moment the main focus of attention, and does not get drawn into a collusive dynamic with the partner who is the focus at that point, and may wish to be the 'special' one. It may be that the other partner feels left out, and has disengaged and internally left the room, although they are physically still present. Sometimes the therapist may need to pause and check how that partner is feeling before resuming the interaction; they may even stop the interaction if the excluded partner needs help with managing difficult feelings. This may be a familiar dynamic for the couple, when one partner takes him or herself to the sidelines, preferring a position of exclusion to involvement, and then feels miserable, wishes they could be found, and bitterly resents their partner and the therapist for leaving them out.

Helpfully, in the couple therapy space, each person can at various times be both witness and participant in a relationship: one partner may witness the therapist and their partner relating in a way that echoes the repetitive dynamic that led the couple to seek help, perhaps affording the opportunity to see the therapist responding in a different way.[2] The therapist may find herself excluded from the couple dynamic as they join together in a defensive or destructive interaction, and, through awareness of the countertransferential feelings that get stirred up, gain insight into the kinds of anxieties and fears that are being defended against, as in the case of Tony and Clare.

Tony and Clare

In the therapy room, Tony and Clare were turned away from each other, as, initially, they only addressed me. They struck me as a polite couple, who were careful with each other in the room, despite the bitterness of their complaints about each other.

At first, the unreasonableness of Tony's unilateral decisions was apparent, and it was difficult not to sympathise with Clare. However, I was struck by Tony's vulnerability and fear of Clare, who could be forcefully articulate. As the therapy progressed, I witnessed how Clare could be relentless in her criticism of Tony, which was how she expressed her pain and need.

Clare was equally forceful with me when she felt I was not understanding her point of view. Her rigidity in insisting on her viewpoint as the right one, leaving little room for Tony's or my views, gradually became clear. I could see how Tony watched and listened carefully to see how I managed when Clare was pressing her point and

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'In seeking therapy, the couple has, consciously at least, agreed to try to find another way, and the involvement of a couple therapist... offers the possibility of a third perspective'

becoming angry if I did not appear to be sufficiently on 'her side'. Clare was equally attentive and quiet when I was addressing Tony, including when he insisted that he was innocent of ill intent and that he had 'not meant anything by' whatever he had done that had upset Clare.

My capacity to retain a 'couple state of mind' in caring for their relationship without siding with either partner gradually helped them see how much they really wanted and were terrified of the same thing: both wanted to feel safe and loved in their relationship. Ostensibly, Clare wanted to be able to talk and argue and be tolerant of each other's differences, and Tony wanted things to be 'pleasant' and free from anger. However, underlying this apparent difference was a shared fear of rejection, and of love. Their shared fear of being unwanted defended them against the dangers of being wanted.

In the course of the 18-month therapy, Clare and Tony were gradually able to withdraw some of their projections and begin to really listen to one another in a new way. A significant breakthrough came in a session when I linked Clare's fear and resentment of her bullying father, who had 'ruled the roost' at home, to how she experienced Tony's unilateral decision-making. Tearfully, she said this was true; she had tried so hard to marry someone very different, but had ended up marrying her dad. Tony had seemed the opposite of her father when they first got together, because he was so kind and considerate. She recalled a time when he had made her jelly when she had a sore throat and high temperature, because she had once told him that was what her mother used to do for her as a child.

Tony was clearly moved that she had remembered this, and offered her his hand to hold. He said it meant a lot to him to hear Clare say that, because sometimes he felt that nothing he did for her was right. He volunteered the information that, as a boy, he had struggled with the feeling that his mother was disappointed in him, because she used to compare him unfavourably with the boy next door. He had tried desperately to please her, but nothing he did was good enough. I put it to Tony that, at times, being married to Clare felt like being married to his critical mother, and that a part of him had decided to ignore her feelings and please himself instead. Tony looked a bit shame-faced and relieved, and said I was spot on. He said he knew he could be a bit of a steamroller, but he felt that, if he wasn't forceful, Clare would completely take over.

I then put it to Clare that her fear of being dominated meant that she could be a bit of a bully herself at times, so Tony then had an experience of what it had been like for her as a child with her dad. Quietly, Clare acknowledged that sometimes she felt she had turned into her dad when she was 'going on and on', as Tony put it, because she was determined to make him listen to what she had to say.

I was aware that making these links was challenging for both of them, but felt confident that, by then, their trust in me and the therapy was sufficiently established for them to take in these interpretations and think about how they each contributed to their relationship difficulties. The fact that they responded by sharing their respective vulnerabilities demonstrated to me that the timing had been right.

> 'For 18 months, I had represented the "third position", but they had now internalised this way of thinking'

These insights set off a long period where they worked through the accumulation of hurt and misunderstanding that had brought them to therapy, but there was a marked difference in their capacity to listen to one another and to think together. There was now space for two people's thoughts, wishes and feelings in the relationship – not just one. As Tony put it, now that he and Clare could understand where they were each coming from, they had far more patience and understanding for each other. They could, in effect, step outside the relationship when they got into difficulty, into a 'third position', and think together about what was going wrong.

The development of this 'third position' signalled to me that they were ready to end the therapy. For 18 months, I had represented the 'third position', but they had now internalised this way of thinking about their dynamic, and I felt confident that they would be able to find a way through difficulties when they occurred, without the help of therapy.

Working with individuals

Tavistock Relationships now offers an MA training in psychodynamic couple therapy that includes working with individuals from a relationship perspective, because we are aware that this capacity to hold a 'couple state of mind' is also important for those working with individuals. Many people come for therapy because they recognise that they have difficulty in relationships, whether they have never had or are no longer in a relationship, and are aware of repeating destructive or unhelpful patterns that they cannot understand and want expert help with. In our view, couple therapists who are trained to work with individuals have much to offer clients, and therapists who come to do a couple training with us tell us that their individual practice has been radically changed. After working with couples, they can never again listen to their individual patients talk about their relationship difficulties without being mindful that what their patient is recounting is but one half of their couple projective system – that, effectively, there are three people in the room. ■

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‘Rosie arrived on time for each session, with her mother holding on to her arm, bringing a small bag of biscuits, drinks and tissues’

I used to work as a counsellor with a local charity. I went to reception one day to meet a new referral, who I knew only to be a woman in her 50s. Rosie (not her real name, but she has agreed to me telling our story) was sitting with another lady, who was very frail and elderly. I wondered if I had read the referral correctly, but invited both of them into the counselling room for a chat, so I could sort out whatever the mistake might be.

Rosie told me that the elderly lady was her 87-year-old mother, who suffered from dementia, and that she was her sole carer. They were from Eastern Europe and her mother spoke only Serbian. The dementia had made her very insecure and vulnerable and she only settled when she had Rosie in her sight. Rosie said she couldn’t leave her with anyone else and, if she herself was to get the help she needed, the only option was to have her mother in the room with us during therapy.

I could see her mother had fallen asleep. She didn’t seem to be aware of her surroundings, but every now and then opened her eyes to look at Rosie, possibly for reassurance.

Rosie’s presenting issue was a complete breakdown of her relationship with her own daughter, who was her only child, and her grandchildren. This seemed to me such a contrast with how she was with her own mother. What to do? I could guess at, and a little bit understand, Rosie’s needs; I was aware of the third soul in the room; I had in my head the conflicts of my own emotions and judgments, as well my ethical code of practice and my agency’s confidentiality policy. I reassured Rosie that I would talk to my supervisor and call her as soon as possible.

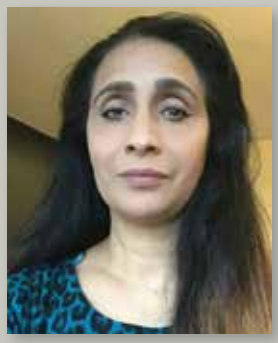
I spoke with my supervisor and we came to the conclusion that Rosie’s mum’s presence in the room was inconsequential, and that it was much more important for Rosie to have access to the therapy she very much needed. Even if Rosie’s mum agreed to sit in reception, we felt Rosie would not be able to engage fully with the therapy during the sessions and therefore would not be able the make the best use of the time. Once this was agreed, the therapy started.

My work with Rosie over the next four months reinforced for me the importance not just of strict boundaries, but of flexibility too, within the ethical framework.

Rosie arrived on time for each session, with her mother holding on to her arm, bringing a small bag of biscuits, drinks and tissues. We allocated her mother a chair behind where Rosie sat, and she would sleep for most of the time. Every now and then, she would open her eyes, sip her juice and eat a biscuit.

I felt it was a three-way relationship: Rosie’s mum became a part of our therapy process. Rosie settled quickly into the work, and felt safe for herself and for her mother. She was able to work on her own feelings and anxieties, and to deal with what we identified were attachment and control issues relating to her own childhood. As the therapy progressed, she was able to start rebuilding a healthy and stable relationship with her daughter and grandchildren.

When our therapeutic relationship came to an end, Rosie left a note saying, ‘Thank you for enabling me to retain both important relationships in my life, with my mother and my daughter.’ ■



About Tasneem

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WHO CARES FOR THE WOUNDED CARERS?

Counsellors working with severe trauma need protection from trauma too, writes **Fiona Dunkley**

'I left my job as I started to suffer from stress and began to think this wasn't the job for me. In hindsight, I realised I was suffering from burnout. The intensity of the job, exposure to traumatic material and lack of support from management all contributed to experiencing cumulative stress and eventually burnout. I constantly felt exhausted, had difficulty sleeping and felt demotivated.'

