

Therapy Today

For counselling
and psychotherapy
professionals

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Reality TV – therapy for all?

Baby boom counsellors – are they ready for old age?

Counselling for Depression vs CBT: a new trial gets underway

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Sarah Browne
Editor

I recently watched an episode of *Hoarders* on BBC1 and found it fascinating viewing. I could see how watching the subjects – both isolated individuals in their old age whose pathological collecting and saving of possessions was preventing them from cooking in their kitchens and even accessing their beds to sleep in – finally getting help and opening up about their problem could be a cathartic or therapeutic experience for the audience. There has certainly been an explosion in TV programmes with a therapeutic element in the last few years, from *Celebrity Rehab* to *Dr Phil* and even *Supremanny*. So is this a good or a bad thing? There has been much debate about the ethics of inviting troubled and vulnerable people to share their problems and undergo therapy in front of an audience of millions. As far as BACP's *Ethical Framework* is concerned, I don't know whether therapy as a spectator sport could ever be fully justified; many would argue that a genuine

therapeutic session cannot take place in the presence of a camera.

Jenny Hamilton, author of our cover feature this month, is more interested in the potential of this genre of reality TV to normalise the discussion of emotions and to offer viewers access to therapeutic ideas in their own homes. Jenny feels that therapy is the preserve of the middle classes, both as clients and practitioners, and quotes Dave Mearns, who has said that counselling is probably only seen as a 'relevant possibility' by about 10 per cent of troubled people', stressing the need to 'actively explore creative models for taking the profession to the other 90 per cent'. While working in community settings with disadvantaged women who do engage with reality TV therapy shows, Jenny realised that, for many people, such programmes are the only contact they have with therapy and therapeutic ideas and so have a real potential for widening participation. We would be very interested to hear your views.

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Students under greater stress

One in five students (20 per cent) are experiencing some kind of mental distress, yet many are not accessing any formal help, a survey conducted by the National Union for Students (NUS) has found.

In the online survey of 1,200 students in higher education, stress was reported by 80 per cent, lack of energy or motivation by 70 per cent and feeling unhappy/down by 66 per cent. Other common problems included anxiety, sleeping trouble, irritability and anger, hopelessness/worthlessness and panic.

Nearly a third of those reporting feelings of mental distress experienced them every week. The main causes were course work (65 per cent), exams and study (54 per cent), personal, family or relationship problems (49 per cent) and financial difficulties (47 per cent).

Of those who reported mental distress, 64 per cent were not using any formal source of support. More than half (58 per cent) said they had talked to their friends, and 45 per cent had talked to family members about how they were feeling, but

only 15 per cent had consulted a doctor or GP. Overall, 21 per cent had sought help from their university services or students' union: 14 per cent had talked to a member of the university academic staff, 10 per cent had talked to their university counselling service and five per cent had contacted a university advice/support or disability service.

Private therapy/counselling was the third most frequently reported formal support (used by nine per cent) and 34 per cent said they would recommend it to someone they thought needed help.

Charlotte Snoxall, Chair of BACP: Universities & Colleges, said: 'Students are potentially under more stress these days, with financial worries and fears about future

job prospects on top of course work and personal issues. It is good to know that students are accessing support from a wide range of sources, including family and friends. What is important is that those who need professional psychological help are able to access counselling within their university. Our members tell us they are being accessed by far greater numbers of students, which may indicate increased need but also suggests counselling services are publicising their presence better, that there is less stigma attached to seeking their help and that they are offering a greater diversity of help, such as groups, workshops and email, phone and video link support, as well as one-to-one counselling.'



Changing the goals helps anorexics

Treatments for anorexia that focus on improving patients' quality of life may be more effective than intensive weight gain interventions, a randomised controlled trial suggests. The trial of psychological interventions for severe and enduring anorexia nervosa (SE-AN) was conducted by researchers in London, Sydney and Chicago and reported in *Psychological Medicine*.

The researchers adapted two standard outpatient treatments – cognitive behavioural therapy (CBT) and specialist supportive clinical management (SSCM) – to focus on improving SE-AN patients' quality of life. Both treatments were delivered in 30 outpatient therapy sessions over eight months: 31 patients received CBT and 32 received SSCM.

Both treatments achieved similar improvements at six and 12-month follow-up. CBT had a bigger impact on eating disorder symptoms and readiness to change; SSCM achieved more improvements in health-related quality of life and depression. Participants' BMI also increased by an average four per cent and 85 per cent completed their course of treatment – almost three times the usual retention rate.

The researchers say this is the first study to show that people with SE-AN can be treated effectively with an outpatient programme and it challenges the prevailing view that the most effective treatment is intensive inpatient refeeding.

Public prefer puzzles to brain booster drugs

Just two per cent of adults and one per cent of young people have used medications to boost their mental performance, a Wellcome Trust Monitor survey shows.

The survey of 1,396 adults and 460 young people included questions about the use of drugs intended

to treat conditions such as dementia and attention deficit hyperactivity disorder to improve mental focus, memory and concentration.

Puzzles were seen as most effective, by 87 per cent of adults and 86 per cent of young people, and 58 per cent of adults and 63 per cent of

young people had used them or had played 'brain training' games. Caffeine supplements were least likely to be seen as effective. A third of adults and young people felt that using medication to improve cognitive ability for an exam or interview was acceptable, and a third disagreed.

Abuse link to food addiction

Women who experienced severe physical or sexual abuse during childhood are at very high risk of food addiction as adults, a US study published in the journal *Obesity* suggests.

Childhood abuse is known to be linked to later obesity, possibly because victims tend to self-medicate with high-sugar and high-fat 'comfort' foods in response to stress. Researchers at Brigham University and Women's

Hospital and Harvard Medical School in Boston collected physical and sexual child abuse histories from 57,321 adult women in 2001 and asked them about current food addiction in 2009. Eight per cent of the women met the criteria for food addiction.

Data analysis showed that women who had experienced physical or sexual abuse before the age of 18 years were almost twice as likely to have a food addiction in

middle adulthood than women who did not have a history of childhood abuse.

Food addiction prevalence was six per cent among women with no history of physical or sexual abuse and rose to its highest, at 16 per cent, among women who had experienced severe physical and sexual abuse.

The researchers say further research is needed before they can say that the link is causal.

In brief

- Women with depression are at higher risk of domestic violence and women victims of domestic violence are at greater risk of depression, a systematic review and meta-analysis of published studies shows. The study, published in the open access journal *PLOS ONE*, also confirms that all women victims of domestic violence are at high risk of suicide. For men there was only a link between domestic violence and depression; men with depression were not at risk of domestic violence, nor at higher risk of suicide.

- Girls are at higher risk of depression in adolescence if their parents separate and the father moves out of the family home when they are very young, a study in the journal *Psychological Medicine* shows. The study found that the father's absence is linked with increased risk of depression in both sexes in adolescence but only among those who were aged 0-5 when he left home, and the risk was much greater among girls than boys.

- NICE has published its first ever guideline on social anxiety disorder. The guideline says people with social anxiety disorder should first be offered individual specialist cognitive behavioural therapy (CBT) or CBT-based supported self-help. If a patient insists they want medication, practitioners should try to address any concerns they may have about psychological therapies before prescribing SSRI antidepressants.

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BDSM users are mentally better adjusted

Far from suffering from psychological disturbance, people who practise bondage, discipline, sadism and masochism (BDSM) have better mental health than so-called normal people, a study in the *Journal of Sexual Medicine* suggests.

The study compared 902 people who practised BDSM and 434 controls on a range of psychological measures of personality type, attachment styles and mental wellbeing. BDSM practitioners were less neurotic, more extraverted, more conscientious, more open to new experiences, less rejection sensitive and had higher subjective wellbeing than the controls. Those who took a dominant role tended to have the best mental and emotional health scores of all.

The researchers say BDSM should be seen as a recreational leisure pursuit, rather than an expression of psychological ill health.

Taking the Pill makes women less competitive, study shows

Taking the contraceptive Pill may make women less competitive, according to a study published in *Evolution & Human Behaviour*.

A research team from the University of Groningen, the Netherlands, asked young women aged 20 to 31 to complete questionnaires to show whether they viewed other women as friends or foes and if this differed when they were taking the Pill.

The women who were in a relationship were less competitive when they were

on the Pill but single women didn't experience this effect. The researchers argue that this is because the Pill suppresses testosterone but the desire to find a mate in single women over-rides this.

Lead researcher Kelly Cobey said: 'Women using hormonal contraceptives are less likely to seek out or switch to a new partner from whom they might acquire additional benefits and may settle and start families with partners whom they otherwise would not choose.'



Walking a path to the unknown

Rachel Freeth

I know Susan had, for several weeks, been thinking about ending her life. I know this because I asked her, having followed up on her various hints and indirect references to her future. Would she have told me about these thoughts had I not asked? I don't know. I do know that I would have felt very uneasy not to have tried to explore more directly with her some of her suicidal preoccupations, given my observations of her deteriorating mood and evidence of increasing disorganisation in her day-to-day functioning.

All the signs were that Susan was now in a place of acute despair – the kind of despair that closes in, like a fog, rendering one incapable of navigation or movement. For some time she had expressed a general weariness about her life and described how getting up each day was like preparing for a battle – a battle she imagined losing. It didn't sound as though Susan wanted to die, but it was clear she no longer wanted to live.

I wondered how I might see myself and my future if I were in her circumstances. The much harder process, of course, was to put myself in her shoes and try to imaginatively enter into how she saw herself and her future, given her experiences and circumstances. Could I sense something of her emotional world, her dreams, hopes and fears – past and present? Could I get alongside her as she questioned the meaning of life, and of her life in particular?

While I wanted, and tried, to engage with Susan's 'suicidal beingness',¹ it was

'It was much more difficult to stay empathically attuned and alongside Susan once I had stepped into a mode of assessing risks'

not long before I slipped into a 'What do I do?' mode. While aware of my helping instincts as a human being who cared, I also started to consider my duties and responsibilities as a professional helper and, furthermore, someone who works within an organisational setting bound by ethical codes, clinical guidelines and organisational procedures.

I now encountered a tension that has become all too familiar to me. To summarise this as a tension between 'being' and 'doing' is too simplistic; I believe it would be incorrect to think of these as two separate and mutually exclusive states, and wrong to suggest that empathy is found only in the 'being'.

Nevertheless, it was much more difficult to stay empathically attuned and alongside Susan once I had stepped into a mode of assessing risks and considering what actions I might need to take if I judged her to be at high risk of ending her life. The nature of my therapeutic engagement with her was, at least temporarily, altered.

