

Therapy Today

For counselling
and psychotherapy
professionals

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Holding sexual boundaries

How neuroscience is changing trauma treatment

Practice dilemmas: new ethical challenge section

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- Promote the understanding and awareness of counselling and psychotherapy throughout society
- Increase the availability of trained and supervised counsellors
- Maintain and raise standards of training and practice
- Provide support for counsellors and those using counselling skills, and opportunities for their continual professional development
- Respond to requests for information and advice on matters relating to counselling
- Represent counselling at national and international levels.

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Sarah Browne
Editor

The maintaining of sexual boundaries in the therapeutic relationship is a topic that fuels the drive towards regulation, so a new qualitative research study commissioned by BACP to identify indicators that lead to sexual boundary violation is timely. But if a therapist is prepared to cross that boundary and reveal or act on their sexual feelings towards a client, isn't that something fundamental to do with them as a person and their conscience? Can any amount of training or guidance really change this?

Professionalisation sometimes seems to create an expectation of the practitioner as some kind of automaton so I found the starting point of this study refreshing, ie that attraction is normal and the therapist is a human being. The participants in the study saw the therapeutic encounter – becoming open and available to the client, and vulnerable to intense emotions – as necessarily risky. They also pointed out that therapists need

to manage plenty of other emotions that get stirred up between therapist and client, in addition to sexual feelings – such as anger, dislike and fear – which could also be potentially harmful to the client. However, talking openly about sexuality and sexual feelings, even in supervision, was seen as being a particular challenge because of the anxieties provoked by confessing them.

Ethical challenges will be the focus of a new section that we begin in this month's journal. Some of you will remember a section called 'Challenge' that the late Caroline Jones edited for many years. We have decided to reintroduce this format with the help of one of our regular contributors, Andrew Reeves. Some of the dilemmas will be drawn from BACP's ethical helpline, representing typical problems encountered in practice. We will be inviting you to respond to each month's dilemma and publishing a range of responses both in the journal and online at www.therapytoday.net

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British Indian children have better mental health

British Indian children have substantially better mental health than white British children, according to research published in the *Journal of Child Psychology and Psychiatry*.¹ The report's lead author, Anna Goodman of the London School of Hygiene & Tropical Medicine, said: 'Most research into ethnic differences focuses on issues where minority ethnic groups are doing worse than average. We believe it is also important to investigate areas where minority groups have an advantage and use this understanding as a way to improve the health of the whole population.'

Researchers used data from the 1999 and 2004 British Child and Adolescent Mental Health Surveys, which took a nationwide sample of five to 16 year olds living in England. The proportion of Indian children with any mental health disorder was 3.7 per cent, the lowest of any major ethnic group and substantially lower than the 10 per cent proportion in white children.



Indian children have fewer behavioural and hyperactivity problems

This Indian mental health advantage was driven by Indian children having fewer behavioural and hyperactivity problems. The pattern was reported by parents, teachers and children alike, suggesting it reflects a real difference and is not the result of chance or biased reporting.

Part of the Indian mental health advantage was explained by the fact that Indian children were more likely to live in two-parent families and had

higher academic abilities. In addition, Indian children did not show the strong socio-economic gradient in behavioural and hyperactivity problems observed in whites. *London School of Hygiene & Tropical Medicine*

REFERENCE:

1. Goodman A, Patel V, Leon DA. Why do British Indian children have an apparent mental health advantage? *Journal of Child Psychology and Psychiatry*. 2010; DOI: 10.1111/j.1469-7610.2010.02260.x

Choice of treatments helps anxious

A US study in the *Journal of the American Medical Association*¹ has pioneered a more flexible approach to treating anxiety, offering a choice of treatments, and giving health professionals a computer-based tool to track patients. The study included over 1,000 patients. About half were given a choice of talking therapy, drug treatment, or both; the other half carried on with the treatment suggested by their doctor. After a year, 64 per cent of those offered a choice of treatment saw an improvement, compared with 45 per cent who'd received their usual treatment. Talking therapy was the most popular choice, 34 per cent choosing just this treatment, and 57 per cent opting to combine it with drugs. Just nine per cent chose drugs as their only treatment. *BMJ Publishing Group LTD*

REFERENCE:

1. Roy-Byrne P, Craske MG, Sullivan G, et al. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. *Journal of the American Medical Association*. 2010; 303(19):1921-1928.

Mental illness and its impact on the developing world

The World Health Organisation (WHO) estimates that neurological and mental disorders are the leading cause of ill health and disability globally, but there is a lack of interest from governments and NGOs (non-governmental organisations). One reason behind this apparent indifference is the market-driven nature of aid. At NGO level, allocation

of funds is strongly correlated with a project's marketability to the general public.

Research has shown people will give about twice as much if they can empathise with an individualised picture rather than being presented with stark statistics of need. With mental health, it is much more difficult to generate empathy: there are no externally apparent symptoms to create

a good snapshot image, and it is difficult to understand what living with schizophrenia or bipolar disorder would be like. As a result, mental health charities struggle to raise funds.

The WHO states that we are 'facing a global human rights emergency in mental health'. Chris Underhill from BasicNeeds says that mental health is not just a medical concern but 'part of a larger

development related problem'. Mental illness adversely affects people's ability to work, creates a potential carer burden on families and can lead to greater poverty. Therefore, it has a significant economic impact on developing countries. Despite this, half of all countries in the world have one psychiatrist per 100,000, and a third no mental health programmes at all. *The Guardian*

Counselling effective in treating depression and anxiety

Counselling is an effective treatment for depression and anxiety within a primary care setting, with 66 per cent of clients achieving a clinical recovery within an average of six sessions. This is the key finding of research conducted by Elizabeth Freire of the University of Strathclyde and Kevin McGeever of the Lanarkshire Counselling Service, which was presented at the 16th Annual BACP Research Conference last month.

Participants in the study were assessed at the beginning and end of

counselling. The results showed that reductions in levels of psychological distress from pre- to post-counselling were large, reliable and clinically significant. The research also compared the improvement that clients achieved during counselling with the improvement they achieved while just waiting for counselling (on average, clients waited for 11 weeks before starting counselling).

The results showed that whereas clients' mental health improved significantly with counselling, no

significant improvement was achieved during the waiting period.

A total of 584 clients with common mental health problems, such as depression and anxiety, participated in this evaluation, carried out across 65 GP practices in West Scotland over the course of a year. Ninety per cent of those participants were experiencing clinical levels of anxiety and 74 per cent were experiencing clinical levels of depression at the initial screening. Clients were offered person-centred counselling or some

integrative modality based on person-centred principles of counselling.

Elizabeth Freire said: 'This research demonstrates that counselling, and more specifically the person-centred modality of counselling, is an effective and valuable choice for primary care patients. Our results show that counselling is an effective form of treatment for depression and anxiety and other non-specific generic psychological problems presented by patients in primary care settings.' BACP

Britain in the grip of 'epidemic of loneliness'

Technology and the pressures of modern life are blamed for creating an epidemic of loneliness, as increasing numbers of people rely on the internet to communicate with friends and family.

A report by the Mental Health Foundation suggests that more than one in 10 people in Britain feel lonely 'often', as increasing numbers choose to live alone, work long hours and see each other less and less. The findings, from a survey of more than 2,200 adults from across Britain, suggest loneliness affects people of all ages but that women are more likely than men to report feelings of isolation.

While the internet has changed the way people communicate, some experts



Technology and pressures of life blamed for 'epidemic of loneliness'

argue that social networking sites like Facebook and Twitter undermine social skills and the ability to read body language, the charity's report, *The Lonely Society?* adds. The report says it is too early to say whether

technology is changing our core ability to relate to others, but [it is] 'soon enough to conclude that technology is no substitute for the human interaction that is a buffer against loneliness'. *Times Online*

Depressed men are often not diagnosed

British men suffering from depression are missing out on treatment, owing to the skewed criteria used by GPs to diagnose the illness, warns Paul Farmer, chief executive of Mind. Men are just as likely to suffer from mental distress as women, and are far more likely to kill themselves. Due to the emphasis on typically female issues and the symptoms of depression, the extent of the problem among men is largely hidden. Farmer said Mind is working on how to encourage GPs to look out for more male symptoms of depression, such as aggression or anger, and is calling for 'the increased provision of mental health services tailored for men'.

The Guardian

Troops in war zones more likely to misuse alcohol

Troops serving in Afghanistan and Iraq have a 22 per cent higher risk of alcohol misuse than their fellow servicemen and women, with the greatest problems reported among those in combat roles, according to a new report published in *The Lancet*.¹

Professor Simon Wessely, the report's author, said concern over the psychological effect of continued combat exposure on military personnel may have masked a greater problem with alcohol.

The report found no 'tidal wave' of mental health problems linked to deployment, as some had predicted. However, reservists serving in Iraq and Afghanistan were found to be three times as likely to suffer post-traumatic stress disorder (PTSD) as



Troops in war zones have a 22 per cent higher risk of alcohol misuse

other reservists, while regular personnel in combat roles were found to be twice as likely to report the disorder. The mental health charity Combat Stress said the surge in alcohol misuse was 'alarming' and called for support for military personnel

to be targeted better.

The Guardian

REFERENCE:

1. Wessely S, et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. *The Lancet*. 2010; 375(9728):1783-1797.

£1m each spent on dangerous killers

A £200m scheme to treat some of Britain's most dangerous killers should be abandoned as it is too expensive with no positive results, and in some cases left prisoners more aggressive than before they entered jail, according to a leading academic. Peter Tyrer, professor of psychiatry at Imperial College, London, said almost £1m per person has been spent to keep 240 prisoners deemed to have dangerous and severe personality disorder (DSPD) in four secure units, but with 'scarce evidence' there was any improvement in outcomes. Tyrer said that prisoners in the scheme spent only 10 per cent of their time doing anything resembling therapy. Despite government denials, the main point of the programme appeared to be protecting the public rather than treating the patient.

Mental health charities called for a radical review of the DSPD programme. Paul Jenkins, chief executive of Rethink, said: 'The principle of preventive detention without an actual offence being committed is dubious from an ethical perspective and open to abuse. In addition, there is no evidence that the large sums of money invested have delivered improved outcomes in terms of either health or reoffending. At a time of pressure on public spending, this money would be much better used in improving services in the community for people with a personality disorder and in finding ways to ensure that people affected by mental illness are kept out of the criminal justice system.'

The Guardian

Relationships stronger following infidelity

Couples who forgive and rebuild their trust following an affair are likely to experience a positive change in their relationship with an increase in openness and communication. This is the conclusion of research by Dr Andreas Vossler of the Open University and Dr Naomi Moller of the University of the West of England, presented at the 16th Annual BACP Research Conference.

Around a quarter of the population commit infidelity in their lifetime, a figure which rises if cases with emotional infidelity, virtual internet relationships and other breaches of exclusivity are included. The study, conducted

with experienced Relate couple counsellors, suggested partners who cope with the impact of the disclosure of infidelity go through several stages, similar to a grieving and mourning process. Engaging with counselling/therapy during this process can help a couple make sense of what has happened, take responsibility for their actions and restore trust, and work openly on underlying relationship issues. The findings indicate varied perceptions and definitions of infidelity, partly connected to issues arising in the context of online social networking and other new technologies. Infidelity is often experienced

as a difficult and relationship-threatening event, associated with complex underlying couple/client factors. However, an affair does not always lead to the end of the relationship. Dr Vossler said: 'While there is quite a bit of research on why and when individuals engage in infidelity, there is little on how couples deal with the aftermath. There is also a lack of research about the best ways to work with infidelity therapeutically. Couple counsellors have... a privileged understanding of both these issues so this study makes an important contribution to the area.'

BACP

Because you're worth it

Kevin Chandler

The two elderly aunts lived together, spinster and widow, my closest relatives other than my wife and small children. I would call by every fortnight or so, and the visits prior to Christmas, Easter, or the children's birthdays took on a familiar pattern. One aunt would wait until the other had left the room, sidle up to me like a septuagenarian drug dealer, whisper, 'Psst, this is for the children, don't tell Nell!' then produce from her apron pocket a sum of money and hurriedly press the notes into my palm. A little while later, once she'd gone to put the kettle on, her elder sister would go through the same routine, 'Here Kevin, treat the children, but don't tell Eva!' Such familial monetary shenanigans; small wonder when I had to ask my first marriage guidance clients for a donation towards the costs of their counselling, I found it an excruciatingly uncomfortable experience, so much so that as I showed them out I walked right past the donation tin without seeing it. My supervisor later challenged me on how I was happy to give but not receive, and projected my own inner neediness onto my clients. I duly bit the bullet, remembered the tin, and over time saw client donations become 'contributions', and in turn, 'payments'. Of course I found it easier, given that the money wasn't mine, but needed to keep the organisation afloat. When I first began counselling for money, it was in a university as a salaried employee, and I was thereby freed from the ordeal of having to ask clients for my wages. But once I ventured out into private practice, there was no middleman, no overarching charitable organisation, no EAP, bringing client and

counsellor together and providing the wherewithal to keep them there. Client contributions had thus completed the final leg of their transformation into 'fees', the amount set by me, every penny of which lined my pocket. Once again, I had to learn how to ask, and how to receive, but this time, I was doing it for myself. I learned much about myself in the process: about self-value, and about the twisted legacy of the Christian message, delivered via school assemblies and endorsed back at home, that it's better to give than receive. Nonsense, it's not better at all; giving and receiving are of equal worth, each inextricably dependent upon the other and meaningless without its counterpart. I learned to no longer avoid eye contact as the cash or cheque was being proffered, and how to say 'thank you' and mean it. I also became aware of some of the deeper, symbolic meanings within the monetary transaction of therapy. (Google David Smail's unpublished talk 'Love for sale' or see 'Turning tricks' in April 2009 *Therapy Today*, volume 20, issue 3).

If I charged more, I might follow the lead of my dentist or local garage owner, and employ a receptionist to receive customers' payments on my behalf. But it would deprive the client of the opportunity to reverse roles and experience the act of giving to me, and I would miss valuable insights

into the client's relationships with therapy and with money, and how they manage intimacy within the acts of giving, receiving, asking and taking.

One client couple always assumed the other had remembered to bring the chequebook, or withdraw the necessary cash, and at the end of sessions, a row would usually break out as to whose fault it was that they could not pay. Another client was desperate to pay upfront and in advance, a month at a time, as if fearful that unless I was in her debt, I might pull the plug on her. Another, at the end of each session, withdrew chequebook from pocket, wrote the first line, then paused to deliver an observation on the session. Five minutes later, he'd have completed the amount and written the date, but would subject me to another discourse on the value of therapy before finally attaching his signature, now ten minutes over time.

I could, of course, have simply asked for the money at the start of each session, but I was more concerned with meanings than management, and his meanings seemed all about power and control. When at last, he loosed the cheque, he reached out and allowed it to flutter down onto the coffee table, where it lay, waiting for me to retrieve it. I thought of pearls cast before swine, of anonymous pennies tossed into beggars' caps. I remembered the embarrassment of my aunts, and my earlier difficulty in asking for help. I picked up the cheque and said, 'Perhaps next week we can begin by exploring your fear of looking me in the eye and saying, "Here you are, thank you."' ■

'When at last, he loosed the cheque, he reached out and allowed it to flutter down onto the coffee table, where it lay, waiting for me'

Kevin Chandler is a therapist and supervisor in private practice, and author of *Listening In: A Novel of Therapy and Real Life*.

In the client's chair

Change is happening

Emma Munro

My therapist reminds me that we are nearing the end of our sessions of CAT (cognitive analytical therapy). I don't remember there having been any discussion about the precise number of meetings we were to have, but I am happy to bring matters to a conclusion. Being in therapy makes me feel raw, vulnerable and unravelled. At times I can overreact emotionally to situations and this isn't comfortable long term. I suspect that people on the outside can detect in me a change of tempo, even if they can't figure out why. I also have a sense of impatience. Enough of all this soul-searching. I want to put myself back together, hopefully in a more positive way, and just get on with things. Therapy makes me less dynamic in other areas of my life and that has its own frustrations.

I think we can say that we have identified early dependency issues and some lifelong, repetitive patterns of behaviour in intimate relationships that stem at least in part from these. The flow diagram my therapist drew for me, that characterises my behaviour, sits between us each session. I have found the diagram helpful, but limiting and increasingly irritating. I'm just not that straightforward or predictable, and I'm sure that would apply to anyone.

Knowing that time is running out instils a sense of urgency and I feel very focused on getting answers and strategies for change. For me, a time limit is a refreshing relief, having experienced psychodynamic psychotherapy with its seemingly never-ending meanderings. I now understand myself a bit better, so what am I going to do about it? How do I fix that feeling of aloneness and emptiness I've had for as long as I can

'I grapple with new ways of thinking and being, trying to catch myself before I go down the same path again'

remember and stop it affecting every intimate relationship that I have? Early dependency issues are difficult to fix, says my therapist. Yes, I know that. He says that CAT helps you to recognise what is going on. To do this he has analysed for me what is happening. But now what I actually want is to be told what to do – a list of dos and don'ts for the future. However my therapist stops short of giving me any answers.

It seems I have to come up with the solutions myself. In the sessions and outside, I grapple with new ways of thinking and being, trying to catch myself before I go down the same path again. I get over-involved in intimate relationships and then get resentful. My resentment and hurt can result in lashing out verbally. So I'm going to try to stop that. I tend to go for people who need fixing or helping in some way, so I have to avoid the weak and the needy. I've certainly got to stop trying to change people. To be fair, often they don't actually ask for my help, although they seem happy, at least initially, to have it. I should spend more time concentrating on myself and let others get on with themselves.

Friends are different. I do not seem to have the same problems with this type of relationship. I've got a problem when I step over an invisible intimate boundary line, apparently. Perhaps it's wise not to make such a step, but then there's no real intimacy

in your life. Possibly getting over-involved is an attempt at being a super wonderful me because I don't feel loveable enough just being myself. How do you feel loveable enough? Love myself, protect myself from harm, believe that I deserve the best and somehow magically I will get what I truly deserve. I'm just back to self-help affirmations again. I had those before therapy. All tools in the box, I suppose.

In the past I have found that the difficulty lies in internalising the lessons that I have learnt. It's all fine and good having the theory, but it's much more comfortable to react and be the way you have always been, especially in a stressful or difficult situation. I'm not in an intimate relationship with a man right now so it's hard to practise and see if I can make a better job of boundaries.

I think the major difference I am noticing is that of awareness. I don't know if this is a result of the therapy itself, the fact that I have given myself some time to think or the influence of Eckhart Tolle's work. It's as if there are two layers of thinking going on in my brain. There is an observer and a doer. The observer is the one with the insight and the new wisdom, the doer is the old me on automatic pilot. In the split second before I say or do something, I am observing myself and am not completely absorbed just in the doing of it. So even if I say or do something that is part of an old pattern, I am instantly aware of it. At times I have acted before I can stop myself, but I believe, in time, I will be able to stop myself more and more. Change is happening. ■

Some details have been changed to protect identities.

Speaking for myself...

Martin Halifax

As we have always known, at the heart of good counselling is the art of communication, the ability to listen keenly and attentively and (more or less regardless of theoretical leaning) to respond clearly and empathically. This involves being able to enter the client's world, to appreciate their position... to speak their language.

In all but very few instances, language would seem to be a common bond between tutors, supervisors, counsellors and clients – we may share the same mother tongue, yet within this shared inheritance there seems to be almost endless possibility for misinterpretation and crossed wires.

The truth of course is that we each speak a different version of English, influenced by class, gender, profession and cultural upbringing; we all have our own *idiolect* – a language store from which we choose appropriate registers for different occasions: I will use a different English in the pub with friends than I would in church with grandparents. To communicate effectively though, you must be speaking your *own* language – a language you own. As we come to the end of two years together as a student group, there are signs that this may be harder than it sounds.

In the field of language study, the measure of a successful or well-meaning relationship is *linguistic convergence*. The premise is that we all start at different places on a language continuum and, in an attempt to allow our minds to meet, we move along the continuum towards each other: when a GP is holding a surgery with a hooligan, the doctor tones down the

Latin and the hooligan curbs the swearing in an effort to meet in the middle and speak a language they can share. But if we begin by speaking a version of English that is misrepresentative of our own position, this can only cause confusion.

In an artful simile, a clear and skilful convergence, (coming to meet me as the sole male in the group) one of my course tutors likened studying on this diploma to entering a sports academy. We have all come armed with a belief in our ability to communicate, just as a golfer might arrive at the academy with an innate ability to hit a golf ball a long way in a straight line. But just as the golfer might spend a year dismantling his/her swing in order to rebuild and perfect it, we have spent two years deconstructing and examining our modes of communication and learning new ways. At first, we are very conscious of these new ways, to the point where communication becomes stilted and jerky. We have acquired new counselling phrases and jargon, a language of mild expertise. I have heard and used a lot: 'I wonder what it's like for you? ...That looks difficult to hold... I may need to work on/process that...' At times, as with new sports kit, though it has been well used, we have been over-protective of it, somewhat

precious and reverent. In other ways it has resembled new kit in feeling awkward and ill fitting or borrowed. Sometimes this jargon has felt like pebbles in my mouth; my tongue has felt as if it were trying to form someone else's words. In terms of the language continuum, it has felt, at times, as if I have set up a dry and awkward interchange where the client with whom I have used these phrases is trying to join me in a language I don't own and can't sustain.