These words are from a trauma counsellor whom I interviewed for my research into the impact on practitioners of working with victims of severe trauma.

I have worked as a trauma therapist for over 15 years now. I started out in witness protection and support, and then shifted to the NHS to work with victims of human trafficking. I supported Transport for London staff after the 7/7 bombings, and then moved into the humanitarian aid sector, where I have given psychological support to staff working with refugees in Afghanistan and Syria, and with survivors of natural disasters such as Hurricane Irma and the Nepal earthquake. I've also worked with humanitarian teams dealing with major outbreaks of disease, such as the Ebola epidemic that swept through Sierra Leone, Liberia and Guinea. In that time, I have seen first-hand how people who work in the caring profession are at risk of burnout and vicarious trauma, and I have been close to burnout myself.

I've become more and more interested in how we support the carers of our world at both the individual and organisational level. This can become even more of a critical issue in times of cutbacks and austerity, when there are fewer resources to support staff. However, how we take care of ourselves as we listen to distressing stories, particularly if we specialise in working with trauma, is something we need to constantly attend to.

In the past year, the organisation I was working for, InterHealth Worldwide, a holistic support service that supported over 500 NGOs and mission and government organisations, ceased operating, as did Report the Abuse, a charity formed to support aid workers who had experienced sexual violence. One of the main factors in both instances was lack of funding. I was involved in supporting firefighters after the Grenfell Tower fire in London in 2017, in which 71 people died, all residents. The London Fire Brigade had drastically cut its in-house counselling team, and was desperately appealing for volunteer therapists. I was horrified to see many therapists who had no specialist trauma training carrying out assessments, without first being vetted. This can be harmful to the traumatised workers, who may not receive the expertise they need, and also to the therapists, who, without the right training and support, are more vulnerable to vicarious trauma and burnout. One recently qualified therapist told me that she was feeling overwhelmed by the graphic details she was hearing, and that she had started to 'imagine bad things happening to [her] family'. She didn't want to inform her manager as she felt she would be perceived as 'not coping'. The number of firefighters on long-term mental health leave has increased by 30% over the last six years.[1] These experiences demonstrate that, although trauma is talked about more, there is still significant underfunding and undervaluing of psychosocial services, even within organisations where the risk is greatest.

In my work with emergency first responders and humanitarian aid workers, I often hear people say that they feel they have a calling, and that they are passionate about creating a safer and better world. Many who work in the field conform to a stereotype: they are self-sacrificing, with a tendency to overlook their own self-care for the greater cause; they overwork; they struggle to maintain healthy boundaries around responsibility, and they are prone to weighty guilt if they think they have let others down. As one aid worker told me: 'This job is more than just a job. It is my life. It requests every part of me. The aid worker in me has to be strong. If I make the wrong decision, I may expose my team to immediate danger.' By the very nature of their work, they will be exposed to traumatic stories.

These pressures and stereotypical traits also apply to therapists, and this makes them particularly vulnerable in the current socio-economic climate. It is not unusual to hear practitioners say, 'I'm doing the job of two people.' When targets are prioritised over staff wellbeing, morale plummets, as does productivity, and workers become paranoid and mistrustful – the perfect recipe for an unhappy working environment. This is ironic, given that targets were originally introduced within organisations to foster healthy competition between staff and departments. However, in some workplaces, the targets have become so impossible to achieve that staff are driven to manipulate data, conflicts arise, harassment and grievance cases ensue, and staff turnover escalates.

When I facilitate presentations on trauma, counsellors repeatedly and increasingly confide in me that they have 'hit burnout'. They tell me that their organisations are limited in what they can offer to protect their therapists, because of lack of resources, ever-higher targets and a lack of understanding of the psychological impact of working with trauma. When we work in organisations, it helps if we have some awareness of systemic trauma. By this I mean some understanding of how an organisation that works with trauma can, through its own structures, processes and environments, traumatise its workers. This is an important issue for those involved in providing therapy within organisations, and has consequences for the individual therapist.

Researching vicarious trauma

My interest in this issue led me to undertake a piece of research into burnout and vicarious trauma. It was a small-scale study using a questionnaire I designed that asked therapists who work with trauma about their experiences and understanding of vicarious trauma and burnout. ▶

'... counsellors repeatedly and increasingly confide in me that they have "hit burnout". They tell me that their organisations are limited in what they can offer to protect their therapists'

IKON IMAGES/MITCH BLUNT

For clarity, vicarious trauma, sometimes called compassion fatigue or secondary trauma, is the emotional residue that carers experience from hearing their clients' traumatic stories. As Tehrani observes: 'There is a cost to engaging with the stories and lives of distressed and traumatised people that can result in the carer experiencing symptoms similar to those of the people that they are supporting.'[2] One trainee counsellor told me: 'I started to feel jumpy and on edge after particularly difficult client sessions. I work in a women's refuge centre. I was looking over my shoulder more and felt a sense of danger everywhere I went. It wasn't until I explored this more in supervision that I realised I was suffering from vicarious trauma.' Burnout is cumulative and often a result of high demands or prolonged stress in the workplace.

The majority of my research participants had experienced symptoms of burnout or vicarious trauma at some point in their career. Reasons for experiencing burnout included workload, lack of support from management, lack of autonomy, and pressure from unrealistic deadlines or targets. Michael Leiter and Christina Maslach,[3] both professors of psychology and known for their pioneering research on work-related burnout, devised a model that highlights six specific sources: lack of control; conflicting values; insufficient reward; work overload; unfairness, and the breakdown of community. Interestingly, many of the therapists in my research said they only realised just how much they were affected when they started to complete my research questionnaire.

The most widely used measure for assessing burnout is the Maslach Burnout Inventory (MBI), developed by Christina Maslach with Susan Jackson at the University of California.[4] Personally, I find the MBI particularly useful, and I recommend that individual therapists and teams of therapists use it regularly, as many are prone to overlook the signs of burnout until it is too late and they are signed off sick or leave the organisation. I also recommend that practitioners regularly review and talk to each other about burnout within their organisations, and suggest that therapists check their personal levels of burnout and review their self-care strategies.

Maslach and Jackson view the effects of burnout as three-dimensional, made up of exhaustion, cynicism and inefficacy. In my own research, the top three reported symptoms for burnout were exhaustion (50%); feeling irritable or short-tempered, and lacking concentration (40%), and emotional outbursts, feeling not good enough and having difficulty sleeping (30%). The top three symptoms for vicarious trauma were feeling helpless, angry or despairing, and experiencing physical illnesses (70%); feeling the need to rescue, demotivated, powerless or not good enough, overwhelmed and lacking energy (60%), and feeling unsafe, jumpy or disorganised, spaced-out or numb, and experiencing intrusive images (50%).

As a supervisor, I am aware how few counselling courses actually offer specialist training for therapists working with traumatised clients. One of my supervisees was supporting an aid worker who had recently returned from Turkey, where they had been working with Syrian refugees. My supervisee noticed that she had started feeling 'unsafe', and was having vivid dreams about the material her client was bringing to the sessions. I discussed with her the psycho-education of trauma, normalisation and building resources, so she felt better equipped to take care of herself and support her client. We also discussed the risk of vicarious trauma and some of the symptoms to look out for (see Table 1 above).

Having worked in an NHS forensic sexual assault unit for four years, I believe some jobs have a shelf life. I knew, by the end of those four years, that I had 'done my time'. I loved my job, felt passionate about what I was doing and could see the value in my role, but I knew it was time to step back and walk away. I was experiencing compassion fatigue and I had become immune to some of the distressing stories I was exposed to.

TABLE 1: SYMPTOMS OF VICARIOUS TRAUMA

- Feeling helpless, leading to the temptation to be the 'rescuer' and becoming overly responsible
- Feelings of anger and despair, which may lead to a 'them against us' attitude
- Feeling we are special and the only one who can make things better
- Going beyond the boundaries of our role and overworking
- Strongly identifying with the client
- Feeling useless, unskilled and unable to see the client's strengths
- Feeling the world is no longer safe
- Little energy for ourself and others
- Seeing mental images related to the events described by the client
- Feeling jumpy, disorganised or overwhelmed
- Experiencing niggling physical complaints and sleep disturbance
- Feeling spaced-out, dissociated or numb
- Changes to smoking, drinking or eating patterns

Protecting ourselves

So what can we therapists do, at both the personal and organisational level, to better protect ourselves from these psychological hazards?

Organisations such as the fire brigade, police forces and humanitarian agencies offer regular assessments and debriefs to staff who are at risk of exposure to trauma (directly or indirectly). This is something counselling organisations and Employee Assistance Programme providers could offer therapists working with trauma. Table 2 (right) lists the recommendations for organisations, collated from the questionnaire responses.

At an individual level, ethically we each have a responsibility to take care of ourselves, and to model good self-care to our clients. Table 3 (right) lists what the therapists responding to my questionnaire did to protect themselves from vicarious trauma and burnout. If I have experienced a particularly heavy trauma session, I may carry out some mindfulness, grounding or Emotional Freedom Technique exercises. Sometimes, if appropriate, I will do these with the client. Other strategies I use after demanding sessions include changing the energy/space

in the room by moving things around or opening the window, taking a short stroll or making a cup of tea. I think it is important that we tune into our physical state directly following such sessions, to work out what we might need in that moment. I also rarely watch the news on TV late at night and try to limit my exposure to traumatic material outside work.