I wondered how Susan experienced my asking her about her thoughts and whether they included specific ideas and plans about how she might end her life. Was she afraid to reveal too much to me,

fearing this might trigger a more medicalised way of managing the situation? Or was it a relief to be given an opportunity to unburden herself of thoughts she had previously felt too ashamed to divulge for fear of judgment? She could have experienced both.

It is often impossible to predict how clients will experience our questions and our actions. In such instances I try to invite clients to let me know, if they are able. Nevertheless, deciding what to say, ask, or what actions to take (for example, whether to inform other professionals) often feels like walking very delicately along a path towards an unknown destination. At times the path seems more like a tightrope.

Working with clients who are wrestling with suicidal thoughts and feelings provides therapists with some of their most stressful and demanding experiences. In clinical practice there are rarely hard and fast rules about what to do; where they do exist it is hard not to view many of them cynically as arising from our risk-averse blame culture. Most often we have to rely on clinical judgments. These are, of course, vulnerable to error.

Eventually Susan was admitted to a psychiatric ward, but I don't know if or how this will help her ultimately. I do know that I need someone who will listen to my doubts and uncertainties and how working with Susan has affected me. ■

Reference

1. Webb D. Thinking about suicide: contemplating and comprehending the urge to die. Ross-on-Wye: PCCS Books; 2010.

In the client's chair

I'm just much more everything

Jason Swinhoe

Basically it started when my granddad died. I never got to see him very much after my mum and him fell out and he didn't come down to see me any more. He was my dad's dad. He used to take us to Butlins in Skegness every year. I didn't just lose him; I lost all that side of the family; they used to come to Butlins as well. They all stopped coming down.

So when he died I felt I never had a chance to say goodbye. I was confused and I didn't know how to act. I felt lost because, even though I hardly went to see him, you knew he was there and when you know he's not there, it's a different story. I just didn't know how to act any more.

I went to see the Head of Community at school and she said she would contact Lynne at Escape and get her to come up and talk to me. I saw her first for an assessment. She was really good. I just wanted to tell her how I felt and for her to understand. She listened and tried to get me to a counsellor as quickly as possible because she thought it would benefit me.

The counsellor I saw was a man. They asked if I had any preference and I said any person would do. I had 12 sessions. For the first couple of sessions I said I wanted to work on my confidence and self-esteem because in my opinion it was really low and confidence was a really big issue for me. I wouldn't have been able to do this interview if I hadn't got more confidence now.

The counsellor made a list of all the words like 'Hmmm' and 'Uuh' and 'I don't know' that I used and gave me an elastic band and said to wear it on my wrist and pull it if I used any of those words and start the sentence again.

I thought it was a bit strange but he said he wore one for remembering things. So I just kept using it and it did work. It made me think what I wanted to say. I was always the shy kid in the corner. I never used to put my hand up in class. I'm using it less and less now because I am realising I have got a mind. I'm more able to chat away and start conversations.

I did stuff around accepting who I am. I first started feeling confused about my sexuality when I was 12 but at about 13 or 14 I started understanding that I was gay. I felt I was by myself; I didn't know how anyone thought and felt about it. I used to talk to my friend about how I felt and everything. He was one of the first people I told. He's been there for me ever since. I told my family when I was 15. I told my older sister's fiancé first, and he told her, and they've been there for me. They said to go round to their flat and talk any time.

I didn't want to tell my mum. She made me tell her. Any little thing was setting me off and my mum was like 'That's not like Jason' and she said 'Come upstairs and say what's wrong'. I was just building it up inside. But she was fine about it. I just cried because I thought she would be down about it. That's why I didn't want to tell her. I gave her a hug and she said, 'Being gay doesn't change who you are; I'll still love you. It doesn't change our relationship.'

Talking is better than not talking and it doesn't hurt to get your point across, no matter what other people think'

My dad was just cool with it too. We get on in a different way. He didn't say much; he just said, 'I'm absolutely fine with it. Just be who you are.'

I haven't told everyone. I'm going at my own pace; I'm not rushing things. I want people to know so I can be myself.

Lynne asked if I'd like to join this steering group at Escape. We organise trips for the younger children for free, so they can do stuff they wouldn't normally get to do and have a good time. I joined the steering group because I thought it would boost my confidence. We did a sponsored trip to climb Ben Nevis last week to raise money for Escape.

The counselling made an absolutely massive difference. We talked about a lot of stuff that I don't want to talk about here; stuff that's personal to me. It's all helped. The counselling and the steering group and my friends just making me talk. Talking is better than not talking and it doesn't hurt to get your point across, no matter what other people think. I'm happier, much more talkative and engaged. I am just much more everything – better and happier and so glad that I had this opportunity.

I'm 16 now. I'm going to college to study marine engineering. I don't want to spend the rest of my life in South Shields. I want to see the world. ■

Jason saw a counsellor at Escape Intervention, a voluntary sector service based in South Shields. Escape offers counselling, anger management, mediation, bereavement training and other support services for young people aged 11–18, their parents and families and professionals working with young people. Visit www.escapeintervention.org.uk

Finding the positives in process

Mel Perry

‘This is *your* process group.’ At college these words are uttered at the beginning of every process group and they seem to render us speechless. We were told from the start that we could bring to the group anything that was important to us but the main focus would be on how we were interacting with each other. To me, it sounded like some kind of threshing machine: once we had been chewed up and spat out, we would emerge with bruised egos but a better understanding of self.

Our process groups are held at the end of each college session and when, on occasion, it has been cancelled, there is always not only an audible sigh of relief but often an open celebration. Clearly there are some avoidance issues going on here... but just what are we skulking away from?

I adopted an observer position early on, neither brave nor foolish enough to allow my fragile sense of self to be exposed in what felt like a cauldron. I was more worried about the threshing and less convinced about the value of the end product. For example, in one process group P took a risk and S took him to task over it. The exchange led to a couple of weeks of animosity and we all experienced quite a bit of the pain, but eventually it got sorted out. It was all about the transference: S had reminded P of his mother, with whom he had a fraught relationship, full of criticism. Once P realised this, he was able to share it with the group and the discomfort of all was resolved.

However, while I and one or two others could see that it was important for all of us to feel the discomfort,

‘Each time I went to say something, someone else spoke and I immediately thought that they had more important things to say’

we struggled to see the good in it. I can see now that I was protecting myself from the criticism that I saw others experience. I’ve since learnt that criticism is a key trigger for me and that I do whatever I can to avoid it, because it causes me such emotional pain. So week after week I hid, making humorous contributions that were safe and would, I hoped, make people like me rather than criticise me.

Another member of the group, K, did this too, but in a different way. She empathised like there was no tomorrow – that was her way of ensuring that people viewed her as kind, thoughtful and generous (a true rescuer rescuing herself). However, her tactic was quickly spotted. The situation was handled in the true spirit of a process group. People spoke to her directly, with honesty, about how they saw her in the here and now: ‘You’re too nice,’ they said (which wasn’t such a bad thing to have said of you). This made it possible for her to reflect and draw links with her patterns of behaviour outside the group.

She often talks about this realisation and what she learnt from the group and we have certainly seen the changes in her and her confidence grow. The support and warmth offered by the group made the medicine taste better.

One of the first things I wanted to say to the group was that I was gay. I guess it felt safe as I assumed people would be positive, which they were. But I waited several weeks before I felt able to tell them. This wasn’t because I didn’t want to say it but because, each time I went to say something, someone else spoke and I immediately thought that they had more important things to say, that their comments would be more valued than mine. In the end I actually put my hand up to ask permission to speak.

There was an important lesson here for me about my ways of relating. After reflecting on it, I realised that, although I might come across as confident and self-assured, I actually have a low opinion of myself. This was also borne out in my personal therapy, where I often felt I didn’t have much of worth to say. Just being part of the group allowed me to see this.

Eventually I felt able to speak up more freely in the group but this has only come about towards the end of the course. Something has shifted in the last couple of months. Perhaps it is the realisation that my chance to become more self-aware is coming to an end. Perhaps I’ve decided that I can finally trust these people. Perhaps I’m just treating them like the stranger on the train – I’m disembarking soon so I may as well tell and run. One thing is clear – when I started on the course I was afraid of revealing myself, afraid of seeing myself and not liking what I saw. Since then I’ve developed empathy and compassion for myself and, finally, have allowed myself to start growing. ■

The researcher

Bettered by Botox and beer

Barry McInnes

In the wake of the publication of *DSM-5* (the fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders*, to give it its full title) last month, I find myself overwhelmed by a sense of irony. Let me explain.

In recent years the map of primary care counselling has been transformed from a garden in which a thousand flowers bloomed, albeit occasionally with some large gaps in the borders, to a largely monochrome lawn. The reasons for this are familiar – Lord Layard, rightly advocating for a more consistent national pattern of provision, planted his flag firmly in the modality with the biggest pile of credible research and said, ‘That’s the model.’ Thus was born IAPT as we know it today.

To gather evidence of the impact of the new framework, the IAPT programme board selected the GAD-7 and PHQ-9. One of the considerations would surely have been the fact that, as brief measures of anxiety and depression respectively, they map conveniently onto our two most prevalent common mental disorders (CMDs).¹ Ironically, however, as both measures were derived from the US, neither had – at that time – UK normative population data.

What’s the link with the *DSM-5*, you might ask? Well, few can have missed the clamorous debate that has preceded its arrival. One of its most vocal critics has been Dr Allen Frances, the psychiatrist who chaired the *DSM-IV* Task Force, which produced the preceding edition. In a blog, Dr Allen noted the resignation in April 2012 of two members of the *DSM-5* Personality and Personality Disorders Work Group because they

‘considered the current proposal to be fundamentally flawed’ with a ‘truly stunning disregard for evidence’.²

The new edition of the *DSM* has also drawn criticism from the world’s largest funder of mental health research, the US-based National Institute for Mental Health, whose director, Dr Thomas Insel, describes as a major weakness the *DSM*’s ‘lack of validity’.³

It is directly from the elements of the *DSM* diagnostic categories for Generalised Anxiety Disorder and Major Depressive Disorder that the GAD-7 and PHQ-9 respectively are derived. US measures, derived from a US manual whose very validity is questioned, have crossed the pond like migrating birds and taken up permanent residence in our therapeutic nest. Irony enough for you?

Now I have that off my chest I feel positively skittish, and there is just room to share with you some recent research snippets suggesting that, if you think the world of therapy is tough now, there may be further challenges on the horizon.

First, evidence that Botox may be an effective treatment for depression. In a study of 84 patients with antidepressant-resistant depression,⁴ patients were randomly assigned to receive either Botox treatment for smoothing out frown lines or a placebo injection into the same facial region. Of

those receiving Botox, 27 per cent reported nearly complete remission of their depression, compared with just seven per cent of those who received placebo. ‘[This trial shows] that inhibition of frowning can lead to remission in depression,’ said Dr Eric Finzi, medical director of the Chevy Chase (yes, really) Cosmetic Center in Maryland.

