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THE WOUNDED HEALER: REFLECTIONS ON A PERSONAL JOURNEY

11

PLUS

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FROM THE EDITOR

Jung's concept of the 'wounded healer' is one to which many of us can relate. It is often through our own experience of pain and suffering that we come to a place of being able to offer empathy and understanding to our clients. Through our work on ourselves, we gain an insight into what it might be like for our clients to sit across from us and explore their psychological wounds. With this in mind, Kay Mackay reflects on how her lived experience of mental health difficulties impacts upon her work as a psychotherapeutic counsellor. She explores how personal experiences of mental health difficulties can help increase empathy through a shared understanding of psychological pain. It is clear that Kay's own experiences allow her to meet her clients on a deeply human level.

'It is often through our own experience of pain and suffering that we come to a place of being able to offer empathy and understanding to our clients'

This is a very personal, reflective piece that can encourage us all to think about how we can use reflexivity to enhance our practice with our clients. As Kay writes, '...it is through telling our personal stories that we draw meaning from suffering, process our experiences, share our vulnerabilities and connect with others.' After all, this is what we ask our clients to do on a daily basis.

The importance of healing psychological wounds cannot be underestimated. Sometimes the consequences of untreated severe mental health difficulties can be tragic, resulting in harm to others and even death. In an insightful article, Estelle Moore describes the provision of psychological support to patients in Broadmoor Hospital. Broadmoor is a high security hospital, with around 200 male patients who have complex mental health needs. Most of them have been involved in violent offending, and have been referred to the hospital rather than a prison because it is more suited to their needs. The hospital provides trauma-informed support to the patients, exploring how their pasts have influenced and shaped their present. The role of the hospital is to help the patients to pick up the pieces after tragedy has occurred and reduce the risk of future harm. This important work provides an opportunity for healing for the individual and increased safety for the wider community.

CONTENTS

No matter the quality of mental healthcare support we provide, there will still be those clients who feel so great a despair about their futures that they believe there is no way out other than to take their own lives. This can be a painful experience for any of us working as counsellors and psychotherapists, whatever our modality. In an innovative and thought-provoking article, Amanda McGarry explores the issue of suicide from a person-centred perspective. She studied a number of suicide notes in order to ascertain whether, in some cases, suicide could be considered as an expression of the actualising tendency – an individual's innate drive to do their best and to grow. Amanda explores how this might prove a conundrum for the person-centred therapist, and particularly for those who work in organisations that have risk prevention policies that try to prevent suicide.

In the July issue of this journal, we included an interview with new BACP Healthcare Executive member, Angela Clarke. This time, it is the turn of her colleague, Gareth Bartlett, to introduce himself to members. Both these new Healthcare Executive members bring fresh skills and experience into the Executive, which will benefit members and help progress the work of the division.

It is a time for both new beginnings and endings in the BACP Healthcare division. Sadly, this is my final issue as Editor of the BACP Healthcare journal, as I am going to be focusing on further developing my private practice. I have learnt so much from my time in this role, and my respect and admiration for colleagues working in the healthcare setting has grown even greater, as I have understood more about the challenges that you face and the pressures of your working environment. I shall take much of what I have learnt into my private practice and hope that I can be a more reflexive practitioner as a result. I would like to thank you all for your support over the past few years, especially those of you who have contributed articles and columns to the publication. It is now time for someone new to take this journal forward and assist members in exchanging ideas and disseminating best practice. I would like to invite you to encourage them in this endeavour by continuing to send in articles about your work and providing suggestions for developing the journal so that it fully reflects your interests.

***Joanna Benfield**, Editor*
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FEATURES

REGULARS

NEWS & RESEARCH

NHS mental health job coaches

NHS England has rolled out its Individual Placement and Support (IPS) scheme to 28 new areas. Under the scheme, employment specialists offer coaching and advice about getting into work to individuals facing mental health difficulties. They also offer practical advice on finding a job and preparing for interviews, as well as actively searching for jobs and liaising with employers and medical professionals on the patient's behalf. Patients with mental health difficulties who want to get back to work can be referred into the scheme by GPs and mental health professionals; individuals can also self-refer. The scheme is now available in eight out of 10 areas of England. By 2020/21, 20,000 people per year are expected to be able to access the scheme, increasing to 55,000 people by 2023/24.

Source: NHS England

REFERENCE: NHS England. Thousands more set to get help as NHS rolls out mental health job coaches. [Online.] NHS England; 2019. https://www.england.nhs.uk/2019/04/thousands-more-set-to-get-help-as-nhs-rolls-out-mental-health-job-coaches/ (accessed 25 August 2019).

Improving the mental health of young people in Scotland

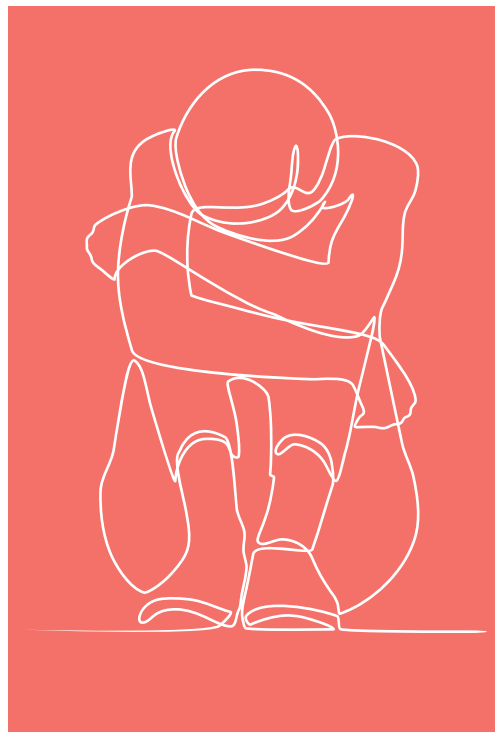
The Scottish Government and the Scottish local government association, COSLA, have published a series of recommendations from the Children and Young People's Mental Health Taskforce, which set out a blueprint for improving the mental health of young people in Scotland. The taskforce was established in order to develop a 'whole system' approach to the mental health of young people in Scotland, which will allow them to access support that is local, responsive and evidence based.

The report recommends that the Scottish Government and COSLA form a strategic partnership with organisations from a range of sectors, including the third sector, to improve young people's mental health. It also suggests that one-stop, integrated mental health services are provided in community settings, and emphasises the importance of involving young people and their carers in decision-making and the development of care plans. The report recommends that the Scottish Government and COSLA jointly commission 'pathfinders' in different parts of Scotland, who would explore how young people's mental health services can be improved. Each pathfinder would be provided with support and funding to focus on two or three key issues.

The recommendations of the taskforce will now be progressed by a new Children and Young People's Mental Health and Wellbeing Programme Board, which will complete its work by the end of 2020. The Programme Board will oversee reforms in the areas of children's services, education, health and community services.

Source: BACP

REFERENCE: COSLA. COSLA and Scottish Government set out blueprint for improving the mental health of children and young people. [Online.] COSLA; 2019. https://www.cosla.gov.uk/news/2019/07/cosla-and-scottish-government-sets-out-blueprint-improving-mental-health-children-and-y (accessed 5 July 2019).



Mental health and suicide prevention in Scotland

NHS Scotland has joined forces with NHS Education for Scotland to develop a set of mental health and suicide prevention learning resources. These resources provide practical advice to NHS and local authority staff, among others, on how to provide support to individuals who are experiencing mental distress or feeling suicidal. The resources consist of three animations that aim to raise awareness of issues that may lead people to consider suicide, and aim to increase healthcare staff's confidence in responding compassionately and effectively. The resources are available online through the link below.

Source: NHS Health Scotland

REFERENCE: NHS Scotland. New mental health and suicide prevention resources launched. [Online.] NHS Scotland; 2019. http://www.healthscotland.scot/news/2019/may/new-mental-health-and-suicide-prevention-resources-launched (accessed 2 July 2019).

Review of mental health policies in Northern Ireland

The last mental health strategy in Northern Ireland covered the period up to 2008, and to date has not been replaced. Ulster University has recently published a report summarising what has been done in terms of mental health provision in the intervening period, reviewing initiatives and assessing how well they have been implemented.

The publication – titled *'A review of mental health services in Northern Ireland: making parity a reality'* – highlights the fact that Northern Ireland is the only UK region that does not have a mental health strategy. As a result, the report's authors claim, the delivery of mental health services in the region is fragmented and does not have adequate resources. The review shows that waiting times for mental health services in Northern Ireland are 24 times greater than in England and Wales combined. In March 2019, around 120,000 people in Northern Ireland had been waiting over one year for treatment. This compares with around 5,000 in England and Wales. The report highlights that mental health issues are the largest cause of ill health in the population of Northern Ireland, with increasing suicide rates.

Source: Action Mental Health

REFERENCE: O'Neill S, Heenan D, Betts J. Review of mental health policies in Northern Ireland: making parity a reality. [Online]. Belfast: Ulster University; 2019. https://docs.wixstatic.com/ugd/198ed6_e5c1efcade6e427ba54de34a30db488b.pdf (accessed 2 July 2019).

Rise in self-harm rates among girls and young women

Rates of self-harm in England have risen from 2.4 per cent in 2000 to 6.4 per cent in 2014, according to a recent study. The study – which was undertaken by researchers from the National Centre for Social Research, the University of Bristol, University College London, King's College London, the University of Leicester, the University of Sheffield and the University of Manchester – was based on three surveys of 16–74 year olds in England, carried out in 2000, 2007 and 2014.

The increase in self-harm rates was greatest among young women aged 16–24, who reported a self-harm rate of 6.5 per cent in 2000 and 19.7 per cent in 2014. Less than half of those in all age groups who reported that they had self-harmed had had any contact with a mental health professional. Male participants were even less likely than female participants to have had such contact. Older participants were more likely to have consulted a health professional than those in the 16–34 age range. The study's authors recommend that self-harm should be discussed with young people, without normalising it.

Source: NHS England

REFERENCE: McManus S, Gunnell D, Cooper C, Bebbington P, Howard L, Brugha T. Prevalence of non-suicidal self-harm and service contact in England 2000–14: repeated cross-sectional surveys of the general population. [Online.] The Lancet 2019; 6(7): 573–581. https://doi.org/10.1016/S2215-0366(19)30188-9 (accessed 25 July 2019).

Derailment as a cause and consequence of depression

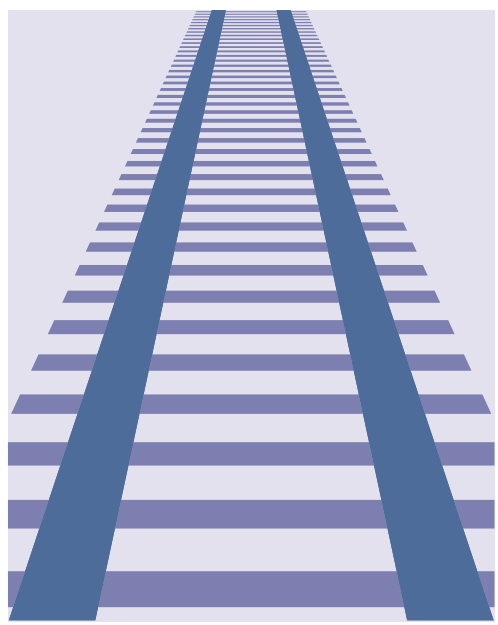
The feeling of being disconnected from our past selves – also known as 'derailment' – has been identified by a team of researchers from Cornell University as both a potential cause and consequence of depression. A consistent sense of self and identity – which is unaffected by big life changes – is an important component of psychological wellbeing. Sometimes, this sense of self can be lost, for example when relationships and social roles change. When a person is derailed, it can be difficult for them to reconcile how their life course has unfolded, making it difficult to identify with their former self.