Within the confines of the course though, a group of individuals who adopted *en masse* this new language in order to become counsellors, have started to talk in an English that eschews this jargon and sounds almost brutal at times. In a whole group discussion recently, one woman described her supervision group as 'a right bunch of b*****'. Of course she was expressing a fairly deep attachment to her supervision group – and her group knew it. It spoke volumes about the importance of language – not just words (the words are the literal opposite of what she meant) but the tone and the intent. There are many ways of saying what you mean. Importantly, the message she wanted to convey was the more powerful because she sounded like herself, not like a counselling trainee or even a counsellor.

Which seems to be the message – and the end of our tutor's extended metaphor: after the deconstruction, the rebuilt swing/conversation needs to look/sound natural, to belong to you. ■

'Sometimes this jargon has felt like pebbles in my mouth; my tongue has felt as if it were trying to form someone else's words'

Some details have been changed to protect identities.



Therapy can be confusing: two people converse in a private room, one in distress, the other described as a helpful expert. At least one of the two is likely to express thoughts and feelings usually kept secret. In other circumstances, the exchange of such intimacies may herald a more physical relationship. For therapists, however, the professional relationship explicitly precludes such contact. The *BACP Ethical Framework for Good Practice in Counselling and Psychotherapy*,¹ for example, requires that practitioners must not abuse their client's trust in order to gain sexual, emotional, financial, or any other kind of personal advantage. Sexual relations with clients are prohibited, along with sexualised behaviour.

While psychotherapists and counsellors generally acknowledge that sexual attraction is a common and often ordinary human response to another, they also recognise that acting on such feelings in therapy will quickly become problematic. The early psychoanalytic community had to confront and respond to such instances as Jung's relationship with Sabina Spielrein.² Rosie Alexander's³ description of the times she sat on her therapist's knee and felt his erection, elicits a mixture of emotions in the reader, not least shock, and the narrative is saturated with a sense of betrayal.

There have been several types of research investigating boundary breaches and sexual boundary violations.⁴ In spite of these, however, there is little certainty

about how common sexual boundary violations are, as the sources of information about them (confession, client reporting, complaints to organisations, and knowledge of colleagues' conduct) are all vulnerable to error. Further studies have attempted to identify characteristics of transgressing therapists and the factors that contribute to such events (see Moggi et al⁵ for an example), and to understand the effects on clients who have experienced therapist-client sex.⁶ If sexual feelings are ubiquitous and sexual attraction a real possibility in the context of the therapy relationship, how are these managed in therapy? Complaints about sexual boundary violations form a small proportion of complaints about therapists and health professionals.^{4,7,8} Is it the prospect of opprobrium from colleagues or the threat of sanctions from regulatory agencies that contains the relationship within professional boundaries? Do reported violations represent only a small proportion of actual sexual boundary violations?

Managing sexual boundary issues

We recently completed a qualitative research study commissioned by BACP to increase understanding of the processes leading to sexual boundary violations by counsellors and psychotherapists. The study explores how practitioners manage sexual boundaries in their work and makes recommendations

If sexual feelings are ubiquitous and sexual attraction a real possibility in the context of the therapeutic relationship, how are these managed in therapy?

By Carol Martin, Mary Godfrey, Bonnie Meekums and Anna Madill. Illustration by Gwénola Carrère

Staying on the straight and narrow

to minimise the risk of any violations.

Employing in-depth qualitative interviews, the study sought to elicit accounts from therapists of episodes in which they had felt attracted to clients and the strategies they had employed to manage the situations without committing a sexual transgression. Thirteen practitioners who met the following inclusion criteria took part:

- Accreditation as a counsellor or psychotherapist
- No previous history of having committed a sexual boundary violation or having been subject to an investigation concerning a sexual boundary violation
- Extensive experience of clinical work since qualifying, some of which was carried out in private practice (see Godfrey et al⁹ for details of methodology).

Three issues are important to note at the outset. First, whilst our particular focus in this study was management of risk of sexual boundary violations, many of our participants, although acknowledging the significance and ubiquity of sexuality and the erotic in their work, made the point that sexual feelings are not the only emotions that may be ‘stirred up’ between therapist and client. Other emotional responses can be evoked that have the potential for destructive and constructive impact on clients – anger, irritation, fear and dislike, for example – and the therapist is required to manage these reactions for client benefit.

Second, clients and practitioners may use sexuality or sexualisation as a way of avoiding or masking relationship difficulties or problems of intimacy. Third, the therapeutic encounter was seen by most participants as necessarily risky in the sense that engaging with and understanding the client means becoming open and available to the other, and vulnerable to intense emotions. Understanding and managing intimacy was viewed as a core activity. Therapists described feelings and attending to those feelings, ie they are simultaneously participants and observers in the clinical encounter. Even so, sexuality and sexual feelings were seen to present particular challenges: they were seen as difficult for therapists to talk about openly, even in clinical supervision, because of the anxieties raised by confessing them.

Managing emotional depth

Through detailed exploration of examples from therapy, we developed a framework or model of the therapeutic process, the components of which appeared essential toward managing emotional depth, including sexuality, in therapy. This comprised five elements organised temporally:

- The first involved noting or asking ‘What is going on here?’, often provoked by anxiety, unease or an awareness of an unusual reaction to the client’s appearance, stance or behaviour
- Next, facing up to it personally:

‘This is something I have to deal with’

- Then reflecting on the way the therapist has become involved, including their own vulnerability and fallibility; processing the personal and professional implications and the contributions of their earlier life and current circumstances to their conduct
- Moving from the focus on self-experience and the relationship to a focus on the client, integrating this knowledge into their formulation of the client’s difficulties
- And lastly working for therapeutic benefit, translating the understanding of the situation into a form that allows a considered therapeutic intervention, whether explicit to the client or not, and which remedies any boundary lapses.

For example, one therapist spoke of seeing a client who wished they could attend a social event together. Although the therapist felt in no danger of agreeing to this, the event nevertheless raised a mixture of feelings, one of which was the wish to agree. On reflection, the therapist understood that, in addition to any attraction to the client, there was a wish not to deprive the client and have the client face loss, rejection and loneliness. In another account, the therapist, who felt attracted to one group member, recognised the risk of alienating the group and began to identify the boost resulting from the idea of a special relationship; this was increased by the experience of current marital conflict. A third spoke of the added vulnerability experienced when single; temptation felt stronger when there was

‘The majority of practitioners concurred on the universality of sexual feelings and felt that feelings of attraction were not in themselves problematic or shameful’

a gap in personal relationships, requiring vigilance about one's own motivations.

The participant-observer stance identified as essential for this process to work well is compatible with Celenza's¹⁰ definition of empathy, which also notes an experiential and a reflective element. This definition describes empathy as a skill comprising two simultaneous processes: one the experience of resonance with the client, the other a capacity for staying separate in order to observe the emotions experienced.

Problematic responses

The therapists described times when they felt they had worked successfully and others when they felt less satisfied. These were sometimes attributed to inexperience and sometimes to characteristics of the total situation, such as events from the therapist's personal life. Often these accounts were accompanied by expressions of shame and regret or suggestions of what had been learned from the experience. It seemed that the process could be derailed at any point along the way. The therapists, however, identified key moments and some predictable reactions. Difficulties arose when therapists felt anxious, ashamed or over-enchained with their clients. Four types of problematic response were identified:

- Self-neediness/over-identification
- Overprotective anxiety
- Protective/defensive
- Moralising/omnipotent.

Whereas the first two were more likely to place therapist and client at risk of a sexual boundary transgression, the others were also problematic in respect of client benefit. At times of personal difficulty and stress, therapists experienced themselves as needy and felt this in relation to some clients. One therapist acknowledged feelings of neediness after a relationship breakdown; working with a client whom the therapist found attractive was experienced as an additional stressor. The therapist described acting rather than reflecting during supervision sessions and having difficulty deciding whether the attraction was real and even mutual. Although this therapy reached its planned end with successful outcomes for the client, the therapist was left with feelings of longing and anguish.

In other examples, therapists found they had over-identified with clients' feelings and had attributed their own distress to the client. In one, a therapist had been so affected by a client's narrative that the client recognised that the therapy had broken down. When this happened, there were sometimes examples of overprotective anxiety, often seen by therapists as maternal. Examples offered included giving a client a personal phone number, carrying on a text conversation outside therapy, and touch. One therapist identified the motivation for reacting maternally to a client's hug as an attempt to minimise or avoid sexual elements in the relationship while not totally rejecting

the client. In these examples, the breach did not lead to a sexual boundary violation but each therapist learned something from his or her activity, often noting anxieties about potential conflict.

In contrast, self-protective or defensive reactions were often identified later, after noting and facing up to them personally. These were instances when anxiety led to an unthinking, sometimes punitive intervention, often one that could easily be interpreted as rejection. In one example, a client sought social contact, and never returned after the therapist reacted by saying, 'This is therapy and we're here to work for your benefit... there's no point in coming here otherwise.' This therapist regretted not exploring the client's request more empathically. Superficially, such interventions seem to be reinforcing the appropriate therapeutic boundaries. Alongside this intention, however, was often a wish for the situation, if not the client, to go away. This therapist prioritised self-protection when managing the anxieties of feeling attracted to a client. Similar to this was a moralising or omnipotent stance. This too involved increasing distance from the client, containing elements of superiority, in either being expert or moral, in contrast to the client, who was seen as weak and the origin of the problem. In one example, the therapist had told a client that therapy was not for being comforted or for socialising, ie it was a professional relationship, where these warm feelings

'Is it the prospect of opprobrium from colleagues or the threat of sanctions from regulatory agencies that contains the relationship within professional boundaries?'

were out of place. In employing these strategies, the therapist acts to maintain their position and reduce anxiety by acting as though the client is bad or not co-operating sufficiently. Although there was no sexual transgression, the therapeutic relationship was damaged, at least temporarily, and in other examples, therapy ended or the client deteriorated.

Sources of support

The major source of support identified by these therapists for managing intimacy and distance was supervision. When this worked well, it seemed to offer a secure space in which to reflect on issues that raised anxiety and embarrassment. Good supervisors were characterised as supportive and challenging; able to recognise and easily discuss sexual issues, taking the experience of attraction as normal; understanding but firm about boundaries; and prepared to explore parallel processes. Other supports included positive experiences of training about ethical issues and boundaries, personal resources, good relationships socially and at work, and a therapeutic framework that allowed the therapist to develop a rationale for keeping to boundaries, for understanding boundary threats and compromises, and for considering appropriate and helpful interventions. What therapists described when managing threats to boundaries well was the capacity to respond to the client's needs empathically, engaging

while continuing to reflect (participant-observer). Successful supervision acted to assist the therapist to regain that dual capability after recognising that the balance of the two had been disrupted. Therapists seemed more likely to experience lapses, distress and boundary crossings if this was not achieved.

The majority of practitioners in the sample concurred on the universality of sexual feelings and felt that feelings of attraction were not in themselves problematic or shameful. For most, the emphasis was on the meaning of and response to such feelings. Signals included anxiety, unease and sexual attraction and sexual conduct outside the normal range of the practitioner – eg flirting or minor boundary breaches that indicated pressure on the therapy boundaries – and took them as signs that something more needed to be understood. Practitioners used a number of resources for this: some mentioned training and clear ethical guidelines; others had developed frameworks for making sense of sexual attraction and sexualised behaviours. In particular, some therapists understood sexualised relationships as protective strategies, masking direct expression of other conflicts or needs. These included attempts to avoid experiencing emotional pain or loss, and therapists' reluctance to face the client's disappointment or anger, or strategies employed to manage self-esteem and self-worth. These formulations

facilitated therapeutic use of boundary breaches to the benefit of the client.

In conclusion, when facing sexual attraction in therapeutic sessions, clinicians experience a number of issues to balance and tensions to manage. While personal characteristics and vulnerabilities may play a significant part in sexual boundary violations (something that this study did not set out to answer), these participants found a variety of ways, more or less successfully, through the clinical situations they faced. Their accounts stress the value of developing skills in the use of theoretical frameworks that aid therapists to understand their experience of therapeutic relationships and in the management of ethical dilemmas, combined with clear, contained and supportive supervision. To answer our earlier question, our participants, while affected by the prospect of sanctions and opprobrium, demonstrated in the most successful examples of their work, a capacity to see pressure on therapeutic boundaries from sexual attraction as integral to the challenge of therapy itself: to maintain or restore an optimal balance of intimacy and distance was a source of satisfaction. ■

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Dilemmas

Reaching out for help

In the first of a regular new column, *Andrew Reeves* invites readers to respond to a typical ethical dilemma

I suspect I am not the only counsellor who has reached for the *Ethical Framework* at times of difficulty or confusion, only to find that the wished-for answer isn't there. Wouldn't it be nice if the *Ethical Framework* could be so all-encompassing that it comprehensively addressed every possible ethical dilemma we are likely to face in practice? That is, of course, impossible and not its purpose. Instead, the intention of the *Ethical Framework* is to provide a structure through which we can develop our thinking and set out clear benchmarks of good practice.

However, once we move away from the generalised into the specific, 'rights' and 'wrongs' are harder to find. Like many of you I am sure, I remember reading the

'Challenge' column in *Counselling* and then *CPJ* in which dilemmas were presented alongside some thought-provoking responses. I found this an invaluable opportunity to help develop and challenge my own thinking; so I was delighted to be asked to relaunch this column.

I plan to outline a typical ethical dilemma encountered in practice in each issue and invite readers to email me their thoughts. I am keen to hear from anyone who has something to say: clients, trainees, psychotherapists, counsellors, policy makers, and so on. To illustrate the structure of the column, some responses to a dilemma are outlined below. The first dilemma I would like your response to is outlined at the end. The situations

and people are fictitious, although they are obviously informed by situations that can occur in practice.

This month's dilemma

Matthew works as a counsellor in a large organisation. He is seeing a member of staff who has been suffering from work-related stress for some time. He receives an anonymous letter about his client, which states that it is important he knows the client has 'mental health problems', and then goes on to detail things they have allegedly said or done in the workplace. The client does not know about this letter, and Matthew does not wish to cause the client further distress by declaring it, given it was anonymous. What should he do?

Rick Fothergill,
Cognitive behavioural
therapist



While there may be issues about disclosing the information to protect the wider public (who may or may not be at risk from the client, due to the client's 'instability'), there are several other issues to consider in making a decision to share information that cannot be verified.

Firstly, one must question the validity of information received from an anonymous source. I wonder why the author of the letter has chosen to hide their identity? There may be many reasons for this: hostility towards the client from a jealous work colleague, or reprisal and malice from a spurned partner hoping to cause hurt or harm, for example.

Secondly, one should consider the effect upon the therapeutic relationship of revealing the contents of the letter. If the client feels that the special nature of the

relationship can be infiltrated so easily, they may lose trust in your commitment to them, or feel judged and then they may not return for further help and struggle to manage on their own, never seeking assistance again. A further risk is that the client finds out later that a letter has been sent to you and challenges your congruence in not telling them about it.

Hence we could argue that the client has a right to see the letter but it should be made clear that you are being objective towards the client, given that the information cannot be verified. This may provide an opportunity to open a dialogue about issues that the client may not have already revealed to you.

All these aspects lead to the final issue. One should carefully consider the professional credibility of counselling. The client might feel betrayed or let down by

your actions, or lack of them, and thus broadcast their feelings to all and sundry. So what to do with the letter? In my view it should be shared with the client. Balancing congruence and respect is never an easy task, but in this case it is necessary. This then prevents dilemmas about ignoring the letter (and the subsequent possible repercussions), its storage and, in the worst-case scenario, reprisals from the client or others. Of course much of this is dependent upon the content of the letter. Clearly, if serious or dangerous aspects were included, the decision to act on it or share it is probably simpler.

On a final note, I'm always aware of situations in the past where practitioners have been criticised for not sharing small concerns that later present a bigger, more serious issue.

Dilemmas

Brian McMinn,
Gestalt psychotherapist



This situation would present a unique opportunity for my client and for me as a Gestalt therapist. I subscribe to the idea, central to Gestalt theory and other humanistic approaches, that we all exist in a co-created field of experiencing; client problems are viewed as relational rather than intra-psychic. I'm interested from when my client enters the room how I play a part in my client's difficulty; and I play some part. In this case, I have additional information, which I wouldn't usually want or expect, and it is part of the client's relating in the field.

By reading the letter, which I could choose not to at a very early stage, I have information about my client which he has not disclosed; someone else's experience of him. There is a possibility of course that he may have sent the letter himself. After I read it I cannot 'not' have this knowledge, but I can suspend my judgment (called 'bracketing' in Gestalt therapy). If I chose to suspend, while I wouldn't be verbalising this information, my embodied reaction remains in the field, and will be known to the client at a subtle level at least.

Who would send such a letter and for what purpose? To derail the therapy process maybe? An oppressor in my

client's world? An oppressed colleague? A well-intended friend? Gestalt therapy is interested in supporting embodied, or 'lived', awareness which emerges from the actuality of my client's experience in the here and now of the session; not about assumptions, rationalisations, interpretations. Whilst these latter elements are an important aspect of experience, they hold importance to the therapy work only in as far as they are embedded as part of the wholeness of my client's and my experience. Attempting to work out a third party's motivation would be futile; assisting my client in reclaiming his projections onto third party others could be rich in possibilities.

How would my client be if I told him of the letter? Would it make him suspicious and affect his functioning detrimentally? Might he experience shame? Could it help him know and explore the impact of his presence on others and on me? If I judged that disclosing would facilitate our work and offer something to the quality of contact between us, and between my client and his world, I would disclose. Of course this is an experiment, and as with all true experiments, the outcome

would be unknown. I would want as far as practicable to be able to contain whatever reaction occurred. My decision, even if thoroughly considered and supported by supervision, could prove to be an error of judgment.

I like Bion's quote that therapy is 'a meeting of two frightened people', and more recently Joan Armatrading's comment, (in discussion with Mark Lawson on Radio 4) that her music comprised 'a bunch of happy accidents'. This for me encapsulates much of the therapy process; it's a series of dialogic interchanges that are often made richer by the more human elements of my presence with my clients. My humanness supports my client in becoming more human, ie closer to his experiencing and more knowing of the impact of a sometimes flawed world. While I by no means set out to make mistakes, when I do they are generally rich sources of genuine meeting and healing (for both of us). Such a letter would be an opportunity to involve more of my client's relational field, and while there are a number of ethical and moral factors to be considered in such a decision, if I deemed my client able to process its presence, with my support, I would prefer to include it in the therapy work.

Andy Bateman,
Integrative counsellor



There are a number of problems here: not wanting to distress the client, keeping the letter private, shredding and forgetting it, for example. Anything Matthew keeps from his client is a hostage to fortune, threatening the trustworthiness of the relationship and the autonomy of the client. The letter refers to 'mental

health problems' and details incidents; but is there a serious mental health issue? If so, is Matthew competent to work with this client? Is anything in this letter true? The sender isn't willing to stand by it, but it may still be true. There could be a number of reasons why the sender might think they should remain anonymous. There is

a world of speculation here. What's the root of the client's workplace stress? Is the letter part of a bullying process? Are there present or possible future disciplinary or litigation procedures? If so, how might the letter relate to these? Its existence could be seen as evidence of a seriously unhealthy organisational culture, or a person within

it, and this might be valuable evidence to the client.

Matthew might reflect on his competence: 'Now I know the truth about my client's behaviour I must stop working with them – it's beyond my competence as they are too ill.' He might also wonder about his client: 'My client is the victim of workplace bullying in this organisation and I need to

support them.' The uncertain truth will lie somewhere in between. Matthew must evaluate how strong the basis is for his judgments before he decides what to do next. He might consider discreetly trying to get a sense of the psychological health of the business and of the section the client works for. Hiding the letter from the client seems untrustworthy, but

sharing its contents needs care. Matthew and his client should first explore the consequences of reading the letter and consider timing carefully. Before this, Matthew will need to decide if the client can withstand its content. In any event, Matthew needs to retain the letter, probably sharing it with his client. Destroying it is not an option.

Andrew Reeves,
Integrative counsellor



Matthew is working with a vulnerable client struggling with 'work-related stress', although it is not clear what that might mean. Certainly the existence of the letter might indicate that there are difficulties in the workplace; perhaps the client is the victim of bullying or harassment?

Or maybe the client sent the letter themselves, to test the integrity of the counsellor or to create evidence for a potential claim against the employer? It is difficult to move beyond these speculations, given the letter is anonymous.

The central question is whether disclosure of receipt of the letter and its contents a) is potentially facilitative of the therapeutic process and the client's wellbeing, or b) potentially harmful to both the therapeutic relationship (where the client

feels profound shame and withdraws from therapy) and their mental state. Without it being attributed to an author, the letter is no better than unsubstantiated gossip.

In my view it would not be helpful to share the letter with the client as the potential harm outweighs the potential benefit. It makes the work environment even more difficult for the client, with them left to speculate as to who might have written the letter and their motives. This could lead to recriminations and further harm. I am aware this decision means Matthew will 'withhold' information – but do we not do that all the time: making careful decisions about what we do and don't disclose? I would retain the letter in the client's notes, marked as confidential.