We all need to be more aware of the warning signs and symptoms of vicarious trauma and burnout, to be able to identify them for ourselves, and also to watch out for our colleagues. Not long ago, I walked out of my counselling room into the corridor and found a colleague standing there, staring into space. She had the 'thousand-mile stare' often associated with trauma. I realised she had just experienced a difficult session and I could see she was struggling. We did some breathing exercises together, I made her a cup of tea, and she took a walk around the park, to help ground her.

However, it's important to understand that burnout and vicarious trauma are not about lack of resilience on the part of the therapist; they are normal responses to the type of work we are exposed to. There is a great deal of research that explains why this happens. Organisations need to become well informed about the psychological risks in the workplace for therapists, and have clear stress and trauma policies in place to support their staff. We and our organisations all have a duty to be alert to the risks and protect the carers of our world, so we can continue to carry out the great work we do. ■

TABLE 2: WHAT CAN ORGANISATIONS DO TO HELP?

- Regular assessments for burnout and vicarious trauma symptoms
- Trauma specialist supervision
- Access to supervision in an emergency
- Managers to receive vicarious trauma and burnout awareness training
- Managers to role model good self-care (many therapists mentioned that their managers overworked, which can also be a symptom of vicarious trauma)
- Peer support groups
- Caseload management, particularly focusing on the weight of trauma cases
- Flexibility and an opportunity to vary tasks (therapists often spoke of the need to have 'space' within their working day – time to reflect and to do their administration work)
- Critical incident stress debriefing (CISM)[5]
- Ensure therapists are not working in isolation
- Good-quality continuing professional development

TABLE 3: PERSONAL STRATEGIES TO AVOID VICARIOUS TRAUMA AND BURNOUT

- Personal therapy
- Exercise
- Socialising
- Taking short breaks/holidays
- Readdressing work-life balance
- Peer support outside of work
- Mindfulness/meditation
- Yoga
- Emotional Freedom Technique
- Becoming self-employed (more control over caseload and management)
- Pets
- Write, listen to music or watch films
- Humour
- Being in nature
- Personal spiritual practice

> '... burnout and vicarious trauma are not about lack of resilience... they are normal responses to the type of work we are exposed to'

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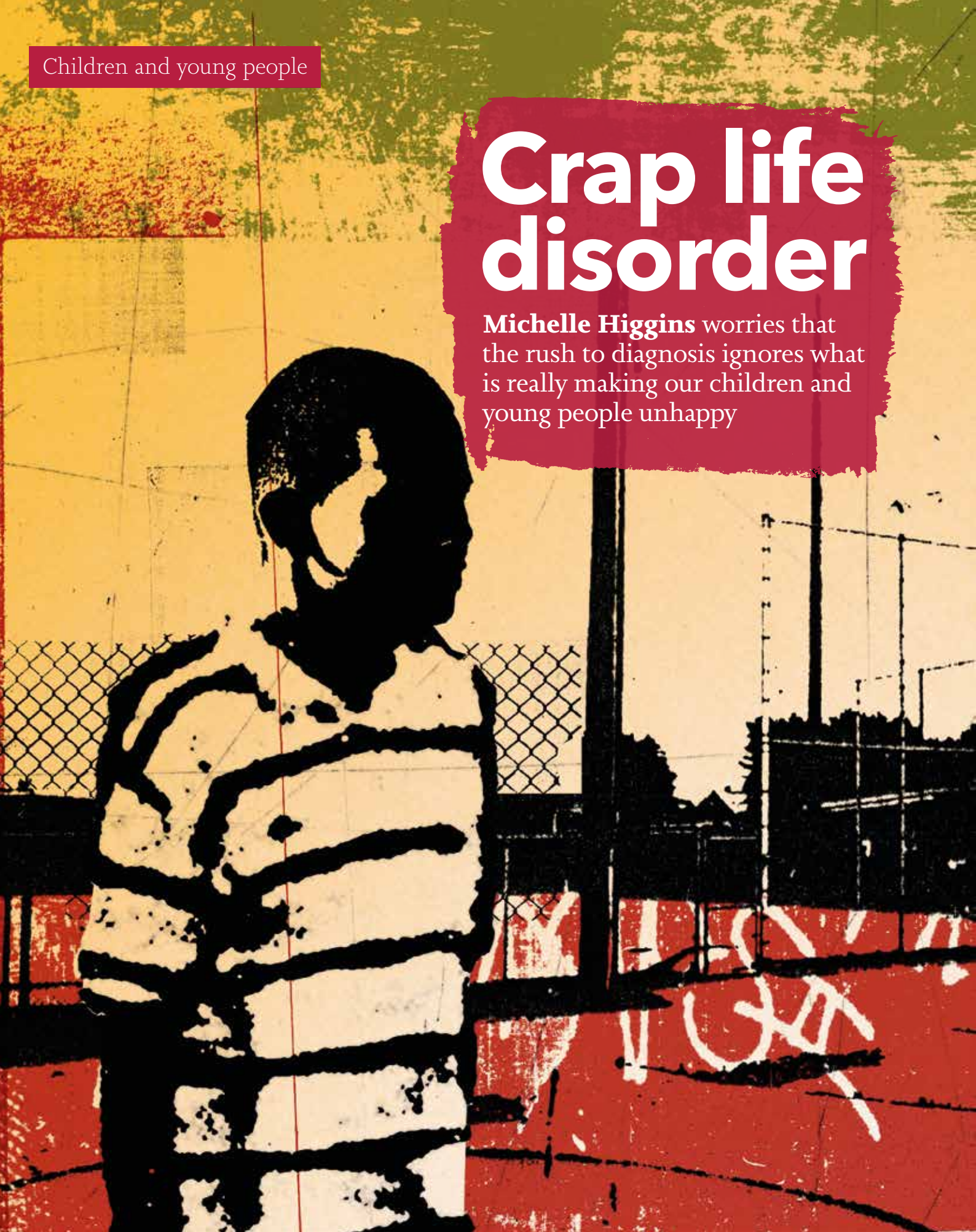
Crap life disorder

Michelle Higgins worries that the rush to diagnosis ignores what is really making our children and young people unhappy



The growing crisis in child and adolescent mental health services is worrying. As therapists and counsellors working on the front line, we know that young people are not receiving the help they need, when they need it. At the same time, growing numbers of children are being diagnosed with mental disorders of one kind or another.

As a counsellor working in a secondary school, I have come across many young people who are diagnosed with depression, anxiety, separation anxiety, attention deficit hyperactivity disorder, conduct disorder or oppositional defiant disorder, to name just a few. I am always curious to discover how the label of a disorder helps or hinders young people, and I listen out for statements and sentiments that express how children absorb the meaning of their diagnosis. On many occasions, I hear how young people internalise the message that there is something fundamentally wrong with them, how their brain does not work 'normally'. Sometimes I hear relief. Being given a diagnosis means that others believe them when they say how they feel – without a diagnosis, they feel their experiences and feelings are not valid.

I have also heard how keen adults, parents and teachers are to attribute diagnostic labels to make sense of children's behaviour and experiences. For example: 'He gets so angry, it's not normal. I think we need to get him tested'; 'She's very up and down. I think she might have a chemical imbalance. Perhaps she needs some medication.' These kinds of statements are evidence that the medical model is seeping into our everyday language and understanding of children's mental distress. Yet, while we therapists may be fully aware of this, in my experience, parents, teachers and other professionals who work with children are not.

This pervading diagnostic culture can promote an acceptance, even expectation, among families and professionals that diagnostic labelling is the definitive answer to a young person's mental health difficulties. This can lead to children being, at best, deeply misunderstood, and at worst, shut down and completely unheard.

All the vignettes in this article are fictional, but based on the stories I hear daily from young people in my work.

IKON IMAGES: ALEX WILLIAMSON

'I struggle to contain my discomfort whenever I hear reference to oppositional defiant disorder. What 'normal' child or adolescent doesn't exhibit defiant behaviour? Wouldn't it be abnormal if they didn't?'

Andy

I was diagnosed with ADHD when I was 10. I've stopped taking the meds now. They make me feel sick. Mum says I should keep taking them. She says I'm worse when I don't take them and if I don't take them, I could get expelled. I get so angry, I can't control it. I punch the wall. My bedroom's got loads of holes in the walls. My mum thinks I've got bi-polar and I should get tested. She saw this documentary and she said everything they said about bi-polar is like me. She says if we know it's bi-polar that makes me so angry, then I could get proper help and everything would get better. I found my real dad on Facebook last year. I've seen him a couple of times now. But last time I was meant to see him, he didn't show up. Mum says I can't trust him and I shouldn't be bothered with him. She only says that because he used to hit her when I was a little kid. But he's alright now. He's got a wife and two kids. He says I can go to his house soon, but I have to wait till he can send me the money for the fare to get there. It's a long way on the train.