The researchers, who published their study in *Clinical Psychological Science*, asked nearly 1,000 students to complete measures of depression and derailment four times over a one-year period. They found a correlation between the scores on the two measures, implying an association of some kind between the two. Higher depression scores at one time point seemed to correlate with higher derailment scores at the next, indicating that depression predated derailment and led to the loss of sense of self. However, higher derailment scores were also associated with lower depression scores at the next point of measurement. The researchers posited that changes in the perception of self could protect against mood deteriorations at a later date.

The researchers recommend that practitioners pay attention to the potential link between depression and derailment, and observe how changes in a client's sense of identity might present in the consulting room.

Source: BPS

REFERENCE: Ratner K, Mendle J, Burrow A, Thoemmes F. Depression and derailment: a cyclical model of mental illness and perceived identity change. [Online.] Clinical Psychological Science 2019. https://doi.org/10.1177%2F2167702619829748 (accessed 2 July 2019).



THE IMPORTANCE OF HUMAN CONNECTION

SATINDER PANESAR

FAREWELLS

I'd like to start by thanking Joanna Benfield for her commitment and hard work as editor of this journal. The Healthcare Executive has been grateful for her passion and absolute patience. We've found her to be very supportive – especially to me, as someone who struggles to put pen to paper. Whenever I've written a column, I've sent the piece to Joanna with a note to say, 'Please work your magic', and she always has.

We are also grateful for the hard work that Joanna has put into sourcing articles for the journal – I know that's not easy. So, on behalf of the BACP Healthcare Executive, I'd like to thank her and wish her all the best in her continuing journey.

MAKING CONNECTIONS

In July, I attended the BACP 'Making Connections' event in Glasgow. I always love these events as they are an opportunity to network, to get to know members and to listen to their views. Some of the members at this event had also been at the 'Working with Trauma and Supervision' event, which was held in Glasgow earlier in the year. I was delighted to hear that conversations around supervision expectations and good practice had continued back in people's workplaces. So, when I had the opportunity to give a two-minute presentation, I invited members to get in touch about their different experiences of accessing supervision within a healthcare setting. I would like to issue the same invitation to readers of this column.

TALKING BOOTH

Also at the 'Making Connections' event, Mia Zielinska, a student from the University of Edinburgh, delivered a superb presentation about her experience of 'seeking connection' and how her desire for connection gave rise to a research project, titled 'Talking Booth'.[1] Mia's project deservedly won the PCCS Books student award, which she received at the BACP Research Conference in Belfast earlier this year.

'...I have made it a mission of mine for years now to greet people with a smile and a "hello". It might be the first time that day that someone has been spoken to...'

The Talking Booth was modelled on the 'Peanuts' cartoon character, Lucy's, psychiatric booth, in which other characters told Lucy their problems. The Talking Booth offered a casual talking space in the university's main library, staffed by postgraduate counselling and psychotherapy students. Students and staff could visit the booth and talk for up to 15 minutes. Mia's research explored whether 'casual chat' was a viable means of community mental health self-support and whether professional therapists and counsellors would support it.

I found myself curious about what would happen if the Talking Booth were based in a main street in Glasgow city centre, rather than in the university; I wonder how many people would stop and welcome a casual chat?

I also found myself wondering how many casual conversations we have every day as counsellors. I know that I have many, as I have made it a mission of mine for years now to greet people with a smile and a 'hello'. It might be the first time that day that someone has been spoken to; so, if I have time, I will have a casual conversation.

During the summer, I joined a walking group and began hill walking. I have met some lovely people and created some friendships and even professional connections. Walking outdoors and chatting just came so naturally to me. I have had many casual conversations while walking in the hills and, on a number of occasions, individuals have thanked me for that chat. We should not underestimate the importance of these casual conversations.

So, I would like to finish with the question, when was the last time you had a casual chat that made a difference to someone's life or even made them smile?

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1 BACP. Talking booth wins student research prize. [Online.] BACP; 2019. https://www.bacp.co.uk/news/news-from-bacp/2019/19-june-talking-booth-wins-student-research-prize/ (accessed 23 July 2019).

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IMPROVING ACCESS

JUDY STAFFORD

COUNSELLING FOR YOUNG PEOPLE

The UK Government has recently announced that it will train teachers to recognise early signs of mental health problems affecting their pupils.[1] While this is a step in the right direction in some respects, it has the obvious downside of increasing teachers' responsibilities and is unlikely to work if there is nobody for teachers to refer pupils to, in order to get help. Children and young people can, in some cases, be waiting 18 months to be seen by specialist staff nationwide.[2] Chief Executive of the British Psychological Society (BPS), Sarb Bajwa, is therefore keen for the new Education and Mental Health Practitioners, who are currently training, to be in role. He believes they will provide interventions for children and young people that will relieve pressure on teachers.[1]

COUNSELLING FOR YOUNG PEOPLE IN SCOTLAND

In Scotland, well over 3,000 people have waited over a year for mental health treatment; this is an increase of 500 since March 2019.[3] The statistics are worrying and, two years after the publication of the Scottish Government's mental health strategy, the hope was that further progress would have been made.

BACP's four nations policy and engagement lead, Steve Mulligan, has said that members are ready to help ensure children and young people in Scotland get the access to counselling they urgently need, and that the figures highlight that Scotland's health boards are still failing to meet the urgent needs of thousands of children and young people to receive mental health support.

The Scottish Government's announcement[4] last year that £80 million would be provided for new counselling provision across Scotland's secondary schools, colleges and universities over the next five years was very welcome. The funding will support 350 new counselling roles in Scotland's secondary school schools and 80 new counsellors for universities and colleges, which will help the overstretched CAMHS services. It seems that the public are supportive of this initiative; a recent survey by BACP and YouGov found that 72 per cent of people questioned believed that all schools should offer counselling.[5]

Research shows that three children in every classroom[6] have a clinically diagnosable mental health problem and that 50 per cent of these problems are established by the age of 14.[7] Early intervention is critical to address the growing mental health crisis. Analysis of the secondary school counselling programme in Wales showed that, of those who received counselling in 2016/2017, 85 per cent did not need onward referral.[8] BACP has therefore urged the Scottish Government to commence the urgent roll-out of the new counselling provision for Scotland's schools, colleges and universities.

NEW BACP RESOURCES

New and recently updated resources in BACP's Good Practice in Action (GPiA) series include:

GPiA 029 *Mental health law within the counselling professions in England and Wales.* ***GPiA 031*** *Safeguarding children and young people within the counselling professions in England and Wales.* ***GPiA 057*** *Suicide – legal issues when working in the counselling professions in England and Wales.* ***GPiA 060*** *Coroner's Court, inquests and confidentiality beyond death: issues for the counselling professions in England and Wales.* ***GPiA 096*** *Disability in the counselling professions.* ***GPiA 080*** *Reasonable adjustment in the counselling professions.* ***GPiA 099*** *Workloads in the counselling professions.* ***GPiA 100*** *Practical guidance in setting up counselling and psychotherapy services.* ***GPiA 109*** *Workload in the context of the counselling professions.*

All these resources are now more easily accessible with a shortened weblink: www.bacp.co.uk/gpia. Any feedback will be gladly received.

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6 *Green H, Mcginnity A, Meltzer Ford T, Goodman R. Mental Health of Children and Young People in Great Britain: 2004. Office for National Statistics; 2005.*

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8 *Welsh Government. Counselling for children and young people: September 2016 to August 2017. [Online]. Welsh Government; 2019. https://gov.wales/counselling-children-and-young-people-september-2016-august-2017 (accessed 28 June 2019).*

This is a regular column by ***Judy Stafford,*** *who works in the Healthcare, Journals and Professional Standards departments of BACP. Judy is also a registered member of BACP and is a person-centred counsellor working in the third sector.*

TIMES OF CHANGE FOR THE NHS

MATTHEW SMITH-LILLEY

INTRODUCTION

While this isn't the first opportunity I've had to contribute something to this journal, it is the first time I have done so in my role as Policy and Engagement Lead for Mental Health at BACP. I took up this role earlier this year, having previously worked in BACP's Policy and Public Affairs team. The role is specifically focused on national policy, legislation and lobbying within a healthcare and NHS context. It is both a hugely exciting role for me personally and hopefully a great opportunity for BACP to more comprehensively engage and influence key policy and legislative developments that are taking place across healthcare and the NHS in the UK.

I come to the role having worked across all areas of government policy relevant to counselling and psychotherapy, and I'm looking forward to being able to focus more exclusively on the developments taking place in healthcare policy, as well as engaging with practitioners and services to find out how national policy impacts on your practice.

I'm hoping that this column will be the first of many, offering a chance to let you know what is currently happening in the policy world and how BACP is engaging with these changes. I hope it will also provide me with an opportunity to listen to your perspectives as counsellors and psychotherapists.

THE NHS LONG TERM PLAN

I think it's an understatement to say that, in the world of politics and healthcare, 2019 has been interesting. The political impasse we have experienced over Brexit has not prevented the UK Government from shaking the magic money tree and promising an end to a decade of funding famine for the NHS in England; it has been replaced by promises of relative riches in the form of an extra £20 billion per year for the health service by 2023/24.[1]

The publication of the *NHS Long Term Plan*[2] for England in January was given a mixed reception. It clearly set out positive ambitions, and we at BACP were particularly pleased to see mental health as a clear priority within the plan. However, the immediate follow-up question was, where's the detail? Ambitions are great, but only when there's a clear plan for their delivery.

That said, the ambitions, while far from perfect, would demonstrate clear progress in improving mental health services; if they are achieved, 380,000 additional adults and older adults will be accessing NICE-approved IAPT services by 2023/24. This is a further increase to the target in the *Five Year Forward View for Mental Health*[3] for 600,000 additional adults a year to access services by 2020/21. Moreover, according to the *NHS Long Term Plan*, 24,000 additional women a year will benefit from perinatal mental health support by 2023/24 and an additional 345,000 children and young people aged under 25 will access NHS-funded mental health support.

In addition to ambitions of increasing access to mental health services for the public, the *NHS Long Term Plan* also promised mental health a £2.3 billion-sized slice of the £20 billion pie by 2023/24.

DELIVERING MENTAL HEALTH SERVICES

One of the glaring omissions from the *NHS Long Term Plan* was any detail about who is going to deliver these promised service expansions. While not universally the case, it is widely acknowledged that many mental health services are struggling to meet the current demand, being both understaffed and unable to offer a full choice of evidence-based psychological therapies. These new targets are not going to ease these pressures, and therefore the ambitions can only be delivered if there is a significant, sustained and sustainable investment in the mental health workforce going forward.

From BACP's perspective, it is clear that counselling and psychotherapy have an important role to play in improving the mental health of the public and that any expansion of mental health services should include counselling and psychotherapy in the planning. Unfortunately, history has

'The political impasse we've experienced over Brexit hasn't prevented the UK Government from shaking the magic money tree and promising an end to a decade of funding famine for the NHS...'