Next, a study that shows that we humans respond emotionally to robots.⁵ Forty volunteers were shown videos of a small robot dinosaur toy being treated affectionately and violently in turn. Their levels of physiological arousal were monitored during viewing and afterwards they were asked to report their emotional state. Higher levels of arousal and more negative emotions were recorded after the violent video, suggesting that participants were exhibiting something like empathy towards the robot. The authors speculate on the socially useful function of robots as ‘embodied conversational agents’.

Last, a study that demonstrates that simply tasting beer, with no effects of the alcohol, can trigger the release of dopamine (closely connected with the pleasure and reward centres) in the brain.⁶

So, even if we can persuade prospective clients that therapy will make a more positive and lasting contribution to their wellbeing than cosmetic surgery or craft ale, we’ll probably all be replaced with ‘embodied conversational agents’ in the end. Maybe it’s already happening. Now where did I put my evidence base? ■

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‘If you think the world of therapy is tough now, there may be further challenges on the horizon’

Something more to say...

The post-war baby boomers are entering old age, presenting a huge challenge to our health, social care and welfare services. *Catherine Jackson* asks therapists in this age cohort if they are glad to be greying *Illustration by Joe Waldron*

‘Hanging on in quiet desperation is the English way/The time is gone, the song is over, thought I’d something more to say.’

Pink Floyd’s album *Dark Side of the Moon* is, arguably, the quintessential expression of the aspirations and values of the baby boomer cohort. Escape the daily, purposeless grind, the lyrics (written by a group who were themselves baby boomers) urge; don’t sit around waiting for someone else to tell you what to do; seize the moment, act for yourself, don’t be eaten by the machine.

The first so-called baby boom occurred between 1946 and 1955, immediately following the end of the Second World War. This was the cohort of young people who, in their late teens and early 20s, began to foment the technicoloured mix of social, sexual and (in some countries) political revolution that is widely associated with the 1960s.

From their birth to old age, this group has enjoyed far greater opportunities than any other: the NHS (they are the first generation to enjoy free healthcare from cradle to grave); better education (the post-war extension of secondary and university education to a far wider swathe of the population) and so greater social mobility; employment (jobs were readily available); wealth (houses were affordable in their youth and many have done well from the property boom); technological advances, and (not least) more liberal social attitudes (decriminalisation of homosexuality, greater equality for women, the advent of the Pill, legalisation of abortion).

But now they are in or approaching retirement age, and their numbers are causing ripples of concern: can the country afford to sustain the burden of so many ageing people all at once,

economically and socially? Will its health and welfare services and infrastructure be able to cope?

Last month the Mental Health Foundation published a report, *Getting on... with life*, that explores how well the baby boomers are prepared for old age. The report is the fruit of its Age Well Inquiry, chaired by Baroness Lola Young, which looked in particular into the mental health, wellbeing and resilience of the baby boomer cohort, what may help them deal with the challenges of ageing and what the Government should be doing to support them to maximise their own resources.

Baroness Young (born 1951), former residential social worker, lecturer in media studies and now cross-bench peer in the House of Lords, accepted the invitation to chair the inquiry because, she says, she wanted to challenge the ‘doom, disability and death’ attitude that she finds among her friends and colleagues in response to old age. ‘It’s as though we have so much knowledge of what can go wrong with us, it’s made people much more pessimistic. To me, that knowledge is a positive thing.’

She in fact dislikes the label ‘baby boomer’, partly because she detests all labels and partly because she feels it obscures ‘some very real differences and schisms in society at that time’ – not least, the inequalities. ‘Swinging London wasn’t the main motif in my life in the 60s. I was brought up in a children’s home and there was no love and peace in my life,’ she points out. There were also very few black British-born children of her age – no baby boom there.

She is clearly enjoying her older age. ‘Although the first 20 years of my life were miserable, I feel lucky to be doing

what I am doing today and I only do what I enjoy. I am fortunate in that I am OK financially; I’ve got a lovely son, good friends and life is fine. And I get asked to do such interesting things. What keeps me going is knowing that I can at least contribute to the debates about some of these issues, if not change things. At its core, that is what life is about for me.’

She has, she says, more freedom than ever before: ‘Freedom to say what I think. I’m not vulnerable any more.’

The Inquiry hasn’t come up with any clear answers to its questions but it has come up with a message: that baby boomers should not be regarded simply as a burden on younger generations. Just as they challenged social expectations in the 1960s, so in the 2010s they will challenge attitudes to old age and change how we care for our elders and how they care for themselves. Baby boomers, the report argues, are entering old age in a spirit of combat and adventure, not ‘quiet desperation’.

We thought it would be interesting to talk to a small and randomly selected group of baby boomer counsellors and psychotherapists about their readiness for and expectations of old age: how well do they feel their life course and choices have prepared them for the inevitability of physical and mental decline and death? Six counsellors/psychotherapists agreed to be interviewed.

Life’s journey

Tim Bond (born 1949), Professor of Counselling and Professional Ethics at the University of Bristol, grammar school and university-educated child of a self-made businessman and a doctor, says he feels very fortunate. While his life has not been without its difficulties,



'I have a real sense of fulfilment and achievement, particularly in close relationships, and I think that brings a sense of purpose and joy that sustains one for the future. On the mental health front, counselling when I needed it, meditation and a balance between intellectual work and physical activity all help. But in the end it's values that enable you to keep going, to endure the more difficult moments and enjoy the successes and achievements. For me, these are commitment to people, commitment to the environment, a delight in human diversity and the cultural energy of this extraordinary period we are living through, and a sustained but quiet commitment to Quaker values of peace, simplicity, honesty and equality'.

Julia Buckroyd (born 1946), psychotherapist and Emeritus Professor of Counselling at the University of Hertfordshire, grew up in Scotland and went to a direct grant school for girls, followed by university, an MA and PhD, all paid for by the state or academic grants, she points out. Like Baroness Young, she believes the baby boomer label conceals important differences: 'For all the stuff about the 60s, certainly where I was living in Scotland, there was not much female emancipation. I think I've struggled all my life except for the past 15 years for equality and autonomy'.

She doesn't see old age as a destination – the armchair by the fireside: 'Settling into old age isn't part of my life plan. My ambition is to be the person I have the potential to be, and this project will continue to the day I die. I have something to offer and I want to offer it. To me age is immaterial but it has the advantage that I feel I now have some authority; I know what I am talking about. And I don't want to go before I've told people what I've found out.'

Even in rural Derbyshire, psychoanalytic psychotherapist Lennox Thomas (born in Grenada 1952; came to the UK in 1960) was aware that he was living through 'probably one of

the most privileged times to have been young. When I look at previous and later generations, I think we had the best of it.' Although there were costs: 'I lost a lot of friends who died way, way too young. One friend died through drugs, three were killed in a Mini going round the roundabout the wrong way for a laugh. Another died trying to cross the North Circular after going out clubbing. I feel fortunate: I might have been with them.'

Family, friendships formed in boyhood in the church choir, his parents' Christian socialist values and insistence that their children should make their own faith choices, and psychoanalysis have all played their part in his preparedness for old age. 'I began to have my own personal psychoanalysis at a pretty young age and that has been very helpful to me. It's made me what I am today, prepared me for who I am now. It's helped me to occupy the whole of myself. I have a sense of my own agency. It's taught me to be clear-minded about relationships and friendships and it's taught me a lot about me and what I want.'

Michael King (born in New Zealand, 1950), Professor of Primary Care Psychiatry at University College London, faced prejudice and arrest as a young man growing up gay in a very conventional society where homosexuality wasn't legalised until 1984. 'I remember seeing men arrested for so-called indecent behaviour. It was not a nice climate. From my 20s, when I came to England, that was when my life began,' he says.

But being gay brings many advantages that are helpful in older age, he has found. 'Maybe you learn quicker to survive in a tough world. When you are on the outside of society you see the hypocrisy much more clearly. You have to survive against people's opinions, so you grow a kind of strength. I have seen death, I have lost friends to AIDS, it doesn't frighten me.' Gay people, and older gay people in particular, seem to have an extra resilience. 'We've done a lot of research on this and up to age

40 there are a lot of mental health problems in gay and lesbian people, two or three times as much, but in our 60s, if anything, the rates are lower.

'Gay people are very independent. There's an adaptability in gay men that is different to the typical heterosexual male with a wife doing things for him. Our relationships are more equal. It could be that we've got to the state we should have been when we were 20. As you get older, you get bolder, and not so embarrassed by things. Though I don't think you necessarily get wiser.'

As old as you feel?

Counsellor, psychosexual therapist and BACP Fellow Carol Martin-Sperry (born 1944) strongly identifies as a baby boomer. 'For me, life started in 1963. Socially it was an incredibly flourishing and rich period. The 50s were all about rationing, smog, poverty, boredom, very class structured, very conventional. But I think we were quite a selfish generation. We took everything for granted and thought we had the right to everything.'

Reality hit Carol Martin-Sperry around her 60th birthday, she says. 'I wish I could retire but I can't because my pension is tiny, my state pension is tiny and my husband is freelance with major health problems. It hit me when I was 60 – but I have no regrets, absolutely no regrets. *Carpe diem* is my philosophy: live as much as possible in the present and make the most of it. There's no point in worrying about the future.'

'In my head I feel I am in my mid-30s but bits of my body keep reminding me I'm not. I think our task is to "mind the gap" between our fantasy that we are still in our 30s and the realities of old age.'

Richard House (born 1954), Senior Lecturer in Early Childhood at the University of Winchester, is an archetypal baby boomer: working-class parents, grammar school educated, followed by Oxford University and the consequent shift into the professional middle classes, although he says he still feels a deep connection to his working-

class roots and has always shared his father's left wing political convictions. House says he doesn't have a sense of being any age. 'I'm nearing 60 and that just seems completely bizarre when I feel I still have the spirit, energy and passion of a 25-year-old. But my body says different. It's only when your body starts to let you down – that does begin to make you more aware of your age.' The fact that he is starting to put on weight around his middle is beginning to worry him – unduly, he suspects.

And he worries too that his resilience may be waning. 'I'm in a demanding job at the moment, which I'm finding very stressful, and I'm not sure whether that is because I'm older and haven't got the resources to cope with these pressures any more, or whether it's the job itself, and/or the Higher Education sector more generally that is toxic. But I'm grateful that I'm more able to process these experiences; I do feel I have a maturity that enables me to manage these things that I didn't have 20 years ago.'