If it were not so alarming, one of the most entertaining diagnostic labels given to children, in my opinion, is oppositional defiant disorder (ODD). As defined in the US *Diagnostic and Statistical Manual of Mental Disorders*, this is identified by a pattern of angry and irritable moods and argumentative, defiant or vindictive behaviour that lasts for six months or more. Persistence and frequency of such behaviours is, apparently, key to deciding if the problem has tipped over into symptomatic defiant behaviour rather than defiant behaviour that is within a 'normal' range.[1] I struggle to contain my discomfort whenever I hear reference to ODD. What 'normal' child or adolescent doesn't exhibit defiant behaviour? Wouldn't it be abnormal if they didn't? And for some, defiant behaviour for a sustained period may be a wholly 'normal' response to their life circumstances. What is 'normal' behaviour for a young person who is being, or has been, sexually abused, for example? Difficult behaviour may well be communicating unspeakable things.

With tongue in cheek, I'd like to suggest a more accurate diagnostic term that may provoke a more helpful response to young people's distress – 'crap life disorder'. For a diagnosis of crap life disorder, perhaps we might consider the presence of one or more of the following criteria:

- physical, sexual or emotional abuse and/or neglect
- living in a family in poverty
- subject to intense pressure to meet others' expectations and outcomes that are deemed to measure success.

Levels of distress may be exacerbated by additional factors from the following list:

- support services unable to offer appropriate and meaningful support to the young person and their family
- school inadequately funded to meet the needs of its pupils
- unmediated exposure to internet/social media platforms
- family receiving inadequate support from children's social care services.

I propose that the fundamental causes of crap life disorder are a toxic mix of societal and relational factors that impair a child's development. Some might say adolescents have always faced numerous pressures as they navigate their way from childhood to adulthood. I suggest that the pressures faced by young people and families today are uniquely manifold and intense. While the 21st century brings many benefits to young ▶

people, in the western world at least, it is also a contaminated container that poisons the essential ingredients for healthy child and adolescent development.

School pressure

Pressure to succeed is taking its toll on our young people.[2] Many believe that our education system has become so focused on targets that children and adolescents are suffering.[3] Learning has become a constant race to keep up and keep on track. The constant focus on grades and targets can distort our conception of success. Young people hear mixed messages about academic performance: for example, 'My dad says, "Just try your best". But that's annoying, because you don't get a decent grade for trying your best, do you?' or, 'One minute you hear, "don't get stressed, the exams are not the be-all and end-all". Then, the next minute, someone says, "If you don't get good grades, you won't get a good job".'

As parents, carers and teachers, we may think we are giving a balanced message about working hard and achievement, but the truth is, children are hearing that falling behind on targets or not achieving an expected final grade translate as failure. Self-worth measured against this backdrop is a constant shadow over many young people's lives.

Jamal

I've got anxiety disorder. It's something I'll always have. It's a condition, an illness. It runs in my family. My nan has anxiety, my mum has always had it. It's hereditary. There's loads of things I can't do. Sometimes, it's so bad I can't get through a full day at school. I don't know why it's so bad sometimes. It just takes me over and I have to go home. I'm not going to get good grades. I didn't do well in my SATS. I never do well in tests. I know I'm going to fail. I don't know if I'll be able to go to uni. I can't see how I would be able to do that. I can't see that happening. How will I get a good job if I don't go to uni? If I don't get a job, how will I ever buy a house and have somewhere to live? How will I ever have a family? It just makes my head hurt thinking about it.

The digital age

Peer influence and acceptance today is largely facilitated by social media. The digital age brings many positives to young people's lives, such as ease of access to global information, immediate communication with a wide network of people with similar interests, an audience for sharing personal ideas and opinions, and a forum for self-evaluation. But these benefits of social media and digital technology can also present problems.

'While the 21st century brings many benefits to young people... it is also a contaminated container that poisons the essential ingredients for healthy child and adolescent development'

In recent years, there has been much discussion about the negative impact of online life: the constant focus on and need for affirmation, the fallacy of happiness, popularity and success portrayed through the screen, and the addictive potential of this medium for self-appraisal.[4] Additionally, sites that encourage self-harm and suicide are a worrying influence on those young people who are vulnerable to the darkness and hopelessness of distress.

Media reporting about world news and events provides a constant drip-feed of fear. Real-life horrors are graphically played out on our screens, 24 hours a day. We might assume this can make us immune to their impact, but this distressing information and these disturbing images are becoming deeply embedded in young people's psychological DNA.

Janita

They've said it's depression. I mean, how can you be 16 and depressed? Everyone else my age is happy. But I'm not like other people my age. I haven't had a boyfriend yet. I don't even want a boyfriend! I won't go to shopping centres or crowded places in case there's a bomb, and I like watching kids' TV with my little brother because it makes me feel safe. What other girls my age do you know like that? None! Everyone else in my class is having fun. They're popular, they're going to parties. I shouldn't do it because it gets me down, but I can't stop trawling through their selfies, looking at what they post, and reading their stories. It's like I have to show myself how great everyone else's life is. I torture myself. I just don't know why I feel so low all the time. I wish I could just get happy.

In addition to the constant drip-feed of horror and the illusion of happiness online, young people can't escape the deceiving depictions of perfect bodies and sexual and gender norms. Many young people have viewed pornography by the age of 14, and the range of pornography, so easily accessible online, is distorting their understanding of what healthy relationships and sexual experiences are.[5] Easy access to information has the potential to support healthy identity development too. For instance, discovering others who have similar beliefs, values and preferences can offer a feeling of belonging and reassurance. This may be a lifeline for young people who are exploring their emerging sexuality and wondering if they may not be heterosexual. However, there are mixed messages out there in the wider world. While gender and identity politics may appear to promise a world where diversity is valued, heterosexuality is still an assumed norm in our society, and many gay, bi and trans young people still experience great prejudice and discrimination.[6]

The numerous routes to access information and communication means that parents have to negotiate a continually changing landscape as they seek to balance age-appropriate freedoms with safety and privacy, in order to protect their children. For example, carrying out random phone checks and being their child's Facebook friend might seem responsible ways for a parent to monitor their child's online life. Remotely following children with a GPS tracking app may seem the perfect way to allay fears about grooming, or children being misled or negatively

influenced by online 'friends' and coming to harm. These strategies might be considered responsible parenting, and, indeed, some may be necessary and helpful to some young people, but are parents' attempts to keep their children safe turning into surveillance? Is this really beneficial for adolescents as they test out their fledgling independence? Are there other ways to help children protect themselves that respect their privacy and help them to develop autonomy? Who supports parents with these dilemmas? Where do they turn for support and guidance?

Keiko

I can't go out unless I have the tracker on. My dad says he wants to know where I am all the time, so that he knows I'm safe. I went to Tom's house the other night and when I got back Dad was mad. He said he couldn't track me and he didn't know where I was. I told him my phone died and I couldn't charge it, but really, I'd switched it off. I wasn't doing anything bad, I just wanted to hang out at Tom's house. I feel bad lying to Dad. We used to be close. We're always arguing now about how much time I'm on my phone and how I'm always in my room. But I shut myself in my room because all we do is argue. I don't want to be in my room on my own so much. It's lonely. Dad takes my phone away sometimes. That's the worst. Then I literally have no one to talk to. That's when I feel like I can't cope anymore. I miss how me and Dad used to be. I miss how I used to be.

Parent and family support

The responsibility of raising a child embraces much more than simply nurturing them through the developmental stages to adulthood. It is about enabling them to love and be loved, to find meaning, to become all they could be. This can be a formidable task, especially if, perhaps as a result of our own childhoods and difficult experiences, we have struggled to achieve this for ourselves.

Many factors can also make family life difficult. For instance, a lot has been written about the impact of poverty on family life. One in four children are living in poverty today,[7] and we know that poverty is linked with domestic violence, substance misuse, mental health difficulties, child abuse and neglect.[8] In families living with poverty, it is not surprising that parents can struggle to provide good enough care.

But it's not only poor families who face problems. Privilege and affluence bring their own, unique issues for families, such as intense pressure on children to succeed and parental shame about asking for help. Shame cuts across all classes and incomes. Family structures, beliefs about childhood and parenting practices are far more fluid in Western societies today, but implicit cultural assumptions and prejudices are still prevalent, including notions of 'good' and 'bad' parenting.[9] This discourse is underpinned by past and present family policies in the UK that aim to address disadvantage and target limited resources on the neediest families.[10] Within this paradigm, parenting support is framed as corrective, aiming to protect children from poor parenting rather than supporting and enabling parents to navigate the phases and transitions of the parenting journey.

Given this toxic brew, perhaps we should be less perplexed about the deterioration of young people's mental health today.

I am, of course, being facetious when I offer 'crap life disorder' as an alternative diagnostic label to describe the aetiology of children's mental distress. But I am also very serious. Pathologising childhood and adolescence ignores the many factors that influence young people's mental health. Pathologising does not acknowledge the psychosocial influences. Diagnostic labels can foster a negative self-concept at the very time that a young person is forming their identity.

Helping children and young people recognise that their difficult behaviour or symptoms are an understandable, human response to difficult experiences may provide a useful platform on which they can build a more accurate picture of their strengths and their potential for change. Understanding the context for their difficulties and the impact of these factors on their mental health may also help families, schools, communities and society as a whole address the underlying causes of young people's mental health difficulties.