'...history has shown counsellors and psychotherapists to be an undervalued and underutilised workforce, with experienced practitioners often overlooked in favour of training a workforce of new staff'

shown counsellors and psychotherapists to be an undervalued and underutilised workforce, with experienced practitioners often overlooked in favour of training a workforce of new staff. At a time when the NHS is looking to increase the mental health workforce to meet rising demand, as well as having budget in place to recruit more practitioners into services, counsellors and psychotherapists represent a real untapped resource of valuable skills, experience and competences, which should be taken account of and seen as a solution to some of the NHS's workforce challenges.

It is encouraging, therefore, that in the months since the publication of the plan, the focus of NHS England and Health Education England has not immediately been on attempting to deliver against new access-to-service targets, but instead on putting together the comprehensive workforce plan that is needed to ensure the health service is staffed safely and appropriately to deliver services, moving forward over the next decade. This is planned for publication in autumn 2019.

The NHS Long Term Plan is a real opportunity for counselling and psychotherapy to play a greater role within the NHS and it has been evident through the work undertaken so far, that the role of psychological therapies, including counselling and psychotherapy, is being more comprehensively considered throughout workforce planning.

In the coming months, BACP will continue to engage constructively – and critically, where needed – with the UK Government, NHS England and Health Education England to ensure that the value of counselling and psychotherapy is better understood and that opportunities for the skills and expertise of counsellors and psychotherapists to be used within the health service are increased.

The next step for the *NHS Long Term Plan* is the publication of the full people plan, discussed above. This plan is in part dependent on the financial settlement from the Government for health education and training, which will be announced in the 2019 spending review. The review was initially planned for autumn 2019; however, the change of Prime Minister in July has delayed the process. We will publish more information about the spending review on the BACP website as it becomes available.

NICE GUIDELINE ON DEPRESSION IN ADULTS

Another issue that feels like it has been rumbling along for years now is the ongoing update to the NICE *Depression in Adults* clinical guideline.[4] The review of the clinical guideline first began back in early 2015; while a routine guideline review usually only takes around 18 months to complete, this review is likely to last over five years. I'm sure many of you are aware of the controversial nature of the existing guideline. If, however, you are not familiar with it, two of the key issues are: (i) the recommendation that counselling should be offered as a second-line intervention for depression, after cognitive behavioural therapy (CBT) and interpersonal therapy (IPT); and (ii) the overreliance on randomised controlled trial (RCT) evidence, to the exclusion of routine outcome data from practice – such as the national IAPT dataset.

These are not the only issues with the guideline, but they are two that have a significant impact upon counselling and psychotherapy. Mental health services are often commissioned in line with the NICE guidance and, as a result, counselling and psychotherapy are often viewed by commissioners as less effective interventions than CBT.

To date, there have been two full consultations on the draft guideline. However, they have not resolved the

'...it is widely acknowledged that many mental health services are struggling to meet the current demand, being both understaffed and unable to offer a full choice of evidence-based psychological therapies'

concerns raised by the mental health sector. In October 2018, NICE finally acknowledged that these concerns were significant enough to go back and begin much of the process again. The new timeline for the development of a final guideline was planned to run from December 2018 to December 2019.

As an organisation, we have long campaigned for a change to both this specific NICE guideline and also to NICE's guideline development process. We want to see guidelines that are fit for purpose and that deliver the choice of evidence-based psychological therapies that the public deserve.

Our campaigning is still ongoing and we are currently working with a coalition of around 40 organisations to keep up the pressure on NICE, as well as mobilising political support for the changes that need to happen to the guideline. BACP is currently in the process of responding to a third consultation on the draft guideline. This will run for six weeks, from 2 October until 13 November 2019.

While NICE has specific rules about who can and cannot respond to its consultations, it is vitally important that as many eligible stakeholders as possible participate. In order to do so, you need to be a registered stakeholder. Registration is free and only takes around five–10 minutes. Unfortunately, it is only available for organisations, not individuals. The NICE website gives eligibility criteria: www.nice.org.uk/get-involved/stakeholder-registration. If you are not eligible, but wish to respond as an individual, you may be able to contribute to the response being submitted by a stakeholder organisation, all of whom are listed on the *Depression in Adults* guideline webpage (https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0725/documents).

If you want to find out more about our NICE campaign, including more information about how to respond to the consultation and some key messages you may want to include in your response, please visit our campaigns page: https://www.bacp.co.uk/news/campaigns/nice-depression-guidance/14-july-2017-how-to-respond-to-the-nice-consultation/.

This has been a very quick dive into some of BACP's healthcare policy work, and hopefully it is of interest and use to you. I hope to bring you more updates in the next issue. If, in the meantime, you would like more information on any of the work, then please do visit the BACP website for the latest updates; or alternatively, if you have a perspective on healthcare policy that you would like to share, please do get in touch.

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*This is a regular column by **Matthew Smith-Lilley**, who is the Policy and Engagement Lead (mental health) for BACP. To contact Matthew, please email matthew.smith-lilley@bacp.co.uk*

THE WOUNDED HEALER: REFLECTIONS ON A PERSONAL JOURNEY

KAY MACKAY EXPLORES HOW HER LIVED EXPERIENCE OF MENTAL ILLNESS IMPACTS UPON HER ROLE AS A COUNSELLOR

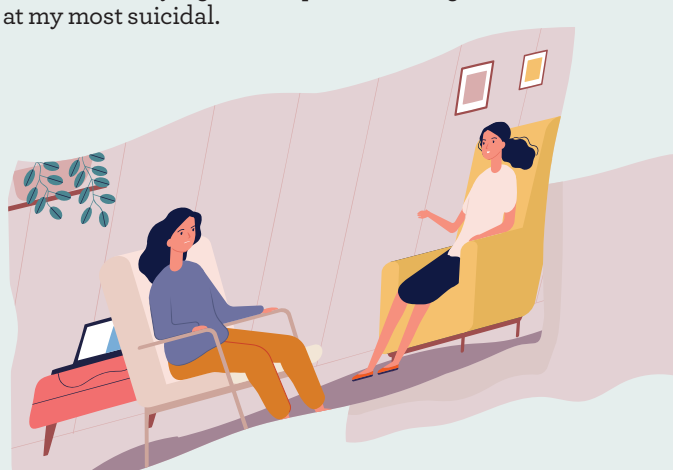
It is well known that many psychotherapists arrive at their profession through a journey that involves a history of pain and suffering, with a curiosity born of self-healing and resolving their own conflicts.[1,2] It was Jung who first created the metaphor of the 'wounded healer', focusing on the ability to draw on one's own experience of psychological woundedness for the purpose of healing.[3] This is certainly a concept to which I can relate.

After a 10-year career in science and research, I was motivated to enter the caring profession and train as a counsellor. I qualified as a humanistic psychotherapeutic counsellor last year. Prior to my counselling training, I was a peer support worker on an NHS acute mental health ward. My motivation for this work came from my personal knowledge of the trauma of mental illness, which made me want to help those suffering similarly. This article explores my personal and professional journey of being a wounded healer. It reflects on how lived experience of having a serious mental health condition can impact upon therapeutic work and identity.

The decision to share my story publicly is not without risk. However, it is through telling our personal stories that we draw meaning from suffering, process our experiences, share our vulnerabilities and connect with others. This is also what we expect our clients to do. If we, as therapists, hope to make sense of something that has common meaning within our profession, why should we not also be able to take this risk? My hope is that my insights will improve aspects of my practice and generate experiential knowledge that can inform the therapy profession.

MY PATH FROM PATIENT TO PROFESSIONAL

Having suffered from depression since my teens, 11 years ago I was sectioned with mania and diagnosed with bipolar disorder. At the time, I was psychotic and dangerously out of control. Shortly after being discharged from hospital, I went into a severe depression that paralysed me for 18 months. I experienced complete loss of my sense of self and endured relentless mental pain. Over the next four years, I was debilitated by episodes of extreme highs and lows, as well as a terrifying mixed episode, during which I was at my most suicidal.



When I was first diagnosed with bipolar disorder, it was a relief and comfort for me because it was recognition that I had a real medical condition, rather than being a weak person. I identified myself as someone with a chronic mental illness and accepted the need to take mood stabilising medication for the rest of my life. I received psychological treatment, including dialectical behavioural therapy, working on breaking the perfectionism-related vicious cycle and self-destructive behaviours that drove much of my distress.

Recovery from mental illness does not necessarily involve complete elimination of symptoms and requires effective long-term self-management. Evidence suggests that people with bipolar disorder experience more extreme thinking styles and heightened emotions, even at times when they are not in an episode of illness.[4] Our feelings and moods are an essential part of who we are. Redefining my sense of self has, therefore, been an integral part of my recovery. Part of this process has involved trying to separate the mental illness from my personal identity.

Living alongside intense emotional experiences can be very difficult. I have come to understand that my defensive reasoning for not managing my mental health well at times is *because* I have a mental illness. I feel disempowered by an internalised sense of 'unwellness' and can sometimes use this as an excuse for when I am not managing my personal difficulties well. I have come to see medication as my safety net. It has undoubtedly helped me – arguably saved my life. Yet I have a complex relationship with it, and still struggle with my need to take lithium. I worry about the potentially damaging side effects and also wonder what it means for me, existentially, to be on long-term medication. As a practitioner, I have an increased respect for medication and the role it can play in a person's recovery, provided it is one part of a more holistic approach.

'...it is through telling our personal stories that we draw meaning from suffering, process our experiences, share our vulnerabilities and connect with others'

What ultimately helped me to get better was a combination of the right drug treatment, psychological therapy, good support, acceptance and, importantly, having a strong reason for living and other people believing in me. Connectedness and positive relationships are the greatest healers. Relating compassionately to myself, through practising mindful self-compassion, helps me to regulate my emotions and tolerate distress.[5,6] This involves taking responsibility for my emotional experience, having the commitment to be kind to myself, and the courage to be imperfect. I recognise that caring for my health and wellbeing should be a priority in my personal life and is integral to the success (and indeed survival) of my professional life. There is implicit modelling in the therapeutic relationship. There is also a fine line between being a competent counsellor and feeling a fraud if you cannot successfully manage your own mental health.

THE IMPACT OF LIVED EXPERIENCE ON MY ROLE AS A COUNSELLOR

I believe my distressing experiences of mental suffering have enabled me to relate meaningfully to the emotional struggles of my clients and to meet them on a deeply human level, even when our backgrounds and life experiences are very different. I think this relates to having humility and an awareness of my own vulnerabilities, and first-hand experience of the impact of stigma. I also have resilience and an increased trust in my clients' recovery, from overcoming my own struggle with overwhelming feelings of hopelessness.

The peer support role I undertook has influenced my approach to counselling. Central to the peer support role is explicitly drawing on and sharing one's lived experience of mental health problems, to inspire hope and genuine empathy. The peer relationship is non-hierarchical and based on mutuality and shared responsibility, within which people help each other as equals.[7] It is an empowering way of connecting with the other person and breaking down the barriers of isolation.

In the counselling relationship, there is an implicit power imbalance, as it is non-reciprocal and counsellor self-disclosure is discouraged. I am not naturally comfortable being in a position of power. I have therefore been inclined to disempower myself in relationship with my clients and I do not always manage boundaries well. For instance, I have sometimes been guilty of going over time with clients because of not feeling able to end sessions. I can also be prone to 'enmeshment', that is, being too emotionally involved and overly responsive to the needs of some clients.[8]

I have noticed my tendency to over-identify with particular clients, who have similar issues to me. This means I can compare myself to my clients and experience certain things through my perspective rather than that of my client. Working with difficult countertransference issues can be challenging and emotionally draining, increasing the therapist's vulnerability to distress and impairment.[9] To prevent my own issues from interfering with the therapeutic process, I realise that I must resolve, or at least understand and sufficiently process, my own psychological difficulties.