Tim Bond is greatly looking forward to retirement and the chance to do all the other things he wants to do in life. 'So long as I am mentally agile there are several things I can move forward on the academic front. And, as I start to step back from academic life, that opens up space for other things that matter to me, such as wildlife conservation. I am looking forward to new friendships and other ways of being in the world.'

He feels 'well prepared' for older age, but is also conscious of the legacy his generation will be handing on to the next. 'We will be creating both a social and financial burden for the young people who will be taking over the economic control of the country, and there's all the environment change, climate change that we have happily handed on. We need to think about this legacy, how we mitigate some of the harm we have done and help the next generation face these challenges but at the same time we need to hand over control.'

Julia Buckroyd is positively relishing old age. 'I am very powerfully driven by purpose and I think part of my drivenness was having to prove myself to my parents and I don't feel that quite as much as I used to.' She called a truce with herself in her 50s, after a final bout of psychotherapy. 'Since then I've been so much happier, so much more content and less worried about just about everything,' she says. 'I went because I was sick of not being the person I thought I had the potential to be. Just the experience with that particular therapist, regular reliable contact with someone who appeared to be pleased to see me, did the job really. It has been extremely freeing.'

And no, she doesn't feel her age. 'I get tripped up by my physical weakening. I am not as strong as I used to be. But I am doing pretty well and I am very fortunate to have nothing of any significance wrong with me. I am much more careful about what I eat and drink and make sure I am rested in a way that I never used to. I am taking better care of myself because I want this state to continue as long as possible. I don't think I could have been that kind to myself before. One of the things I enjoy is my competence. I feel as if I know what I am doing with clients and that is a nice feeling. That could overbalance into a ridiculous conceit, but I don't think it does. I feel confident doing the work.'

Resilience

So what are the qualities and ingredients of life that these baby boomers think will serve them well in old age?

'Faith,' says Michael King. 'I have always had a strong Christian faith, not as a crutch but because I am fascinated emotionally and spiritually in God and what our life means. It gives my life meaning. My partner. We've been together nearly 30 years. The fact that we can live openly together.' And his job: 'I like my work and living in Europe.' The personal qualities that he thinks will help him through old age include his 'foolish optimism', and his gregariousness:

'People don't bore me. That's why I'm a psychiatrist. I love seeing people, it keeps me intellectually alert.'

Lennox Thomas is looking forward to retiring at 65. 'Then I will do voluntary work because it will benefit me and other people. I wouldn't want to be stuck doing nothing. I want to be doing something useful.' He says his children (now in their late teens and early 20s) keep him mentally young, even though physically he does feel his age. 'They keep me in touch with things and optimistic.' A sense of humour and readiness to see the best in things are also going to serve him well, he believes. 'I can't stand grumpy people.'

For Richard House 'it's the old humanistic cliché about knowing myself; being able to be myself more fully, to be real, authentic in relationship – classic Rogers stuff. I'm sure that has helped me no end, not just in personal relationships but professional ones as well.' Passion and conviction will, he believes, help him weather old age. 'It's about being passionate about life. I have a strong sense of what is wrong with the world and I'm on a crusade to set those wrongs right. It sounds grandiose and pompous and it's probably classic baby boomer stuff but that is my life journey. I don't want to be lying on my death bed knowing that I didn't do justice to what I am here for. I want to feel I have really given it my best.'

For Carol Martin-Sperry, the keys to a healthy old age are self-awareness, actively taking care of her health, and acceptance of death; 'it gives one a certain kind of energy,' she says. She wishes she could find a group for people in their 60s to 'talk experientially about where we are now'.

'Death will come to us all and we have to make the most of our relationships and friendships. I went to a workshop recently on professional retirement. The consensus was that working until you drop is a defence against fear of death and giving up work and taking up lots of activities is also a defence against death. We are all going to die. That's OK.'



Debate

This article examines the therapeutic possibilities of the emerging genre of reality television therapy (RTVT) – a term I have proposed to describe commercial programming that features therapeutic interventions with members of the public who have applied (or in some cases have been invited) to participate. These programmes, which include shows such as *Dr Phil*, *Celebrity Rehab*, *Hoarders*, *The Biggest Loser USA*, *Losing it with Jillian*, *Intervention*, *Supernanny*, call in coaches and therapists to address issues ranging from relationship problems and parenting issues to addiction, obesity and compulsive hoarding. They are watched by millions of viewers worldwide. Yet little if any research has been conducted on their therapeutic value for their audiences.

RTVT has been critiqued within the academic disciplines of media studies, cultural studies and sociology, yet the focus tends to be on the genre's failure to consider the wider social and economic context of therapeutic issues (a critique also levelled at therapy generally). The counselling world has given comparatively little consideration to the genre, except perhaps to wonder at the ethical conundrums it seems to present. But does RTVT make therapy more accessible to more people and, crucially, is watching these programmes a therapeutic experience for audiences?

Therapy as TV show

The emergence, in the late 20th century, of self-help as a billion dollar industry coincided with a cultural and political shift in perceptions of state provision of welfare in the US and UK, from benevolent to bureaucratic, authoritarian and likely to foster dependency.¹

Alongside, the deregulation of television, the introduction of satellite and cable technologies created more channels and more airtime to fill. Lifestyle and reality TV programming can be relatively cheap to produce.²⁻⁴ As viewers became 'customers' in the emerging TV programming 'market', this 'market model' became central to lifestyle television where, as Palmer argues, 'the idea that one can create oneself from a supply of commodities is fundamental'.⁵

Ouellette and Hay⁴ propose that RTVT helps to produce self-managing and ultimately self-caring individuals who fit better with the demands of advanced consumer capitalism. However, the genre takes us beyond simple self-help: audiences seem drawn by the chance to gain insight into the closed world of therapy and the lives of therapy clients, traditionally hidden from public view. RTVT might even be indicative of TV viewers' desire that programme makers go beyond merely documenting to actually helping – a kind of commercially viable altruism.

Reality TV as therapy

Jenny Hamilton asks if reality TV programmes can provide a genuinely therapeutic experience for audiences *Illustration by Joe Waldron*



What happens in RTVT therapy?

Palmer⁵ notes that TV self-help gurus such as Dr Phil and Paul McKenna tend to use less 'time intensive', more 'media friendly' CBT style models of therapy. This appears to reflect wider trends in public awareness and therapy provision. Conservative MPs have praised in Parliament the CBT methods used in the reality TV show *Supernanny*;⁶ CBT has become the talking therapy most commonly offered by NHS IAPT services (although CBT practitioners might argue that some RTVT shows present a superficial version of the model).

However RTVT shows also draw on a wider range of therapeutic techniques. *Celebrity Rehab*, for instance, (as its name explains) follows a group of celebrities through an addiction rehabilitation programme. While the show reflects the medical understanding of addiction, it adopts the Alcoholics Anonymous model of peer support where former-addicts become the counsellors, and the daily process group, often more associated with person-centred approaches. Similarly, alongside the confrontational and CBT-based sports coaching interventions, shows such as *The Biggest Loser USA* also use therapist self-disclosure and techniques such as self-acceptance, releasing anger, writing letters and making photo scrapbooks. In the weight loss show *Losing it with Jillian*, personal trainer Jillian Michaels takes a holistic approach, acknowledging some social issues, helping clients to work through relationship problems and unresolved emotional issues, giving contestants money to resolve financial difficulties as well as addressing diet and exercise habits.

The appeal of reality TV

Mearns argues: '...counselling is probably only seen as a relevant possibility by about 10 per cent of troubled people. We need to be... actively exploring

creative models for taking the profession to the other 90 per cent.'⁷

Considered in relation to RTVT, this statement raises the issue of the genre's potential to widen access to therapy: to offer a kind of therapy for the masses where the medium of television preserves a sense of the intimacy of a more personal relationship with the on-screen helper. Aslama and Pantti⁸ argue that, although reflective of increased cultural acceptance of emotional expression, RTVT is indicative of a wider trend towards the 'commodification' or 'McDonaldisation of emotion', evident not only in TV lifestyle programmes, film and drama but also in advertising, news media and wider corporate and political culture. However, in their feminist analysis, they also acknowledge the 'visibility of the ordinary' in the genre and the valuing of emotional expression and personal experience in contrast to 'the patriarchal enlightenment ethos and authority power of television'.

Despite the commercial nature of RTVT, it potentially normalises discussion of emotions and offers viewers access to therapeutic ideas in their own home. Programme websites often allow viewers to create their own action plans and in this way RTVT may make therapy more accessible, by cutting out the long waiting lists for NHS treatment or having to pay for expensive private therapy.

RTVT may also reach more isolated or socially excluded groups who would not normally engage with therapy services. RTVT audiences may be more active participants, as viewers may make their own, more subversive readings of shows, questioning or rejecting ideas presented and potentially mitigating the therapist's power or influence. Ultimately, the TV viewer is perhaps not as invested in the therapy as a paying client or someone who has been on a long waiting list for treatment, and the viewer can, after all,

simply switch off the TV if the therapy isn't right for them. RTVT may further offer viewers practical strategies to overcome some of the social inequalities and barriers to health and social mobility that they face.

Is watching RTVT therapeutic?

So how might RTVT work as a therapeutic experience for audiences? RTVT shows use the conventions of TV filming and editing to create emotional drama and intensity, such as cutting between speakers, close ups on eye movements and facial expressions, editing out less emotionally charged material, self-disclosing monologues and use of music to heighten emotion. Aristotle⁹ identified catharsis as a process of emotional purging experienced by the audiences of Greek tragedies. RTVT programmes almost invariably seem to follow the stages of therapy recognised by both Rogers¹⁰ and Snyder:¹¹ an initial stage of catharsis (through emotional disclosure, often via monologues to camera); a phase of insight (provided by both the helper and participant), followed by 'positive choice and action'¹⁰ as we watch the participant embark on a change process.

The viewer may identify with participants and feel they have shared in their emotional journey. They may experience emotions associated with the therapeutic process, or tap into or release emotions around their own issues, as in group therapy where significant issues can be prompted by others, raising clients' self-awareness and offering '...the invaluable healing factor of simply knowing that you are not alone with your issue'.¹²

In another de-mystifying convention of the RTVT genre, the on-screen helper engages in periodic confessional monologues to camera, discussing their own concerns, frustrations and feelings in relation to the participant and offering

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unique insights into the therapist's experience that are usually confined to the privacy of the therapist-supervisor relationship.

Bohart and Tallman¹³ propose that 'all therapy is ultimately self-help and it is the client who is the therapist', highlighting that self-help has proven to be as helpful as contact with a therapist and can suit some clients better.¹⁴⁻¹⁸ They argue that 'ultimately clients must manufacture solutions from their own experience...' and that therapists need to be 'open to any unique solution that might fit the client's life space'.¹³ RTVT may be a therapeutic avenue available to the client within their own 'life space'.