Of course, the client has the right under law to access their

notes, and this is to be kept in mind. However, there may be an argument for withholding the letter in the event of a request for access to notes, on the grounds that reading it could cause the client serious emotional harm. Should the client discover a letter was sent (or indeed if they sent it themselves) and challenges Matthew about it, I believe there is a strong justification for the decision, and Matthew would need to openly and transparently talk his thinking through with the client. Ultimately no option is a cost-free one, but minimising harm is the imperative here.

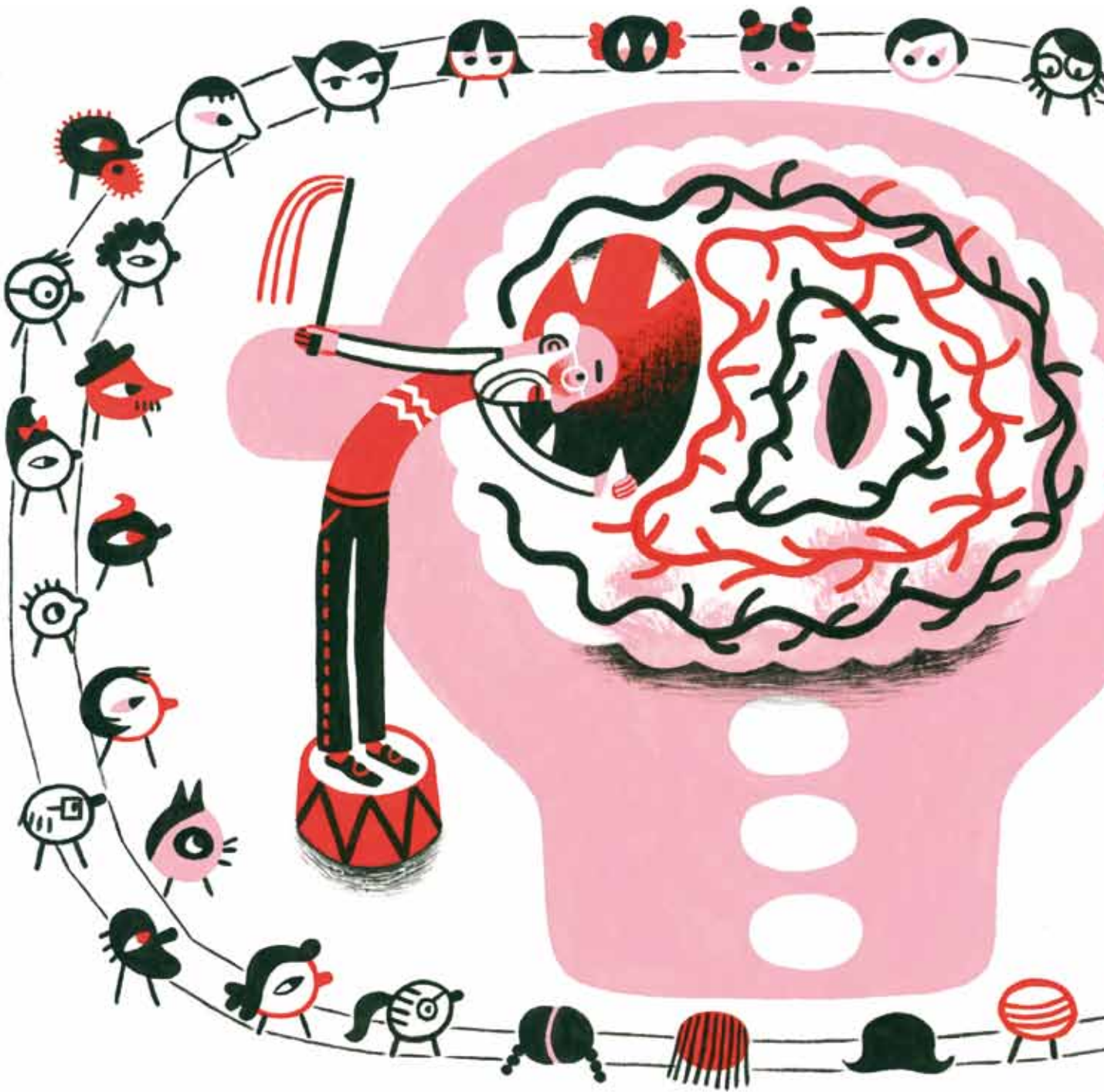
Andrew Reeves is a counsellor at the University of Liverpool Counselling Service and Editor of Counselling and Psychotherapy Research (CPR). To respond to the dilemma below, please email andrew.reeves@bacp.co.uk

Next month's dilemma

Khalil is a counsellor who works for a specialist agency supporting adult survivors of sexual abuse. His client, Angie, discloses abuse perpetrated by a family friend when she was eight years old. She has recently discovered that the alleged abuser has moved in with her auntie who has a child – a boy aged 11. Angie has never disclosed her

abuse to her family and does not wish to do so now. The agency policy is to provide total confidentiality to clients, other than when legally obliged to do otherwise. Angie minimises any current risk and states that she only told Khalil because of the agency policy to protect her confidentiality. Khalil is not sure what to do.

Please keep your responses to 500 words or less. It is important that you outline your response to the dilemma, and make your thinking as transparent as possible. A small selection of answers will be published in *Therapy Today*, with others appearing on our website (www.therapytoday.net).



New developments in trauma therapy



Many practitioners have taken up the challenge of assimilating new neuroscience findings into psychotherapy, resulting in a changing culture of treatment for traumatised clients. The good news, writes *Jane Ryan*, is that it is possible for all therapists to quite easily learn the basics of neuropsychology. *Illustration by Gwénola Carrère*

In the past three to five years a plethora of advances in the treatment of psychological trauma have emerged in the light of recent developments in neuroscience. These range from sensitivity to the developmental issues facing the adult who experienced persistent childhood trauma, to techniques for working with a recent but disabling post-traumatic stress disorder (PTSD). But these welcome developments present the practitioner with complex decisions about which treatment approach best suits their own therapeutic style and the needs of specific patients. How is one to select from EMDR or sensorimotor psychotherapy, a developmental, attachment-focused approach or a psychodynamic relationship? And is a specific training for working with trauma needed at all?

Many psychotherapists and counsellors feel unsure and unskilled about how to best work with the trauma cases they will inevitably encounter, especially those who trained more than five years ago. Most of us have not been versed in the assessment, diagnosis or treatment of the range of post-traumatic stress disorders and attempt to work with traumatised people in the same way as any other person coming into therapy – by engaging with their story, empathic connection and compassion. The many theoretical

frameworks that underpin talking therapy have not traditionally included psycho-neurobiology, and this is precisely the complex domain of knowledge that has resulted in the most effective treatments for traumatised people.

Assimilating neuroscience into psychotherapy

One of the most intriguing tasks facing therapists today is assimilating neurobiology, including the structure and chemistry of the brain, autonomic nervous and neuroendocrinal systems into their psychotherapeutic framework. Many psychotherapists have attempted to grasp this new, exciting knowledge but it is not simple. Even those who have made it their life's work admit to the inconclusive nature of many findings in the brain sciences. These are new areas of research that the psychotherapist can only be expected to tentatively grasp.

How much knowledge is essential for the psychotherapist to offer effective work with trauma? It appears that some knowledge is a lot better than none and some, excitingly, can make a big difference to the effectiveness of trauma work. Fortunately, there are both psychiatrists and psychotherapists with a sufficient in-depth understanding of the nature of post-traumatic stress disorders

'New modalities have evolved that enable any practitioner to acquire not just new theories but also techniques that can transform their effectiveness in working with trauma'

to lead the way. Dr Allan Schore, Dr Bessel van der Kolk and Dr Pat Ogden in the USA and Dr Ellert Nijenhuis and Dr Onno van der Hart in The Netherlands are pioneers who are transforming the field. Here in the UK we have our own theoretical leaders – those focusing on very challenging work with dissociation, such as Dr Valerie Sinason, founder of the Clinic for Dissociative Studies, and psychiatrist Dr Felicity de Zulueta, who runs the Traumatic Stress Service at the Maudsley Hospital. Many other notable practitioners have taken up the challenge of assimilating new neuroscience findings into psychotherapy, and the result is a changing culture of treatment and a new paradigm in practice: one that theorises the mind as an embodied, dynamic process and takes a highly practical approach to working with traumatised people.

An integrated approach

What theoretical themes do these new thinkers bring to the fore in an integrated neuropsychosocial approach? In her work, Dr Felicity de Zulueta pays great attention to the early social environment mediated by the primary caregiver and how it influences the evolution of structures in the infant's brain. 'The adult who experiences a traumatic critical incident that precipitates the need for therapy,' she explains, 'may have issues with the maturation of their orbitofrontal cortex and the brain circuits involved in regulating their emotions if they have also experienced persistent childhood trauma.' It is important to hold in mind, she would argue, the limitations in the patient's potential to respond to a therapeutic process. In cases of childhood trauma, neglect or abuse, de Zulueta says, the capacity to absorb and benefit from the therapy may be the first issue to consider.

Dr Nuri Gene-Cos, who also works at the Traumatic Stress Service at the

Maudsley Hospital, is similarly sensitive to the psychobiological states of the traumatised patient's body and alert to how biochemical changes arise in response to trauma. In her work she is always conscious of how her patients' traumatic experiences are impacting upon their autonomic nervous system, their capacity to affect regulate, and the state of their neuroendocrine system. For her, this information is a central part of developing an effective psychotherapeutic treatment strategy for each traumatised patient. An understanding of the neurological organisation of the emotional operating systems, specific neural circuits affected by trauma, and the extent to which the patient's brain or nervous system may be compromised, enables her to adapt that knowledge to provide the most effective treatment for each individual.

Most practitioners of psychotherapy, however, do not have training in psychiatry or medicine that enables them to make these kinds of assessments and the new vocabularies and concepts may feel beyond reach. The good news is that it is possible to quite easily learn neuropsychological basics, for example how the autonomic nervous system responds to danger; how attachment trauma in childhood impacts on the development of the parts of the brain that manage relationships; how trauma leads to primitive defensive positions in the form of fight, flight or freeze; the concept of affect dysregulation. The pioneers in the field are also writers, communicators, and trainers and new modalities have evolved that enable any practitioner to acquire not just new theories but techniques that can transform their effectiveness in working with trauma. Elizabeth Wilde McCormick, a mindfulness-based cognitive analytic therapist, does not believe it is possible to work effectively with trauma without

specific trauma-related theory and technique. 'I was very excited to be shown a picture of the brain and how different areas were affected by trauma,' she explains. 'We can now see how our neuroendocrinal and autonomic nervous systems are disrupted by traumatic experience or disorganised attachment. This knowledge is not only crucial for me in understanding what has happened to my traumatised clients, but also in helping them to understand what has happened to themselves. If I begin a therapy by showing a new client a diagram of autonomic arousal, and give them some basic psycho-neurological education about why they feel such agitation, we can take steps together to regulate their affect – to settle the space between their hyper- and hypo-arousal. That in itself is an essential part of the recovery from trauma.'

The embodied mind

Whereas in most therapies the thinking mind is emphasised, in trauma work the embodied mind is a key principal. Dr Liz Hall, who organises Pat Ogden's innovative sensorimotor trainings in the UK, says, 'The body is often the site and source of our pain from life's injuries. Sensorimotor psychotherapy explores the somatic resourcing for clients for whom the body has become disowned, avoided or perceived as the enemy. It also allows us to process the trauma through the body using present moment experience.' Tony Buckley, from the London Underground Counselling and Trauma Service, explains, 'The body often holds the unprocessed traumatic material in the form of autonomic dysregulation, and the intrusive re-experiencing of images, sounds, smells and associated sensations. There is also often constriction, pain and numbing which accompany reactivation of the defensive

'How is one to select from EMDR or sensorimotor psychotherapy, a developmental, attachment-focused approach or a psychodynamic relationship?'

movement patterns (fight, flight, freeze) all part of our natural survival response.'

This awareness leads directly to bodily-based psychotherapies, such as sensorimotor psychotherapy. Dr Allan Schore, whose groundbreaking integration of neuroscience with attachment theory has led to a rapid increase in our understanding of the relationship between psyche and soma in cases of developmental trauma, fully endorses this approach. He says, 'Recent advances in the trauma, neurobiology, developmental, and psychodynamic literatures... strongly suggest that bodily-based behaviours, affects, and cognitions must be brought to the forefront of the clinical encounter.'

Developmental trauma

Developmental trauma is a key concept in this field. In complex cases, where a critical incident type trauma in adulthood, eg a car crash or mugging, is combined with a traumatic childhood, the client's capacity for therapeutic work will be markedly different from the person who is suffering from PTSD as a result of a critical incident, who otherwise has a foundation of secure attachment relationships. The client with layered developmental trauma will need especially careful therapeutic pacing to ensure the work does not re-invoke the primitive flight-fight-freeze responses that the therapy seeks to undo. Their receptiveness for relating, trusting and connecting may be impaired not just emotionally but also in the neurological patterning of their body.

Resourcing the patient may be the first step in establishing sufficient trust and safety with any traumatised person, but especially someone who has had ruptured or abusive attachment relationships. 'The therapy relationship itself is a triggering environment,' Dr Liz Hall says. 'The key emphasis is on working within the therapeutic relationship to avoid

potentially de-stabilising the client.' The theme of the therapy relationship as simultaneously the potential trigger and container of the traumatised client is emphasised by trauma specialist and body psychotherapist Morit Heitzler: 'When offering interactive regulation to engage with and complement the patient's disturbed auto-regulation, the therapist becomes a container for the trauma,' she explains. 'Because most of the psycho-biological stress of the trauma is communicated non-verbally, via right-brain to right-brain attunement, this process relies on the therapist's own sense of embodiment and internal body-mind regulation.' In her work she explores how body psychotherapy offers treatment options and techniques that are capable of reaching down into the roots of trauma in somatic experience. 'We look at how therapists can develop the internal resources and capacities needed to regulate the body-mind impact of traumatic relational dynamics.'

Body-based therapy

What is it like being a client of a somatic-based therapy? Roz Carroll writes about receiving a training-based session with Babette Rothschild, author of the acclaimed book *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*.² 'I told the story of my experience of 16 hours in labour,' she writes. 'During this narrative, Babette stopped me frequently to gather further information, to help me pay attention to my body, to slow me down, and to encourage and support grounding and containment. Being interrupted so often was quite challenging for me as a client, but it is crucial to the external regulation that the trauma therapist provides. The acceleration of process – thinking quickly, being flooded with images – is symptomatic of sympathetic nervous

system (SNS) activity. From a biodynamic point of view, it makes sense to slow down the headlong pace so that the story itself can be "digested". This breaking cuts through the self-enclosure – also characteristic of narcissism – which re-enacts the sense of profound isolation that is a mark of traumatisation.'

Sanja Oakley, a trauma specialist with London Underground, and trauma work consultant, strongly believes that trauma work demands specific training and techniques and that time is wasted when practitioners believe they can adapt their usual therapeutic method. 'Many therapists think that a diagnosis of trauma is reductionist,' she says, 'but you will offer the greatest relief to your traumatised client by normalising their trauma-related symptoms.'

Oakley believes there is a risk when a treatable area of PTSD is left to fester while the therapist gradually brings to the fore early childhood trauma or other areas of unhappiness. 'Many therapists believe that by focusing their attention on PTSD they would be disregarding the whole person. On the contrary, when you are working with the person affected by trauma, unless you address that trauma, you will be minimising the person's expressed reality as this person's existence has now become defined by the effects of the traumatic event.'

Oakley would argue that new therapeutic methodologies should be offered in order to provide traumatised people with the quickest and most effective help available. 'Moreover,' she continues, 'the whole person can still be seen concurrently, through an existential or psychodynamic lens, whilst the trauma is being worked with. The pivotal point is that treatment of traumatic presentations is given specific, regularised and targeted attention.'

‘Whereas in most therapies the thinking mind is emphasised, in trauma work the embodied mind is a key principal’

Dissociative identity disorder

For many patients, a history of traumatic childhood abuse leads into an adulthood of risk and continuing disturbance. Dissociative identity disorder (DID), also referred to as structural dissociation, may appear as a psychosis in some or extreme phobic reactions. It is perhaps the most challenging area of trauma work and crucial to diagnose accurately.

Dr Ellert Nijenhuis, a Dutch authority on the treatment of trauma and complex dissociative disorders, has evolved various treatment phases for chronically traumatised dissociating individuals. These phases rest on new trauma theory that suggests that traumatisation divides the psychobiological system that constitutes an individual’s personality. All trauma-related disorders involve a particular division of personality that reaches the summit of complexity in dissociative identity disorder (DID), previously referred to as multiple personality disorder.

This basic division appears between psychobiological action systems that direct us in functions of daily life such as attachment, play and exploration, and the reproduction system that is concerned with the survival of the species. In chronic traumatisation, Nijenhuis explains, ‘This structural dissociation becomes ever more complex and fixed, and requires specific phase-oriented treatment approaches. Effective therapy rests on an understanding of psychobiological systems, biopsychosocial development, attachment theory and the nature of dissociation. Specific therapeutic skills need to be engaged, particularly in the balancing between moving forward to make the traumatic memory increasingly more bearable, while holding back and containing to keep that exploration safe.’

Adah Sachs works with Valerie Sinason

at the Clinic for Dissociative Studies and has developed a new attachment classification that advances our theoretical understanding of the roots of the dissociation. Sachs says, ‘The most severe form of dissociative disorder is invariably linked to extreme traumatic experience, usually originating in childhood or infancy, and often still occurring. As well as the confusion of the person’s multiplicity, the therapist is also exposed to very distressing and largely uncorroborated trauma narratives, and to frequent states of emergency. It is often hard to know how to view this volatile material and how to respond to it clinically.’

The importance of training

Sinason, who brings a psychoanalytic understanding to the treatment of trauma, is interested in how at different historic times the internal consequences of trauma have been privileged more than the external reality and vice versa. ‘Sometimes the internal world with all its terrors and archaic templates is a distraction from outer reality; sometimes the reverse is true,’ she says. The recognition of the reality of trauma is in itself a great breakthrough, a recovery of Freud’s original thesis on the reasons for hysteria. The recent breakthroughs in theory and practice are extraordinary achievements. ‘How does the clinician avoid secondary traumatisation,’ Sinason wonders, ‘whilst avoiding protectionist pseudo-professionalism to protect them from the power of the patient’s traumatic narrative?’

This very challenging work demands both a strong theoretical framework and a capacity for presence and connection to the client or patient. Fortunately, today’s therapist can go out and select a training programme that will give them the specific insights and skills to transform their work with traumatised

people. Choosing from the range of possible approaches perhaps involves an intuitive understanding of what would be the most comfortable personal fit – EMDR or sensorimotor psychotherapy, a developmental, attachment-focused approach that integrates neurobiological insights, or training in how to work with structural dissociation? Each approach has its own history and nuanced approach, but all combine an understanding of the role of the body in holding buried trauma and enabling the traumatised individual to survive. ■

Available trainings in the UK include: workshops at the Cambridge Trauma Body Centre in somatic trauma therapy training; an introduction to traumatic incident reduction, an integrative mindfulness-oriented approach to counselling offered by Mindfulness Training in London; trauma-focused cognitive-behavioural therapy offered by the Oxford Cognitive Therapy Centre; sensorimotor psychotherapy training held in Lincoln; and EMDR training with EMDR Training and Consultation.

Confer is running a week-long trauma skills summer school (5–9 July 2010) led by several of the UK’s leading trauma experts to provide a working knowledge of the spectrum of trauma-related disorders, neuropsychological issues, and an introduction to the technical skills involved in several approaches. For more details, visit www.confer.uk.com/traumaskills

Jane Ryan trained at the CAPP (the Centre for Attachment-based Psychoanalytic Psychotherapy). After eight years in private practice, she set up Confer and now runs its programme of seminars and conferences.

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Questionnaire

Alain de Botton

For philosopher, author, and founder of The School of Life, *Alain de Botton*, writing is a form of consolation and therapy

What gives your life purpose?

My ability to write, which is a way for me to interpret what happens to me, intellectually and emotionally, as opposed to merely facing it in a naked way. Writing is therefore a form of consolation and therapy and helps me to achieve a necessary level of calm and wisdom.

What is your earliest memory?

It is a nightmare: I was standing by the shores of the lake of Zurich (where I grew up), leaning against a railing I thought would be safe. Suddenly, to my horror, the railing gave way and I fell, not just into the water, but into the mouth of a giant, hostile, waiting whale. I associate the dream with anxiety, with insecure boundaries/restraints and with problems with my mother.

What are you passionate about?

Understanding things, and curating and responding to beautiful things. In other words, wisdom and beauty excite me.

Do you always tell the truth?

Definitely not – and I reject the idea that complete truth-telling is moral or kind. Social life is complex and our projects sometimes so diverse and incompatible, that we need to be able to build watertight compartments.

What has been the lowest point in your life?

My father died when I was 30. I had had a very difficult relationship with him and we were never reconciled. I think of him once a day at least, trying to imaginatively inhabit him and trying to overcome hurt.

How do you relax?

I have a bath and read something that will touch



no emotional triggers, like *The Economist*.