I think I have grappled with my professional identity as a counsellor because of my patient/peer support identities, which I had seen as being mutually exclusive.

The literature indicates that wounded healers face identity-related dilemmas of having dual-identities, 'professional' and 'patient', with considerable imbalance of power between these, which sits in favour of professionals. Research findings have shown that therapists constructed either separate 'unintegrated' identities, or personally valued 'integrated' identities.[10,11] The process of negotiating professional identities reflects the 'them-and-us' dichotomies that exist in mental health services and society.[12]

THE IMPACT OF LIVED EXPERIENCE ON CLINICAL WORK

As part of my enquiry into the effects of lived experience of mental illness on professional practice, I have held reflexive dialogues with collaborators from my personal and professional network. I found conversations with my family were trickier, because of their personal associations with my illness.

My parents and my husband believed that lived experience of mental illness could be an asset in understanding other people's problems, provided that the counsellor is fully recovered and back to 'normal'. However, their general view was one of concern that the nature of the work may be too triggering. My sister and brother-in-law, who are both medical doctors, declined my invitation to have a conversation, saying I would take it too personally. I wondered on reflection whether their unwillingness to engage said something about their own anxieties and scepticism, possibly reflecting their professional attitudes and highlighting polarities between the medical-technical and humanistic-relational philosophies. There is a preconceived idea that therapists should embody the perfect model of mental health. As a wounded healer, managing other people's anxieties can be an added pressure.

I have collaborated with five NHS mental health professionals, made up of peer support workers and various therapists, all of whom have had personal experience of mental health issues. I explored with them how their own lived experiences had impacted their clinical work. Table 1 summarises the co-constructed themes that emerged from these discourses.

The overriding message was that lived experience of mental health problems can increase capacity for deeper empathy through shared understanding of psychological pain, whether utilised implicitly or explicitly. Judicious self-disclosure was thought to emphasise the human relationship and redistribute power. There was a sense that the more experience of personal difficulties a person has had, the more insight and awareness of themselves and others they may develop, which can enrich therapeutic practice and foster authentic, trusting relationships. The implication

TABLE 1: EXPERIENCES OF 'WOUNDED HEALERS'

STRENGTHS	CHALLENGES
Deeper empathic connection	Vulnerability to relapse
Insight into experience of distress	Stigma and discrimination
Belief in client and in recovery process	Pressure to be seen to be coping well
Increased capacity for holding hope	Vicarious trauma
Increased motivation to help	Boundary issues
Ability to empower clients	Over-identification
Emphasis on human connection	Poorly managed countertransference
Therapeutic self-disclosure	Lack of emotional presence
Role modelling recovery	Risks of professional disclosure
Positive integrated identities	Feeling a fraud

is that the practitioner, by the very nature of their personal experience of mental distress, is able to offer a more empathic and effective service to clients. This is supported by Kottsieper,[13] who asserts that the hope fostered by the wounded healer, as an embodiment of the possibility of recovery, is more powerful than an intervention by one without lived experience. Indeed, when I first became unwell, I scoured countless first-person books on depression, searching for reassurance from someone who had experienced, understood and survived what I was going through.

'...my distressing experiences of mental suffering have enabled me to relate meaningfully to the emotional struggles of my clients and meet them on a deeply human level, even when our backgrounds and life experiences are very different'

The caveat is that, in order to add value, wounded healers must treat their own wounds as part of a rigorous self-care regime and be able to seek help as appropriate. Good quality supervision was seen as vital, and all the mental health professionals emphasised the importance of their own self-care and self-understanding. This includes being able to recognise stressors and monitor anxiety and burnout, and to take time off when needed. People spoke of how client work can trigger difficult emotions and reactivate painful memories, affecting them more profoundly if they have had a similar experience. One person spoke of the need to delineate boundaries within herself, in order for her work with clients not to affect her mental health. Another expressed the sense of feeling the pressure, not so much not to have difficulties, but to be able to manage them effectively, which adds to performance anxiety. Stereotyped beliefs of low expectations of people with serious mental health disorders had undermined another person's self-confidence.

The therapists felt cautious about disclosing their mental health problems within their professions because of worries about being seen as 'unwell' or not coping. This prevented one person from asking for support, while another person felt discriminated against when she disclosed her difficulties. Professional wariness towards wounded healers is based on concern about relapse and chronic dysfunction.[14] I chose to disclose my diagnosis to my training provider, in order to access disability-related support, as well as to my training group. While I don't want to be defined by my bipolar, I believe the very act of dealing with mental illness has shaped me and strengthened my character, and ultimately I see it as an important part of myself.

PROFESSIONAL SUPPORT AND GROWTH

Fear of judgment can lead to efforts by people to hide their wounds and a reluctance to speak openly about their experiences or to seek help when they struggle.[15] Individuals who receive stigmatised treatment may internalise the negative stereotypes that they perceive as self-stigma.[16] I have realised that not talking about my mental health difficulties breeds stigma and shame. Personal therapy has helped me with this. What is more, I understand that it is difficult to challenge stigma and public misperceptions if I cannot choose to safely disclose to others within my profession without fearing adverse consequences.

Unfortunately, the fear of having one's professional competency scrutinised or questioned means the risk of disclosure to other professionals can seem too great for many, especially for those early on in their careers or struggling with ongoing mental health issues. The decision whether to seek support from an organisation that provides your training or employment, by formally disclosing your mental health condition, is a dilemma. My experiences have taught me that professional disclosure does not necessarily serve in a person's best interests. Tutors/managers may not always be sensitive to the needs of counsellors with mental health issues and can make assumptions about their experience or abilities. The reality is that organisations may not have the proper infrastructure in place to offer meaningful support and adjustments to individuals defined as having a mental health disability. This needs to be addressed. It is essential that commitment to equality, diversity and inclusion within the profession is more than just words and is backed up with the necessary resources and understanding.

An approach of greater openness and support regarding the wounded healer is important in cultivating the safety necessary to promote resilience and growth, and is especially pertinent during formative years of training.[14] Dialogue and supportive exploration of psychological difficulties are central in assessing and reducing therapist impairment.[17] Supervisors have some responsibility in addressing the wounds of their supervisees.[18] Being able to have an open and trusting

relationship with my supervisor, in which I can discuss my personal difficulties, has been very important in addressing my countertransference issues and shaping my therapeutic interventions.

THE MEDICAL MODEL OF MENTAL ILLNESS

There are many assumptions about mental health labels being harmful, while the meaning of having a diagnosis to the individual is often overlooked. It is no accident that the medical model of mental illness is dominant in our society. Having a medical diagnosis validated and normalised my experiences of mental distress. It also offered a bridge between me and my family, helping them to make sense of my experiences. My diagnosis has offered me access to treatment, support, the welfare system, and essential specialist perinatal care. *The Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*[19] is the bible of psychiatry, providing a shared language for understanding mental ill health; but some see it as nothing more than a great work of fiction.[20,21] The problem is that diagnosis is categorical. Diagnostic labels say nothing about a person's personality or strengths. This can reduce a person's sense of self and create ambiguity around issues of personal responsibility and identity, as it did for me.

It was while working as a peer support worker that I began to question the medical model of illness. I didn't like how it pathologised and medicated people, rather than empowering them to make meaning of their experiences and take more control of their lives. I felt conflicted. On the one hand, I knew how much the medicalisation of my psychological problems had helped me. But on the other hand, as I advocated for the rights and choices of my detained peers, I identified myself as a psychiatric survivor/activist and reacted against the medical model. Trauma-informed approaches view distressing experiences as a natural part of common humanity, understood in the context of life events and interpersonal narratives.[22] Essentially, understanding mental distress only from a medical perspective is meaningless as such experiences are simply part of the complexities of being human. Indeed, there is a danger that medicalising our common normal emotional difficulties could lead to an erosion of society's resilience and devalue serious mental illnesses.

I have encountered the dichotomous approaches to understanding and working with mental ill health in my two counselling placements. I am a trainee psychodynamic counsellor in an Improving Access to Psychological Therapies (IAPT) service, which is built on a model of pathology. 'Patients' are assessed and must meet the diagnostic criteria in order to access therapy. The treatment is then prescribed according to the diagnosis assigned, in line with evidence-based protocols that prioritise symptom reduction over client choice and personal meaning. This pragmatic approach is often criticised by counsellors but it is the only way to meet the volume of demand. I also practise at a specialist counselling charity that provides a low-cost counselling service to women in the perinatal period. In contrast, it offers a holistic and personalised approach to clients and embraces a culture of non-stigmatising language.

A spirit of co-operation and respect for difference, individuality and idiosyncratic preference is important. There are diverse explanations for mental distress and I do not think it is helpful to narrowly confine yourself to one model or another, as each way of understanding is valid and each approach has its strengths and limitations. I believe my condition is a result of a combination of biological, psychological, social and environmental factors. In my view, therapeutic practice should be complementary to psychiatry. It should not be driven by ideology or a purist approach but by values and open dialogue where we can learn from different perspectives. Each person's needs are different and may change over time; recovery is deeply personal.

TOWARDS AN INTEGRATED IDENTITY

In the anxious early days of being a counsellor, I hid behind the use of theory and interpretation, because I was afraid of not being enough. This reflective enquiry has strengthened a belief in myself in knowing that I can own my moods, rather than continue to feel disempowered by a mental illness. Through this process of personal reflexivity, I have adjusted the way I relate to my mental health condition, so that my illness identity is not all-encompassing. I have begun to experience less of a discrepancy between my 'patient' and 'professional' identities, knowing and accepting both parts of myself and understanding that there is an important relationship between them. By embracing my strengths alongside my vulnerabilities, I am cultivating a positive integrated identity, drawing on all of my experiences together and seeing them as interdependent and complementary.

'...the fear of having one's professional competency scrutinised or questioned means the risk of disclosure to other professionals can seem too great for many, especially for those early on in their careers or struggling with ongoing mental health issues'

I have come to deeply understand the questions of identity that can be stirred when a person has a mental health diagnosis. This includes understanding that people exist not in isolation, but within a wider socio-cultural-political context that influences the construct of their self-identity. Recovery from mental illness is about the whole person and whole lives. My practice is rooted in humanistic values: holistic sense-making, non-reductionism, empowerment, self-determination, self-actualisation and human connection. There is a need for a paradigm shift in the culture of mental healthcare, towards a compassionate and recovery-focused service provision, that places equal value on a model of humanity. As a patient/client, I think the psychological therapy that has helped me the most was that in which I felt profoundly heard and understood and was able to tell my story.

CONCLUDING THOUGHTS

I feel strongly that my experiential knowledge has added a valuable dimension to my role as a counsellor. Lived experience of mental health problems can be instrumental in one's clinical practice and enhance therapeutic effectiveness, and I would argue that, rather than a professional impairment, it should be seen as an additional competence. I will endeavour to establish my own therapeutic integration that fosters a mutually empathic, real relationship with my clients and responds flexibly to their individual needs. Finally, the process of acquiring a professional identity where all aspects of myself are integrated, will shift and evolve as I continue to grow, first as a person then as a practitioner.