As therapists, we have valuable knowledge about distress, behaviour and the perils of mental health diagnosis, and our young clients benefit from it. We need to find ways to enlighten others who care for and work with children, so that our younger clients are better heard and understood. ■

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RESEARCH MATTERS

Engaging with research is like visiting a museum or art gallery. Some items fascinate; others leave you cold; those that help you see the world from a different perspective can be totally transformational, writes **John McLeod**

A warm welcome

Everyone knows that some therapy centres and clinics are warm and welcoming, while others have the ambience of a dentist's waiting room run by Basil Fawlty. But does this make a difference to the effectiveness of the therapy they provide? A recent study suggests that the client's experience of administrative hospitality does seem to have an impact:[1] clients' perceptions of their reception at the therapy centre was linked to better outcomes.

The design of this particular study did not make it possible to determine whether it is supportive relationships with admin staff that contribute to good therapy, or whether the client being on an improvement trajectory changes how they perceive the agency environment. Further research is needed to clarify these (and other) possible interpretations of the findings. What makes this article exceptional is the quality of the theoretical model, its intriguing case vignettes, and the way it invites consideration of an aspect of the therapy experience that is largely taken for granted.

Politics in the therapy room

Working with refugees and asylum seekers has to be one of the most demanding areas of therapeutic practice. Given current global events, this specialism is likely to become increasingly significant in the landscape of professional practice. An important way in which practitioners can support each other in their work with this client group is to share what they have learned. In a study carried out in Australia, therapists operating in this field were interviewed about the topics and issues that came up for them in supervision.[2]

Apart from the usual themes associated with the supervision process, what emerges powerfully from their accounts is the extent to which therapy with refugees and asylum seekers triggers a steep learning curve in two aspects of practice that tend not to be given much coverage in primary training: how to adapt mainstream therapy approaches to meet the needs of individuals from different cultures, and how to make sense of, and position the work within, current political and legal debates and procedures around the status and entitlements of these clients.

'Rather than offering hard and fast linguistic rules, what these studies do is help us monitor how we communicate with clients, and be more aware of how different ways of talking can open up or close down client options'

It's the way that you say it

Although language is one of the main tools of therapy, it is not at all easy to understand how it functions in therapy, because linguistic processes are highly complex and hard to pin down. A valuable strategy for studying how different ways of talking influence the process of therapy is to identify positive and negative shifts within sessions, and then look at whether these shifts are preceded by the therapist's use of particular linguistic skills or strategies.

In one such study, clients with good and poor outcomes were compared in terms of the language their therapist used that triggered the client to shift into a more reflective, meaning-making way of exploring their problem.[3] The study found that what seemed to be particularly helpful were observational statements – for example, where the therapist pointed out something that had struck them in the client's conduct or story. 'When you talk about your marriage, you look sad.' Much less helpful was silence, or use of questions.

In another study that adopted a similar approach, the researchers analysed the therapist statements that facilitated active client involvement in change.[4] In this case, what turned out to be most useful for clients were statements that were affirming, complex reflections (similar to the observational statements in the previous study), and open questions. Less helpful were a whole set of non-collaborative ways of talking (for example, closed questions, or giving advice without permission).

While these studies offer some clues to ways of using language that are helpful or otherwise, we need to approach their findings with caution. As is typical in this area of research, the two studies use different linguistic categories, making it difficult to compare their conclusions. Also, as in anything to do with language, it's all in the detail. Obviously, there are occasions when silence or a closed question can be exactly the right way to go, and where an observational statement can be inappropriate. Rather than offering hard and fast linguistic rules, what these studies do is help us monitor how we communicate with clients, and be more aware of how different ways of talking can open up or close down client options.

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.

Getting the full picture

A topic that has received considerable coverage in recent issues of *Therapy Today*, has been the way in which official bodies create clinical guidelines based on systematic reviews of research evidence. A review of the effectiveness of therapy with people from indigenous cultural groups (eg Native Americans, First Nations and Métis of Canada, Inuit people, Indigenous Pacific Islanders, and others) provides an example of a different way of approaching this task.[5]

The content of this review is extremely interesting, in terms of highlighting issues associated with therapy with people who have strong indigenous healing systems and who have usually suffered economic hardship and oppression. However, of equal significance is the model this article provides of how to achieve a balanced, comprehensive analysis of research knowledge within a specific area of therapy.

The authors of the review gave serious and careful consideration to all the evidence that was available to them: randomised trials, practice-based outcome studies, qualitative studies of both client and therapist experience, published studies, and also unpublished dissertations. The conclusions of the review offer contrasting perspectives on the material, make tentative suggestions for practice, and identify priority areas for further research.

Although the article includes some technical data, it is nevertheless presented in a way that is accessible for therapists, clients, and other community members.

Meaningful feedback

A major success story in recent years, in relation to using research to inform practice, has been the growing application in therapy of brief process and outcome measures as sources of feedback that enable therapists and clients to work more collaboratively. Most of the measures currently used, such as the CORE-OM, were originally developed as outcome measures, and only subsequently pressed into service as feedback tools.

A study carried out in Norway asked therapists and clients about the kinds of feedback that they would find most valuable.[6] What emerged was a list of topics that are not covered in existing tools: client-therapist trust; direct interpersonal communication; how the client is functioning in their everyday life; 'canary in the coal mine' (capturing early signs that things are getting worse for the client), and client ownership of the therapy process.

This is an important study because it is one of many projects currently being pursued worldwide that are trying to find out how to make feedback tools more user-friendly and relevant. Over the next two or three years, a second generation of feedback tools will be become available, based on these initiatives. ■

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

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THIS MONTH'S DILEMMA:

How can I leave my long-standing clients?

Elsa has been a counsellor in private practice in Sheffield for 15 years. She is conscientious in her support of vulnerable clients in their slow journey to a fully functioning life.

Elsa restores her equanimity by walking in the Lake District, where nature refreshes her soul. During her long walks, she often receives the insights that lead to her best client work.

Elsa applied for, and has just been offered, a counselling job in Cumbria. She would like to take the plunge and move north, but her new employer wants her to take up her post as soon possible – within a month at most.

A few months ago, a client who has been seeing Elsa about a bullying line manager uncovered memories of severe childhood sexual abuse. As a result, they are now working intensely together in twice-a-week therapy. In addition, the foster parents of a child she has been working with have suddenly and unexpectedly announced they are giving up fostering next month, on health grounds. Elsa is aware she will then be the only stable presence in this child's life.

WHAT CAN ELSA DO THAT WOULD BE BEST FOR HER AND HER CURRENT CLIENTS?

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.

Life goes on

Simone Lee UKCP, MBACP
Existential psychotherapist, relationship counsellor and supervisor in private practice

Elsa is wise to nurture her self-care through communing with nature and any other means that is restorative, especially as she works with a vulnerable client group and is notably conscientious. If, as I suspect, Elsa's care for her clients errs towards taking too much responsibility, then she needs to keep reminding herself to take a step back and challenge this tendency.

Can Elsa tolerate the fact that dilemmas do not always resolve into what might appear to be the 'best' outcome for everyone? Probably not. She needs to accept this reality and embody this belief in her practice - including now, if she wishes to help her clients in their problems with living. If she chooses to take the job and her prospective employer does not have the flexibility to change the start date, all is not lost. She has four weeks to offer a supportive, engaged and grounded ending with her current clients and, during this period, as part of her duty of care, she can arrange to refer them on, so they continue to get the support they need.

These final sessions should be seen as an integral part of the therapeutic relationship. They will give Elsa and her clients an opportunity to explore their shared disappointment about the foreshortened work, focus on the work they have been able to do and the conversations they have shared, and name the outstanding issues that lend themselves to future therapeutic exploration and support, while preparing for the next phase. They offer a rich opportunity to confront the existential givens of uncertainty and endings, which Elsa's departure have brought into acute focus.

Model courage, Elsa, and don't let unhelpful narratives colour these last sessions with your clients. Remember, it is the quality, not the quantity, of therapy time that really counts. Life rolls on. Good luck in your new adventure, and enjoy the daffodils.

> 'Model courage, Elsa, and don't let unhelpful narratives colour these last sessions... Remember, it is the quality, not the quantity, of therapy time that really counts'

Colliding needs

Peter Leitch BACP (Snr Accred)
Psychotherapist and clinical supervisor

Given that Elsa has only now realised that she is working with a client who has experienced child sexual abuse, and in response has increased their sessions to two per week, is there a danger that a possible ending with them could be rushed?

Elsa's walks suggest she is a thoughtful and patient therapist. She supports vulnerable clients in their slow journeys to a fully functioning life, and is therefore committed and engaged. With two current clients whose situations have radically changed, she is understandably torn between Cumbria and what is best for her clients. The child client is about to lose their foster parents. Another client has uncovered memories of severe child sexual abuse and is, in part, yet another hurting child. I wonder what Elsa's own childhood was like, and note too that her older client has a bullying line manager, while Elsa has a prospective employer putting her under pressure for a decision. Supervision could be very helpful here.

Referring these clients on is risky and may be injurious. But what of Elsa's needs and plans? Might she contact her prospective employer

in Cumbria, inform them that her work commitments do not permit such an early move, and ask for an extension? If granted, she could use this time to the best advantage of her clients - preparing, if necessary, for the best possible onward referral. While awaiting a response, she might reflect on her present freedoms and the risk that she may lose them if she moves to an employer who has already given her some indication of the culture and expectations in the new post.

Our work involves us in the lives of others. When needs collide, perhaps it is our duty sometimes to forgo our own, at least for a while. There is indeed a plunge ahead - only Elsa can decide whether to jump.