Rogers¹⁹ identified that a common healing element of all therapy is an accepting, genuine and empathetic therapeutic relationship. This raises the question: can RTVT provide an adequate substitute for the therapeutic relationship? This is difficult to answer without extensive audience research, but viewers may feel as if they are in a helping relationship with the RTVT show therapist; they may engage with others through website support forums or watch as a communal activity with peers or family, which may replicate some of the therapeutic elements of the helping relationship or group therapy.

Ethical issues and limitations

It is important to acknowledge that watching RTVT may be an inadequate substitute for working directly with a qualified therapist. The genre also presents ethical challenges. It is potentially exploitative of participants – they sign away their rights to confidentiality at a time when they may be vulnerable or unable to afford services. There is a degree of potential commercial exploitation of audiences – the programmes are funded not only by overt advertising during commercial breaks but also often by more covert

techniques such as branding and product placement within programmes, as the shows' 'experts' recommend products and even promote their own brands and associated products. Other ethical issues echo those raised by 'the Gloria tapes' in which Rogers, Perls and Ellis were filmed conducting therapy with a real client to produce a training video for counsellors. West²⁰ questions whether Gloria could really have given 'informed consent': could she have been fully aware of the extent to which the tapes would be viewed and how that would feel or affect her life? Similarly, alongside the ubiquity of television repeats, the expansion of the world-wide web gives anyone around the world access to footage of RTVT shows; do we know the full effects of this on participants? Indeed, a common criticism of the RTVT genre has been its 'hit and run' effect: participants are encouraged to visit deep emotional places but may then be left without follow-up or aftercare. (Although programme makers have responded with more follow-up support for participants.)

Despite these ethical challenges, RTVT shows may demystify therapy and destigmatise issues such as addiction, compulsive hoarding and obesity through sympathetic portrayal. Even where the shows present issues as pathological, they often link them to traumatic life events, eg accidents, bereavements or abusive experiences. Diamond,²¹ in his discussion of *Celebrity Rehab*, comments: '... part of what makes such programming so compelling is our compassion for the suffering souls we see struggling literally for their lives. And our... identification with their struggle... These "reality" shows are, at their best, indeed about learning to confront rather than retreat from reality'.²¹

McMurria²² notes that, while RTVT's 'commercially sponsored... corporate benevolence' can mask underpinning social inequalities, the 'fan chat' is 'filled with empathy'. Similarly Feasey⁶

sees both socially conservative and progressive possibilities for the show *Supernanny*, noting its use of surveillance techniques to 'berate' beleaguered working-class mothers but pointing to its valuable 'educational possibilities'.

Implications for practice

While further research is needed, there are many possible implications for practice. Clients may come to therapy because RTVT has de-stigmatised both the idea of therapy and the issues they wish to discuss. RTVT may shape client expectations and increase familiarity with the language and conventions of therapy. The client may have already undertaken therapeutic 'work on the self' using RTVT as self-help and the therapist may need to work with the individual's self-therapy routines. RTVT could become a springboard for therapeutic dialogue. In combination with face-to-face therapy, RTVT may enhance or accelerate the therapeutic process or cause the client to question the therapist or therapeutic approach. If working alongside RTVT, therapists may need to consider the ethical challenges inherent within the genre. Non-directive counsellors may need to consider tensions between the genre's more directive approach and their own. Critiques of the RTVT phenomenon highlight the need for counsellors to be aware of socio-economic and cultural inequalities and to be willing to engage with these issues within guidelines for anti-oppressive practice. ■

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Counselling for Depression vs CBT

In an interview with *Therapy Today*, *Michael Barkham* explains the PRACTICED trial – a randomised control trial funded by BACP to test the effectiveness of Counselling for Depression delivered in primary care settings

Professor Michael Barkham and his research team at the Centre for Psychological Services Research, University of Sheffield, have been awarded funding (subject to contract) by the BACP Research Foundation's Scientific Committee to conduct a randomised controlled trial (RCT) to test the effectiveness of Counselling for Depression (CfD) in primary care (see BACP News, *Therapy Today*, May 2013).

Here Michael Barkham explains the focus, scope and methodology of the trial and how its findings may benefit counselling and its clients.

First, what is your interest, personally and professionally, in conducting this trial?

My interest in this trial is at many levels. At a personal level, I have always valued the discipline and profession of counselling. I carried out my doctoral research on the concept of accurate empathy and my interest in the core conditions has never dwindled. As a researcher, I have had an abiding commitment to ensuring a level playing field between contrasting theoretical interventions – that is, securing a situation whereby we can generate a fair test between such interventions, be they, for example, counselling, cognitive behavioural therapy or psychodynamic therapy.

In addition, I have an abiding commitment to securing a broad and robust evidence base – hence I have a particular commitment to combining the methodological strengths of RCTs with those of practice-based studies. When I considered tendering for this research work, I saw the potential for bringing together all these interests.

What is the trial's significance for the world of counselling, and also for you?

For me, professionally, I see this as a methodological challenge to bring the worlds of the RCT and practice-based studies together so that practitioners in everyday services see that they can contribute to the evidence base in a meaningful way that has direct implications for their client work.

For the world of counselling, I think this trial is hugely important. We – whether we are researchers, practitioners, managers, commissioners or, most importantly, clients – need robust evidence for the effectiveness (or otherwise) of *bona fide* interventions. We live in a climate where there is increasing scrutiny of our interventions and NICE has a huge influence on decisions about which psychological interventions are recommended and which are not. Researchers need to deliver evidence that is acceptable to the stringent criteria employed by NICE. The evidence also has to fit the needs of stepped care that is driving much of service development.

So, I think little would be achieved by, for example, trying to show that CfD was superior to no intervention or self-help. Equally, little would be added by restricting the client group to those with mild or moderately severe depression. The challenge is to test the effectiveness of CfD with clients presenting with moderate and severe depression and to test whether it is non-inferior to cognitive behavioural therapy (CBT), which can be viewed as the benchmark.

The trial will provide answers to these questions. In addition, analyses will help us understand which factors may lead some people to achieve better outcomes. This information will yield an evidence-based procedure for deciding which intervention might be better suited to a particular person.

Can you outline briefly your trial's methodology? What are you attempting to establish and how will you do this?

There are many components to the trial, so let me introduce the title and then unpack it. The acronym for the trial is PRACTICED, which stands for Pragmatic Randomised Controlled Trial assessing the non-Inferiority of Counselling and its Effectiveness for Depression.

The primary aim of the trial is to obtain evidence on the effectiveness of CfD. It is called a pragmatic trial as it is being carried out in the routine setting of the Sheffield IAPT service, drawing on people who meet a specific threshold for moderate or severe depression and are stepped up to counselling via its psychological wellbeing practitioners (PWP's). The comparator treatment will be CBT, also delivered in the Sheffield IAPT service. Clients selected for the trial will be randomly allocated to receive either CfD or CBT. The trial is termed a non-inferiority trial as the hypothesis is that the outcomes of clients receiving CfD will not be significantly inferior to the outcomes of clients receiving CBT.

The trial requires a total of 550 people – 225 for each intervention. The number is high because the trial needs to be adequately powered to detect what may be a small difference between

these interventions. Achieving this number is possible because the Sheffield IAPT service sees a huge number of clients each year.

But it also provides us with another exciting component to the study. In most trials many people decline or are not selected for the trial but we have no way of knowing what their outcomes are from the treatment they subsequently receive. This has fuelled the view that study samples are not representative of people seen in routine services. But, because PRaCTICED is based in a routine service, any one who is excluded or declines to join the trial will receive treatment in the usual IAPT service anyway. So there will be data on their outcomes too, and we will be able to use these data to make comparisons between our trial findings, the outcomes of those who declined to join the trial, those who were excluded, and with the IAPT service as a whole.

Clients will be assessed to ensure that they meet the required threshold of depression. I am aware that there is a debate about the value of diagnosis but the bottom line is that, unless we have this component and can meet specific criteria regarding diagnosis, then the trial – whatever the outcomes – will not be considered by NICE.

The interventions will be delivered by IAPT practitioners who have satisfied the IAPT criteria for either CBT high-intensity or CfD training. Training for CfD practitioners and supervisors is taking place and the trial will start once these practitioners – or a sufficient number of them – are ready. As you might gather, there is a huge amount of work to be done up-front in setting up the trial. Like many tasks, good preparation is the key to success.

The funding is for three years and we have designed the study to fit within this timeframe. We have calculated the throughput of clients from earlier data in the Sheffield IAPT service.

There is a growing body of opinion that RCTs do not capture the breadth and complexity of the outcomes of counselling/psychotherapy and that NICE, for example, should recognise the validity of qualitative trials and case studies. What are your views on this and how will this RCT augment the evidence base for counselling as an effective intervention for depression?

RCTs denote one particular design for securing evidence. What is debatable is the weight placed on this specific approach at the expense of other methods.

As many people know, I have argued long and hard for a complementary paradigm of practice-based evidence. But what this study offers us is the opportunity to combine trials and practice-based approaches by embedding it in a practice-based setting. I am on record as saying that we cannot build a robust knowledge base for the psychological therapies on trials alone – nor, in fact, on any single methodological approach alone. So we absolutely need trials methodology as part of a wider knowledge base. My aspiration would be that we move away from a sense of hierarchies of evidence towards, for want of a better expression, a landscape of evidence that considers the whole picture – the overall weight of evidence: one that values all forms of evidence, recognising that each approach has its own strengths but also its own vulnerabilities.

Similarly, there seems to be a growing view, particularly among person-centred and psychoanalytic counsellors/therapists, that CBT has become ubiquitous and is being used with clients for whom a long-term, less behavioural approach would be more suitable. Do you have views on this? Why compare CfD with CBT at all as a measure of its effectiveness?

Having trained as a clinical psychologist, I also did further training in CBT and also in psychodynamic-interpersonal therapy. So, from a practice viewpoint, I know the value of a range of interventions. But from a research perspective, I also know that there is robust evidence for the efficacy and effectiveness of CBT. So CBT is the benchmark against which other interventions need to be tested.

Practitioners may have their own views about the appropriateness or effectiveness of particular therapies, but endorsement of specific therapies at a national policy level will only be based on scientific evidence – and that is why we have selected CBT as the comparator. I think it is important that we offer clients a choice of *bona fide* therapies; no single brand of therapy will suit all clients. But we need to show that what we are offering is effective.

What about the outcomes measures – clients will be randomly allocated to either CBT or CfD. Given that the two approaches are quite different and work in different ways, how are they comparable? Are there any ethical considerations in the random allocation?