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READER RESPONSE

The author would welcome feedback on this article. To contact her, please email hcpj.editorial@bacp.co.uk

AN INTERVIEW WITH *GARETH BARTLETT*

COUNSELLOR, PARAMEDIC PRACTITIONER AND BACP HEALTHCARE EXECUTIVE MEMBER

CAN YOU DESCRIBE YOUR JOURNEY TO BECOMING A COUNSELLOR?

It started over 20 years ago, when I completed my Level 2 certificate, having previously been interested in counselling and psychology. It was around that time that I joined the Ambulance Service, so I didn't take it any further at that point. With hindsight, I'm glad that I allowed myself time to mature and gain life experience before moving into a counselling role.

After a few years in the NHS, I became involved in a peer support scheme called LINC (listening, informal, non-judgmental, confidential), which was aimed at providing a support network for colleagues. That led me to undertake an introduction to TRiM (Trauma Risk Management) course and my Level 3 diploma. It was about two weeks after completing this that the 2005 London bombings happened and TRiM was used to great effect at the time. I felt that my training allowed me to support my colleagues through what was a very difficult time for some.

A few years back, I found that working in acute healthcare was taking an emotional and physical toll on me and, following a family bereavement, I experienced some mental health difficulties myself. Having been referred for counselling, I was able to discuss what I really wanted to do in life, and I was then guided towards a local Level 4 course provider.

I still work occasionally in a clinical setting, although this can sometimes be difficult. However, I feel that I can now move ahead in a role that I love, while using my experience to inform my client work.

'I am primarily a person-centred counsellor, and I've seen the look of recognition on other counsellors' faces when I say that the modality chose me'

HOW HAS YOUR EXPERIENCE IN PEER SUPPORT AND TRIM INFLUENCED YOUR DEVELOPMENT AS A COUNSELLOR?

Peer support taught me a lot about active listening and exposed me to the wide range of issues that clients can bring. It also introduced me to supervision, which we were expected to undertake four times a year, individually and in group; and working with the employee assistance programme provider. It made me aware of the support available to someone working with vulnerable people and when to use it; I recall working with a suicidal colleague in the early hours of the morning and knowing that I was being supported through the peer support scheme and supervision. I learnt a lot about risk assessment in the counselling world from that encounter.

I feel that TRiM has given me a better chance to recognise the symptoms of post-traumatic stress disorder and helped me to understand how to work with clients presenting with this issue. At this stage of my career, it's all about knowing when to refer to someone better suited to that work, although I feel it would be an interesting area to explore further, given my prior experience.

HOW DO YOU INTEGRATE THE DIFFERENT MODALITIES OF THERAPY IN WHICH YOU ARE TRAINED?

I am primarily a person-centred counsellor, and I've seen the look of recognition on other counsellors' faces when I say that the modality chose me! I believe that the three core conditions (empathy, congruence and

unconditional positive regard) can be seen as basic building blocks of any counselling practice. I also trained in Gestalt and transactional analysis, which I use to support my work. For example, I may explore my client's body language or introduce the drama triangle to help them understand what is going on; however, I always return to the person-centred approach. I feel it's a real privilege to walk with a client as they find their own answers.

HOW DOES BACP MEMBERSHIP SUPPORT YOU AS A COUNSELLOR?

As a student, I found my membership of BACP extremely helpful in providing guidance and structure to the way I worked, as well as providing an ethical basis to work from. Since then, I have attended a BACP student networking event, which led me to apply for this role. I've also joined the CPD hub, which has allowed me to find ways to develop my skills and knowledge, and to learn from my more experienced peers.

Having experienced the development of the paramedic profession following the move to registration, I see some sort of need for regulation in order to protect qualified counsellors and support them in their work. I believe that BACP is in a good place to contribute to that discussion and I feel that I have a real opportunity with the Healthcare division to contribute to the promotion of counselling in that sector.

WHAT MORE WOULD YOU LIKE TO SEE THE BACP HEALTHCARE DIVISION DO TO SUPPORT ITS MEMBERS?

From what I've seen so far, there's a lot of good work already being done. On a personal level, I'd like to see us working with employers in the healthcare sector to look at developing career pathways for newly qualified counsellors.

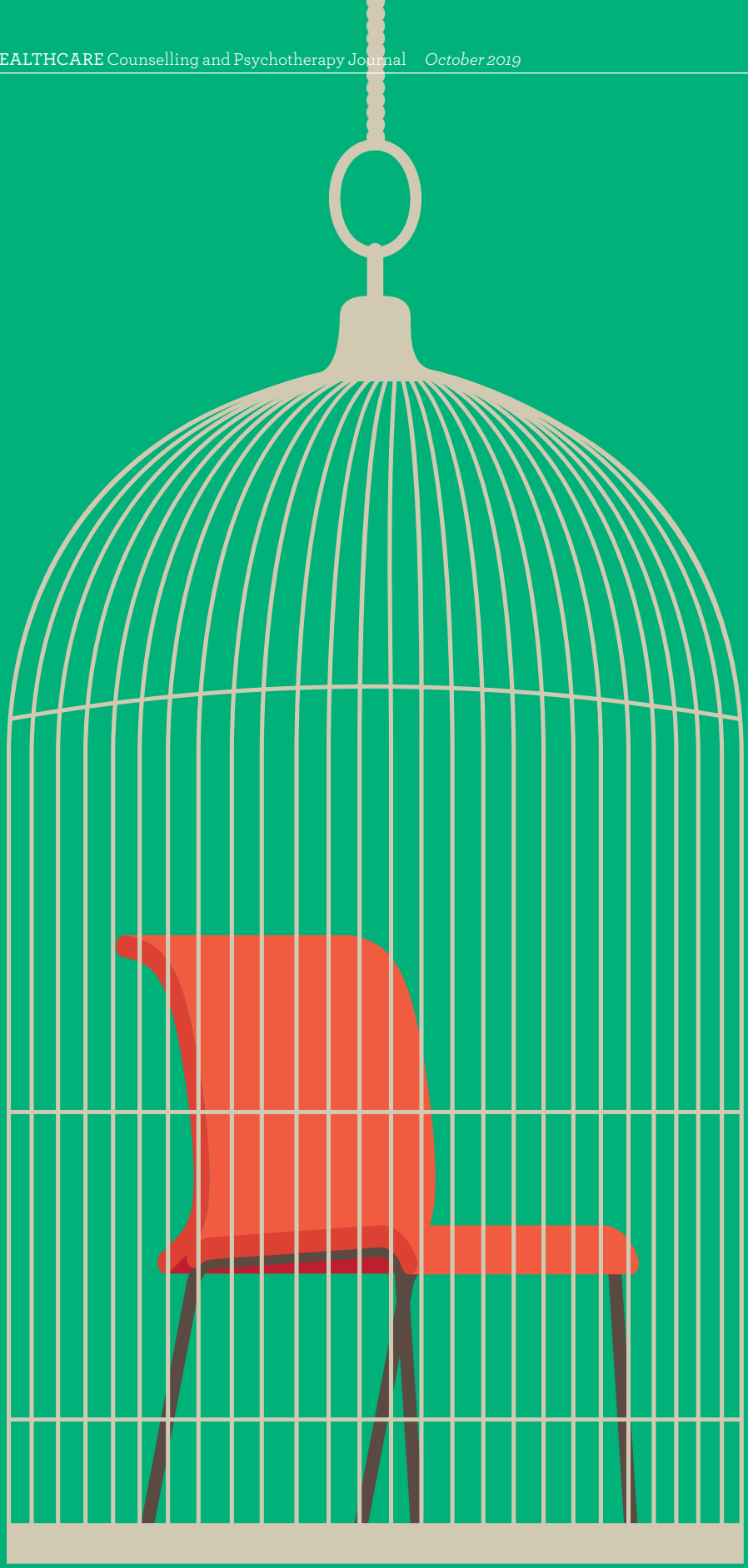
HOW DO YOU SEE YOUR FUTURE IN THE THERAPY PROFESSION?

I'm about to start working with Rennie Grove Hospice, providing support to patients and their families affected by terminal illness, and supporting volunteers. I have also recently started to work with a charity called TIC+, providing counselling to schools in Gloucestershire and working closely with the children and young people's service – Gloucestershire's version of CAMHS. This is part of the NHS Trailblazers project, which looks at developing counselling for young people. I also continue to work as a paramedic in minor injury units.

With regard to ongoing education, I have just started to study for a Level 5 qualification in working with children and young people, in order to support my role with TIC+. I'm interested in using this training to develop experience of working with young people suffering with chronic and terminal illness, and I hope that these skills will help me improve the lives of young patients as they face their illness.

This feature is aimed at showcasing the work of our members working in the NHS and NHS-funded services. If you would like to be featured in this column or can recommend someone else whose work warrants greater exposure, please contact hcpj.editorial@bacp.co.uk

***Gareth Bartlett**, counsellor, paramedic practitioner and BACP Healthcare Executive member*



TREATING TRAUMA FOR PUBLIC SAFETY:

THE CONTRIBUTION OF PSYCHOLOGICAL SUPPORT FOR PATIENTS IN HIGH SECURITY HOSPITALS

ESTELLE MOORE **EXPLORES THE IMPACT OF A TRAUMA-INFORMED SERVICE MODEL FOR PATIENTS IN BROADMOOR HOSPITAL**

INTRODUCTION

If anything distinguishes the therapeutic task in forensic services from other settings, it is the potential for people's stories to shock and move us in powerful ways, sometimes even challenging the fabric of our understanding about what it means to be human. High secure hospitals, in their recent past – and still, in some forums – often have negative and potentially stigmatising associations, which enjoin references to risk and mental ill health in a frightening fusion of labels, perpetuating fears about 'madness' and 'badness' in fellow human beings. Typically in the media, when a violent crime is committed, the headlines provide only the immediate outcome or impact. The public are told about the loss of life at the hands of someone suffering from a mental illness, or a vicious attack committed at random by someone with unmet mental health needs. What is less frequently reported is that childhood adversity often plays a causal role in the mental health problems[1] that can directly relate to offending.

It is these themes and inequities that high security hospitals find themselves addressing. The therapeutic work of picking up the pieces post tragedy, with the goal of reducing future harm, involves safely looking back to traumas, known and hidden, in order to move on. The work is typically characterised by complexity, and unpacking layer upon layer of harm.

A quarter of a century ago, therapy in high security hospitals was not as accessible to all, even if there was some evidence that patients might benefit from it. In today's National Health Service, accessibility is a prioritised value: this has changed the nature of the provision of psychological work with patients in high security settings, and the range of staff who might be involved in its provision. This article explores a framework within which we can deliver more timely therapeutic support in the most integrated and helpful way, in order to lower risk towards others in the future. Therapy provides a bridge into the internal world of the 'offender patient', who is also a person to whom things have happened. It offers a supervised opportunity for connection within a network of support for those whose needs have typically not been met, time and again, in their lives during and preceding their offending.

HIGH SECURITY HOSPITALS AND THEIR ROLE

Broadmoor Hospital plays a role in the health service in the south of England, described by one patient as an 'end of the road' facility for those whose actions present grave and immediate risks to others. The site provides just over 200 beds for men whose complex mental health needs are thought to be functionally linked to serious interpersonal violence. Some patients are transferred from NHS mental health facilities because they have extra security needs, while others are transferred from prison because they have become mentally unwell and the prison cannot provide them with the right kind of care. There is also a small group who are sent by the courts to hospital as an alternative to custody in prison; these tend to be cases where it is clear that mental illness has played a major role in their violence towards others. There are only 700 high secure psychiatric beds in England and Wales. This is many less than 50 years ago, as a better understanding of the relationship between risk and mental illness has led to better service provision.