Smooth transitions

Lesley Ludlow MBACP (Snr Accred)
Counsellor and supervisor based in Croydon

While Elsa's primary duty of care will be to her clients, the move to Cumbria is clearly important for her personal wellbeing. The short notice period isn't ideal; ideally, Elsa would need at least a month to allow time for the transition to Cumbria.

Client A is an adult but the sexual abuse issues suggest that they are likely to struggle with trust and forming relationships. It seems a big step that the client has agreed to see Elsa twice a week, and she needs to be sensitive to the possibility that they are likely to feel let down if she leaves now. There is a risk also that the client might view Elsa as another abuser, which could cause them to withdraw. Elsa will need to reinforce the difference between their therapeutic relationship and the client's relationship with their childhood abusers. Could she consider continuing their sessions online, if the client is willing to try it? Could she talk to the client about a referral to a trusted therapist?

> 'If she stays, and loses the chance to move north, how will she then feel about her clients? She may, at an unconscious level, blame them... which may lead to a therapeutic rupture'

Client B is a child and the presenting issues here are ones of rejection and abandonment. This client faces losing both caregivers in a month's time, which will create instability. Elsa will need to find a trusted therapist who can take over before she leaves, to ease the client's fear of being left alone completely. It might help if the new therapist could sit with Elsa and the client in one of the final sessions to create a smooth transition.

Inevitable endings

Heather Dale MBACP (Snr Accred)

I'm curious that Elsa is so concerned about only two of her clients. We are not told how extensive her practice is, but it sounds as if she may be over-invested in these two. If so, she needs to consider her own issues and why these clients are so important to her. It is possible that the intense work she is doing with them has hooked a need in her, and she may be in danger of building an unhealthy dependency with them.

Elsa can explore options other than either accepting or declining the new post. For example, she could negotiate a longer notice period with her new employer, or ask to work part-time for the first month so she can return to Sheffield for a day a week to see out her existing clients. She could offer telephone or online counselling for a couple of months, if this is feasible.

If she cannot find a way of working with her clients beyond the month, and if her new employer refuses to be flexible, then Elsa must consider her own needs. If she stays, and loses the chance to move north, how will she then feel about her clients? She may, at an unconscious level, blame them for her staying in Sheffield, which may lead to a therapeutic rupture. In any case, if she decides to leave Sheffield, she should signpost all her clients to other local services, such as their GP, or to alternative therapists through an online advertising service such as BACP's Find a Therapist.

In particular, Elsa needs to remember that endings are an inevitable part of life. Sometimes they cannot be given all the time we would like, but they can still be well managed. ■

June's dilemma:

Fusun, a counsellor in her mid-60s, is employed by an independent counselling service where she averages 24 hours of client contact time per week. In her final slot on a Friday evening, she is seeing Victor, an unconfident and lonely man seeking help to overcome difficulties in forming intimate relationships.

Fusun experiences Victor as cut off from his emotions and she struggles to keep focused through what she experiences as Victor's monotonous, aimless narratives. After some weeks, Victor apologies to Fusun for boring her and causing her to fall asleep at what he knows is her last session at the end of a long week. Fusun says her sleepiness might be a response to his dissociating, perhaps as a result of repressed, early trauma. This doesn't resonate with Victor, who recalls a predominantly happy childhood.

In supervision, Fusun wonders whether she might not be the right match for Victor, but the service is overloaded and her manager says it is not possible to refer him to anyone else in the team.

WHAT ARE FUSUN'S OPTIONS GOING FORWARD?

Please email your responses (300 words maximum) to John Daniel at dilemmas@thinkpublishing.co.uk by 30 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.

Time, please!

Following on from last month's topic – starting sessions – how do you close sessions?

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

Steve Delaney
Psychoanalytic psychotherapist and group analyst in private practice

Analytically, separation is a very important developmental experience, so I am always interested in how clients end sessions, because it gives me a glimpse of how they have experienced other endings and separations in their lives. Usually, I don't alert the client that we are coming to the end of the session, unless they have been very upset, when I'll give them a little bit of a warning so they can gather themselves before they leave. When I'm doing the initial assessment, I will note if there has been some loss or sudden trauma in the client's life, as the ending of a session may bring up these difficult feelings. Otherwise, I leave it alone. How clients deal with the end of sessions tells me a lot about how they deal with endings generally. Some talk right up to the end – they are giving me the responsibility for ending the session. Some bring things up right at the end, and I'll wonder if they are unconsciously testing the boundaries. Some people keep a close eye on the clock, and they'll try to find a way of ending the session that means they are in control.

Jennie Cummings-Knight
Psychotherapist and counsellor in private practice, and lecturer and writer

I arrange my clients so that I have 30 minutes between them – I like to have time to write my notes and get the previous client out of my head, and it also allows me to overrun by 15 minutes if the client is very upset and needs a few more minutes to get themselves back together again. You can't just throw them out in the street. It also preserves that illusion of 'specialness' – it ensures they don't meet the next client on the doorstep, and you don't need to tell them, 'I have another client waiting.' That notion of being the only one at that moment in time can be rudely shattered by an abrupt ending.
Some clients do get upset near the end – those door-handle revelations can be a way of subconsciously lengthening the session; they're aware they've got a whole week to wait until they next see you. I have a clock we can both see, and a watch I covertly look at. Sometimes my internal clock works very well, and sometimes it doesn't – it depends on how engaged I am with the client's material, and the depth we are working at. When clients find it hard to talk, an hour can seem a long time.

Gareth Vaughan
Specialist oncology counsellor, working in the NHS

I'll check the clock around 15 to 20 minutes before the end, and I'll tell the client when we have about 10 minutes left. Obviously, I won't do that if it doesn't feel right to bring it up then; if they are in the middle of something, I'll wait another five minutes. If a client is very upset about something, I'll suggest we pick it up first thing at the next session, and I'll encourage them to think about it over the coming week and see if things change, or they feel less distressed by it. I want them to know I'm not shutting them down. Most of my clients seem to be very conscious of the time: they'll ask me how much time we have left; some will even tell me, 'We have 10 minutes.' I think it's partly that people have so much to say that they don't want to start something and be cut off. I also think, with cancer, people want to be in control of the things they can control.

SHUTTERSTOCK

Clare Jerome
Student in the final year of an integrative counselling diploma

My main college tutor is psychodynamic-existential, so he's very strict on boundaries and what it signifies if a session finishes early or late, and he encourages us to explore this. The service where I'm doing my placement uses a person-centred approach with women offenders, whose lives tend to be very disorganised. My supervisor always stresses the importance of grounding the client before ending the session. I found that out with my first few clients, as the sessions can be very heavy, and sometimes they can become quite upset. My supervisor suggested I allow at least 10 minutes before the end to wind them down and make sure they are ready to leave, as it's better to go over if it helps them leave safely. I usually warn the client when we have 10 minutes left, and ask them how they are feeling and whether they feel ready to leave, and we'll do some grounding techniques together, if needs be. I'm very aware of the time, and I have my own clock, as well as the main one in the room. I'll tell clients, 'If you do see me looking at the clock, it's not that you're boring me; it's because I am responsible for timekeeping and don't want you to worry about it.'

Suzie Chick
Integrative transpersonal psychotherapist, working in private practice

Some clients are fine with just a few minutes' warning. Some struggle to self-regulate and, just when we're coming to the end, they will open up something that is really quite heavy. I'll say, 'I'm sorry, we are running out of time,' and I'll add time reminders in the next session – say, every five minutes for the last 15 minutes – to help the client regulate themselves. But I'll add them on to something else I am saying, so it doesn't look like I'm clock-watching. How they manage endings is really useful material – you can learn a lot about what is going on in their lives, what their boundaries are like in other relationships and how they regulate their emotions outside the therapy room. If a client is very emotional at the end, I will always give them a few extra minutes to gather themselves. I'll suggest we take some breaths together. With most clients, it only takes them a minute to ground themselves. Some clients have little techniques for stretching the time boundary – they'll take ages to get their money out of their wallet, for example. If necessary, I'll get to my feet – that is quite a strong move.

Effie Lunn
Young people's counsellor and adult psychotherapist

I use CBT in my work with young people, so the sessions are very structured. We set an agenda at the start of the session. We may not stick to the agenda; if the young person has something huge that has happened in the week and they want to talk about it, then what we've agreed can go out the window, but it's there to remind us what we want to talk about and where we are going with the counselling. I find it very useful – I use it in my psychotherapy work with adults too. With the young people, I always start the sessions with a check-in, and I allow about five minutes at the end to check out, and that's when we'll talk more relationally about how things are, what they are going to take away with them from the session, what has worked and what hasn't. That's an important part of the session, and I'll often carry stuff forward from it, to go on the agenda for next time.

HOW DO YOU TAKE CARE OF YOURSELF?

Pilates helps **Dawn Humberstone** tune in to what her body is telling her and gives her brain a break

German physical trainer Joseph Pilates developed Pilates while he was interned in Britain during World War 1. He was determined that his own and his fellow internees' general health would not suffer, which led him to develop a regime that was about 'the complete coordination of body, mind and spirit'.

Thankfully, I wasn't facing imprisonment when I found Pilates, but it was a time when I was struggling both physically and mentally. Pilates provided a place of sanctuary throughout my counselling training and into my early days of practice, and continues to be an integral part of my self-care today.