To provide evidence to NICE of the value of any intervention for depression,

there needs to be a *bona fide* depression measure. RCTs require a single primary outcome measure and we have chosen the PHQ-9, which is mandatory in IAPT services and focuses on depression, as our primary index of clients' improvement. We will also use the Beck Depression Inventory as a *secondary* outcome measure, along with the CORE-OM, which taps a broader constellation of items, including aspects of functioning (eg social and close relationships). In addition, clients will complete the standard IAPT measures, including the PHQ-9 and GAD-7 weekly.

In terms of any ethical concerns about the randomisation, clients have to agree to be randomised – that is, they understand that they stand an equal chance of receiving either intervention. If clients have a strong preference for one intervention over the other – and I stress the word 'strong' – then they will not be entered into the trial.

The trial puts a particular emphasis on ' equipoise', and on 'noninferiority of outcomes'. Could you unpack the significance of these terms in relation to what you hope to learn from it?

The term *equipoise* is crucial in carrying out a trial. It refers to being in a state of balance. In other words, we are not favouring one treatment over the other. We are putting as much emphasis on CBT and its delivery as we are on CfD. We want the CBT that is delivered to be the best possible – and we also want this for the CfD. So this *equipoise* is an absolute position. It is not ethical to run a trial from a position of non-*equipoise*.

Noninferiority is easiest to explain by briefly describing the three main types of trials: *superiority* trials, *equivalence* trials and *noninferiority* trials. Most trials have aimed to determine the *superiority* of one intervention over another condition – an obvious example would be a wait-list condition. By contrast, an *equivalence* trial would predict no difference between treatments. However, the numbers of clients required for such trials is huge because you are trying to detect no difference with confidence. This was simply not practical.

If the comparison being made is between two *bona fide* treatments – in this instance, CfD and CBT – and the prediction is that CfD will not be meaningfully inferior to CBT, then we can frame this as a *noninferiority* trial. So, it may be that the outcomes for CfD do not quite match those of CBT but that the difference is sufficiently small that, for practical purposes, a practitioner

would be unlikely to tell the difference. In this situation CfD would be deemed as not being inferior to CBT within a predetermined margin. The margin is operationalised in terms of points on the PHQ-9, which is our primary outcome measure.

Importantly, we have set that margin *a priori* – that is, before running the trial. It is not a matter of getting the results and then debating whether the difference is meaningful or not. Part of the requirement of a trial is that the protocol sets out all these criteria ahead of analysing the data.

Readers may like to know more about you and your team – your areas of interest and expertise.

I have been involved in research on the psychological therapies since 1985 – the Sheffield Psychotherapy Projects – and then in promoting routine outcome measurement – the development of CORE. This has led me to promote practice-based evidence as a paradigm for practitioners, which has then led me to my current focus on therapist and service effects – that is, understanding the natural phenomenon of variability across practitioners and services. I think these issues are as important as focusing on specific interventions.

The team of investigators is one short of a rugby team in numbers – there are 14 of us. There is a core Sheffield team – me and Dave Saxon (project manager/statistics), Gillian Hardy (clinical psychology/process research), Steve Kellett (clinical psychology/CBT), Glenn Waller (clinical psychology/evidence-based treatments), John Brazier (health economist), and Sue Shaw (service user). We also have Mike Bradburn, who is our expert from the university's Clinical Trials Research Unit. From Sheffield Health and Social Care NHS Foundation Trust, we have Simon Bennett (service manager). Further afield, the co-investigators are Dr Lynne Gabriel (York St John) and Professors Pete Bower (Manchester), Robert Elliott (Strathclyde), Michael King (UCL) and Steve Pilling (UCL). There is also funding for a full-time research assistant and a PhD student, who will assist with the trial. There are also other people at Sheffield currently working on other projects and they will become involved in the trial at later stages.

It should also be said that, even in these early stages, BACP members have been incredibly helpful and supportive, particularly in relation to training issues, which is very encouraging and for which I am very grateful.

You are publishing a regular newsletter reporting on the trial's progress. Is this usual in such trials?

The newsletter is specifically for the practitioners in the Sheffield IAPT service – the counsellors, cognitive behavioral therapists, and the psychological wellbeing practitioners. We feel it is important that we give the practitioners as much information as possible about the trial and its ongoing progress; we are dependent on them. So we are sending out a newsletter every month or thereabouts. At this stage it is only for them, as it is a good way of communicating directly with them. Once the trial gets going, we will give brief updates on both the BACP and University of Sheffield websites, which will be accessible to everyone.

And finally, there is an ancillary study, unconnected with the RCT, that will be using the same sample groups and data. Could you describe that for us and how you think it may augment knowledge and practice?

A parallel research study is being carried out by Jo-Ann Pereira under my and Steve Kellett's supervision. This focuses on components that the practitioners bring to their practice, be it counselling or CBT. So it focuses on practitioners as people rather than the interventions they are delivering. It seems to me that, if we are to understand and enhance psychological therapies, we need to pay as much attention to practitioners as we do to interventions. Practitioners are our greatest resource and it seems appropriate to place them at the heart of research activity. Data collection for this study will be completed before practitioners begin the trial, in order to keep the study and trial distinct, but the data from the study will provide rich and complementary material to that from the trial.

Thank you, and good luck!

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Talking point

Ever-changing rules

Following the publication of *DSM-5* Pete Sanders points up the flaws in the medical metaphor for mental distress

It surely must be a contravention of several professional codes to not know that the American Psychiatric Association published the fifth edition of its *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5) on 18 May 2013.

The DSM-5 is the latest issue from the marriage of the medical model of mental illness, neoliberalism, American cultural imperialism and all that floats in their combined wake. It was supposed to ensure the dominance of the medical model but, caught in a perfect storm of critical evidence, changing professional interests, growing service-user voices and powerful social media, the whole house of cards is teetering.

In his 2003 book *Madness Explained*, Richard Bentall compared psychiatric diagnoses to astrology, and not in a good way. Bentall, and a host of critics driven by evidence, cannot see sufficient reliability and validity in DSM to trust it as our way of understanding distress. Diagnoses and the medical model are constituent parts of a medical metaphor for distress.

Metaphors are representations of reality; psychological disorders are names for theories, not names for things that exist in nature. If people want to believe in astrology, that's OK by me – it's part of the entertainment industry. The problem with DSM is that it is a metaphor that doesn't entertain. It defines normality and medicalises diversity, has the power to imprison people and medicate them against their will, and keeps re-drawing the lines every few years, based on ever-changing rules. It really does bear repeating that the

DSM regarded being gay as a mental disorder up until 1973, and *DSM-III* (published in 1980) came very close to stating that being the victim of domestic violence could mean you had 'masochistic personality disorder' – put plainly, you were asking for it.

Many might argue that psychiatry has learned from these cultural *faux pas* and that the DSM-5 will put it all right. However, all we find is a different set of cultural drivers sitting behind the wheel of the Mark-5. Not religion or taste, but global capital and neoliberalism – the dream ticket for everyone with anything to sell, including the whole manufacturing arm and distribution system of the mental health industry. The best way to increase footfall in mental health is to create more illnesses and disorders, and DSM-5 does this very nicely, thank you.

Such medical progress ensures there will soon be a diagnostic category with your name on it, literally. Mapping your genome will provide your personalised diagnosis and a pill for it. Now that's what I call *\$pecial!* The you-that-is-worth-it is the nexus of the commodification of mental illness and the expansion of Diagnoses-R-Us to its logical conclusion. So rest easy.

In the UK we have seen opposition to DSM-5 from, among the many, the Hearing

Voices Network (HVN),¹ and the British Psychological Society's Division of Clinical Psychology.² Psychiatric diagnoses, HVN observes, miss the point: 'By focusing on "what's wrong with you", diagnoses can stop professionals asking, "What's happened to you?"' The clinical psychologists' position statement explains: '... the current classification system as outlined in *DSM* and *ICD*, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations, consequently there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system which is no longer based on a "disease" model.'

BACP's position statement similarly points out that 'reducing complex human experiences to a check list of symptoms is not always beneficial for people suffering from common mental health problems'. It goes on to warn of an 'increase in prescribing at a time when... we know that patients often want counselling rather than drugs'.³

Since models of counselling and psychotherapy are predicated upon psychosocial theory and practice, medical diagnostic systems are *neither appropriate nor helpful* in understanding or achieving psychological change. The late John Shlien, Harvard professor and therapist, put it most succinctly and, for many, best. Medical model diagnoses, he wrote, are 'simply a form of evil'.⁴ ■

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'The problem with DSM is that it defines normality and medicalises diversity [and] keeps re-drawing the lines every few years'

'Time is the wealth of change, but the clock in its parody makes it mere change and no wealth' – Rabindranath Tagore.¹

Time permeates our lives, yet we scarcely notice it, much like a fish not noticing the water in which it swims. Just as the Sufi poet Rumi wrote of God being closer than our aorta,² so might we describe the intimate closeness of time. And, as time is so inextricably bound with our existence, it is to be expected that our relationship with it will have a huge impact on our life, and the problems we experience in life – whether practical or psychological – are likely to reflect issues in our relationship with it. However, I believe that in counselling and psychotherapy the client's relationship with time is too easily overlooked, with the obvious exceptions of boundaries and the links between endings and issues of temporality and mortality. Yet that relationship may be fundamental, and its exploration in psychotherapy could be very fruitful.

I have a longstanding particular interest in time, in the contexts of physics, cosmology, culture and philosophy as well as in psychotherapy. My psychotherapy and counselling MA dissertation is on the theme of our relationship with time.³ This article will outline some concepts of time and time-related issues in therapy and give an overview of my own approach to exploring and working therapeutically with the client's relationship with time and temporality.