One important development is our understanding of how the experience of childhood adversity and trauma can be a risk factor for both mental disorder and violence in adulthood. Some prisons have been working to develop a new practice orientation called 'trauma informed care'

(TIC), and Broadmoor Hospital and its sister sites in Liverpool and Nottinghamshire have been working towards operating as trauma-informed hospitals. As such, they are required to deliver care with sensitivity and awareness, safety and trustworthiness. When an individual is admitted to a high security hospital, the task for the therapeutic staff is to stabilise mental health, learn about what maintains safety for the individual and address the reasons for the dangerous behaviour that threatened public safety. The staff must get to know the person and their story, seek to understand the distress they may have encountered and perpetrated, and reduce the risks of re-enactment. The therapist maintains a professional frame of reference, yet also reacts to the out-of-the-ordinary disclosures in ways that are idiosyncratic, generating radical empathy. Being trauma informed is not about being 'nicer' to patients, but is a genuine attempt to prioritise trustworthiness and transparency, to reframe symptoms as understandable adaptations, and to work in partnership in a setting which is attuned to emotional and physical safety.

CAN WE SAFELY OPEN THE 'CAN OF WORMS'?

What are our fears about supporting those with offending histories to look back? 'Don't open that can of worms' is a warning that arises often in mental health work. It invites us to attend to the litany of troubles we might discover if we take the lid off the tin with unknown contents. What if the worms are seen? What if they are allowed to wriggle? What if they go in search of solutions to their troubles? And who will be responsible for putting the lid of the can back on if things don't go well?

This literary cliché encapsulates important fears. The warning may be a sensible and considered view, which indicates that the system is not ready to handle distress. We do not know what we will find, or whether we will have the resources (personal or professional) to cope with what we see. It therefore helps for staff of all disciplines to have had some training in what happens to the brain when exposed to a traumatic experience, whether it is a service user's past, or the complex present for them and the staff. It is important to understand how our neurology, biology and anatomy change as an instinctual response to an overwhelming experience.

Two illustrations from forensic practice describe the complexity faced on a daily basis in a high-security (locked ward) environment. On a busy day, the nursing team is responsible for caring for a detained man with a history of childhood sexual abuse, assaults on staff and self-harm. He appears agitated following a psychology session. The ward staff experience something akin to anger at the injustice in the patient's situation, and find themselves irritated with the colleague who has 'just upset him'. Who will have to cope with any fall-out from the session? The answer is everyone: the patient, the 24-hour team around him and all the staff who walk alongside when distress is evident or enacted. The nurses ask at the next handover, 'Should we be doing this? It's making him upset!'

In another instance, on an intensive care ward, the 'reducing restrictive practices' team of nurses and healthcare facilitators attend to support a patient to come out of seclusion for some fresh air. The ward staff report that he is not in a good frame of mind. The team persuade him to work with them and walk to the garden area. He subsequently refuses to return to his room, and becomes specifically hostile to the ward-based team, one of whom is bitten during a struggle, resulting in restraint. Both teams experience emotional tension associated with the whole process.

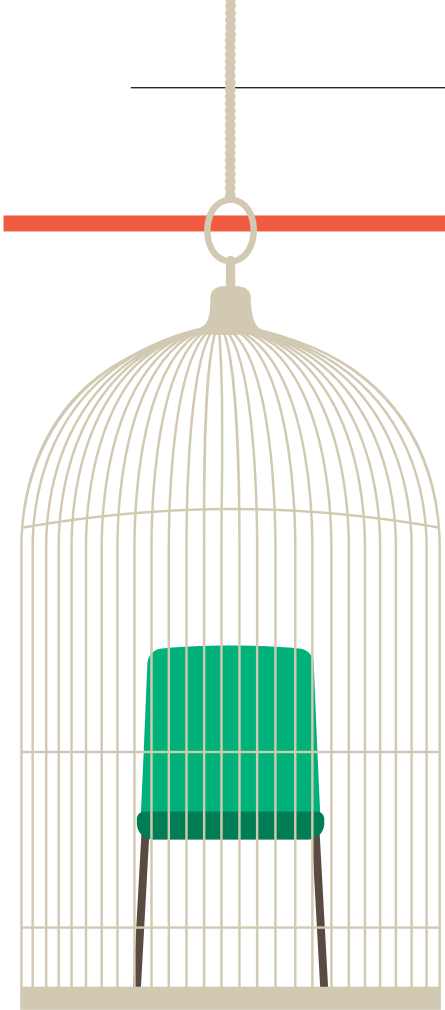
'Being trauma informed is not about being "nicer" to patients, but is a genuine attempt to prioritise trustworthiness and transparency, to reframe symptoms as adaptations, and to work in partnership in a setting which is attuned to emotional and physical safety'

THE MULTIDISCIPLINARY INFRASTRUCTURE FOR TRAUMA-INFORMED CARE

What do we need to know to do this work safely in this environment? We must all understand and be as in tune as possible with what is perhaps happening for the patient. We must hold their wellbeing in mind. We must acknowledge the fact that many experiences in our services can also be re-traumatising (such as locked doors and enforcements). We need to be aware of the myriad of ways in which we have power over people when they feel most vulnerable (for example, the power to keep a door locked, rather than open it). We need to contain, remain calm and explain distress and the mind-body continuum. We have to communicate with everyone involved before, during and after we try to do something different. We have to keep a focus on empowerment for everyone (not only staff or only the patients, as this generates imbalances that can be unhealthy). We need to respond with sensitivity and care, and we need to stick at it, often for extended periods of time. To support the patient to move beyond the harmful impact of traumatic experience requires the support of the whole team in thinking in this way, and at least one trusted therapeutic alliance within which the past can be sensitively 'held'.

TRAUMA ENQUIRY IN FORENSIC SERVICES: WORKING WITH BODY AND MIND

Research that has highlighted the lack of routine enquiry about people's history of trauma tells us some important things about what responsible responding to the impact of trauma might look like in an informed mental health service.[2] For clinicians to be concerned and interested in the experiences of the patient, and to be capable of validating and 'bearing unbearable' information at times, there must be relevant support and training. They must work in an integrated way with all members of the forensic clinical team. Training can assist them to ask about trauma with sensitivity, and then be prepared to stay in connection with the person to work out what they most need thereafter to cope with the physical



impacts of states such as hyperarousal or dissociation. In forensic settings, multidisciplinary teams and supervisors must also be interested in the experience of clinical staff who undertake such enquiry; what is the impact on them of their alliance with the patient, and how might that influence safety in practice? Staff also need support to reflect on their own experiences of vicarious traumatisation while encountering the strong emotions of those for whom they are responsible. Similarly, those in rehabilitative roles require support to work alongside patients to rebuild confidence in their bodies and fitness, to support patients to participate in activities that regulate the mind, and to help 'ground' them through tension release.

For a system to be 'trauma informed', it assists if the survivor's perspective is viewed as holistic, as unique, necessary and adaptive.[3] This perspective can be obscured or overshadowed where there are also actions/activities linked to the perpetration of harm. Staff require a frame of reference for their experiences, and hopefully spaces in the workplace, including supervision and reflective practice, where this can be explored. Patients are often dealing with unprocessed sensations (such as flashbacks and disturbing memories) that result from unresolved harm; this can be difficult to witness when it is unrelenting, and inevitably converted into hostility and mistrust. Staff are not immune from reacting to this either.

OPENING THE CAN, TOGETHER AND WITH CARE

It is, of course, a reality that the human brain has both dangerous and callous propensities.[4] There are times when it is absolutely right that we fear other people whose intention is to harm us; we cannot deny the seriousness of psychological disturbance that places others' lives in danger.[5] Even in cases where the intention of perpetrators may not even have been to harm, offending is always associated with a serious failure of accountability, and with actions that are deeply traumatising in their impact on others. Risk and mental states are dynamic phenomena, which require constant review and appraisal to minimise (tragic) oversights in everyday life, and subsequently, in the case of a detained patient, for the duration of their treatment and care.

Although detention and sentences are inevitably feared for their enduring impact on people, and often administered at times of acute vulnerability, the high secure hospitals themselves can represent containment: a solid holding place for patients whose needs are immediate and serious, assessed by the Care Quality Commission in the same way as other locations. The therapeutic task of the hospitals takes the recovery journey several steps further: can the risks that were once catastrophic in impact be reliably lowered to enable people to move on, to allow past harm to be accepted and sufficiently minimised – healed even – for the future?

Trauma-informed systems are distinguished by their acknowledgement of needs, the importance of asking ('screening') for trauma history; their understanding of the impact of trauma and the demands of survivor-hood; the capacity to differentiate power and control, and the structures to keep people safe in the present.[6] From this foundation, working together, with teams supporting the body and the mind, long-term trusting relationships can become part of the journey of recovery and repair. Interventions cannot follow a 'one-size-fits-all' formula, as each individual will need to set the pace and nature of their journey for themselves. It has been said that letting go of the past is, in the end, the responsibility of each trauma survivor.[7] In forensic settings, this can be one way of demonstrating and delivering accountability, where possible, for those who have been victimised, and who victimise others through serious harm.

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A PERSON-CENTRED PERSPECTIVE ON SUICIDE

AMANDA MCGARRY EXPLORES WHETHER SUICIDE HAS THE POTENTIAL TO BE CONSIDERED AS AN EXPRESSION OF THE ACTUALISING TENDENCY

A PREVENT AGENDA

There are approximately 4,500 suicides in the UK each year – that's 13 people every day.[1] In 2015, suicide was the second leading cause of death among 15–29 year olds globally;[2] in the UK, men aged 45 and under are more likely to take their own life than die from any other cause.[3] The current UK policy on suicide focuses on reduction and prevention,[4] aiming to identify high-risk groups and then reduce access to the means of suicide within these groups.[5] In October 2018, the UK Government appointed its first ever Suicide Prevention Minister, who was tasked with reducing the suicide rate by 10 per cent by 2020.[1]

There is no doubt that suicide prevention is high on the agenda for all those in organisations and charities working with people in psychological distress.[6] Many will have policies and procedures in place to identify and reduce the risk of suicide and self-harm. However, this potentially poses a conundrum for person-centred practitioners, who work from a fundamental perspective of client autonomy. The person-centred approach is a phenomenological approach, centred around the client's individual view of their world.[7] Within this, the individual's basic tendency is to grow, either through maintenance or enhancement; this is known as the actualising tendency.[7] Taking this into account, some researchers[8] argue that it might be 'anti person centred' to defer to an external authority, such as a government or an organisation's policy, when, as a practitioner, you have agreed to join your client in discussing their unique and subjective position.

As some researchers[9] have highlighted, the Mental Capacity Act[10] states that individuals have the right to make choices about their own life, as long as they are deemed to have the capacity to do so. Any decision to break confidentiality should be made on the basis of this Act.[10] Overall, it seems to me to be a confusing position for person-centred practitioners. I therefore decided that, as part of my master's degree in counselling, I would carry out research to consider the person-centred perspective on suicide.[11] My focus was on whether the act of suicide has the potential to be considered an expression of the actualising tendency. This article sets out some of my key findings and reflections.