What keeps you awake at night?

The progression of a chapter, the flow of an argument, certain muddled thoughts that I want to get untangled for the next day.

What makes you angry?

Injustice, unfairness, malevolence, coldness.

Which person has been the greatest influence on you professionally?

I have been much influenced by Donald Winnicott. His manner of writing charmed me from the first; his ability to be sincere and yet casual, and drop in, almost as if by chance, some astonishing, aphoristic truths.

How do you keep yourself grounded?

By spending time with my children, who are three and five; two delightful boys entirely focused on themselves, their latest projects with Lego, their games – and who take safety, their parents and existence entirely for granted, as they should and must.

Do you believe in God?

No, but I am immensely sympathetic to the structure which religions bring to life: I like the way they structure days and calendars, the way they make special occasions for forgiveness and gratitude.

Do you fear dying?

Very much so. I hope not to die before 70, so that I can be around for my children. I also hope not to succumb

to some debilitating illness before then.

What would you have written on your tombstone?

He said a few things that needed to be said.

What do you feel guilty about?

That I have hurt people I love through selfishness and stupidity.

What makes you laugh?

Anything outrageously pessimistic.

Where will your next holiday be and why?

Tenerife – there's a great family hotel, where I would previously never have dreamt of going and now see as my spiritual home.

If you could change anything about society what would it be?

Reform the education system root and branch, from infancy through to one's death.

What is your idea of perfect happiness?

To be in a job that is hard but doable and aiming at the most serious ends.

To be surrounded by people who are kind, sympathetic, giving and who help me to reciprocate.

What's your most treasured possession?

A painting I inherited from my father by the artist Michael Andrews.

What do you consider your greatest achievement?

Three of my books: *Essays in Love*, *How Proust Can Change Your Life* and *The Pleasures and Sorrows of Work*. ■

Alain de Botton was born in Zurich, Switzerland. A best-selling author, his subjects include love, travel, architecture and literature. His books include Status Anxiety, The Art of Travel and The Architecture of Happiness. He is also the founder of The School of Life. Visit www.theschooloflife.com

Recalled to life

The Cancer Reform Strategy seeks to improve psychological provision for those who are living with and who have survived cancer. But there is a general lack of awareness of the psychological and emotional impact of cancer upon those who physically survive, says *Christine Knowles*.
Illustration by Gwénola Carrère

The Department of Health's Cancer Reform Strategy states: 'Survival rates for cancer are... improving, with 10-year survival rates having doubled in the last 30 years and continuing to increase.'¹ Cancer Research UK reports that 54.5 million people worldwide have been diagnosed with cancer in the last five years and 45 per cent will be alive after five years.

According to the National Institute for Health and Clinical Excellence (NICE),¹ over 230,000 people are diagnosed with cancer in England and Wales each year, with cancer accounting for one quarter of all deaths. Improvements are attributed to increased screening leading to early detection, combined with advances in drug therapy and more successful surgical interventions.^{2,3} The increasing number of cancer survivors is a major achievement of biomedical cancer research,⁴ but as Doyle and Kelly comment, 'It is important to recognise that the saving of lives is more than a statistical exercise.'⁵ The World Health Organisation (WHO) now classifies cancer as a chronic life-threatening illness rather than as a terminal disease, yet the psychological aftermath of successful treatment remains under-researched and not clearly understood.

In the year 2000, within my role as counsellor at St Cuthbert's Hospice in Durham, I was aware of an increasing number of patients being referred for counselling who needed day hospice input during the acute stage of their illness, but who then went on to recover physical health. At the point of discharge from hospice care, recurrent themes were voiced, including feelings of abandonment by healthcare professionals, fear of the cancer

returning, and feelings of isolation, even within the family. This suggested an unmet psychological need amongst this client group, a view that was confirmed by an increasing number of counselling referrals being made by hospital oncologists relating to 'well' patients presenting with depression at routine follow-up clinics.

Moving on after cancer

As a result, in 2001 I piloted a 'moving on group', bringing together four women aged between 40 and 50. Three had been diagnosed with breast cancer, the other with cancer of the colon. Each had undergone successful surgery and was regarded as being free of disease, but each presented with symptoms of anxiety and depression that prevented them from moving on with their lives. The aim of the group was to bring together cancer survivors who felt alone, providing a therapeutic space where the trauma of diagnosis could be processed and moved on from. I facilitated the group, along with another member of staff, and it ran for one afternoon each week for eight consecutive weeks. Two counsellor-trained hospice volunteers provided additional support. The sessions were informal, flexible and participant-led. They were divided into two parts: the first, mainly discussion, on themes identified by group members. These were explored in the second part via literature, artwork, narrative or poetry. Each meeting ended with a relaxation exercise. Verbal feedback was sought during the final session and following subsequent review sessions. Written feedback was provided via comment sheets distributed at the final session and the facilitators were also



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asked to submit their comments and meet with an external adviser to evaluate the pilot study. All of this was generally positive, with three of the four participants reporting significant improvements in dealing with their fears, at six- and 12-month review.

As a result, during the intervening eight years, a further 10 groups have taken place, comprising between four and eight individuals. The groups are now facilitated by one member of staff and two trained hospice volunteers and run for six weeks rather than the original eight. Although each group has been individual in terms of agenda and content, the underlying themes have been similar in terms of the anxieties expressed: a common sense of a loss of direction in life, and a sense of changed identity. Feedback has been consistently positive, indicating that the changes brought about by diagnosis and treatment have been processed, self-esteem promoted, coping strategies and support networks identified, and the future explored. The group has provided an opportunity for participants to emotionally deal with what has happened physically throughout illness and treatment. This has enabled members to focus on health and the future rather than on the past, and to regain some sense of normality and personal control. However, the group has highlighted the general lack of awareness amongst professionals of the psychological and emotional impact of cancer upon those who survive. As a result, in 2003, I embarked upon a research inquiry to increase knowledge and understanding, seeking to inform and develop professional practice and psychological provision to cancer survivors.

The psychological needs of cancer patients

Since the 1960s there has been an increasing recognition of the psychological needs of cancer patients. Over the last 40 years there has also been an acknowledgement that life-threatening illness may generate psychological issues from point of diagnosis,^{5,6} and Fawzy⁷ suggests that coping with the diagnosis of cancer, even if the patient is cured, can be a lifelong phenomenon. However, despite the awareness of the need for an holistic and longer-term approach to cancer care, the 'moving on' groups appeared to suggest that the psychological needs of cancer survivors were not being adequately provided for.

The concept of cancer survivorship has appeared in literature from the 1980s, but there is a lack of consensus as to when survivorship begins. For some, survival begins from the point of diagnosis, whilst for others the term is applied at a given point after treatment ends. Mullan,⁸ in his reflections of a physician with cancer, refers to 'seasons of survival'. The first season of 'acute survival' begins with diagnosis of the illness. This moves on to a period of 'extended survival' when the patient enters a phase of watchfully awaiting the effect of treatment. Mullan's third season is that of 'permanent survival', when treatment is regarded as successful and the patient is free of disease.

Hassey Dow⁹ continues the theme of seasons in survival and refers to a universality of survivorship, noting a similarity of experience between those surviving disasters, those surviving other life-threatening events, those surviving chronic illness, and those surviving

cancer. She refers to universal themes in survivors of disasters and serious illness. These include an element of suffering, an intense emotional response, and a perspective on personal mortality. She notes that those able to derive meaning are better able to process the experience and go on with their lives. However, unlike other survivors, those who have experienced cancer continue to deal with fear of recurrence and uncertainty, as well as living with the life-changing physical impact of the disease.

As Hassey Dow points out, the lack of knowing whether the disease might return, affects the sense of mastery over life and can produce isolation within families, who believe that the crisis is over and normality has returned. Little et al¹⁰ refer to a state of 'liminality', a place between two living spaces. Having passed through illness, patients do not emerge into the world they perceived as normal prior to diagnosis. There is a new awareness of the fallibility of the body and its mortality and a consciousness that the survivor has lived through 'an extreme experience' and is alone with that experience. Because the most dangerous characteristic of cancer is its tendency to spread and reappear in any part of the body, the threat of recurrence never goes away.^{11,12} As a result, the body becomes a 'house of suspicion',¹³ which places the future constantly in question.

Action research

My inquiry was based upon a system of action research, narrative accounts and focus group, and involved 18 cancer survivors who had participated in 'moving on' groups over a three-year period. Data, which was analysed by a system of thematic analysis, confirmed

'The aim of the group was to provide a therapeutic space where the trauma of diagnosis could be processed and moved on from'

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that cancer survivorship issues which begin at the time of diagnosis, continue indefinitely, with a particularly critical point when treatment ends. Although cancer may no longer be physically present, the psychological effect continues, necessitating ongoing support. The study examined the value of the 'moving on' group in helping individuals to process the experience of cancer diagnosis and treatment and demonstrated that this enabled an integration of the event into their lives, so that fears of recurrence became more balanced. One outcome of the research is a professional training DVD which features several cancer survivors 'telling their story', in terms of the felt experience of surviving cancer, to develop awareness amongst healthcare personnel and to improve and develop psychological practice. An additional product of the research is a training workshop based upon the DVD, which takes place regularly at St Cuthbert's Hospice, Durham.

The theoretical model that has underpinned my work is person-centred, and the assumption that everyone has an instinctive movement towards the constructive accomplishment of an inherent potential, an instinct to journey towards the actualisation of the 'real' self. This is appropriate to this area of research, in which clients are challenged by the experience of cancer survivorship, an experience that does not fit into a specific psychological configuration. As a person-centred therapist displaying congruence, realness and genuineness, I have been able to create a climate within the group in which members have felt safe and accepted, and where therapeutic change has been able to

take place. Being in touch with a complexity of feelings, thoughts and attitudes that flowed through the dynamics of the group as a whole, I sensed from their responses and body language that I was perceived as a real person rather than a remote professional. Sensing my essential humanity and an involvement that communicated an unconditional acceptance and empathic understanding, a climate was produced in which therapeutic movement could take place. However, not every cancer survivor chooses to participate in a group facility. Some prefer to engage in individual counselling. It is therefore important that those who provide psychological therapies to this client group are aware of the issues involved, both during the course of the cancer journey and in emergence into survival.

The trauma of diagnosis and treatment

Many clients report the moment of diagnosis, and a vivid recollection of that point in time, a trauma that cannot be processed immediately due to the rapid onset of treatment. The additional trauma of surgery, chemotherapy and radiotherapy can involve significant changes in body image, both temporary and permanent, such as mastectomy, colostomy, hair loss, and lymphoedema. For the patient, a grief process needs to be embarked upon, whereby a life transition is negotiated, and so enabling a new sense of identity to emerge. Whereas families may expect their loved one to 'return to normal', the person who has survived a traumatic experience has come face to face with the possibility of death, and their sense of personal identity will have fundamentally changed, together with

their faith in the predictability of life.

Although cancer may have gone away physically, it may never go away psychologically, so a 'new normality' needs to be negotiated within a lived experience of balancing the fear of the cancer returning, and the need not to allow the uncertainty to dominate and thereby spoil the overall quality of life. Because families may not understand the profound effect of the cancer experience upon the individual, s/he can be left feeling changed, isolated, and not understood, within an environment which previously may have been perceived as supportive and secure.

The Cancer Reform Strategy seeks to improve psychological provision to those who are living with and beyond cancer. However, for this to take place, there needs to be a better understanding of the emotional and psychological impact of a life-threatening diagnosis, the effect of traumatic treatments, and the resultant significant personal and life changes. This includes accommodating any potential fears regarding the threat of recurrence for those who are regarded as free of disease. Research suggests that for those survivors who successfully process the cancer experience by negotiating the journey from patient to survivor, significant personal growth can result. For those of us who are counsellors, psychotherapists or psychologists, we are in a privileged position to share and facilitate that journey. ■

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'The psychological aftermath of a successful cancer treatment remains underresearched and not clearly understood'

A supervision model

Currently completing a postgraduate certificate in clinical supervision at the University of Derby, *James Rye* presents a model that attempts to represent what actually takes place in supervision

The starting point for the model opposite was a statement made by Watkins: 'A theory is a road map to help us better navigate the territory we need to cross.'¹ At the core of the model there are various routes moving from supervisor towards the client, passing through the supervisee.

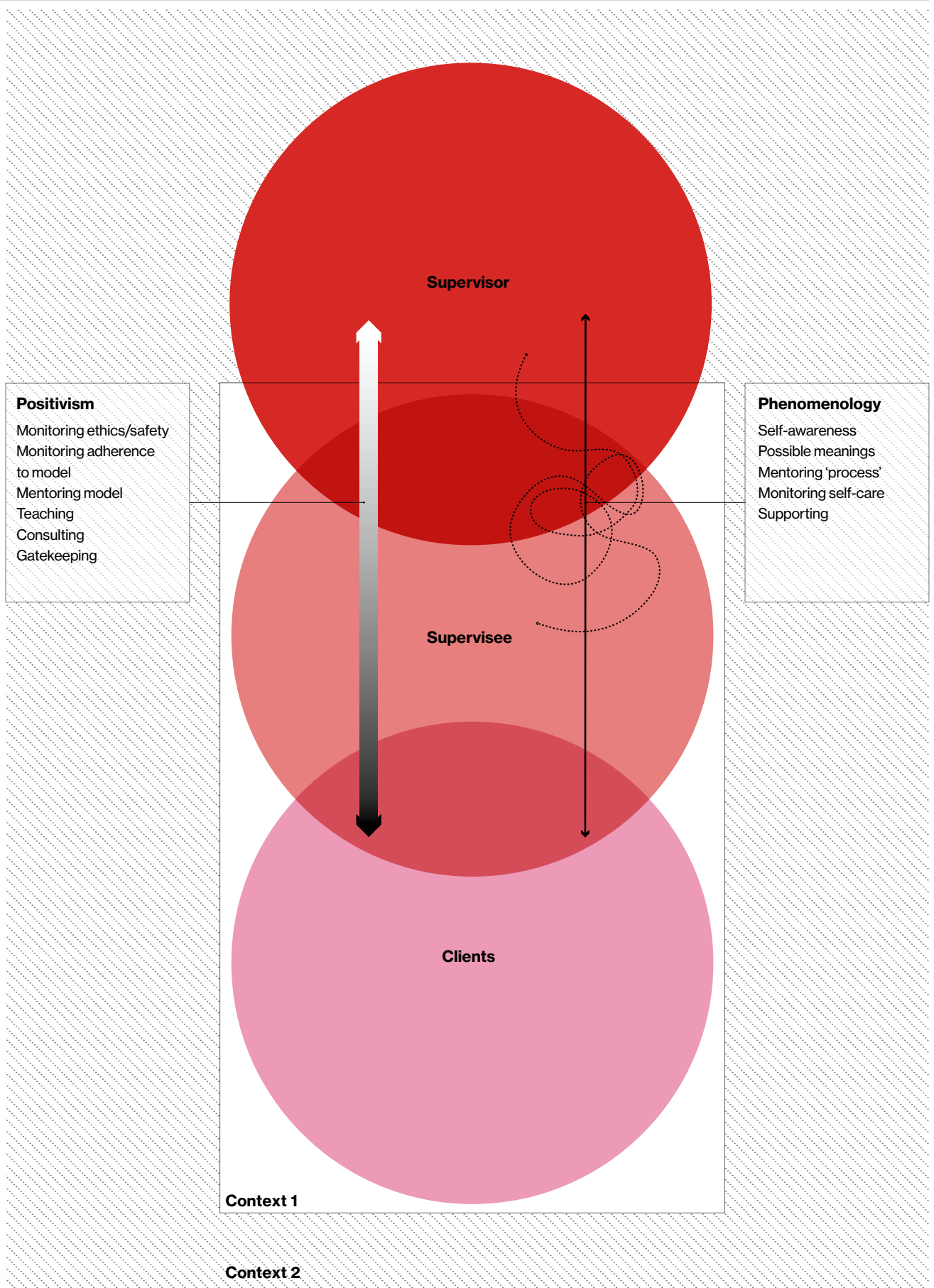
Boxes

Before I discuss the core, though, there are two boxes. These are attempts to represent the context in which both counselling and supervision take place.

This context has a significant impact on the work of supervision. In working with the supervisee, the supervisor needs to be aware of both the context in which the supervisee is working (Context 1), but also a much broader professional context (Context 2). A counsellor working mainly in a prison would have a very different context to one working in private practice, for example, not only in terms of caseload and type (or perhaps complexity) of problem, but also in terms of different pressures on their work, and different contextual problems

– clients being prevented from coming to regular sessions because of security lockdowns, for example, or clients suddenly finishing because of not being able to afford to continue. Different contexts can present different ethical dilemmas, and the ground rules for each context need to be clearly understood by both supervisee and supervisor.²

The supervisor also has to be aware of the need of the broader professional context. Is a counsellor being asked to compromise a generally accepted broader ethical stance in the context



of his or her work because of a particular management policy, for example? How are national changes likely to impact the work of a particular therapist or agency?

Circles

Within the boxes are three circles – the key players in the supervision process – though technically only the supervisor and supervisee actually ‘play’ during supervision. When reflecting on the circles, two key points should be borne in mind. These are issues about validity and quantity. Think for a moment about the ‘distance’ between the supervisor and the client. In a sense the supervisor never really knows the client(s). A client only reveals to a counsellor what s/he wishes the counsellor to know. Similarly, the supervisee only reveals to the supervisor what s/he wishes the supervisor to know. At worst, the experience of working with a guarded client is misrepresented to a supervisor by an insecure counsellor. As Feltham³ has argued, the abusive counsellor is hardly likely to reveal that abuse in supervision. At best, the supervisor sees a version of partially revealed truth mediated through the lens of a fallible counsellor. In my representation there is very deliberately no direct overlap between client(s) and supervisor.

This potential ‘distance’ has at least two implications for the supervisor. As with counselling, some of the best work takes place once a relationship of trust has been established and the client feels less guarded and more open. The supervisor needs to create a climate of safety for the supervisee. Webb and Wheeler⁴ found that there was a positive correlation between the quality of the supervisory working alliance, as experienced by the supervisee, and the extent of his or her self-disclosure. As Efan and Lukens⁵ observed (paraphrasing the epistemologist Humberto Maturana): ‘You do not change organisms – you design an

‘When the supervisee and supervisor share the same orientation, modelling is maximised and theory is more integrated into supervision’

environment in which organisms thrive, reason, and change themselves.’ And just as a good counsellor is not naïve about what a client presents, and often waits for further information or gently probes to clarify the meaning behind the spoken words, so too the good supervisor may need to more actively seek greater truth about what is presented. The overlapping circles are also an attempt to represent issues to do with quantity as well as quality. Despite regularly having one-and-a-half hours’ supervision a month, and having worked with the same supervisor for nearly five years, it recently struck me how little of my counselling work my supervisor actually knows. She may of course infer from what I take to her, and she may know a lot about a few clients, but there is a considerable amount that she never gets to see. In my representation, perhaps the overlap between counsellor and client (the part mediated to the supervisor) may be larger than is actually the case. The arrows and dotted lines imply that supervision has some impact on counselling practice and hence on clients. While there may be anecdotal and qualitative evidence to support this, I would be interested to read qualitative research on the size of any impact.

Arrows and dotted lines

The arrows and dotted lines are an attempt to represent what actually takes place in supervision, and I have categorised that interaction as falling into two distinct camps, with the left-hand side representing positivism, and

the right-hand side, phenomenology. They are distinct (but often contemporary and overlapping) routes through the supervision 50-minute hour. Both sets of arrows flow in both directions, implying interaction between supervisee and supervisor and a degree of mutuality of respect and status. This mutuality sits more comfortably on the right-hand phenomenological arrow, where there is more uncertainty and an attempt to discover any meaning. The upward arrowhead needs to be fainter on the left-hand side where the movement in one direction (downward) is sometimes more pronounced, particularly with very inexperienced counsellors (even if that downward movement is expressed in an apparently non-directive and conciliatory way).

Positivism postulates cause and effect relationships and often implies a ‘rightness’ and ‘wrongness’. The left-hand arrow is bigger because it sometimes feels stronger and more certain. This arrow is where a large part of the four of the five functions of supervision that Beinhart⁶ has identified (monitoring and evaluation, instructing and advising, modelling, consulting, and supporting) takes place. When walking along this route with the supervisee, the supervisor often has a definite road to follow. This is when ethics are discussed. (The application of principles may be difficult and uncertain, but there is an agreed set of standards that need to be applied.) When on this road, the supervisor is assessing a supervisee’s adherence to a particular model, or mentoring a particular model because of a belief that a set of interventions might cause a particular effect in the best interests of the client. This is the road where negotiated growth and learning about theory and technique takes place. It is where potential crossings of the boundaries to the therapeutic frame⁷ are monitored. It is also on this road where the supervisee agrees to accept

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supervisory authority while maintaining independence and self-esteem, and the supervisor learns to have authority without being authoritarian.⁸ This road also has rare stops where the supervisor has to negotiate a halt and act as gatekeeper. This is the road where travellers predict that counsellors become more competent if encouraged to see professional truth.