The concentration required to perfect the technique, while also (importantly) remembering to breathe, forces the mind to eradicate all other thoughts. It's no wonder Pilates has earned the tag 'mindfulness in motion'. For me, taking this time to focus totally on my body gives my busy mind a reprieve. Being more aware of my posture, bodily tensions and imbalances means I am better able to self-monitor and recognise when I'm pushing myself too hard and need to take stock.

A stronger core and better posture have helped me physically during the hours I spend sitting with clients. A few roll downs and stretches in the breaks between clients also provide the perfect antidote to tension and help clear the mind in preparation for the next session. (I'm just glad no one can see into my counselling room during these physical antics.)

I have private, one-to-one Pilates sessions, where I can focus on my individual needs, and I also attend classes - being with a group makes a welcome change from the solitary work of counselling.

I've been working with my Pilates instructor for over 13 years now, so another benefit is that I've gained a friend who is tuned in to my physical and mental state and can offer just the right kind of session I need that day. Whatever type of workout I have, I leave feeling stronger, both mentally and physically. ■

'A few roll downs and stretches in the breaks between clients also provide the perfect antidote to tension'

About Dawn

Dawn Humberstone is a psychodynamic counsellor working at Affordable Counselling Epping Forest, in Epping, and Counsel for Life, in Woodford. To find a Pilates instructor near you, visit **www.bodycontrolpilates.com**

From the Chair

This month I'm enjoying a change of topic from government policy-making and the challenges we continually seem to face. I have good news – Making Connections events are back!

As we have grown over the years, the links between BACP Head Office and members in the world beyond Lutterworth have become increasingly stretched. Making Connections, for those who have only recently joined BACP, are regular events that we used to hold all around the country, where members could meet their elected and executive officers, we could meet them, they could meet each other, and we could all discuss issues of current, internal, external, national and local importance. The events are free to BACP members, and include speakers, but also ample opportunity to network. They have always included what we call the 'two-minute platform', where members can, in two minutes precisely, showcase to their peers a project or piece of work they are doing.

For me, they have always been a really good forum for meeting the full diversity of our membership, and I can safely say the same goes for the rest of the BACP Board of Trustees. Much of the point of Making Connections is that we, the BACP officers and staff, come to you, to tell you about developments within BACP and what the Association is doing on your behalf, and also to listen, to discuss your interests and concerns, and to feed these back into the Association.

DAVID HARRISON

The last time we held one of these very popular events was back in March 2016, and I'm delighted to announce that a new programme has been scheduled for 2018/19, starting in May, in Nottingham, and thereafter every two months, in venues across all four nations.

With our new programme, we won't just be making connections on the day - we aim to keep members connected by filming the events, so members can watch them online afterwards, if they can't make the live event.

So, great news for enabling better communications and links between us all, and I look forward to meeting you soon, sometime, somewhere in the UK. Check the website and *Therapy Today* for details.

email
andrew.reeves@bacp.co.uk

Twitter
@Reeves_Therapy
@BACP

BACP round-up

Our monthly digest of BACP news, updates and events

Professional Development Days

Our Professional Development Days combine clearly defined learning outcomes with interactive content, helping you to develop your skills in a variety of areas.

Taking place all over the UK, each session is delivered by an expert tutor to groups of around 25 people. The 2018–2019 programme is now open. Event topics include working safely and therapeutically with domestic abuse, how to integrate artwork into your counselling practice, and working with under-prepared clients.

To find out more and book, visit our website or email **events@bacp.co.uk**

Working with critical incidents

As a counselling professional, how prepared are you for the crucial role that you could play in responding to critical incidents? Join us in Edinburgh on 17 April to explore how counsellors and psychotherapists can contribute before, during and after serious incidents.

At this event you'll develop your knowledge and skills so that you can help those around you, and also self-care skills. For more information and details of how to book, visit our website.

Winner of 2017 CPCAB award

The CPCAB Counselling Research Award aims to make research accessible to all counselling trainees and practitioners.

The 2017 award was won by Tracey Fuller, an education teaching fellow and doctoral researcher at the University of Sussex. Tracey's research is called 'The trust is the work: exploring how school counsellors maintain alliances with young people when sharing information because of safeguarding concerns – a phronetic case study'.

The research explores information-sharing and safeguarding concerns for school counsellors and was conducted in several school projects run by the charity Place2Be. Tracey said: 'It came out of my experience of working as a school counsellor and how stressful those situations can be when you're trying to keep an alliance going with a young person when you may be having to share information in order to keep them safe.'

The 2018 award winner will be announced at our Research Conference in May.

Visit the CPCAB website to watch a video of Tracey discussing her research.

www.cpcab.co.uk/researchaward

Media spokespeople

We love to see BACP members give the benefit of their experience and knowledge in the news and we're regularly contacted by the media to provide an expert opinion.

Our bank of media spokespeople includes a variety of specialisms, but there's always room for more. Contact us at media@bacp.co.uk if you're interested in becoming part of our group of media volunteers. We'll talk to you to find out your areas of interest and what level of media you'd be comfortable dealing with.

If you blog, or are featured in the news, we'd love to hear about it. We use a media monitoring service, so we know when BACP and our members are in the news. However, if the piece doesn't mention that you are a BACP member, it's unlikely to get picked up.

So, if you've been in the media, or are about to be featured, get in touch with us at **media@bacp.co.uk**

SHUTTERSTOCK

Helping to combat loneliness

We've joined the ***Campaign to End Loneliness***, a network of people and organisations working to raise awareness of the dangers of loneliness through community action, good practice, research and policy.

Loneliness affects people of all ages but is particularly common in older people and is often related to retirement, poor health, loss of independence, and bereavement.

The UK Government has recently added loneliness to the ministerial brief of Tracey Crouch, Minister for Sport and Civil Society, and the Scottish Government has published a draft consultation about the causes of social isolation and loneliness.

Both of these actions follow the publication in December last year of the report of the Jo Cox Commission on Loneliness, 'Combatting loneliness one conversation at a time: a call for action'. The Commission found that nearly half of all people aged over 75 in the UK live alone, and six per cent of older people leave their homes less than once a week. The report also highlights that loneliness can trigger mental illness, and vice versa.

We support the Jo Cox Commission on Loneliness and its calls to action, and we'll continue to promote increased access to counselling and psychotherapy for older people. We'll keep you updated on our website, in future BACP round-up pages, and in the monthly e-bulletin.

Improving our membership services

We've brought together a number of our different procedures into a handful of simple policies that we hope will give you a clearer understanding of some of our processes.

The new policies are available on our website and relate to areas such as refunds, membership categories, complaints, and how we use the information we hold about you.

We'll be asking you to read and agree to these policies when you renew your membership online, and to check them regularly so that you're familiar with the content and any changes.

Book now for the research conference

'Counselling changes lives: research that impacts practice' is the title of our research conference, which takes place in London on 11 and 12 May 2018.

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

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

Online Certificate of Proficiency assessment

From April 2018, the Certificate of Proficiency (CoP) assessment can be taken from your home or workplace.

We're making the move to online invigilation in response to your feedback. This change will take away the cost of attending an assessment centre and means you won't have to travel to complete the test.

We'll put guidance about online invigilation and the assessment dates on the website in the next few weeks.

There will still be a small number of assessments around the country, and we'll work with you as we develop this new way of taking the CoP. For more information, visit our website or call us on 01455 883300.

BACP round-up

Reforming regulation

We've issued a joint statement with the British Psychoanalytic Council (BPC) and the United Kingdom Council for Psychotherapy (UKCP) welcoming the Department of Health consultation on 'Promoting Professionalism, Reforming Regulation', which closed on 23 January 2018. The consultation was an important opportunity to comment on the future of the regulatory environment and the fundamental issue of public protection. Currently, BPC, UKCP and BACP have registers accredited by the Professional Standards Authority, and have in place robust professional conduct procedures. You can read the full joint statement, and our response, on our website.

Sage books special offer

BACP members can now get a 30% discount off counselling and psychotherapy books, through an exclusive offer from Sage Publishing.

The offer is open now, and is available to our members until 31 May 2018. Visit the Sage Publishing website at **uk.sagepub.com** to see the full range of counselling and psychotherapy books included in the offer. To get your discount, just type in the code UKBACP18 at checkout.

Working with children

You can now access the webcast of the Children and Young People Conference 2018 'Working with Children in their World', which took place in London on 24 February.

You'll discover the challenges facing counsellors and psychotherapists when working with children and young people on the ASD spectrum, and gain an insight into the impact of trauma and broken attachments on childhood development. You'll also explore how to connect with children and young people within their environments, leading to better outcomes.

The webcast is available for a limited time only. Visit our website or call us on 01455 883300 for more information.

State of Child Health

One year after it published its *State of Child Health* report, the Royal College of Paediatrics and Child Health (RCPCH) has produced scorecards that chart progress on its recommendations. The scorecards are available for England, Scotland and Wales.

The findings show that the Scottish and Welsh Governments are taking greater steps to introduce policies to improve child health, including Scotland's new mental health strategy.

The report also recognises the Prime Minister's announcement that every secondary school in the UK will have funding for mental health first-aid training and notes the launch of the Green Paper on children and young people's mental health, which sets out plans to transform mental health support in schools and colleges in England.