FINDING MEANING

When I outlined my research proposal to my tutors, a few eyebrows were raised. Some appeared to be out of interest, some out of scepticism and others in mild horror. How on earth could you equate someone taking their own life with an expression of them fulfilling their potential? There was a feeling from some that, by even considering such a notion, I was perhaps being disrespectful not only of those who had died but also of those they had left behind. The wish to keep a client safe will always be at the forefront of my mind. However, I did, and still do, believe that this chosen behaviour should be viewed in the same way as any other behaviour would be, taking into account that there is no philosophical or empirical evidence to support the idea that the chosen act of suicide is principally any different to any other chosen act.[12]

My tutors' next concern – and rightly so – was how I would research this. I believed that suicide notes provided me with a way of entering an individual's frame of reference at the time they had chosen to end their life and, following ethical approval, I began my research. I decided to focus my analysis on a collection of suicide notes collated in two books by Schneidman and Farberow,[13] and Etkind.[14] My aim was to try to understand the different reasons that individuals had chosen to end their life. I grouped the reasons together to provide clarity. The four groups (or narratives) that I identified were 'Can't live with...', 'Can't live without....', 'The other' and 'No other'.

There were various aspects of life that the note writers said they couldn't live with; these included: not being 'good enough'; not being able to live with a feeling of guilt, shame or regret; and not being able to live with physical or emotional pain. One note writer stated, *'I have never been much good, I have only hurt everyone'*;[13] another wrote, *'I've thought this over a million times and this seems to be the only way I can settle all the trouble I have caused you and others'*.[13]

In terms of things an individual couldn't live without, the most common aspect was a relationship or a specific love. This seemed to include not only romantic relationships, but also relationships with children. This is highlighted by one individual who wrote, *'Mary, I love Betty and I can't stand being without her'*, with another stating, *'Dearest Mary – I just can't go on without Tom, John and you.'*[13]

The other two groups of narrative I identified as reasons why a person took their own life were those I termed 'The other' and 'No other'. In terms of 'The other', some people stated that it would be best for others financially if they were no longer here; similarly, some said it would be best for others emotionally. Others simply made it clear that they were taking their life as they believed that was what the other wanted or that it was the other's fault. One individual wrote, *'I knew that if I went to a doctor I would lose my job I think this is best for all concerned.'*[13] Another stated, *'I know you will find someone better for you and the boys'*.[13]

Within the grouping of 'No other', there was one consistent message from those taking their own life, namely that the course of action being taken was the only way out. Two examples of this are, *'I've thought this over a million times and this seems to be the only way I can settle all the trouble I have caused you and others'*, and *'I'm sorry honey, but please believe me this is the only way out for me'*.[13]

'...behaviour which can appear on the surface to be destructive can actually be viewed as constructive, when seen from within the client's frame of reference'

SUICIDE AND THE ACTUALISING TENDENCY

Armed with my data analysis, I proceeded to try to understand each note in relation to the actualising tendency, being explicit about the fundamental tenets that make up this tendency. This included analysing: (i) whether the action was self-directed or autonomous;[15] (ii) whether it could be seen as constructive, if viewed from within that person's world and (iii) whether the individual was acting within 'perverse or unusual conditions' (Rogers[15] stated an individual can only cause themselves pain or act in a way that could be deemed self-destructive, if the circumstances in which they find themselves are considered to be 'perverse or unusual').

I concluded that there were some notes that indicated that the act of suicide could potentially be an expression of the actualising tendency. An example is shown below.

Dear Mary.

You have been the best wife a man could want and I still love you after fifteen years. Don't think to badly of me for taking this way out but I can't take much more pain and sickness also I may get to much pain or so weak that I can't go this easy way.

With all my love forever –
Bill[13]

Assessing this against the tenets of the actualising tendency, I concluded that the writer, Bill, did not appear to have been influenced by anyone else to come to the decision; his choice was self-directed. In relation to the constructive nature of his action, Bill would no longer be in pain and, from his point of view (his perceptual field), it seems he believed it better for him to die before he experienced any further pain, which would render him unable to end his own life. In addition, I concluded that, for Bill, living with intolerable pain could be deemed a 'perverse' circumstance.

WHAT DOES THIS MEAN AS A PRACTITIONER?

If you are working in an organisation, you are likely to be required to complete some form of risk assessment in relation to suicide. However, increasingly, research seems to conclude that these risk assessments are ineffective predictors of behaviour.[16] When we consider this alongside a prevent agenda and the fundamental person-centred value of respect for a client's autonomy, it presents a complex picture for practitioners' ethical practice. It seems clear that there can be many difficult choices that a practitioner has to make when dealing with risk, and the consequences of those are multiple. How do you strike the 'right' balance in terms of ethics, legality, your chosen way of working, the wishes of the client and your own personal position?

USE OF SUPERVISION

Reeves[9] outlines the importance of supervision when working with risk, and my research seems to underline this further. Utilising supervision may be particularly relevant when working with a suicidal client and Reeves[9] highlights the potential outcomes from doing so. Supervision enables the client work to be explored in depth and allows the counsellor to receive feedback.[9] One crucial aspect of the client work to explore might be the 'judgment' of whether the client's behaviour is 'constructive' or 'destructive'. My research highlighted that behaviour that can appear on the surface as destructive can actually be viewed as constructive, when seen from within a client's frame of reference. Given the fundamental phenomenological basis of person-centred therapy, the client's position surely has to be the starting point for any work. In addition, the supervisory relationship can enable an exploration of ethical and legal factors involved in working with risk, and the creation of space for personal and professional development.[9]

THE COUNSELLOR'S PERSONAL POSITION

Reeves and Mintz[17] noted the potential impact the counsellor's beliefs on suicide could have when working with suicidal clients. Those who did not believe in suicide as a valid choice felt more clarity around when to break confidentiality with clients, whereas those therapists who felt that suicide was an individual choice struggled with this decision, feeling they were betraying their client.[17] BACP's *Ethical Framework*[18] is clear that confidentiality can be broken if permitted by the client or by law; what is not clear is how to establish if the current risk that the client is demonstrating is 'enough' in order to break confidentiality. Principles of autonomy and non-maleficence within BACP's *Ethical Framework*[18] may be particularly relevant here. The first highlights the client's right to self-govern and the latter the counsellor's commitment to avoiding harm to the client. Again, it may be reasonable to state that, regardless of the counsellor's views – on suicide, in this case – they should endeavour to understand the client's position from within their perceptual field as much as possible, before making a decision to break confidentiality.

THE COUNSELLOR'S FEELING OF COMPETENCE

Reeves and Mintz[17] highlighted counsellors' feelings of incompetence when dealing with risk, and the potential impact this may have on the client work, noting the various responses of counsellors to working with suicidal clients. In their research, counsellors reported feeling a lack of perspective and competence in their ability to handle any issues relating to the client's suicidal thoughts appropriately, referring to both ethics and the safety of the client. Feelings of anxiety, panic, impotence and fear were also highlighted.[17] It seems reasonable to suggest that, if the counsellor's response to their client is based on their own

'...some researchers argue that it might be "anti person centred" to defer to an external authority, such as a government or an organisation's policy, when as a practitioner, you have agreed to join your client in discussing their unique and subjective position'

personal fears or anxieties, it will not be based on the client's internal world. It is, therefore, unlikely to fulfil the core conditions as set out by Rogers, as they include the client experiencing empathic understanding for their perceptual field, unconditional positive regard and congruence.[19]

POTENTIAL CONSEQUENCES OF RISK ASSESSMENTS

Reeves[20] acknowledges the desire as a practitioner to want clients to be safe, but also acknowledges research from Large et al,[16] which highlights how inaccurate tools aimed at predicting risk can be. In addition, Procter[21] highlights that one of the aims of therapy from the person-centred approach is to reduce 'power over' a client. It seems reasonable to conclude that directing the dialogue between client and counsellor through a risk assessment questionnaire is likely to give the counsellor power. Reeves[20] highlights counsellors' '...willingness to abandon discourse when it comes to suicide in favour of risk questionnaires...', but the points made here and throughout this article perhaps reinforce the importance of dialogue between counsellor and client. They also underline the importance of supervision as a means to explore not only the client work, including the ethical and legal considerations, but also – crucially – the position of the counsellor in relation to suicide, in order to enable a thorough understanding of the direction of the work and any potential influences placed upon it.

FINAL THOUGHTS

Through completing this study, I was surprised at how little research and commentary there was about working with suicide from a person-centred perspective. Rightly or wrongly, I was left with a sense that discussing a client's suicidal feelings is not viewed as a person-centred counsellor's job, or that, as counsellors, we might judge those who feel suicidal. However, it feels to me that it is of vital importance to have a dialogue about suicide and to provide a space for practitioners to discuss their personal views, given the current rates of suicide, and presumably, therefore, the frequency with which counsellors are dealing with the risk.

As a person-centred practitioner, I work according to the fundamental principles of actualisation and trust in the individual, and the process of stepping into another's world, without judgment, while being genuine and empathic. I hope to hold on to this at moments when I may be considering if I am enough for a client and perhaps considering reaching for a risk assessment. Of course, the wish to keep a client safe will always be at the forefront of my mind. However, I also recognise that I do not want any of my clients to feel judged or isolated and, having spent hours immersed in notes written by those who were about to take their own life, I felt that those feelings were apparent. On that basis, this research has only made me more determined to discuss all of my clients' feelings, regardless of how difficult they may be for me, as the counsellor in the room.

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A FRIENDLY RESPONSE TO CRITIQUES OF IAPT

ELAINE DAVIES

I have been keenly aware over the last few months of the criticism that is being levelled at the use of CBT within the NHS, and in particular within IAPT in England (in other parts of the UK, CBT is less a subject of controversy). Three recent articles in this journal,[1] *Therapy Today*[2] and *CBT Today*[3] have been scathing about the focus on CBT within IAPT, as has a recent publication – *The Industrialisation of Care: Counselling, Psychotherapy and the Impact of IAPT*[4] – and the conference that accompanied its launch. As a CBT therapist, supervisor and lecturer, I have found myself becoming angry and felt overwhelmed; I have found some truths that were hard to accept and heard some myths that I wanted to bust.

'The NHS has been like a family to me for 35 years; how can I pretend not to care?'

When I told a non-counselling friend about how upset I had felt at the launch conference, she said, 'If that were me, I would have left and gone shopping'. It made me both smile and reflect on why I could not do that. Key values that I hold are 'family first' (not just the one we are born into), loyalty, compassion and kindness, all peppered with spirituality and religious faith. The NHS has been like a family to me for 35 years; how can I pretend not to care?

When I began writing this article, I wanted to criticise and retaliate against the negative views I had heard and read. I was fuelled by anger and frustration about the NHS, IAPT, CBT and politics (with a big and small 'p'). There is plenty to write about IAPT – all NHS services and public services, in fact – police, doctors, nurses, and teachers. Many are feeling helpless, worthless, underpaid and under-resourced. We can have heated debates about these services – and the philosophical, political, social and environmental travesties – but if we do not have each other, then none of this will be relevant.

And so, instead of expressing my anger and frustration, I have chosen to sit and reflect on my own thoughts, feelings and behaviour, which, in turn, has created change. So, what I want to say to those who have been critical of IAPT is: I get it, I really get it. You are hurting, you are chasing your dreams; some of you are filled with anger, sadness and frustration. I am too. We are all travelling this road together, at a time when, as human beings, we seem to care less and less about how we impact each other. We forget about the feelings of others in pursuit of our own gratification; I see that in myself too.