Concepts of time

In nature there are astronomical, physical and biological clocks – the

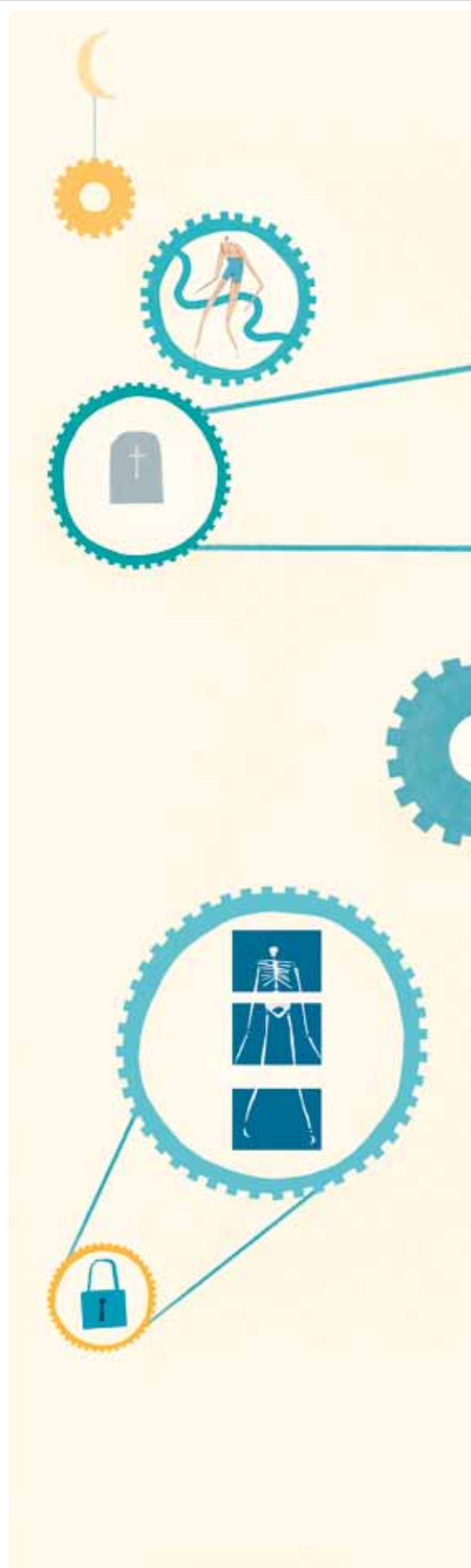
cycles of the seasons, night and day, heartbeat and atomic vibrations. However, since the development of mechanical timepieces, technological clock time has increasingly dominated Western society, and is increasingly dominating other societies too. That kind of time is rigid (notwithstanding quantum physics and Einstein's theory of relativity), consensual and considered to be objective. Technological clock time is the time used in science, transport schedules, broadcasting, education timetables and the workplace (with possible exceptions such as agriculture, which is based more on the more variable earth-and-sun clock time). Even the therapeutic frame is tied to the law of the technological clock (not in Lacanian psychoanalysis, however, where the end of the counselling session depends on when a point of understanding is reached).⁴ By contrast, *lived time* – time as experienced – is subjective, fluid and elastic and it is precisely the *experience* of time that can be explored in psychotherapy.

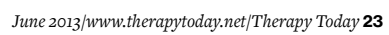
The predominant concept of time in modern western society is linear, with its clear, unidirectional movement from past, through present to future. This links to the Judaeo-Christian (and Islamic) view of there being only one life on this earth, and the associated importance attached to historicity. Equally, the linear concept of time underpins the belief in scientific and technological progress, the communist belief in revolution and the capitalist preoccupation with constantly increasing profits and economic growth. Linear time is goal-driven.

Charles Gordon-Graham explores the significance of time in our lives, and how counsellors can incorporate this awareness into their work

Illustration by Joe Waldron

Time in our lives





By contrast, time is seen as cyclical in traditional religions and philosophies of the East, such as Hinduism, Taoism and Buddhism, and this view also characterises the sophisticated calendars of the Mayan civilisation. Other cyclical views of time are found in Nietzsche's idea of eternal recurrence and some cutting edge cosmological theories.⁵ Cyclical views of time are associated with ideas of reincarnation and take in the cycles of day and night, seasons, individual lifetimes and mind-bogglingly enormous periods of time – billions of years and more.

With notable exceptions, such as Mary Lynne Ellis⁶ in relation to psychoanalysis, there seems to be little written explicitly about the concepts of time underlying most schools of counselling and psychotherapy. Of course, in gestalt therapy, there is the idea of the gestalt cycle or cycle of interdependence of organism and environment⁷ in which, for example, a need or desire emerges, leading to action (therefore contact), satisfaction of that need or desire, and withdrawal. However, it is primarily existential therapy that is most explicit in conceptualising time.⁸

The existential view of time is found in Heidegger's *Being and Time*,⁹ which posits a very close connection between time and being. Time is seen not as linear but as past, present and future – three distinct dimensions or 'ecstases', with the present containing past and future within it. The focus is on experienced or lived time, the time of our being-in-the-world. This close relationship between time and being is taken further by Merleau-Ponty,¹⁰ who said 'I am myself time' – this being unchanging time.

Zen Buddhist philosopher Dōgen¹¹ went even further. In his philosophy, being and time are identical: every moment is the totality of being, the world. According to Dōgen, time, being, space and the whole universe

are ultimately one. In Buddhism the present moment is paramount; however, it is regarded as embracing past and future, and all three are interdependent.¹² Katagiri's account of Dōgen's philosophy of time¹³ applies it to existential suffering in life, in a sense rewriting Buddha's proposed path to enlightenment, and in a recent book Lama Surya Das has explicitly interpreted Buddhism in terms of time.¹⁴ This way of viewing time forms the philosophical basis for my way of working with time and temporality in psychotherapy.

Temporal orientation

A particularly important element of our relationship with time is *temporal orientation*: are we primarily focused on the past, the present or the future, or equally focused on all of them? We may be drawn to the past for its glories and achievements, or through guilt, trauma, or anger about past events, or through dissatisfaction with the present and fear of an unknown or anticipated future. We may wish to avoid the past and instead think only of our next move in the future; or we may be centred on the present – in some cases in opposition to the past and future, in others embracing past and future within the present. In my clinical work I have identified a clear distinction in clients' attitudes to the past – some dwell on it, speculating about what might have been; others look at the past only occasionally and in order to learn from it for the future.

An intriguing article by Mann, Siegler and Osmond from 1968¹⁵ links temporal orientation to Jung's four functions: past orientation to feeling, present orientation to sensation, future orientation to intuition and a balance of past, present and future to thinking. I would take issue only with their specifically linear conception of time being linked to the thinking function. Personally, I believe that I am fairly

balanced in how I think about the past, present and future (which has not always been the case), but I do not hold a linear view of time.

I would also add the possibility of there being different temporal orientations in different contexts. For example, someone who is very ambitious in their career but who has given up on romantic relationships may be future-orientated in the context of career and past-orientated with regard to romance.

The predominant temporal orientations of different models of psychotherapy vary considerably, from the past orientation of early psychoanalysis, through the present orientation of the more intersubjective approaches, person-centred therapy, focusing, gestalt and third wave CBT approaches such as ACT and mindfulness-based cognitive therapy, to the more future-oriented approaches of classic CBT (goals, SMART targets), Maslow (self-actualisation) and psychosynthesis (unfolding of potential).¹⁶ However, counselling and psychotherapy are implicitly future-oriented in that they seek some kind of future change in clients – changes in behaviour, cognition, emotions, lifestyle, way of relating, awareness, how they experience and engage with the world – or towards significant decisions that will effect changes in the life of the client.

Time in therapy

There are in principle many time-related issues in psychotherapy. The (lengthy) list includes time boundaries, time pressure, persistent lateness, finding one's own timing and natural pace, procrastination, difficulty waiting, ageing, mortality, guilt or regrets about the past, dread of a predetermined future, fear of an uncertain future, difficulty making plans, major turning

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points in life, anxiety over incomplete gestalts, feeling of meaninglessness in one or more dimensions of time, and the potential clash between one's own time-related values and those of society at large (for example, if an individual does not share society's linear concept and commodity metaphor of time).

In my clinical work I have, for example, seen older clients who have been carrying a lifetime's burden of suffering from the past. Some have struggled with 'anticipatory anxiety'. Some have come to me with issues of mortality, failing health, bereavements and no work, facing a future that they regard as very bleak. Yet other clients have been experiencing a number of concurrent positive major life transitions in their older age.

I have been developing a way of working with issues related to time and temporality and the client's relationship with them, which I call Time and Temporality Therapy (TTT) and which I have embedded in my integrative therapeutic approach. Indeed, I no longer see this as a separate activity; for me, it is a way of working with time issues that can be applied within therapy more generally, consistent with the understanding of time as central to life.

My aims with TTT are that clients gain insight into their experience of time and temporality, have a more integrated relationship with the three dimensions of time and with the universe, and can function more effectively and more freely within temporality. It is a basic principle of TTT that all beings and the universe are temporal and therefore many problems in life are connected with a problematic relationship with time and temporality, so an insight into our relationship with time can help us to deal with many life issues. A healthy relationship with time and temporality involves integration of past, present and future within the psyche, which in turn involves recognising that we can choose

our attitudes and actions in the present and the future and, even if we cannot change the events of the past, we can change our attitude towards them and the meanings we attribute to them.

In TTT I see the therapist as a facilitator in the phenomenological exploration of the client's experience of time and temporality within his/her gestalt field. Alongside Rogers' core conditions, the therapist cultivates mindfulness in the therapeutic work and encourages the client also to develop mindfulness and an attitude of finding happiness, meaning or fulfilment in the present moment. Issues might arise spontaneously or be 'invited' by the therapist, and in either case are explored phenomenologically, and the therapist works with the client to identify how these issues are connected to the client's relationship with time and temporality and to his/her basic attitudes and metaphors of time.

Clients may be able to explore and accept all three dimensions of time as experienced. Past and future are brought into the present, for example, by noticing the links between past experiences and the present situation, or the client narrating in the present (as in gestalt dreamwork). Sedimented thinking is challenged, and the client then sees other points of view. Incomplete gestalts (unfinished business) are explored, and ways in which the client may wish to effect change, and he or she feels motivated to work constructively with past and present in the process – while also bearing in mind the gestalt paradoxical theory of change (one can only become what one already is).¹⁷

Clients can then integrate their relationships with time and temporality into their lives in ways that they find meaningful. Contextualisation in the client's relationship with time and temporality is considered and explored (ie the possibility of the client relating

to time in different ways in different contexts of his/her life).

TTT includes opportunities for dialogue, Socratic questioning, drama (re-)enactment, drawing, two-chair work, guided visualisation, experiential mindfulness work and thought experiments ('what-if' situations) such as imaginative time travel, in which the client can, for example, look at the choices that were possible in a particular past situation or what choices may be available in some future scenario.

Conclusion

Time is a mystery and there are various ways of viewing it – whether linear or cyclical or in terms of the existential three dimensions. We may regard time as a commodity or a galloping horse, as a prison, a devourer or a river, as an illusion or the very essence of being and the universe. Either way, existence is entwined with time and we would therefore expect that many of the problems we face in life may reflect or be reflected in our relationship with time and temporality. TTT provides a means for clients to explore their relationship with time and temporality and work towards greater integration in their relationship with time, embracing past, present and future, which in turn is reflected in their lives within and outside the therapy room.