Dr Andrew Reeves, Chair of the Association, says: 'This is an important report card on the Government's progress around children and young people's mental health and, significantly, comes as we are considering the proposals in the Government's Green Paper. We are concerned that key proposals within the Green Paper might negatively impact the existing counselling workforce who deliver services in schools and colleges and, importantly, fail to deliver the services that will most benefit our children and young people.'

Postgraduate research funding

This year, we're offering two bursaries for students wanting to undertake PhD research into topics relating to the evidence base for humanistic therapies or counselling for older adults. To apply, you should be educated to master's level in a relevant discipline, or have equivalent research experience, and a good record of educational achievement that shows you have what it takes to study for a PhD.

You'll need to demonstrate how your proposed project meets the relevant objectives and send evidence that you have a doctoral supervisor in place.

The bursaries are for PhD study starting in October 2018 at any UK university. For pre-submission enquiries, contact amy.clarke@bacp.co.uk. For more information about the scheme, visit our website.

SHUTTERSTOCK

Transforming children's mental health

We'd like to thank everyone who supported our campaign calling on the Government to look again at the proposals in the Green Paper on transforming children and young people's mental health provision.

The paper, which applies to schools and colleges in England, put forward three proposals: the introduction of designated senior leads for mental health in schools and colleges, the creation of mental health support teams, and a four-week waiting-time target for accessing children and young people's NHS mental health services. We feel that this was a missed opportunity and called on the Government to include provision of school-based counselling across all schools and colleges.

Thank you for writing to your MP, getting involved on social media and sharing your views on our blog series. We really appreciate your encouragement and support. We'll give an update on our response, and the Government's next steps, on our website and in next month's BACP round-up.

Children and young people in Northern Ireland

Last year, we met with the policy team of the Northern Ireland Commissioner for Children and Young People (NICCY), to help shape their review of children and young people's mental health services. The review was launched by the Commissioner, Koulla Yiasouma, and aims to highlight good practice and identify the barriers faced by children and young people needing mental health support.

The interim findings show that 8,285 children and young people were referred to specialist mental health services for an assessment in Northern Ireland last year – 58% were accepted, and 42% were not accepted. The percentage of rejections has increased by nine per cent in the last two years.

We believe that growing demand needs to be matched by growing investment. However, the NICCY analysis shows that, for every pound spent on mental health in Northern Ireland, less than 8p goes to children and young people's services. We'll continue to work with NICCY to make sure this is addressed.

EVENTS CALENDAR

10 March
Professional development day
Bridging the gap – working with unprepared clients
Birmingham

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

16 April
Professional development day
Integrating artwork into your counselling practice
Bristol

17 April
Working with critical incidents:
Prepared not scared – are you ready to respond?
Edinburgh

27 April
Professional development day
Suicide and Suicidal Ideation
Belfast

30 April
Professional development day
Societal rape: myths and traumatic reactions
Newcastle

11 May
Professional development day
How to help clients with their anger – a therapist toolkit
Glasgow

11–12 May
Research conference
Counselling changes lives: research that impacts practice
London

21 May
Professional development day
Working safely and therapeutically with domestic abuse
Liverpool

NEW DATA PROTECTION REGULATIONS

The General Data Protection Regulations will change how we can store and use client data. Susan Dale explains

The European Union's General Data Protection Regulations (GDPR) come into force on 25 May 2018. They apply to all European states, including the UK. The Data Protection Bill is currently going through Parliament to implement the regulations in law here. Although not all the guidance has been issued yet, the Information Commissioner's Office has released some information.

The GDPR will affect how counsellors, psychotherapists and counselling and psychotherapy services (the 'data controllers') store and use sensitive personal data on their clients (the 'data subjects'), and the client's rights to access and request erasure of their data, including when it is held by another person or organisation, such as an IT company (the 'data processor').

This includes information about a client's:

- racial or ethnic origin
- political opinion
- religious belief or belief of a similar nature
- trade union membership
- physical or mental health condition
- sex life
- criminality, alleged or proven
- criminal proceedings, their disposal and sentencing
- genetic data, and
- biometric data, where it uniquely identifies an individual.

Personal data relating to criminal convictions and offences are not included, but similar, additional safeguards apply to their processing, as set out in the Data Protection Bill.

Rights of the client

The recording and use of sensitive personal data already require the client's explicit consent, and will continue to do so. The client has to actively state that they are agreeing to a record being kept and used, and that they have been informed of the purpose(s) for which the record is being made, how it will be used, and any limitations on confidentiality.

A simple 'tick-box' approach is not sufficient. This is the case whether you are keeping computerised records or you store manual records in some form of organised filing system.

Under GDPR, clients will have:

The right to erasure – this is not an absolute 'right to be forgotten', but clients can ask for their personal data to be erased and to prevent processing:

- where the personal data are no longer necessary for the purpose for which they were originally collected/processed
- when the individual withdraws consent
- when the individual objects to the processing and there is no overriding legitimate interest for continuing the processing
- if the personal data are unlawfully processed (ie in breach of the GDPR)
- where the personal data have to be erased to comply with a legal obligation
- where the personal data are processed in relation to the offer of online services to a child.

The counsellor/therapist can refuse to comply with a request for erasure where the personal data are held:

- to exercise the right of freedom of expression and information
- to comply with a legal obligation or in the public interest, or the exercise of official authority
- for public health purposes in the public interest
- for archiving purposes in the public interest, scientific research, historical research or statistical purposes, or
- in the exercise or defence of legal claims.

There are extra requirements when the request for erasure relates to children's personal data. This is because a child may not have been fully aware of the risks involved in the processing at the time of consent.

The right to data portability – clients can request and reuse their personal data for their own purposes across different services. If a therapist receives a request to transfer a client's personal data, they must provide it in a structured, commonly used and machine-readable form, and the information must be provided free of charge.

The right of access – clients will have the right to request to see the information that is being held on them, whether these are electronic or manually stored records. The request should be made in writing, and the data should be given to them within one month and free of charge.

If a client believes there is an inaccuracy in their record, they can ask for it to be corrected, with the agreement of the therapist. If there is disagreement about what would be a correct record, the therapist should include a record of the client's objections in their notes. ■

Susan Dale is BACP Good Practice Manager

For full details about these changes and the legal safeguards around data processing, BACP members should download *Good Practice in Action Legal Resource 097: Update on Data Protection Legislation* from the BACP website.

Guidance on the new GDPR is still being issued and updated by the ICO. Members should check the ICO website regularly for updates at ico.org.uk/for-organisations/data-protection-reform

Analyse me

Marie Adams speaks for herself

Why did you become a therapist/counsellor? The catalyst was working with journalists returning home from conflict zones, frequently troubled by what they'd witnessed. The deeper reason, though, is the profound connection often established within the therapeutic relationship.

Where do you work?
My clinical practice is in Lyme Regis and in Exeter. I also teach in London, at the Metanoia Institute and the Institute for Arts Therapy in Education.

How do you work?
Integrative, with a focus on attachment theory and the relational. My training began with person-centred counselling and continued through to psychoanalytic psychotherapy.

What's your special interest?
I'm not sure I have a special interest, although trauma is often embedded in my clients' narratives.

What do you do for self-care?
I run and I walk and I listen to music. I am also a voracious reader - novels and biographies, mainly. When I'm particularly stressed, I read Scandinavian thrillers.

Why do you think therapy works?
People long for connection, for someone to truly hear them and see who they are, behind their troubled actions. The recognition of their distress and the fact, often never before experienced, that they are taken seriously, can be enormously transformational.

What advice would you give to someone entering the profession today?
To make use of your own therapy, to take yourself seriously, to face your own demons and understand that you are as human, and often as troubled, as those whom you seek to help.

Why supervision?
A good supervisor is a necessity and a gift. Who else can enable us to think through the complexity of our clients' stories and our responses to them?

What is the meaning of life?
Heavens! If only I knew.

What do you think happens when we die?
Not a lot. I'm afraid I see death as final, so my obligation is to consider how I spend life here on earth, with personal meaning and purpose.

Where is your happy place?
I have a small cottage on a quiet lake in Canada. I go there for an extended break in the summer, to write.

What gives your life meaning?
Working, writing, spending time with my husband and his family and, increasingly, engaging with my extended family and friends in Canada.

What is your favourite piece of music, and why?
Emmylou Harris singing 'Boulder to Birmingham'. She is one of my heroes, always authentic and I take great comfort in her music.

What's the most recent book on therapy/counselling you've read (and can recommend)?
I am currently rereading Winnicott, though I'm also a fan of learning from novels and memoirs: *Plot 29*, by Allan Jenkins, and Olivia Laing's *The Lonely City* are two. *Grief Works* by Julia Samuel is a must for anyone working with bereavement.

When will you retire?
I am still active and energetic, although every therapist needs to consider when their life as a clinician must end. In his 90s, my father wrote a book on ethics - I can only aspire! ■

About Marie

Now: Writer and psychotherapist working in private practice, and trainer. My books include *Myth of the Untroubled Therapist* (Routledge, 2014) and *Telling Time* (Karnac, 2015).

Once was: Journalist and news producer at the BBC, working primarily on Radio 4's Today programme.

First paid job: In the book department of a large department store in Canada, having left school at 16. I was promoted to 'housewares', but, after a few months, gratefully returned to the book section.

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