I will continue to strive to be open to discussions about IAPT, but I will stop at abuse. I would encourage us all to show compassion for the attitudes and experiences that lie behind behaviour that we find unpalatable, and separate the behaviour from the personality. I hope we might all make more effort to understand ourselves and our own reactions. We can do this in reflective logs, through writing articles and in supervision. Doing this will reduce the risk of retaliation.

Beck[5] refers to the rigid expectations of compulsive attempts to regulate the behaviour of others, what he calls 'the tyranny of shoulds'. People should..., the NHS should..., services should..., clients should... All of these are bound to lead to disappointment, frustration and – adding my own word – fatigue.

Lately, I have been working on my own authenticity, and this article is a reflection of that. It's not easy because I have aspirations and dreams left to fulfil that could be marred by this. Authenticity allows us to bring our full selves to our work. There will be less of a divide between the personal and professional self. Leadership and role modelling can be the centre stage for authenticity, integrity, respect and love for another. As Ryde & Sofianos[6] emphasise, my authenticity sits with me, yours with you. In writing this article, I have had a moment of clarity that has helped me, but more importantly will enhance my work with clients and supervisees.

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RETHINKING THE DELIVERY OF IAPT ASSESSMENTS

VICKI PALMER

THE STATE OF ASSESSMENTS

Where there is high demand for talking therapy, there are always tensions between cost effectiveness, clinical effectiveness and demand. We want to see people quickly (which we know works best), yet we have a commitment to achieving the best for our existing clients and we have to consider cost. For as long as therapy has been offered through the NHS, these tensions have been prominent for therapists and have tested our ethical sensibilities.

In order to manage high demand at the front door and reduce cost, it seems logical to offer brief assessments, delivered by the least experienced workforce, and then enable clients to see the best therapist for them, when they next have space available. This is the model that has been adopted since the original IAPT demonstration sites were established in Doncaster and Newham in 2003–2006. All IAPT sites offer a phone assessment of 30–40 minutes, using primary care wellbeing practitioners (PWPs), the cheapest part of the workforce.

QUESTIONING ASSUMPTIONS

However, together with colleagues with many years of experience of providing counselling in primary care, I began to question these assumptions. We wondered what would happen if we offered more expensive, longer initial sessions of one-and-a-half hours with our most experienced therapists, and delivered both therapy and assessment in the first session. In 2015, South Gloucestershire Clinical Commissioning Group thought it worthwhile to test these ideas. They invited the University of West of England (UWE), the University of Chester and their two current IAPT providers (the local NHS Mental Health Trust, AWP, and our third sector organisation, Oasis-Talk CIC) to design and conduct a research project. When it came to delivery, AWP decided not to proceed, so Oasis-Talk CIC conducted the two-year pilot. The universities could only support the first year, so the second year results were not part of the research project; they were analysed instead by the Oasis-Talk data analyst as a refinement of the pilot.

RESULTS OF THE PILOT PROJECT

In the first year, Oasis-Talk conducted one-and-a-half-hour, face-to-face therapeutic assessments (consisting of therapy plus assessment), delivered by the most experienced – and therefore more expensive – therapists. The results were surprising, with the longer sessions producing a more cost-effective and clinically effective way of delivering assessments. In the pilot study, 39 per cent of service users found that this one therapeutic assessment session with an experienced therapist was sufficient for their needs. A follow-up was carried out within four weeks to check that this was still the case. Those clients who did need therapy required fewer sessions overall than under the existing system. This was due to them receiving the right approach for them and their issues, and to them understanding what the therapy would be offering them. Recovery rates for these people were 10 per cent higher than for those service users who saw exactly the same therapists for their therapy, but had received a phone assessment with a less-experienced PWP.

'Where there is high demand for talking therapy, there are always tensions between cost effectiveness, clinical effectiveness and demand'

In the second year, we delivered cheaper therapeutic assessments of one hour. We found that 32 per cent of service users found this sufficient, together with follow-up. Those who needed therapy required more sessions on average and the improvement in recovery rates reduced from the first year.

Chester University carried out a cost modelling exercise, comparing the whole treatment for people receiving the longer face-to-face therapeutic assessment with experienced therapists, with those who received the usual cheaper phone assessment. They found that it was significantly cheaper to offer the longer therapeutic assessment because of the reduction in average overall sessions needed. Knowing that there could be independent factors influencing this outcome, such as different organisations contributing to the cost modelling, Oasis-Talk created its own cost model for longer therapeutic assessment; this showed that it was marginally cheaper to offer the longer therapeutic assessment.

IMPLICATIONS

Going forward, Oasis-Talk is adopting this model, as it offers greater patient satisfaction, clinical effectiveness and cost effectiveness. It is important to note that the pilot involved a relatively small cohort of the population and has not been tested over a large population for viability. It will take courage for a service to adopt this longer therapeutic assessment in a larger population and remains counter-culture for now. However, we hope that this model will offer a viable alternative for other organisations hoping to improve service provision and service user recovery.

*This is a regular column by **Vicki Palmer**. Vicki is a BACP senior accredited counsellor and supervisor, and a member of the BACP Healthcare Executive. She has also developed and taught on counselling and supervision diploma courses in England and Scotland, and is the CEO of Oasis-Talk. To contact Vicki, please email hcpj.editorial@bacp.co.uk*

REVIEWS
BY JOANNA BENFIELD

BOOKS *REVIEWS*

COUNSELLING SKILLS FOR WORKING WITH GENDER DIVERSITY AND IDENTITY

Michael Beattie and Penny Lenihan, with Robin Dundas

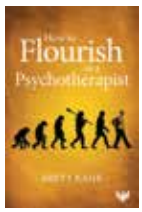
Jessica Kingsley Publishers

ISBN 978-1-78-592741-6 £25.00 (paperback)

This excellent book provides a comprehensive introduction to gender identity and gender dysphoria. It combines theoretical and practical aspects and covers legal, employment and medical aspects of gender dysphoria, as well as providing a comprehensive guide to psychotherapeutic skills and approaches for working with this client group. It is structured into three parts, the first of which takes a general look at gender and gender identities.

The second section explores gender dysphoria, while the final part considers practitioner self-care and supervision. Each chapter includes exercises, case vignettes and reflection points that help the practitioner to make sense of the material in relation to their own practice. The authors emphasise the importance of reflexivity for cisgendered practitioners working with transgender clients. They challenge readers to explore their own prejudices and to gain an understanding of the challenges that many transgender clients face in everyday life.

This book does not attempt to make the reader an expert, but instead equips the therapist to be able to sit alongside their client with a greater sense of understanding and empathy for their lived experience.



HOW TO FLOURISH AS A PSYCHOTHERAPIST

Brett Kahr

Phoenix Publishing House

ISBN 978-1912691036 £24.99 (paperback)

Having enjoyed listening to Brett Kahr speak at a number of recent conferences, I was very keen to read his latest work. He is an erudite, reflective psychotherapist, who has a real skill for presenting his ideas well, both in person and on paper. This book is a personal reflection on Brett's own experience of carving out a successful career as a psychotherapist, as well as a useful pointer to those of us considering how to develop our own professional lives. As I am leaving my role as Editor of this journal, the book gave me a useful opportunity to reflect on how I might continue to develop my professional practice in the months and years to come.

Brett takes us on a journey through the potential career path of the psychotherapist, from training to practising and supervising, teaching, researching and writing. He also considers how we might support ourselves outside our professional lives, and addresses professional pitfalls, such as the inevitable sedentary lifestyle.

In terms of my own reflections on reading this book, I realised that I need to carve time into my day for movement and fresh air, away from my therapy room, as well as make time for writing. I believe there is much in this book that will give therapists pause for thought, and help them reflect on the changes they might make, in order to ensure professional and personal fulfilment.

COUNSELLING SKILLS FOR WORKING WITH SHAME

Christiane Sanderson

Jessica Kingsley Publishers

ISBN 978-1-84-905562-8 £22.99 (paperback)

Shame is an emotion that we come across regularly in our therapy rooms, not only in our clients but also in our own responses to their material. This book helps therapists to identify shame responses and build resilience, both in their clients and in themselves.

The author begins by exploring the language of shame and highlights its positive aspects – which promote bonding – and its negative aspects, which can erode the self. She explores how shame develops in early attachment relationships and examines the intergenerational transmission of shame. Subsequent chapters explore the sources of shame and shame reactions. The chapter on sex and shame highlights an area often not covered in training programmes.

Of particular interest for me was the focus on shame in the therapist and how we might recognise and regulate this in client sessions. The author considers how therapist and client shame can become entwined in the therapeutic process, and helps therapists to identify triggers for shame.

This book is skills based, and includes reflection points, exercises and practical suggestions for working with clients. All in all, I found it to be a useful and insightful resource.

BACP HEALTHCARE ROUND-UP

FORTHCOMING BACP EVENTS

AGM

BACP Annual General Meeting
7 November – Salford and online

Professional development days

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

Developing your understanding and skills in practice to work with erotic transference and countertransference
15 November – Cardiff

Facilitator: Sally Openshaw

Working with soul across the lifespan
20 November – Wigston

Facilitators: BACP Spirituality division

'A bit of a strange thing' – the unprepared client and therapy
30 November – Exeter

Facilitators: Trish Blundell and Marcia Hayley

Suicide and suicidal ideation
13 December – York

Facilitator: Kirsten Amis

Developing your understanding and skills in practice to work with erotic transference and countertransference
17 January – Belfast

Facilitator: Sally Openshaw

'A bit of a strange thing' – the unprepared client and therapy
25 January 2020 – Nottingham

Facilitators: Trish Blundell and Marcia Hayley

Culturally and linguistically sensitive supervision
6 February 2020 – Exeter

Facilitator: Beverley Costa

Integrating artwork into your counselling practice
11 February 2020 – Glasgow

Facilitator: Pauline Andrew

Therapeutically working with domestic abuse: exploring relationship dynamics and safely managing risk
28 February 2020 – Manchester

Facilitator: Gary Williams

Societal rape myths and traumatic reactions
2 March 2020 – London

Facilitator: Sally French

How to help clients with their anger – a therapist's toolkit
23 March – Southampton

Facilitator: Martin Hogg

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

About BACP Healthcare

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

Aims

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

— Sharing good practice – via the *HEALTHCARE Counselling and Psychotherapy Journal*, networks and interest groups/events.

— Providing information and resources.

— Representation at external meetings.

— Contributing to BACP responses on relevant policy consultations.

— Communicating with members (via enquiries and/or meetings).

Membership

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

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

Subscription Fees

Individual membership: £30*

Reduced individual fee: £15*

Organisational membership: £50*

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

MEMBERS' AREA

Visit the members' area of our website to download guidance for best practice and full issues of the *HEALTHCARE Counselling and Psychotherapy Journal*. https://www.bacp.co.uk/bacp-divisions/bacp-healthcare/

BACP divisional journals

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

Private Practice

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

BACP Workplace

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

BACP Children, Young People & Families

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

University & College Counselling

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

Coaching Today

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

Thresholds

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

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

To enquire about joining a BACP division, call 01455 883300. For a free of charge consultation on advertising within these journals, contact Jordan Ngandu on 0203 771 7220, or email **jordan.ngandu@thinkpublishing.co.uk**

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