Bruner⁹ wrote that 'life experience is richer than discourse. Narrative structures organise and give meaning to experience, but there are always feelings and lived experiences not fully encompassed by the dominant narrative.' If positivism is concerned with the dominant narrative and its truth, phenomenology is concerned with the feelings and lived experiences not fully encompassed by the search for objective truth. The right-hand phenomenological routes are less certain and harder to see. Sometimes they only appear briefly before disappearing. I suspect that a supervisor's ability to identify these routes and to consciously encourage supervisees to travel down them with her/him is one of the more difficult skills a supervisor has to learn. On these routes there is an attempt to discover not objective truth as such, but personal meaning. The supervisor/supervisee relationship is brought into focus and the dynamics and patterns of that relationship reflect what may be happening with clients, and what may be helping or hindering supervisee and client development. The clear focus here is often interpersonal process and what it may mean. On these routes there is a standing back from technique to ask about thought and feeling during the transaction and about what was left unsaid and why. Both supervisor and supervisee are struggling to hypothesise about what might be happening. It is on these routes that the counsellor's temptation to become the client in the supervision and to turn the supervisor

into the therapist² is made conscious and discussed. The short-term aim is increased self-awareness, but the longer-term goal is a more self-aware and reflective practitioner who is constantly learning through reflection.^{10, 11} In the process of gentle probing and reflection (and silence), the supervisor is also mentoring important aspects of the therapeutic process to the supervisee. It is also on these roads that negotiations and reflections about practitioner self-care take place. The dotted phenomenological arrows are best drawn as rambling swirls rather than straight lines. Human interaction is usually 'interesting' and rarely straightforward. These are the roads where travellers predict that counsellors become more competent if they are more able to hypothesise about the meaning of interpersonal interaction.

Weaknesses

The above model has many weaknesses. At a simplistic level it is too rigid and certain. For example, the Context rectangles imply stasis and clarity. They might be better hand drawn with fainter lines and irregular shapes. Both contexts are constantly changing, sometimes at quite short notice. A cloud, rather than a rectangle, might be a better metaphor for them. Similarly the positions of the circles and the extent of their overlap will vary considerably with different clients, and even when discussing a single client. A major weakness of the model is that it fails to account for two important variables in the supervision process. It tends to imply certain invariability, when in practice there is often quite a lot of variability.

The positivism road can be quite strong where both supervisee and supervisor share the same therapeutic model. However, this isn't always the case, and the growth of eclectic training courses suggests that it may become even less so in future. Bernard and Goodyear¹² have pointed out that when

the supervisee and supervisor share the same orientation, modelling is maximised and theory is more integrated into supervision. When orientations clash, conflict or parallel process issues may predominate. In some cases, before a left-hand route across the supervision country is clear, it may first have to be constructed by both parties, with both agreeing what templates can be used for assessment and mentoring practice. Clear contracting is always important,^{2, 13} but even more so when models clash. This is another argument for making the left-hand arrow fainter (especially at the beginning of a supervisory relationship). When the arrow is stronger, the implication is that both parties are accepting (in part, at least) an orientation paradigm for supervision. Another big variable in the supervisory relationship is the developmental stage of the supervisee. While both right- and left-hand roads will always need to be present, it could be hypothesised (from the work of Stoltenberg & Delworth¹⁴ and Wosket & Page,¹³ for example) that the left-hand road will be used more often with an inexperienced therapist, and less often once that therapist is able to work with more independence and less anxiety. Perhaps the key point is that in reality, the size of the lines, and their respective importance, varies considerably, not only within each session and between clients, but also in accordance with the stage of development of the supervisee. This reflects the fluctuation on the continua between unilateral-bilateral, direct-indirect, supervisee-supervisor, goal directed-not goal directed (adapted from Best and Rose).¹⁵ ■

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Pathway of care

Carmel Dennehy set up and heads a maternity counselling service at Whipps Cross University Hospital in London

*Interview by Julia Bueno
Photographs by Phil Sayer*

I wake up at 6.45am and practise a 10-minute meditation which helps to set me up for the day. I have a shower and breakfast and leave home at 7.45am. My journey, by bike and train, takes me from northwest to east London in 40 minutes, which is impressively short!

I was recruited to set up a maternity counselling service last August, and it is already very busy – this week I received my 150th referral. I have proposed employing more counsellors to meet this demand and remain hopeful, despite the current NHS cutbacks. Meanwhile, I'm on my own. I am usually checking my emails and voice messages by 8.30am and I see my first client at 9am. Morning sessions are popular for parents with children in school or childcare, and they are good for me as I work well in the mornings.

Many of my clients are women who are coming to terms with a foetal abnormality, a traumatic experience of birth or a pregnancy loss, or women suffering from perinatal or postnatal depression. Most of the referrals come from midwives working on the delivery suite, as they would have cared for them. Clients can also self refer, although they rarely do. I am seeing an increasing number of couples, with a record 28 in the last four months. I think this may be because there is less stigma attached to counselling than before. Sadly, there is a high incidence of couples separating after the death of a baby, so it is beneficial when they come together to process a bereavement. I also facilitate a monthly group for bereaved parents and some couples drop in from time to time.

Almost 40 per cent of my caseload involves counselling vulnerable pregnant mothers through their pregnancy and the postnatal period. I used to work in a similar counselling service at the

Royal Free Hospital in northwest London until 2006 and I have noticed an increase of referrals of vulnerable teenagers. There is a higher incidence of teenage pregnancies in the hospital catchment area, as well as this being nationally on the increase. Some are very young and often have a wide range of complex problems.

I see three or four clients before breaking for lunch. The canteen is in another building, so I usually bring my own lunch and eat while checking emails and messages. Sometimes I'll use the time to catch up with colleagues over a coffee. Afternoons are spent seeing a couple more clients, attending meetings or catching up on paperwork.

As well as my individual work, I facilitate a fortnightly reflection group for staff. I'm conscious of how emotionally demanding the maternity department environment can be, and that often there is little space available for people to process what can happen. This is particularly the case when a woman's pregnancy is not going as planned or a death occurs. I may request the sister-in-charge to release staff who say they would like to attend but are too busy – I can be quite persuasive. The group offers a confidential space for staff to unload, without fear of what's being said being fed back to their managers.

Sometimes I'll offer a one-off support group where a particularly tragic incident has happened, although sometimes consultants or clinical managers approach me directly. With 20 years' NHS experience I am aware how difficult it is for healthcare professionals to ask for psychological support, so I always make time for that.

Since arriving I have set up a monthly Rosebud Forum – 'rosebud patients'





‘Many of my clients are women who are coming to terms with a foetal abnormality, a traumatic experience of birth or a pregnancy loss, or women suffering from perinatal or postnatal depression’

refer to women who have lost a baby, and a ‘rosebud’ sticker on their file serves to alert staff to treat them sensitively. At the Forum we aim to provide a compassionate and transparent pathway of care for such bereaved patients. Healthcare professionals from various parts of the department have been involved so far – midwives in the community, antenatal clinic, delivery suite and those working on the postnatal wards, a consultant obstetrician, a member of the day assessment unit, administrative staff and a sonographer, included. We discuss issues that may have come up in the previous month, and if something has gone ‘wrong’, we try to make it ‘right’ and clearly aim to not repeat any mistakes. For example, it used to be the case that bereaved couples coming to see their doctor for a follow-up consultation after their baby had died, would sit in a waiting room amongst pregnant women. Now changes have been made to ensure they wait in a separate building, away from the maternity department.

I may attend meetings that keep me in the loop about what is happening in the Trust. As with many NHS Trusts, there is an under-funding issue and this is combined with increasing pressures on staff from a birth rate that has recently shot up. In January of this year we hit a 570 record delivery rate. I have set up other psychological services in the NHS and the two main challenges I have faced over the years are getting healthcare professionals to value counselling enough to recruit enough staff to meet needs, or to prevent service cuts. I also struggle to secure comfortable and appropriate rooms for client work, and I am still waiting for a dedicated counselling room here – which is frustrating. To help raise awareness

of the importance of psychological care, I also lecture staff about the psychological impact of pregnancy bereavement and trauma. Recently I taught a group of 40 doctors at a regional meeting, and twice a year I lecture up to 50 trainee midwives. I am not a naturally brave lecturer but my passion about the subject overrides my fears. I feel I do something worthwhile in my life and I do make a difference in the world. My lectures are usually well received, which is always rewarding.

I have a few private clients who tend to have longer-term psychotherapy issues, which is different from the shorter crisis-focused work at the hospital. I also supervise a group of trainee counsellors and psychotherapists during term times at the Centre of Counselling and Psychotherapy Education and I love the variety of work this all brings.

While I find my work inspiring and emotionally demanding, I am aware of the need to look after myself professionally and personally. I have weekly individual therapy and supervision twice a month. Often I have extra supervision when I have an intense workload. Personal issues can affect my professional role, of course, and sadly my father died suddenly in January this year. It has been a painful process and at times I have felt bereft while working with bereaved women and parents.

I’m just getting back on my feet in terms of my usual patterns and am beginning to appreciate the beauty of my home after stressful but exciting renovations – it is now a real sanctuary. I would usually go from the hospital to a yoga class, which helps me come back to myself and to let go of my day. In the summer I may bike a longer route home through Primrose Hill Park and absorb myself in the wonderful view it offers of London. ■

Body and soul

A very wise counsellor I have worked with for many years once said to me: 'It is not that the body has a soul; it is the soul that has a body.'

Your April 2010 cover illustration shows two body parts: a leg labelled as 'somatic' and a brain labelled as 'psycho'. No reflection on your artist, who was presumably following his brief. Psyche, however, means soul, and I am quite certain that the soul does not reside in the brain, any more than the BBC exists inside a radio. The picture seems to me to illustrate the way in which a reaction to the worn-out dogma of medieval religion has given way to an equally unproductive faith in science as The Way, The Light and The Truth. Because soul cannot be measured, it therefore does not exist, and the spiritual baby has been thrown on the rubbish heap with the holy water.

It is, to my way of thinking, poor science that takes this stance, and more indicative of a need for certainty in the face of ignorance than any real desire for knowledge. One dogma has been replaced by another. And there are just too many things that the science of technological measurement cannot explain.

This doesn't mean that we have to opt definitively for some other theory – that's just another route towards dogma. What it does mean is that the many spiritual practices which exist the world over, and which have one commonality – the existence of some sort of energy or existence which lies beyond the physical and cannot normally be seen – are worth noting as the myriad facets of some sort of truth. There is something here, and to say that, so long

'The point about soul is that it is neither airy-fairy nor a product of religious dogma, but something very precise and real'

as it cannot be measured, it cannot exist, is as foolish as ignoring bacteria or nuclear fallout.

My counsellor's statement resonated for me. What he was saying was that the energy systems which surround my physical body are not some sort of after-thought, tacked on to the body, relatively unimportant until I die, at which point, by some magical process, everything that I am will transfer to the soul, ready to go to heaven, hell, reincarnation or oblivion, depending on which particular stance I take.

My soul is who I am, and my physical body, without which I have no existence on this very physical planet, is the means through which the soul expresses itself.

Emotion, pain, disease, thought – all these things find voice through my physical existence. And what I experience through my body, including self-care and physical healing, is reflected back into the heart, essence and soul of who I am.

There is no separation; physical matter is, after all, only a form of energy, held in a very tight matrix. I say only a form of energy; it is, I think, the most remarkable manifestation of energy that there is; and everything that I perceive as both beautiful and terrible, together with my ability to perceive it,

expresses through the colossal energy that my physical self represents.

My counsellor's statement resonated with my own experience; for others it will be different. The blind men gathered around the elephant and describing their god are alive and well if we allow them to be.

I certainly cannot accept the Western medical refusal to consider the energetic body even as a possibility, despite all the evidence for its existence. (Anecdotal evidence, if it represents the experience of millions of people over thousands of years, is evidence of a very potent sort.)

What saddens me is that so many counsellors also appear hesitant to accept the possibility of what 'mind' or 'soul' might really be. Is it for fear of being ridiculed by mainstream thinking?

This is something touched on by Salma Khalid in her 'Day in the life' interview in the May *Therapy Today* issue. The point about soul is that it is neither airy-fairy nor a product of religious dogma, but something very precise and real – even if we do not yet have tools precise enough to define it objectively.

Our own sensitivities, however, are alive to the existence of soul if we are prepared to allow our own experience – and the experience of our clients.

The Enlightenment must have been a terrifying time for those whose security depended on faith in Christian dogma – as terrifying as Darwinism is for hard-line creationists. And, if there is any truth in the concept of the energetic body, then much mainstream medical thinking and practice becomes a nonsense. If I were

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a doctor with years of hard training, I should hardly relish that thought.

Astrophysics is now further challenging us with the notion that 95 per cent of what exists cannot (yet) be seen or measured. How can the implications of this not be threatening?

I have a choice then either to join the retreat into terror, deny such existence and persecute anyone who says otherwise; or I can become excited by the thought that, just as it seemed there were no hidden corners left to explore – unless that is I had access to billions of dollars and a few rockets – the psyche might itself be a realm to explore, unimaginably huge, on a scale which transcends normal concepts of time and space; and all I need to explore it is a willingness to be open to experience.

William Johnston

Positive practice

I read the interview with Salma Khalid in the May issue with great interest. I applaud her desire to integrate a greater awareness of spirituality in all forms into her work. This element was certainly covered on my counselling diploma course, and I felt able to choose those elements that were of relevance to me and leave behind those that were not. In my practice I have been able to connect with clients of several faiths in a meaningful way.

I am a firm believer in the positive effects of accepting that each one of us has a spiritual element which many of our clients may not

be aware of. We live in a very secular society, driven by the need to have more, and surrounded by noise from many sources. A walk in the country, where peace, fresh air and a connection with creation have been shown to improve our wellbeing, can do wonders for our mental health.

Where I feel some anxiety is the section of this interview that highlights a shortcoming in one Christian conference. As a Christian myself, I am fully aware that there are shortcomings in Christian settings. However, having worked with a church-run family project for several years now and met many other Christian counsellors, I am aware of the excellent work that is done. This work is often carried out free or with small donations, supported often only by church members. High standards of training and supervision are accessed regularly. It would have been more helpful if Salma Khalid had shown not only the shortcomings of Christian counselling but had also mentioned the positive practice that does abound.

Jill Britten

Spiritual synchronicity

The May issue of *Therapy Today* contains a piece of synchronicity that should not pass without comment. In her client column, Emma Munro notes that her “‘problems” may be in large part spiritual’. She attempts to share her interest in spiritual issues with her therapist so he

can ‘understand where I’m coming from’ but ‘he doesn’t seem to see it as being something to work with’. She concludes her piece by noting that behavioural change is not enough for her, she wants ‘change in [her] soul’.

Later in the same issue, my APSCC colleague Salma Khalid is the subject of the ‘Day in the life’ interview. She focuses on embracing spirituality and says of her work with the APSCC executive, that she is working ‘towards changing perceptions of spirituality within the profession’.

The experience that Emma Munro describes, of raising spiritual issues in therapy but them not being taken up, is one I hear about on a regular basis, both in my own client work and research, and through APSCC (www.apscc.org.uk), BACP’s division focussing on spirituality. BACP recently adopted, among its Policy and Position Statements, the following: ‘BACP encourages high standards of training and awareness in spirituality and especially in its relationship to counselling and psychotherapy’; ‘BACP encourages counsellors and psychotherapists to engage with the aspects of faith and culture if their clients bring these to counselling/psychotherapy.’

Members who would like to know more about how to turn these encouraging words into action, to the benefit of clients like Emma Munro, may wish to make contact, subscribe to our divisional journal, *Thresholds*, or consider joining the APSCC division.

Chris Jenkins

PhD, MBACP, Chair APSCC, Editor of Thresholds

Challenging perceptions

I would like to commend you for your inclusion of the ‘Day in the life’ interview in the May issue regarding spirituality and the perspective of therapist Salma Khalid regarding counselling from an Islamic perspective.

Having recently received my BACP certificate of accreditation, one of my interests is to work more actively in the black and minority ethnic (BME) arena by promoting psychological therapies and eradicating the stigma often associated with it among ethnic minorities.

On completing my counselling training and a BA (Hons) degree in psychodynamic counselling in 2009, like Salma, my own experience as a female British Muslim was that any focus on the issues of difference and diversity were largely given a focus on the teaching curriculum because it was more the ‘politically correct’ thing to do. Training institutions still seem reluctant to incorporate faith and spirituality within their programmes.

One of my former tutors, who had left Catholicism before entering the counselling profession, often struggled with my inclusion of my faith within written assignments, believing it had little connection to counselling work. I felt undermined at times. It is as if some in the profession feel that they are threatened by faith.

In fact, this was one reason that inspired me to conduct research regarding

Western models and their effect in relation to BME groups. I would add that this was not hugely encouraged in my training and was a project that I undertook with independent and determined spirit. The other motivation is that I have grown up with the harsh and painful reality of family members who suffer from psychosis and who are ashamed of the very concept of 'mental' health, trying to pretend that it would simply evaporate.

Though we are moving on slowly, there is still a long way to go in altering perceptions, but Salma seems well on the road to achieving this, perhaps partly due to residing in a culturally diverse area. Asian individuals are underrepresented within the profession of psychological therapies and not enough space is afforded to the very important issue of identity and how it may be connected to a person's religious or spiritual perspective. If it isn't talked about, it becomes the elephant in the room.

Like Salma, I have followed *EastEnders* for 20 years and am glad that it has brought to the forefront the difficult issue of a Muslim family encountering homosexuality. It has opened up the discussion around working with clients who might be gay but from a Muslim background and the extreme prejudices that this would invite.

In the same vein, when counselling an individual who is defined by their faith, among other factors, it is surely only ethical to be able to talk about it in a 'competent' way in order to fully and sensitively reach those we are counselling. It will take time to invest in, but hopefully change

will come for both the clinicians who are delivering counselling and those who are on the receiving end, but might be both fearful and sceptical of it. We are dealing with individuals whose psyches are defined by a range of external and internal influences, but essentially who are human beings first.

Fauzia Gaba
MBACP

What makes a man a man?

I'm sorry that James Hennah (Letters, *Therapy Today*, May 2010) has felt so threatened as a man in the world of therapy. It's true that there are more female therapists and therapy trainers than men, and I share his experience of working in a professional context dominated by women.

However, I cannot agree with his assessment that men are consistently dismissed as 'irrelevant' or 'dangerous': that may be his felt experience, but it isn't helpful to generalise personal experience to all men everywhere. Certainly, beyond the field of therapy, where men continue to dominate the world of business and politics (ie where they continue to fill positions of power), the charge could more easily be argued that women are discriminated against.

I am sorry, too, that James Hennah appears to be so firmly wedded to essentialist notions of masculinity and manhood. These suggest that there is a biologically determined

male 'essence' that is different from the opposite, female 'essence'. This can lead to the suggestion that this male 'essence' needs particular nurturing to avoid contamination by the female. (Interestingly, the opposite fear is rarely voiced. It seems that masculinity is still seen as the fragile achievement of men who have had to rigorously reject all associations with femininity in order to do so.) Such beliefs are widely promulgated through books such as *Men are from Mars, Women are from Venus* or *Why Men Don't Iron*.

However, a social constructionist view of men and women would suggest that, in fact, many of the so-called 'essences' are culturally contingent and that we are socialised into masculinity/femininity (and heterosexuality/homosexuality) from an early age. We come to see men and women, masculinity and femininity, as opposites and really believe that there is something fundamentally different about us – rather than seeing how much we have in common.

Deborah Cameron's book, *The Myth of Venus and Mars*, is an excellent, refreshing alternative to such essentialist concepts. I would argue that there is nothing essentially 'masculine' about men and that those qualities that are culturally labelled as 'masculine' are actually just as available to women – only they are not 'affirmed' in exhibiting them.

As therapists, I believe that it is incumbent upon us to see beyond these culturally constructed norms. I see many men in therapy who are oppressed by the demands of

masculinity and who feel unable to be a 'proper' man. It is only by being able to see beyond such categories that we can help clients to question whether those categories are helpful or whether there may be more fulfilling alternatives for them to discover.

In his letter, James gives the impression that he has a unique ability to affirm masculinity/maleness for male clients. I think he needs to be careful that he does not unwittingly oppress clients with unexamined assumptions and beliefs about what a 'proper' man is, when a richer engagement with questioning the validity of culturally-driven assumptions may enable a move beyond them. One obvious question to ask is, which version of 'being a man' does James want to affirm? What does his simple use of the word 'lads' (in referring to young male clients) imply?

I believe that all therapists need to engage in a 'queer' (ie social constructionist) questioning of categories that can so easily dominate our lives: male or female, man or woman, heterosexual or homosexual, black or white...

It may not be easy to reach beyond these categories, but I believe that it is not our job simply to affirm them unquestioningly. Hopefully therapists – male, female, transgender or intersex – offer more than a simple reiteration of oppressive stereotypes of gender, and instead offer a unique opportunity for their clients to embrace something which is richer.

David Mair
MBACP (Snr Accred)
practitioner

A counsellor's duty of care

I write in response to the article by Peter Jenkins ('Children at risk: a confidential space') in the May issue of *Therapy Today*. I believe that it is a counsellor's duty of care to children/young people to report child protection issues. Counsellors may not always have all of the relevant information regarding the child/young person's circumstances or whether there may be others at risk, and cannot make an adequate judgment that the child/young person or others are not at risk of harm. Child protection teams have the expertise to judge whether the child/young person or others may be at risk. They may have evidence of historical disclosure and other information that can substantiate the child/young person's story. My experience of child protection officers is that they are sensitive, and rather than go in all guns blazing, take a low-key approach.

Counsellors are either misguided or arrogant if they believe that they are only doing what is best for the child/young person, and by not reporting child protection issues are colluding in a serious crime. It is only by studying the psychology of perpetrators that we are able to understand that they do not stop at abusing one child and that the more they are able to be left unchecked, the more they will continue and, in many cases, become more intense and aggressive in their pursuit.

In my work with adult survivors, almost everyone has expressed the wish that someone had noticed the signals that they were giving for help. Further to this, they

articulate concerns for others who may have been in contact with their perpetrator. Many of these perpetrators may still be at large. I would encourage counsellors to make a contract with their children/young people that leaves them in no doubt of their limitations regarding confidentiality; then there can be no breach of trust.

Mary Rodgers
Service Manager

Food for thought

I read with interest your article on postnatal depression (*Therapy Today*, May 2010). It was curious that there was little mention of the physiological changes a woman undergoes during pregnancy and after birth. From my understanding, the vital nutritional support a baby requires to develop is taken from the mother, potentially leading to her being severely depleted unless she has been able to get adequate nutritional intake before, during and after pregnancy and has a healthy constitution to start with.

The findings in the article corroborate those of Gerson Therapy, which is probably the most successful alternative treatment for cancer. This treatment is based on providing maximum nutritional support that is carefully targeted to a specific illness. What they are discovering is that the quantity of nutrients found in present-day foods is far less than in earlier times, hence people are taking a longer time to recover. Does this tie in with the increased incidence of postnatal depression? The lack of nutrients in our food can be attributed to over-farming, the

use of chemical fertilisers and environmental pollution, not to mention poor diet.

Gerson Therapy maintains that there is a direct link between adequate nutrition and good mental health. This would indicate the need to look at diet for any woman contemplating having a child, especially during pregnancy and particularly after birth. I am sure that much of what I am writing is quite obvious to most of your readers but it is curious that it has been overlooked in this article, and I wonder if this is because we have become so professionally compartmentalised and are not looking at the bigger picture. It also opens up the issues of how much of a role diet plays in current-day mental health problems, and whether we are giving this enough attention in our modern society that is dominated by a desire for the instant pharmacological/therapy cure.

Michael Hutley
MBACP (Accred) holistic practitioner

Relentless positivity

Barbara Ehrenreich's article, on the dangers of what I call 'relentless positivity', was much appreciated. I would like to expand on her links between affluence and happiness by pointing out that once nations have become affluent, further rises in wealth count for less and less. What starts to matter hugely is equality, for both rich and poor. As we know, the gap between the wealthy and the less well off has significantly increased in Britain, bringing with it far-reaching effects including a worsening of

violence and mental health.¹ Fairer societies and good social relationships have been shown to contribute far more than wealth to wellbeing.¹

Colette Priestley

MBACP

REFERENCE:

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Unsympathetic view of empathy

Does the concept of empathy stroke therapists more than it empowers clients? Whose needs are being met by the definition of empathy – the client's or the therapist's? The capacity to participate intimately in another person's inscape is one definition. Even at their less grandiose – accurate awareness of another's feelings, say – definitions tend to flatter therapists. There's no instrument sensitive enough to measure empathy except the human heart, whose conclusions aren't verifiable. Empathy is as hard to define as it is to achieve, but I suspect it begins with therapists taking clients as they find them and ends with leaving them alone.

The likelihood of empathy may increase the more therapists get to know their clients, but it's always going to be easier for them to empathise with those who are most similar to themselves. How can somebody who has never experienced bipolar/manic depression empathise with clients who suffer with this? I can't even begin to imagine. Like so many mental disorders it would seem to be beyond empathy. Claims

for empathy should be tempered with caution – acute sensitivity to the feelings of others is less common than tentative speculation. Some have defined empathy as the antithesis of autism, but it might be more realistic to assess where therapists are on the continuum between autism and empathy we all live on. Understanding is almost always an overstatement. What purports to be empathy is often a more or less bungled attempt to discern the nature of a client's interior world, but ultimately the client is the only one who can fully understand her/his inner life. Efforts to empathise may be appreciated, but perhaps it matters less that therapists understand than that they're touched by a client's predicament and prepared – for a fee – to sit by while s/he tries to understand. Therapists' willingness to accept their own inability or slowness to understand might be more beneficial to clients in the long run.

Empathy has been equated with burden-shouldering, in some instances endowing the therapist with almost superhuman strength. I think it's misleading to suggest that the therapist takes the weight of the burden from the client. Although the burden may be lifted, it's a joint effort. Client and therapist might drop the burden any number of times but when they do it falls between them: at this point the client is no longer alone. No longer alone, but separate. The moccasin-donning dimension sometimes attributed to empathy strikes me as far-fetched. Therapy is difficult enough without insisting that the therapist wears the client's shoes into the bargain. It's painful to see therapists behaving like so many ugly sisters trying

in vain to squeeze their feet into three-sizes-too-small moccasins when it would be more helpful to clients if they kept their feet on the ground.

It's easier to say what empathy isn't. It certainly isn't when therapists choose adherence to an ideology or theory over a client's needs; although that, too, has been perpetrated in empathy's name.

When therapists apply their shelf-knowledge without due regard for the individual they're sitting with, it's not unlike the way hospitals flaunt their technology to the detriment of the child-bearing mother. The latter, like the client, is made to feel small at a critical moment in her life; a leading lady reduced to a walk-on-lie-down-and-shut-up role. If we see therapists as midwives, supportive but restrained and forbearing in a way doctors so often fail to be, the idea of them absorbing a client's pain in the way some textbooks recommend becomes as absurd as a midwife ingesting a baby she just helped deliver. The consequences of the burden-snatching that sometimes passes for empathy may be as harmful to the client as they are to a mother prevented from seeing or holding her child. S/he might not be ready to hold the burden herself/himself, but for the therapist to internalise it might jeopardise the therapeutic process.

Far better, in my view, to keep the pain in the space between them where the client can see it and they can work on it. After all, the client is the mother of her/his pain; it doesn't belong to the therapist.

If the aim of listening isn't so much to hear others as to allow them the opportunity to hear themselves, the process of empathy as I'm formulating

it isn't so much about bearing clients' pain as enabling them to bear it themselves. The challenge for a therapist isn't to absorb a client's suffering but to hold it in such a way that the client can re-own it when the time is right for them.

Therapists should be wary, in their enthusiasm to empathise, of perceiving clients as empathy-objects. Empathy isn't something that's done to a client; it's part of a process in which s/he takes an active role.

Too much is made of the strength offered to clients by the therapist, too little of the strength displayed by clients who embrace the one-way disclosure that characterizes so many psychotherapies. The client/therapist relationship is both more and less equal than is sometimes appreciated.

What I've proposed above is a more modest but at the same time less narrow definition of empathy. For me, suffering, misery and confusion don't have to be embodied in the therapist. A client's expectations of the therapist may be more realistic, ultimately, than the therapist's expectations of her/himself. And if they're not, well, who's to say disabusing clients of unrealistic expectations isn't as important as trying to empathise with them?

Too many definitions of empathy say more about a therapist's aspirations than a client's experience. Some who lay claim to empathy will, on closer investigation, turn out to be empathological liars. This doesn't make them bad therapists necessarily; it serves to remind us that they're only human beings, not only at the end of the day, but during the therapeutic encounter itself.

Gary Egan

Obituary

Antony Grey (1927 – 2010)

Antony Grey died on 30 April 2010 after a long fight with leukaemia. He was no stranger to doing battle with opposing forces. As a tireless Parliamentary lobbyist, he helped bring about homosexual law reform, later continuing his work through the Albany Trust. He continued to champion, train and counsel on issues around AIDS and the relief of sexual oppressiveness, whether straight or gay.

However, I did not know Antony in any of these capacities. I met him initially at the SCATS (the Standing Conference for the Advancement of Training and Supervision, 1979–1995), which grew out of the newly formed BAC's annual training conference. Antony was a dear and loyal friend: a witty man with a wicked sense of humour. His clerihews were a special joy. Not a man to suffer fools gladly, he could be impatient and intolerant, particularly of bigotry and small-mindedness.

His partner of over 50 years told me that Antony wanted neither funeral nor memorial. I am sorry about this as I, with others, shall mourn his passing and miss him hugely.

Caro Bailey

I would like to add that as one of his counselling skills tutors, I have always remembered watching videos of Antony counselling; the quality of his attention and engagement was such that I could almost see a bubble surrounding him and his client. I have often referred to this special state which is generated in a deeply enabling helping relationship.

Brigid Proctor

Addressing the big questions of society

Social symptoms of identity needs: why we have failed to solve our social problems and what to do about it

Mark Bracher
Karnac 2009, £21.99
ISBN 978-1855756540
Reviewed by Colin Feltham



This is one of the most interesting and potentially important books I have read for some time. Mark Bracher, who is both a professor of English and a director of psychoanalytic studies, takes on the big questions of society and its apparently intractable problems. His book is a well-structured and clearly-written psychoanalysis of delinquency, crime, violence, terrorism and war. It also looks at old age, disability, drugs and alcohol, poverty, homelessness, early pregnancies, homophobia, racism, and the problems of hyper-masculinity. He asks what it is in us that does not want to meaningfully address and resolve these problems; why our attempted solutions so often fail, and why we scapegoat certain social groups.

Individual chapters examine causes of social problems, the nature of identity, particular social problems as symptoms, 'phobic objects', and damaging cultural forces; the final chapters focus on promoting 'identity contents' and decommissioning harmful defences – in other words, potential remedies. Bracher's power of argument should reinforce the suspicion of counsellors and psychotherapists that their theories and practices have as yet only weakly understood and barely utilised possibilities.

Although not wholly original (much has been written on social and cultural analysis), Bracher's work is incisive and compassionate and includes reasoned suggested remedies. He isn't naïve enough to think he has the answers, but this book does offer leverage to all psychotherapeutic

perspectives on social malaise; not only commending individual therapy, but also extensive education in common defence mechanisms.

For an American text it is extremely liberal and does not flinch from severe criticism of the Bush administration, for example. Bracher is hard-hitting in his analysis of punitive social policies. His central thesis is that identity is our most basic human feature, that our identity needs must be recognised and respected, and that when they are not, serious and widespread social problems are the inevitable result. One strong message is that it is counterproductive to humiliate and shame individuals and groups.

In some ways this book is rather uncritically promotional with regard to standard psychoanalytic principles and terminology. It has little to say about climate change, religious superstition, and population problems. It is not as up to date as it should be, nor does it engage sufficiently with texts of a similar genre. For my taste Bracher is quite utopian and relatively uninterested in additional or alternative aetiologies of social problems, including genetic factors. One wonders too, as always, whether the very people who might most benefit from reading it (eg politicians) are at all likely to do so.

However, the strengths of this book far outweigh any shortcomings and I suggest it be included in the reading lists of all socio-cultural modules in counselling and psychotherapy courses.
Colin Feltham is Professor of Critical Counselling Studies at Sheffield Hallam University

Collaborative conversations in the community

Psychology in the real world: community-based groupwork

Guy Holmes
PCCS Books 2010, £19.99
ISBN 978-1906254131
Reviewed by Chris Rose



The photograph on the jacket of this book shows a dog looking into the camera and a man turning back towards the riverside path where they have apparently been walking. If Guy Holmes is inviting us to look back at his own pathway, we will need to reflect upon 'community psychology'. This embodies a way of thinking and relating that challenges dominant ideas of mental health and that looks squarely at issues of power and difference. Over many years, he has been influential in creating a culture of groupwork within the psychological services in Shropshire that challenges the contemporary fixation upon short-term individual 'interventions', the medicalisation of distress, and the diminishment of the NHS into a business venture.

Patients, clients, service users, practitioners, trainees, carers and psychologists all find a place here as people with common human experiences and struggles, who need other people and

healthy environments in order to live their lives as best they can. Holmes has developed and facilitated a range of short-term groups or 'courses' based in community educational settings that are open to all. The process is that of 'collaborative conversation', where the author and fellow facilitators share knowledge and ideas whilst encouraging others to do the same. Without being unrealistic about the benefits, Holmes points to that invaluable potential that groups have in helping people appreciate their own unique qualities and their shared humanity.

Courses include 'Understanding ourselves and others'; 'The black dog: understanding depression'; 'Thinking about medication'; 'Toxic mental health environments'; and 'Walk and talk' along the banks of the River Severn. Some of these groups have spawned others, led by participants, and there is clearly a culture built up over many years within which people can learn from each other ways of restoring and maintaining their mental health. It is also a testimony to the much-ignored value of long-term relationships, of staying in the same place and getting to know people well.

The book is a collection of course contents, flyers, testimonies and discussions put together as a detailed and varied resource. This comes interspersed with chapters about group processes and theories, all in an unaffected and accessible style. But however much I liked the content, the book tries to draw together so much material that it becomes confusing and cumbersome. There is another book waiting to appear from all this material – one in which the wisdom and experience

have been distilled, and Holmes looks directly at the camera. *Chris Rose is a group psychotherapist and writer*

Attachment theory in practice

Exploring in security: towards an attachment-informed psychoanalytic psychotherapy

Jeremy Holmes
Routledge 2009, £21.99
ISBN 978-0415554152
Reviewed by Gabrielle Brown



'To mentalise is to construct a reparative bridge over the chasm of loss... the narcissistic self-preoccupations and potential traumata of everyday life' (p95). Holmes summarises his stance in a chapter called 'Poetising', which links the theoretical and practice-based sections of this remarkable book. Attachment theory books often provide more diagnostic formulae than clinical engagement: long on attention to 'repeating', short on the process of 'remembering and working through'. However, this book is genuinely rich and will appeal to students as much as to seasoned clinicians, both to learn from and quarrel with. A helpfully detailed index allows the book to be used as an ongoing resource.

Holmes provides eight detailed and well-researched chapters on the principles of establishing the therapeutic relationship, meaning-making, and promoting change. He then

reviews ideas for working with issues of sexuality, dreams and endings, and with clients who attract a borderline personality diagnosis. Theoretically, he draws from a wide palette, for instance putting 'mentalising' into the context of Bion, Matte Blanco and Kleinian thought. Clinically, he provides long, rewarding vignettes from his work as both psychotherapist and psychiatrist. Additionally, he offers analysis of his own dreams, reflections and moments of 'self-preoccupation' from his career.

Few textbooks can also be read as an intellectual biography of a distinguished practitioner. Holmes shows how his theoretical 'secure base' has enabled him to explore ideas and experiences in his professional roles, including the move into semi-retirement. He is as generous with his fleeting thoughts – 'When in doubt, shut up' (p83); 'In psychotherapy, nothing never happens' (p154) – as with important clinical precepts for difficult cases. A useful chapter on elaborating meaning in suicide and self-harm, for instance, reminds the reader 'the therapist needs to feel that it is someone else's job to keep the client alive' (p141).

The attachment model is often thought to lack sophisticated understanding of the unconscious, of the aggression and sexuality proposed by Freud and Klein. Holmes seems mindful of this criticism. There is extensive guidance on problems in sexual relating. Case examples illustrate the effects of disorganised, avoidant and perverse attachment patterns upon healthy sexuality, termed 'hedonic intersubjectivity'. Dreams are also valued for their access to the unconscious: they 'triangulate both the playfulness and truth-seeking

aspects of therapy' (p152). 'Playfulness', in Winnicott's sense of secure creativity, is Holmes' considerable contribution to the concept of mentalising. The book portrays an infectious delight in exploring theory, in thinking about thinking and awakening clients' curiosity to generate reparative meanings. *Gabrielle Brown is a psychodynamic therapist*

Brief solution-focused DVD

The miracle question & its use in anger management (DVD)

Paul Grantham
Psychotherapy DVDs 2010, £34.95
Reviewed by Bill O'Connell



Over the years as a tutor and trainer I have struggled to find video material to which my students and trainees can relate. For one reason or another, they fail to identify with the therapist, find the clients unconvincing or unrepresentative, and in many instances find the tapes boring. In some instances they have trashed the work of internationally famous therapists and founders of schools of therapy!

So I would love to say that I have found a DVD that showcases my own favoured model – brief solution-focused therapy. But alas, I have to be honest and say that I haven't. I have attended one of Paul Grantham's excellent seminars. He is a fine presenter, a good communicator and no doubt

an excellent therapist. On this DVD he delivers a competent and confident explanation of the intervention known as the 'miracle question' and its use in the context of anger management. I thought this was the best part of the DVD.

Following Grantham's presentation, the main part of the DVD is one of his sessions with an actor role-playing a client. Personally, I think it is impossible to role-play responses to the miracle question – it demands an in-the-moment-like condition from the client. An actor cannot replicate the authenticity required. My second problem with the actor is that he looks and sounds to me like a mild-mannered, studious, gentle person, yet he is supposed to be someone who has an anger problem and has been violent towards his partner. I do appreciate that clients may present one face to a therapist and another to their partner, but it doesn't make for a very convincing session.

In a real session, the client's answers to the miracle question are often mundane. This is hardly surprising, as the intervention isn't really about a miracle, it is a powerful linguistic device to bypass problem-talk and draw out the client's preferred future. In that sense, the taped session is true to a real one, as the answers given by the 'client' are about small events of daily life. Unfortunately, that makes for rather boring viewing.

A purchaser of this DVD would probably want to use it in a teaching or training context, but the producers warn that to do so requires a further licence. Since the DVD itself costs £34.95 online, this may be a cost too far for many. *Bill O'Connell is the director of training for Focus on Solutions Ltd*

The art of listening

The 3-point therapist

Hilary A Davies
Karnac 2009, £9.99
ISBN 978-1855757462
Reviewed by Joyce Allen



This little book is a gem. Written in the third person by an anonymous narrator, it consists of a fictional account of a number of meetings between two female protagonists named as 'the therapist' and 'the trainee'. They could equally have been called 'the supervisor' and 'the inexperienced therapist' as this book is really about supervision as the psychotherapeutic world knows it.

The context of the book is family therapy but the contents are relevant to all therapies. It may at first appear to be simplistic, as the main focus is not on the latest theories and academic writing but on the most basic yet important thing to be learned in counselling work – the art of listening. In fact, the way the book begins is reminiscent of the way fairy stories are written, with a 'Once upon a time' flavour to it.

When they meet, the therapist tells the trainee that she can teach her only three points. The trainee is disappointed, thinking that research papers were needed to enable her to 'become the best therapist anyone could be'. The points are not

revealed immediately and the tension created as the reader anticipates what they might be makes the book a real page-turner. The way these points are gradually and skilfully revealed keeps the reader glued to the text.

The trainee is sent away after each meeting with simple instructions and asked to return to report how the therapy with her family is progressing. Little by little she becomes aware of what is being taught and the three points are skilfully revealed to her. She realises that 'theory is not practice' but is nevertheless essential when reflecting on practice and in supervision. The therapist emphasises the need for a good knowledge of theory to inform best possible practice. She helps the trainee to understand that her own anger with the client is an indication of what might be going on for the client: in theoretical terms, a projection.

The chapters are short, succinct and aptly named and the reader becomes engrossed in the unfolding story. The only point that might cause difficulty for some readers is the fact that the therapist insists that the parents in a family are addressed as Mr and Mrs and not by their first names. She states that it shows respect and that it is a professional relationship. These are valid points, but many couples today are not married and it could also sound a little too formal in these times of first names for everyone. There is a lovely moment at the end when a male character is introduced, thus providing the reminder that this is not an all-female book.

It is amazing that so much wisdom about how to conduct

therapy can be packed into a little volume of only 106 pages. The author is evidently a person of great experience, and her compassion and love for the work are clear. To read this book is a moving and humbling experience. Every therapist should read it. *Joyce Allen is a psychodynamic counsellor and supervisor*

Everything a trainee counsellor will need to know

What is counselling and psychotherapy?

Norman Claringbull
Learning Matters 2010, £18.00
ISBN 978-1844453610
Reviewed by Dahlian Kirby



What is Counselling and Psychotherapy? is part of the Counselling and Psychotherapy Practice series, which has been specifically written for students on counselling and psychotherapy courses. Norman Claringbull is the editor of the series. The book is laid out rather like a course manual: each chapter has an introductory core knowledge section and also includes reflection points, case studies and suggested activities for the reader. This format will appeal to many students in the earlier part of their training.

In the preface, Claringbull tells us that it is an exciting time to be a counsellor. He takes on the job of explaining the background of counselling

and psychotherapy, moves on to defining various types of therapy, then offers a third section about different environments that therapists work in. At the end of the book he brings us right into the present, making predictions on how counselling and psychotherapy may change and how practitioners might be affected.

My initial feeling about the book was that the author tries to do too much in too short a space, ie cover everything in an easy-to-read handbook. On reflection, I realise he has cleverly put together just about anything a trainee counsellor would need to know. The book quotes many sources and gives suggestions for further reading. In this way, it can be seen as a starting point: each reader is able to look deeper into whichever aspect of the subject interests him/her most.

I am not clear how useful some of the questions, reflection points and activities are. Some of the reflections are written rather vaguely and it is difficult to understand their point. For example, in the introduction to the section 'What do therapists do?', one reflection point asks, 'Is it always wrong for counsellors to know better than their clients?'

Overall I enjoyed reading the book and felt that Claringbull was genuinely pulling us in to share his knowledge and listen to his fears and hopes for the

future of counselling and psychotherapy. I personally found the section on the complex issue of confidentiality in school-based counselling interesting and thought-provoking.

The book will be particularly useful to students, who sometimes can't quite work out what is meant by a certain term or theory and can't bring themselves to ask. And that, may I add, is probably all of us.

Dahlian Kirby is a writer and teacher currently in the first year of a diploma course in therapeutic counselling at Barry College, Wales

The power of patterns

Understanding transference: the power of patterns in the therapeutic relationship

Lesley Murdin
Palgrave Macmillan 2009,
£21.99

ISBN 978-1403921185

Reviewed by Ann Bowes



Out of her many years of experience as a psychotherapist, trainer and

supervisor, Lesley Murdin has written a primer for trainers and trainees in psychotherapy and counselling. She relates the psychotherapeutic experience to the theoretical concepts of how transference works. This is an approach leading to an understanding and use of transference in all its manifestations, whether negative or positive.

The book starts with an examination of how patterns help us to think about clinical experiences with a patient/client. It offers various ways of defining transference, and how to begin to make sense of human experience through it. It continues with 'how to apply' theoretical approaches to the use of transference as a defence. Then it moves on to transference as a manifestation of earlier family relationships; for example, the difference between the experiences of being the eldest or youngest sibling.

Thought is then offered about how such an understanding can assist the client, in the clinical setting, to free themselves from counterproductive repeated cycles and begin to live in the 'here and now'. The question of power when a therapist works with transference – its use and misuse – is also addressed. The book concludes with a discussion of how transference affects

relationships with training supervisors and training bodies, and the potential changes with statutory registration.

Common technical terms are illustrated. The realities of cost and time constraints for psychotherapeutic help are considered. There are illustrations through the use of questions at the beginning and end of each chapter, so that the beginning therapist can start to approach the complex experience of transference. She also interweaves salient clinical examples, which give an evocative sense of the consulting room, using her working knowledge of Freudian, Jungian, Lacanian and person-centred approaches. Her use of a theoretical base is wider than pure psychoanalysis, giving space to developmental biology and neuroscience. The language is everyday and ordinary and also gives space to therapist errors. In the therapist's slow unpicking of the client's habitual responses, the transference roots are revealed, allowing a change in the client's perception of 'truth'.

This book is a useful, lively and thought-provoking handbook for trainers; those in training might wish to dip into it and see what 'speaks' to them.

Ann Bowes is a psychoanalytic psychotherapist

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Understanding the aims of the NAPT

Lorna Farquharson, clinical advisor to the National Audit of Psychological Therapies (NAPT), talks to BACP about the aims of the project

Could you tell us about the aims of the NAPT for anxiety and depression?

The NAPT aims to engage psychological therapists across England and Wales in a process to evaluate and improve the quality of treatment and care provided for people suffering from depression and/or anxiety. It will gather evidence on access, appropriateness, acceptability and outcomes of treatment.

We hope to obtain a true picture of NHS-funded service provision and performance across England and Wales; and will work with both services and therapists to ensure we include the full range of therapies available. We will collect data on NICE-approved treatments such as CBT, interpersonal therapy, couple therapy, brief dynamic therapy and counselling; we will also collate data on other forms of therapy that are being provided.

The ultimate aim is to help the Department of Health (DH) and NHS Wales understand what is actually happening in the field of NHS-funded psychological therapy provision and to inform the future development of appropriate work programmes, policies and targets.

Can you tell us more about the four key areas you mentioned – access, appropriateness, acceptability and outcomes?

We describe these as the

four dimensions of quality:

1. Under access we will explore who is offered therapy and how easy it is for people to take up the offer.
2. Under appropriateness we will look at what kind of therapy is provided and whether it is consistent with best practice.
3. Under acceptability we will consider whether the type of therapy offered is acceptable to the patient. To examine this we have designed a new satisfaction questionnaire in conjunction with people who have experienced anxiety and depression in the past, to get meaningful feedback for services.
4. Under outcomes we want to know if people feel better and are better able to cope with their anxiety and depression as a result of therapy. This is about asking the fundamental question: ‘Does the service provided “work” for its users and potential users?’ This dimension is concerned with looking at outcomes, regardless of whether the therapy provided is in line with NICE guidance. In addition to outcomes scores, the audit also looks at service users’ views on therapeutic alliance, recognising that outcome scores are not the complete picture.

Who is eligible to take part?

The NAPT is open to all adult NHS-funded outpatient services, including voluntary sector services, which provide psychological interventions for anxiety and depression.

This includes:

- Primary and secondary care services
- IAPT and non-IAPT services
- All therapy modalities
- The whole of England and Wales.

Please contact the NAPT project team for more details of who can take part, or download the decision tree, which is a flow chart to help you make a decision about eligibility (see www.rcpsych.ac.uk/pdf/NAPT%20Decision%20Tree.pdf).

What are the benefits of participating in the NAPT?

In addition to helping to improve our collective understanding of how NHS-funded psychological therapies are delivered and the contribution they make to patient care, there are benefits to the individual services and therapists that participate.

The audit will enable services to benchmark themselves against common standards and other participating services, whilst remaining anonymous to other organisations. To achieve this we will present results by organisation and service code.

Through the service user questionnaire and feedback, services will also find out what people really think about the psychological therapies service they receive. The combination of service user feedback, clinical outcomes and benchmarking will enable services to identify areas

in which they are performing well and areas for quality improvement.

Involvement in the audit also helps services demonstrate to their local commissioners that they are collating and providing data that will help commissioners deliver world class commissioning. In addition, the DH has recently issued guidance requiring service providers to report on their participation in the NAPT as part of their Quality Accounts.

What will it involve?

There are four audit tools that are designed to measure the previously-mentioned dimensions of quality:

- Service context questionnaire: a one-off questionnaire that will provide background information about the participating service
- Therapist’s questionnaire: a one-off questionnaire, which is to be completed by each therapist about their training and the therapies they deliver
- Retrospective audit questionnaire: to be completed by the service for each client who has completed or dropped out of treatment between 1 September and 30 November 2010. This includes details of an individual’s care pathway, ranging from the date of referral to the outcome measures used
- Service user survey: a brief, anonymous survey to be completed by all clients in

therapy on a census date in October 2010 and returned directly to the NAPT project team.

When does the main audit begin and how do services sign up for it?

The national roll-out of the audit began in May 2010. However, services can sign up for the audit until September 2010. Data collection will take place in stages, starting in May 2010 and ending in February 2011 to allow services plenty of time to collect and submit data.

You can sign up now by downloading a registration form online (please see www.rcpsych.ac.uk/napt). We can also keep you updated on the progress of the audit by sending you our newsletter. If you wish to be included on the distribution list, you can contact the NAPT project team directly (please see the details below).

What do services need to do after they have registered?

If you have already registered, you may find it helpful to consider the following points in preparation for the audit:

- How to co-ordinate the audit locally
- Ways of publicising the audit to all stakeholders
- Use of existing data collection systems
- The role of individual therapists
- How to track progress and ensure timely submission of all data collection tools.

How do I find out more information?

The NAPT project team is very happy to be contacted by phone or email. Please call 020 7977 4974 or email napt@cru.rcpsych.ac.uk

A coaching division for BACP

BACP has launched a coaching division to meet the needs of an estimated 3,000 plus current members who coach alongside their counselling and psychotherapy practice.

'We have been increasingly aware that some of our members' needs are not being met within the current BACP structure,' says Linda Aspey, inaugural Chair of the new division. 'So we want to provide a voice for BACP members who coach or who want to develop their practice into this domain, and to create a supportive and creative space for dialogue, networking, learning and professional standards.'

A former BACP Board member and an accredited counsellor and psychotherapist, Linda Aspey is also an executive coach (accredited by AC and APECS, two of the main coaching bodies) and organisation development consultant.

'Whilst there's a lot of crossover between coaching and therapy, there's also a lot of unnecessary polarisation. Some clients and practitioners have an inaccurate perspective that coaching is for quick

solutions and therapy is long and painful,' says Aspey. 'We'd like to facilitate more conversations recognising that there are many different kinds of both, and to encourage more research, particularly around the coaching/therapy boundary.'

While a number of coaching organisations already exist, they do not necessarily have the therapeutic orientation that BACP Coaching will provide, although the aim is to work collaboratively with them, for example through the Coaching Bodies Roundtable, where the main professional coaching bodies are working together to build coaching standards and the profession in the UK. BACP is currently exploring how the existing BACP *Ethical Framework* needs to be adapted to inform coaching practice, and also considering how best to support members who are seeking accreditation as coaches.

Additionally, since the introduction of the coaching column in *Therapy Today*, BACP has had numerous requests from members for information and advice about coach training. 'It's quite hard

for people to know where to start looking at how to choose a training route, so we're currently mapping out the various options with the aim of providing some signposts for our members,' says Aspey. The coaching column will now evolve into a series of in-depth features about coaching, with contributions from leading-edge coach practitioners and academics.

The BACP Coaching membership and application process are currently being developed, including a new website and plans for a series of regional coaching events and, in due course, a journal and conference. An online group – BACP Coaching – has been started on LinkedIn (www.linkedin.com) for all BACP members to network, and letters will soon be going out to members who have previously expressed an interest in coaching, inviting them to get involved in shaping the new division. Details of how to join the new division will be given in the next issue of *Therapy Today*.

For more information, please email linda.aspey@bacp.co.uk or cris.holmes@bacp.co.uk

Calling all independent practitioners

The Association for Independent Practitioners (AIP) is a BACP division that offers support and advice for those working in part or full isolation from organisations. New AIP members have joined the executive, adding their knowledge of working independently. The executive is actively involved in preparation for the change of leadership of

AIP at the end of this year.

Apart from offering assistance with networking, peer support and how to set up in private practice, we distribute a quarterly journal, *The Independent Practitioner*, full of useful articles for independent therapists. In a drive to improve and expand our journal, we would like to ask all therapists to share their

knowledge and consider writing an article for publication about their experiences or anything they consider might be useful to others in the same field.

Please send your submissions to *The Independent Practitioner* editor, Margaret Akmakjian-Pitz (email makmakjianpitz@googlemail.com). For further information about AIP, visit www.aiponline.org.uk

Improving access to psychological therapies update

As reported in February's *Therapy Today* and in April's *HCPJ*,^{1,2} the IAPT team has issued guidance for the commissioning of a range of evidence-based therapies. In support of this, work continues on the development of competencies and associated training for humanistic counselling, brief psychodynamic therapy, interpersonal therapy and couple therapy, all within the context of working with people who have a diagnosis of depression. This work is expected to translate into more choice of therapy within IAPT services, with an expected launch ahead of the new academic year this September. Despite this welcome development at national level, BACP is aware that a range of psychological therapies is not currently being provided across the board, and that there is much to be done locally to persuade commissioning bodies. This is why BACP continues to work at national and local level in support of members making the case for a range of therapies. This update provides examples of this work since the May issue of *Therapy Today*. BACP recently received findings of a contracted

consultation exercise entitled 'An exploration of the information needs of commissioners with respect to planning psychological therapy provision for the whole community'. The project involved interviews with 25 IAPT commissioners. In addition to exploring information needs, the project tested some of their views on offering a range of therapies. The findings indicate that, for the most part, this group of commissioners were either already commissioning a range of therapies, or planned to commission a wider range in the future.

In parallel with this project, two further pieces of work looked at members' experiences. Members in the Southwest were asked for an update on the situation in their Strategic Health Authority area. This was in follow-up to previous reports of threats of service closures following the implementation of IAPT. Sadly, in several PCTs there is now no NHS counselling and there has been a reduction of choice for those who cannot afford to pay for therapy. It is important to point out that the NHS does, however, continue to fund some third sector provision

in many areas of the Southwest. There are pockets of good news for NHS counselling in the Southwest where services have been maintained as a result of the commitment of enlightened commissioners, GPs and counsellors, who have made the case for counselling. The news of plans to develop counselling provision as part of the full roll-out of IAPT offers hope that, in the mid- to long-term, a range of therapies will be more widely available. The second piece of work involved collating information received from members since March about current challenges for NHS-funded counselling. There was one report of counselling service closure and two of uncertainty over future funding and job losses due to cutbacks. Other employment issues included counsellors feeling under pressure to do bolt-on CBT training, and feelings of unfairness in the banding of high intensity CBT therapists at Agenda for Change Band 7 with counsellors allegedly undertaking comparable work within the service at a Band 6. We also received reports from third sector services; two indicated that referrals had reduced; in one, GPs had

been instructed not to refer. Conversely, other third sector services have reported increases in referrals due to IAPT services building up a waiting list. There was also a report of IAPT services making inappropriate referrals to third sector services – a result of trying to clear a long waiting list. Other themes in your correspondence were requests for more information to help equip you to communicate and work with commissioners, opportunities to network with other members, and support with preparing letters for MPs. This summary makes uncomfortable reading in parts because of the threats and challenges to NHS-funded counselling. We are also in contact with members and services where counselling is offered alongside IAPT or is fully integrated and valued within IAPT.

If you have a perspective to share on IAPT, please get in touch. It would be particularly useful to hear from more third sector providers. Please email healthcare@baccp.co.uk

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Postcode check – can you be found?

BACP will soon be launching a new public-facing website. Aimed at giving the public a stronger understanding of the uses of counselling and psychotherapy, the site will also include a new search engine for searching the Find a Therapist Directory. This new search facility will allow potential clients to find

a therapist within a user-determined radius of their home postcode. This means it is now vital that each member's full postcode is on their directory entry so that they may all benefit from this.

We urge all Find a Therapist Directory entry holders to check that their full postcode is on their directory entry or

entries. Any required update can be made via the 'Find a Therapist Entry' menu option on the members' area of the BACP website or by contacting Chris Sayer (see details below).

Some of our members have expressed concern at having their postcode entered onto the directory as they do not want it to be seen by the

public. This is understandable, but we wish to emphasise full postcode details will only be used to create a more accurate search and will not be made available for general viewing.

If you have any comments or questions, please contact Chris Sayer, Directories Officer, on 01455 883334 or email chris.sayer@baccp.co.uk

Volunteers wanted to pilot new supervisor accreditation scheme

The Professional Standards department of BACP invites members considering applying for accreditation as a supervisor of individuals or groups or both, to apply to pilot a simplified supervisor accreditation scheme planned to replace the current interim scheme. In the first instance, we are looking for 10

applicants to take part in the pilot.

If you choose to join the pilot, you will be sent the revised forms and will have to make your application no later than 31 August 2010. There will be no charge for your application, as you will be helping BACP to test the revised criteria, forms and

guidance. If your application is successful, you will gain your supervisor accreditation free of any charge. There will be no difference between your accredited status and that awarded via the existing interim scheme. If you do not become accredited under the pilot scheme, we will not record this as an unsuccessful

application, and you will be able to resubmit, to make a new application under the current scheme, or appeal, if you choose. The relevant fee will be applicable at any of these stages, however.

Please contact BACP's Professional Standards department on 01455 883300 to request an application pack.

Policy and public affairs

Andrew Lansley CBE, MP has been appointed Secretary of State for Health following the general election. Mr Lansley, MP for South Cambridgeshire and a former civil servant, had been Shadow Health Secretary since 2003 under Michael Howard and then David Cameron. Mr Cameron had long guaranteed Mr Lansley – who has played a key role in convincing people that the NHS is a high priority for the Conservatives – the role of health secretary in a government led by him.

May's general election saw a record number of new MPs elected; in all, 232 new MPs will arrive in Westminster. Those losing their seats included the minister with responsibility for mental health, Phil Hope, and the Liberal Democrat mental health spokesperson, Sandra Gidley.

The National Assembly for Wales consulted on the 'Mental Health (Wales) Measure'. The proposed measure places duties on Local Health Boards and local authorities in Wales

in relation to the assessment of mental health and the treatment of mental disorder. BACP commended the development of the proposed mental health measure. BACP suggested that local mental health services should include a range of psychological therapies to ensure that patients have a choice of intervention. BACP referenced the work of the IAPT Wales group, who have been working on 'Policy guidance for psychological therapies in Wales', at the request of the Welsh Assembly Government, and are now finalising the implementation guidance to deliver improved access to psychological therapies. BACP suggested it is essential for the measure to include this guidance as a supporting document, which will provide specificity on key areas, such as current service provision, the Welsh policy context, a service model design, quality standards required and implementation steps.

For further details, please contact policy@bacp.co.uk

BACP improving accessibility

Cultural Deaf British Sign Language (BSL) users can now access BACP's *Ethical Framework for Good Practice in Counselling and Psychotherapy* online as the result of a joint venture between BACP and the British Society for Mental Health and Deafness (BSMHD).

To view the BSL version of the *Ethical Framework*, please visit the BACP site (see www.bacp.co.uk/ethical_framework/ETHICAL%20FRAMEWORK%20%28BSL%20VERSION%29/index.php). A PDF of the *Ethical Framework* can be accessed at www.bacp.co.uk/ethical_framework/

As the professional body for counselling and psychotherapy, with a membership of over 33,000,* we recognise that accessibility cannot be overstated and that if we are to improve access then there is a need to be proactive in developing the services we offer. We have therefore been working in partnership with third sector organisations to ensure that our members are able to

easily access our services. As a result, we are now the only professional body to provide linguistic access for our deaf members and users of therapy services.

In addition, visually impaired members of BACP can access *Therapy Today* by logging onto the website www.therapytoday.net and selecting the section titled 'Files for the Visually Impaired'. Within this section, Word documents of *Therapy Today* issues can be utilised by a screen reader software programme, such as Jaws.

There are over 220* visually impaired members of BACP, and having this access will mean they will be able to make full use of their membership by being aware of any developments in counselling and psychotherapy.

For further details about accessibility within BACP, please contact Ian Thompson, BACP's Equality and Diversity Advisor, on 01455 883330.

* BACP membership figures for April 2010.

BACP seed corn research project focuses on premature menopause

Most young women grow up with the expectation of starting a family. For those who experience a premature menopause, however, this dream – however vaguely formed – is cruelly dashed. This is a relatively understudied group of women, who represent a number of clinical challenges.

The average age of menopause, most commonly defined retrospectively as 12 months after the cessation of periods, is 51 years, and has remained relatively constant in the developed world. Definition of when the change is premature is somewhat arbitrary, but most commonly it is taken as 40 years or younger.¹ The prevalence has been cited as between one to three per cent of the population.²

Current terms used in the medical literature are mainly premature ovarian failure (POF) or premature menopause (PM). Premature ovarian dysfunction (POD) or insufficiency (POI) have been put forward as more accurate, as ovarian function is not always totally absent, hence the occasional spontaneous live birth in approximately five to 10 per cent of women, even after a number of years.³

Causes

For the majority of women, causes are ‘natural’ ie it just happens. About one-third of cases have a family history of POF. A proportion of cases are related to genetic conditions and/or autoimmune disorders. Other causes tend to be the result of medical intervention such as oophorectomy (removal of the ovaries) or

hysterectomy (removal of the womb) for endometriosis, chronic pelvic infection, or chemo- or radiotherapy for the treatment of cancer.

Emotional impact

In a qualitative study of 13 women diagnosed between the ages of 16 and 40, diagnosis was found to be nearly always a source of confusion and distress, experienced as devastating and even traumatic: ‘like a death verdict’.⁴ Damage to self-esteem, particularly in the face of predominantly negative social stereotypes of menopause at even the ‘expected’ time, was an additional burden. Distress was compounded by the time taken until diagnosis was established, reported at that time as varying from one to eight years, increasing anxiety and uncertainty. Dissatisfaction with the way diagnosis had been communicated and the paucity of age-appropriate information was also widespread.

Further studies investigating the needs of this group have shown high levels of depression, low levels of self-esteem and negative effects on sexual functioning, with lifelong implications for patients, their families and partners.^{5,6}

There are few robust studies of service provision for women with POF. Relatively little is known about what services are available or how women who live with this condition perceive existing

arrangements and the impact the condition has on their physical and mental wellbeing.

Background

Some three years ago, at a North London specialist menopause clinic, in response to a perceived need for information and support, a monthly clinic for young women with POF was instituted. A series of forums was organised and chaired by the counsellor attached to the clinic, often with topic-focussed meetings led by members of the multi-disciplinary team (eg consultant pharmacist, senior nurse specialist, GP associate). These forums, open to women aged 40 or under, provided an opportunity for women to meet each other and discuss common issues and concerns about their condition. The forums were publicised on the Daisy Network (a web-based support group). A similar support group was later started at a second clinic, facilitated by the same counsellor.

Feedback from the meetings, both formal and informal, has always been extremely positive with one main criticism: not enough fellow participants.⁷

The study

A cross-sectional, single group survey design was undertaken with the aim of improving understanding of the psychological adjustment process following a confirmed diagnosis and

to assess women’s response to existing service provision.

A questionnaire was specifically designed for this purpose and over 200 were mailed out from the databases of two London multi-disciplinary clinics, which included the researcher and a community sample via the Daisy Network (DN) with a 62 per cent response rate and an almost even split between the clinic population and the DN.

Results

There was little significant difference between the two populations (clinic versus website). The oldest respondent (now 61) had been told of the diagnosis at the age of 17 by her mother and it was never discussed between them from that point. Although she received hormone treatment, nothing else, eg psychological support, was offered. Fortunately, on the whole, things seem to have improved. The fact that this participant took the time and trouble to respond to the questionnaire over 40 years after diagnosis attests to the strength of feeling this condition can evoke if not well managed. The youngest respondents, aged under 20 and diagnosed between the age of 15 and 20, often felt they were not taken sufficiently seriously and, in effect, patted on the head and told to come back later when they wanted children. Even a nurse and medical doctor who formed part of the sample, felt the condition was not properly explained to them.

Most women in the study

had been diagnosed within the past 10 years. Nearly half received a diagnosis within six months of seeking help and about a third between six months and three years. A small number had to wait four or more years until diagnosis was established while a slightly larger number had to undergo surgery immediately, suggesting a slight improvement at least in London-based clinics. Most were on HRT, in line with the current medical view that this should be the case at least until the average age of menopause. A number had tried several varieties of HRT or alternative treatments previously but most felt settled on HRT. Several expressed the view that prescriptions should be free on the NHS and nearly all reported that GPs in particular were not sufficiently knowledgeable of the condition, provided them with little relevant information and made (inaccurate) assumptions about their needs.

Fertility remained the single largest area of concern for most, whether or not they already had children. Those who had undergone surgery or other sort of medical intervention felt that they had not been properly informed as to the implications of their treatment on future fertility and quality of life, including sexual functioning – these concerns growing after the immediate threat to life and treatment ended and they were feeling better physically. Nearly all agreed that this condition affected their self-confidence as women, whether or not they were in a relationship, and impacted on sexual functioning, with the minority who were not in a relationship finding their

condition particularly hard to come to terms with and fearing a lonely, childless future. The greatest sources of support were family, fellow sufferers, partners (if they had one), sometimes friends, but not always, as it was often felt that they did not properly understand. Counselling and psychotherapy were also cited as helpful, and sometimes the only outlet where they could process feelings safely, with those who had accessed such services feeling very fortunate to have done so but often wishing they had not had to do so privately.

Conclusion

The women who responded to the current study were a highly motivated group and largely London-based. This meant that they had access to more specialist service provision than elsewhere, as those not based in large urban centres tended to have greater difficulty accessing services and finding support, except via the DN web-based support group.

Most women reported finding the time prior to diagnosis, confirmation of diagnosis and the time immediately thereafter difficult to deal with, both physically and emotionally. The prevailing view was that, while physical needs were relatively well addressed (at least eventually), their emotional needs were on the whole poorly understood and inadequately catered for. An overwhelming majority expressed the wish for a specialist, preferably local, one-stop clinic catering specifically for young women and girls with this condition, where they could access ongoing care as their needs, physical and psychological, changed. There were

suggestions for age-banded information, especially for the under-20s, the provision of expert psychological support as a matter of course and regular follow-up (medical and psychological).

More broadly, respondents reported that although articles occasionally appear in the mainstream media highlighting the plight of women with POF, mainly these tend to be ‘success’ stories of women who have achieved a family against the odds and fail to address the needs of those who do not attain this outcome. As a result, many remain reluctant to discuss their situation with anyone, least of all work colleagues or males in general. This results in a kind of vicious circle where women tend not to speak openly about their experiences for fear of being seen as ‘not a proper woman’, making it harder to form relationships or get the kind of publicity that might help counter negative views. Therefore, it was felt that more balanced articles, validating and normalising their experiences, should be actively disseminated, both in professional journals aimed at health practitioners, and in more mainstream media to help the public understand the condition and to reduce stigma. The aim should be to promote better understanding and to impact positively on clinical practice.

Additional resources and services, particularly in the current recessionary climate, may be a tall order, but greater understanding of the psychological impact of this condition, by counsellors and other professionals, would be of immense help. It is hoped that further research can be undertaken to ascertain what

support and psychological interventions are likely to be the most useful for this group.

Dani Singer is a specialist counsellor/psychotherapist at the Menopause Clinical & Research Unit, Northwick Park Hospital, and London PMS & Menopause Clinic, Queen Charlotte's & Chelsea Hospital.

Visit www.daisynetwork.org.uk

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Acknowledgements

Special thanks to the participants who gave so generously of themselves and their time to complete the questionnaire and share their experiences so openly for the benefit of others; to the Daisy Network for their help and cooperation; to the lead consultants and hospital trusts who supported the project and allowed the study to proceed; to Professor Myra Hunter, without whose expertise this would not have been possible; and above all, thanks to BACP, who provided the funding for this project.

Evaluation of the supervision competence framework

A team of researchers at the University of Leicester have won a competitive tender to evaluate Roth and Pilling's competence framework for counselling and psychotherapy supervision. While this framework was originally commissioned for use on the IAPT programme, it clearly has potential as a general resource, not only for training and assessing clinical supervisors, but also for informing research into clinical supervision.

The framework was developed by a group of expert clinicians, with

reference to research articles and other relevant texts. The research project, which is funded by BACP, seeks to clarify the extent to which this framework reflects the actual practice of supervision, and the formal development of skills on supervisor training courses.

Over the next few months the opinions of clinical supervisors and supervisor trainers will be surveyed. The data collection will take the form of a short, online survey, to canvass opinion of the competence framework as a whole, followed by an optional email survey, to

elicit in-depth opinion of the framework's individual elements.

It is important that the survey should attract the maximum possible participant response, and should canvass the views of all relevant interest groups in the field of counselling and psychotherapy. With this aim in mind, counsellors, psychotherapists and supervisors out in the field are invited to participate in the survey.

If you are interested in participating, contact Dr Valerie Owen-Pugh at the email address below. As soon

as the survey form has been drafted, participants will be emailed the weblink for the online survey, which should take only about 10 minutes to complete. The survey form will also seek participants for a further, in-depth email survey, on an entirely voluntary basis. All possible steps will be taken to ensure the anonymity of participants at all stages of this research.

For further information, please contact Dr Valerie Owen-Pugh (email val.owen.pugh@leicester.ac.uk) or visit <http://www.le.ac.uk/lifelonglearning/counselling/>

New University of Leicester research clinic opens

Thursday 29 May 2010 saw the opening of the University of Leicester research clinic. Students, counsellors and academics attended a lively reception with presentations by Professor Sue Wheeler, Julie Folkes-Skinner and John Mellor-Clarke. The opening followed many months of hard work by the steering group, led by Julie Folkes-Skinner. Supported by BACP's Research department, the clinic is the only one of its kind in England and

follows the establishment of similar clinics, also supported by BACP, at the universities of Abertay and Strathclyde. The clinics provide valuable infrastructure for research activity and build capacity within the profession to increase the evidence base for counselling and psychotherapy. Providing a valuable service to students and members of the public encountering a variety of psychological problems, the Leicester clinic

also provides opportunities for students and academics at the university to undertake research firmly rooted in routine practice. Clients will complete CORE measures at every session, sessions will be recorded and data collected on the impact of supervision. This will provide rich sources of data for both qualitative and quantitative research projects. The opportunity to research the experiences and outcomes of 'real' clients in routine

practice is rare in higher education settings, with many universities steering students towards secondary research in order to avoid the ethical complexities of using clients as participants. The clinic will undoubtedly enhance the student experience at Leicester and produce important new findings for the field of counselling and psychotherapy.

For further information, contact Julie Folkes-Skinner at jafs1@leicester.ac.uk

New research information sheet: 'Introduction to conducting qualitative research'

We have recently published a new information sheet, entitled 'Introduction to conducting qualitative research' by Dr Rita Mintz (April 2010). This information sheet provides a basic

introduction to qualitative research. It is aimed at practitioners considering undertaking qualitative research for the first time and counselling students conducting research as part

of their degree studies.

BACP members can download this information sheet free of charge on the BACP website (please visit www.bacp.co.uk/information/information_sheets.php).

Both BACP members and non-members can purchase our published information sheets for £2.50 each by contacting the Customer Services department on 01455 883300.

Professional conduct

BACP Professional Conduct Hearing

Findings, decision and sanction

Keith Rice

Reference No 588301

Harrogate HG2

The complaint against the above individual member was taken to adjudication in line with the Professional Conduct Procedure. The complaint was heard under BACP Professional Conduct Procedure 2009 and the Panel considered the alleged breaches of the BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy*.

The focus of the complaint, as summarised by the Pre-Hearing Assessment Panel, was that Mr A's son (child X) attended counselling sessions with Mr Rice from June 2008 in relation to behavioural and adoption issues.

On 21 April 2009, Mr A alleged that he became aware that Mr Rice had breached client confidentiality by making several separate references to his son's case on two popular social networking sites. Mr A made reference to additional comments made on 8 July 2008 and 9 May 2009 by Mr Rice on these sites, which he alleged called into question Mr Rice's integrity and professional conduct. Mr A alleged that when confronted by concerns that his comments on one of the social networking sites were inappropriate and that the client could be identified, Mr Rice rejected these warnings, claiming that, despite the tiny risk his client may discover the comments, they were outweighed by the advantages of getting his work better known.

Mr A alleged that Mr Rice's conduct demonstrated that he failed to recognise and

safeguard his client's best interests. Mr A alleged that vulnerable children were put at potential risk through his actions, which was an indication that he was not competent to counsel vulnerable children. Mr Rice's written apology, sent to Mr A on 24 May 2009, was considered unsatisfactory by Mr and Mrs A, and following a formal complaint to the school where the counselling took place, Mr Rice's employment was terminated.

The Pre-Hearing Assessment Panel, in accepting this complaint, was concerned with the allegations made within the complaint, suggesting a contravention of the *Ethical Framework*, and those in particular were as follows:

- The alleged breach of client confidentiality by Mr Rice, in making identifiable references to his client on popular social networking sites
- The alleged breach of the client's trust; specifically in relation to making references to the client's adoption and publishing his comment in relation to psychoticism
- The alleged motive behind making such disclosures on the two sites; specifically that Mr Rice's intentions in making such references were to gain personal advantage in getting his work better known and be informed on psychology theories
- The alleged failure by Mr Rice to provide good quality of care; specifically regarding Mr Rice's limitations of training and experience in relation to counselling vulnerable children and his competency to diagnose psychoticism
- The alleged behaviour of Mr Rice, as experienced by Mr A, suggesting a contravention of the *Ethical Framework*, and in particular clauses 2, 11, 15, 16 and 18 and the ethical

principles of fidelity, non-maleficence and justice.

Findings

On balance, having fully considered the above, the Panel made the following findings:

- Mr Rice accepted that he had breached the trust of the A family by making reference to family members on social networking sites
- The Panel found that these references to family members, on such public sites, amounted to a breach of confidentiality
- The references about family members resulted in the family members themselves being able to recognise that they were the people referred to. Additionally, the Panel decided that the family was capable of being recognised more widely by others reading Mr Rice's social networking sites
- The Panel was not satisfied, on the evidence available to it, that Mr Rice's intention to publish the information about child X and family members was driven by a desire to seek personal advantage
- Mr Rice had previously apologised in writing to the A family, and reiterated his apology to Mr and Mrs A at the Hearing
- When questioned, Mr Rice stated that he had no specific training, qualifications, or experience to counsel children and vulnerable young people
- Mr Rice stated, when questioned on the issue of supervision, he had not had any supervision arrangements in place when working with child X. He stated that he had had some very limited email correspondence on the matter but the Panel was not satisfied that the nature of this correspondence provided

him with the necessary support and/or feedback to direct his attention to the fact that he was working outside the limits of his competence and was providing a service for which he was not adequately trained or experienced. Mr Rice was not aware that, under the *Ethical Framework*, he is required to have regular and ongoing supervision in the provision of his counselling/psychotherapy work

- When questioned, and despite being given repeated opportunities, Mr Rice was unable to give the Panel a single example of any ethical considerations specifically required when working with children and vulnerable young people. The Panel concluded, therefore, he was totally unaware of any special requirements in this respect
- Practitioners are required to be aware of, and understand, any legal requirements concerning their work. Mr Rice failed in his obligation to consider the legal requirements of working with children on adoption issues, as required under the Adoption and Children Act 2002; the Act requires that adoption issues must be provided by a registered adoption agency, which he is not. He also stated that he was unaware of the existence of this Act. In addition, Mr Rice stated on a social networking website entry, when he was working with child X on adoption issues, 'I didn't understand adoption'
- The Panel was gravely concerned by the lack of competence indicated by the failures detailed above. While Mr Rice may be a trained teacher, the Panel found that, in all of these findings, Mr Rice had not taken seriously

his obligation to consider carefully the limits of his counselling/psychotherapy training and experience and, in addition, that he failed to work within these limits.

Decision

Accordingly, the Panel was unanimous in its decision that these findings amounted to professional malpractice on the grounds of incompetence, recklessness, negligence, and the provision of inadequate services.

Mitigation

Mr Rice had sent a written apology to the A family. He also admitted in his response to this complaint some breaches of the *Ethical Framework*, for which he apologised to BACP.

Sanction

Mr Rice must not work therapeutically with children and young people at least for the duration of this sanction and/or until such time as he is appropriately trained and experienced to do so, with

confirmation that any such work is appropriately and regularly supervised by a BACP (or equivalent) supervisor, knowledgeable and experienced in this particular field.

Within one month of the imposition of this sanction, which will run from the expiration of the Appeal deadline, Mr Rice should provide a written report detailing his immediate reflections on his learning from this case. In this report, he should also demonstrate his understanding of his obligations under, and the requirements of, the *Ethical Framework*, as a member providing counselling/psychotherapy services, particularly but not exclusively, in relation to the ethical and practice issues that relate to working with children and young people.

Within two months of the imposition of this sanction, Mr Rice should provide details of a BACP (or equivalent) supervisor he has appointed to work with

him on the following part of this sanction.

Within six months of the date of imposition of this sanction, Mr Rice should provide a further, more detailed report of his ongoing learning and understanding of the ethical and practice issues relating to working with children and vulnerable people. This report should include his understanding of the particular issues of working with children on adoption issues as required under the Adoption and Children Act 2002 and what safeguards he has put in place to ensure that he does not, unless he is appropriately registered under the above Act, place himself in a position of working in this area. It should further demonstrate what strategies he has in place for making an appropriate referral if he finds himself in such a position. This second report must be signed by his supervisor as a true and accurate record of his learning.

By 1 September 2011, Mr Rice must provide BACP with

the following for approval:

- Evidence that he has applied for, and been accepted on, an approved counsellor or psychotherapy training course. This training must be a training of at least 450 hours, and should lead to a recognised and professional qualification. The majority of the training must be taught face-to-face, rather than distance learning
- Evidence that he is working with a BACP accredited (or equivalent) supervisor in any placement work and/or at any other time he is providing counselling/psychotherapy services to any client group
- Evidence of satisfactory completion of the same course no later than 1 August 2013.

This sanction will not be lifted until such time as Mr Rice has satisfactorily completed the above.

These written submissions must be sent to the head of professional conduct, by the given deadlines, and will be independently considered by a Sanction Panel.

Newly accredited counsellors/ psychotherapists

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

Anthea Adams
John Adlam
Julia Anderson
Paul Ardies
Helena Baxter
Sara Bishop
Joanne Blackmore
Russell Bloom
Judith Boyle
Gavin Bracewell
Jill Bradley
Gill Brisk
Linda Buchanan
Tracey Burke

Irene Butt
Mo Cahill
Deborah Carr
Christine Chell
Richard Clarke
Karen Clements
Karen Collins
Valerie Collins
Julia Cornell
Catherine Cox
Carol Crockett
Lynda Deans
Raymond Doyle
Catherine Dwyer
Juliet Edwardson
Gerard Egan
Carl Ely
Birgit Ewald
Maureen Ewer
Paula Exley
Christine Felicien
Pat Foxon

Marie Franks
Paul Frazer
Jonathan Freilich
Fauzia Gaba
Sue Gould
Heather Greenbank
Ruth Groff
Christopher Gwilliams
Jan Haggard
Bernadette Haley
Janet Hall
Gill Harvey
Jacqueline Henry
Anthony Hewing
Ann-Michele Hinton
Sue Houghton
Joanna Huntley
Barbara Impey
Inger Jackson
Lynne Johanson
Melanie Jones
Julie Joyce

Michael Keating
Betty King
Stephen Langstaff
Jay Laville
Denise Lyall
Marion Lynch
Denise Mair
Catrin Martin
Kevin Martin
Laura Mayhew
Brenda McAuliffe
Victoria McGlade
Olwen Minford
Anthony Mitchell
Ian Mountford
Gina Neale
Nicola Neath
Naomi Partridge
Liliana Perry
Veronica Phillips
Tracey Phillips
Belinda Priestley

Anne Rivers
Jennifer Robertson
Diana Ross
Jane Ross-Wheatley
Margrit Ruegg
Delphine Ruston
Catherine Ryan
Kristine Sampson
M Scriven
Garnet Shotbolt
Angela Shrimpton
Lorraine Simpson
Steve Smalec
Martin Smith
Paul Stockwell
Paul Styles
Paul Sullivan
A J Sutherland
Val Taylor
Eleanor Thomas

Karole Thomas
Alan Tidmarsh
Mandy Todd
Paul Turley
Rosemary Underwood
Aileen Walker
Elisabeth Walters
Heather Wootten
Leslie Worrall
Sonia Yeandle
Emine Yoca
Negeen Zohari

**Newly accredited
counselling service**
South Kent College

**Successful counselling
service re-accreditation**
Brunel University

**Newly accredited
counselling/psychotherapy
supervisor of individuals**
Maureen Broomhead

Newly accredited course
University of Glamorgan –
BSc (Hons) Counselling
(accredited 20 April 2010).

**Members not renewing
accreditation**
Whether it is through
retirement, illness or perhaps
moving on to a different
career, we would like to
thank the following for their
contribution, to offer our
good wishes for the future,
and to confirm that they

may no longer describe or
advertise themselves as
BACP accredited members:

Elizabeth Allery-Standing
Rita Arundale
Julie Bambrick
Anna Benedetto
Mary Cutts
Patricia Downey
Christine Fremantle
Paula Kendrick
Karen Pitt
Susan Prestwood
Margaret Radford
Sue Robertson

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

Applying for accreditation: issues of difference and equality

The following excerpts
might be apocryphal:

‘There are no ethnic
minorities in Myddle
Charming, so I have no
opportunity to work with
issues of difference.’

‘Everyone is equal so I
treat everyone the same...’

The putative applicant
might have added ‘but some
are more equal than others’.

Facetiousness aside, these
issues are of course very
important in therapeutic
work; thinking about them is
essential for a safe and ethical
practitioner. Therefore, the
accreditation process asks
applicants to address them
in two of the sub-criteria:

8.1.3 Describe how issues
of difference and equality
impact upon the therapeutic
relationship. In your case
material account for:

8.2.3 How your practice
demonstrates your awareness
of issues of difference and
equality and the impact they
have on your counselling/
psychotherapy relationships.

Our putative applicant

has not considered issues
of difference and equality;
he has taken one visible
difference and, with a
startling piece of
reductionism, has excused
himself from giving them
another thought. His thinking
about issues of equality is
equally devoid of thought.

There are of course many
taxonomies of difference and
many issues of equality; the
assessors are not looking for
a condensed version of the
latest training on diversity but
having attended such a course
will help inform applicants’
thinking. These criteria offer
an opportunity to show what
your thinking is and how you
translate this in your work.

For both criteria, the
assessors want to see that you
have an idea about what issues
of difference and equality
might be, whether you have
worked with them or not.
Such issues may include the
visible, such as age, gender,
race, physical disability; the
audible, such as language;
or the invisible, such as class,

religion, politics or experience
(none of these lists are
exhaustive). They might
include ideas about power
differentials in the relationship
between counsellor and client.
They also include how clients
perceive themselves in
relation to the world.

How do you see these
impacting on the therapeutic
relationship? In other words,
how do you work with them?
How does your awareness of
the differences between you
and your clients affect the
way you work? And what
about similarities? It’s easy
to be seduced into
overidentification by apparent
similarity – how do you guard
against this?

8.1.3 is the more theoretical
of the two criteria, in which
you show how you would more
generally address these issues
in your thinking about your
work. In 8.2.3 you have the
opportunity to demonstrate
your awareness and show, in
your illustrative case material,
how you worked with it in
particular examples.

Remember: criteria beginning
8.1. are concerned with the
why, what, how and when of
your practice; those beginning
8.2 are concerned with the
demonstration of practice.

A final ‘not’ to our putative
applicant quoted above: please
remember that the person who
sits in the client’s chair in your
consulting room is not you,
is different from you, and that
will inform the way you work
with them. And however
attentive to the principle of
justice you are, clients don’t
necessarily feel it is an equal
relationship. So tell us about it.

To help with preparation
for counsellor accreditation,
BACP organises workshops
and surgeries around the
UK. Workshops cover all
application criteria. Surgeries
are short, individual sessions,
appropriate for people who
are concerned about one or
two particular criteria. They
are popular, so early booking
for either is advised. See the
BACP website for details.

Kate Thompson
Accreditation assessor