It is important to emphasise that TTT is work in progress – psychotherapy is a living, organic process. ■

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Mick Cooper looks to a positive future for counselling in secondary schools amid wider developments in research, training and cross-sector collaboration

Counselling in UK secondary schools

Counselling services were first established in UK secondary schools in the 1960s. By the early 1990s they had all but disappeared but in the last few decades there has been a significant revival. In recent years, much more data have also become available on the nature and outcomes of school-based counselling, and these have now been critically reviewed in a recent report published by BACP.¹ This article briefly summarises the report's key findings and future potential developments.

Service provision

Today, school-based counselling is one of the most common forms of psychological therapy for young people in the UK. It has been established in all post-primary schools in Northern Ireland since 2007 and in all Welsh secondary schools from 2008. In England, it is estimated that 61–85 per cent of secondary schools provide young people with access to individual therapeutic support; in Scotland the figure is 64–80 per cent.

School-based counsellors in the UK primarily offer humanistic or integrative forms of therapy. Clients tend to be referred to school-based counselling through school staff, particularly teachers with responsibility for their social and emotional development (sometimes called 'pastoral' or 'guidance' teachers). Self-referral rates are quite low: between five and 25 per cent of all clients.

Waiting times for school-based counselling tend to be very short: around half of all referrals are seen within one week, and the majority of the remainder will be seen in less than four weeks.

Service users

Around one third of the young people coming to school-based counselling have levels of psychological difficulties that can be classed as 'abnormal', using the well validated Strengths

and Difficulties Questionnaire (SDQ). A further third have difficulties that are classed at 'borderline' levels. For most, their problems have been present for six months or more.

The most frequent problem with which young people present – and discuss – at school-based counselling is family difficulties. Anger issues are also very common, particularly for males. Other common issues include 'behaviour', bereavement and low self-worth, and school-related problems such as bullying. Asked about their goals for counselling, these young people are most likely to say they want to increase their self-confidence and sense of self-worth.

Young people from black and minority ethnic (BME) backgrounds are under-represented among those using school-based counselling services; young people from Asian backgrounds are particularly under-represented, although it is not clear why. However, there is some evidence that this may be reversed when counselling is provided online.

Effectiveness

'Non-directive supportive therapy' is recommended by the National Institute for Health and Care Excellence (NICE) as a treatment for mild depression in children and young people, and many school-based counsellors can be considered to offer this type of therapy. A recent programme of research has also found that 'school-based humanistic counselling' – a distillation of school-based counselling practices in the UK – can lead to significant reductions in psychological distress in comparison with a waiting list control, and can help young people move significantly closer to attaining their personal goals.

In support of this, evaluations of school-based counselling services from across the UK have shown that it is consistently associated with large positive benefits, and that young people – as well as their teachers and

headteachers – are very positive about the counselling being provided. Young people and their teachers also report that school-based counselling can lead to positive improvements in young people's capacity to study and learn: it helps them to get things 'off their chest' so that they can concentrate more fully in class.

How does it help?

When young people experience life difficulties, like parental discord or being bullied, it can lead to a whole range of painful feelings, but the experience of having difficulties in itself can also lead to a range of distressing responses. Talking openly and honestly to a counsellor about their difficulties seems to do a number of things. First, it may help the young person move towards some solutions to their problems, and thereby reduce the distress caused by the problems. Even if they cannot easily do that, the counselling may help the young person overcome some of the 'secondary' feelings evoked by the distress. It may give them a sense that they are not alone with their difficulties, some clarity about what is going on for them, the opportunity to get things off their chest and stop ruminating, greater acceptance of themselves and less shame. Learning to talk through problems with a counsellor also seems to help some young people develop the skills and confidence to open up to others in their lives and develop better relationships.

What's working well?

So how does school-based counselling in the UK measure up to a contemporary, 'young person-centred' mental health agenda? Perhaps the greatest strength of school-based counselling is that it increases the likelihood that every young person will feel that they have someone to talk to about difficulties in their life. In a school of 1,000 young people, research suggests that around 600 will have a significant emotional concern

– often longstanding – and around half of these, 300 or so, would also like to talk to someone about this problem. Many of these will have someone close with whom they can discuss this – for instance, a parent or friend – but research suggests that at least 20 per cent or so (60 young people) will not. A school-based counselling service – and particularly one with good routes of self-referral – maximises the likelihood that *all* young people will feel that there is an independent, skilled professional to whom they can turn when they want to talk to someone about their difficulties.

A closely related strength of school-based counselling is its accessibility. This is not only because of the relatively short waiting times; its location in schools makes it easy for young people to access. School-based counselling is also accessible in the sense that it is open to *all* students, regardless of how ‘serious’ their problems might be regarded by others. This means that school-based counselling may have the potential to act as an early intervention, ensuring that all young people can get timely help for their problems and potentially reducing the likelihood of more serious problems emerging at a later date.

What needs working on?

School-based counselling seems to bring about positive benefits, but these might be significantly enhanced if counsellors were to make more use of the evidence on effective practices. For instance, there is an emerging body of research that suggests the use of systematic feedback from children and young people on the process and outcomes of therapy (for instance, through the YP-CORE form) may significantly enhance its effectiveness.

Increased use of outcome monitoring would also provide much-needed evidence to commissioners on the effectiveness – or otherwise – of school-based counselling. Indeed, although there are instances where evaluation

methods have been applied successfully in the school-based counselling field, recent research suggests that only around seven per cent of services are using systematic outcome monitoring. One reason that school-based counsellors are often reluctant to implement these systems is because they believe that young people will not want to do it. However, the reverse is often the case. Indeed, in some instances young people have said that completing outcome forms was one of the most helpful parts of their counselling.

Although school-based counselling tends to be an inherently young person-centred intervention, it might also be enhanced by a greater involvement of young people at the service design and development level. Closely related to this, there is a need to ensure that school students are fully aware of the counselling provision available at their school and know how to self-refer, and there is a particular need to ensure that young people from BME backgrounds and those with learning disabilities have equal access to services.

While many school-based counsellors already offer a range of interventions beyond one-to-one therapy – for instance, groups for young people affected by drugs – this may also be an important area for development, provided that adequate resources are available. Meeting their parents as well as the young people themselves might be another area of expansion for school-based counselling work. It is also possible that school-based counsellors might become more involved in providing targeted and universal mental health care provision in schools, as part of a ‘whole school’ approach to improving mental health and wellbeing. There is evidence that such initiatives are more successful when they seek to change the wider school environment and culture as well as address the psychological difficulties of individual

pupils. Where one-to-one counselling is provided, there may be opportunities for offering a greater range of therapeutic styles. For instance, research suggests that some young people want a more interactive and challenging style of counselling than that which a non-directive counsellor might provide.

A final area for development in school-based counselling – as well as for those working in related fields – is the improvement of systems of communication and care across services. Currently there is limited evidence of local protocols for ensuring integrated and appropriately stepped pathways of care between school-based counselling and other mental health services, such as specialist CAMHS. In addition, in the minority of instances when school staff or other professionals do criticise school-based counselling, it is generally due to a feeling that they are not getting enough information on particular young people. Hence, there may be a need for more communication and agreement at local levels on what should be shared and with and by whom.

What’s being developed now?

Currently, there are some significant developments in the school-based counselling field, and in the wider field of children’s and young people’s mental health, that may go some way to addressing these limitations.

First, BACP is developing a set of evidence-based competences for counselling young people. This uses the Roth and Pilling methodology,² which draws together the understandings and skills that underpin effective therapeutic practices in specific fields. So, for the first time, a framework for evidence-based counselling in schools will be available. These competences will support school-based counsellors to develop their skills in such areas as systematic feedback, increasing user involvement and choice and integrated working across services.

‘Both young people and their teachers report that school-based counselling helps young people to get things off their chest so that they can concentrate more fully in class’

In addition, they will draw extensively on the CAMHS competency framework already developed by NHS Education for Scotland, thereby enhancing the potential for shared understandings, practices and skills across services and models of therapy. This project is due for completion this summer.

Second is the development of the Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) programme, which is part of the Department of Health’s *Talking Therapies: a four-year plan of action*. This is a four-year service transformation project that began in 2011, working with existing specialist CAMHS, and is focused on client-guided, outcome-orientated, evidence-based practice with a strong emphasis on participation of children and young people. Although this project is not directly targeted at school-based counselling, in 2012 it received extra funds that have allowed it to include a workstream to support counselling children and young people (see www.iapt.nhs.uk/cyp-iapt/counselling). A particular significance of this development is that it has, again, brought counselling together with specialist CAMHS to develop better coordinated support strategies for children and young people.

A third major initiative, which is both a central focus of the CYP IAPT counselling workstream and based around the new competences for counselling young people, is the Counselling MindEd programme (www.counsellingminded.com). This Department of Health-funded programme will develop e-learning resources to support (not substitute for) the training of school and youth counsellors and supervisors working in primary, secondary, tertiary and community settings, as well as the independent sector. It is part of a wider national initiative, MindEd, which is developing an extensive portfolio of

e-learning resources for all professionals working with children and young people. The Counselling MindEd programme is being delivered by BACP and is due for completion in 2014. Again, in this project, counsellors will be developing resources alongside fellow professionals – offering the opportunity to develop a more shared set of understandings, practices and pathways of support across the field.

The development of these competences and e-training resources then offers the opportunity to develop specific accreditation for counsellors working with young people. This is currently being considered by BACP, and a collaborative endeavour here – in association with other developments such as the Better Outcomes, New Delivery programme (BOND – a Department of Education-backed initiative to build the capacity of the voluntary and community sectors to deliver early intervention mental health support to children and young people)³ would help to ensure that all counsellors working in schools are practising at the necessary level of competency.

Finally, there are some important developments in school-based counselling research and evaluation. In particular, BACP’s Practice Research Network for counsellors working with children and young people (see www.bacp.co.uk/schools) provides a valuable forum and opportunity for all practitioners in the field to become involved in research, whatever their level of expertise, and to help to develop an understanding of its processes and outcomes.

Summary

Secondary school-based counselling is now a distinct feature on the map of mental health and wellbeing provision for young people in the UK. It is working with young people with a range of levels of psychological distress. An increasingly robust evidence base is indicating that it is effective at reducing this distress,

and that it is helping young people move towards their personal goals for life. It seems to do this by providing young people with a ‘space’ in which they can find ways forward with their problems and also feel differently about having problems – less overwhelmed, stigmatised and alone.

The key strengths of secondary school-based counselling are its accessibility, and that it helps to ensure that all young people have someone to talk to. But it could also draw more fully on the evidence base of effective practices and on the views of young people, develop more diversified practices (if resources are available), ensure equality of access, and develop better links with other services such as specialised CAMHS. Recent developments in establishing competences and e-training for CYP counsellors may do much to address this, as may the establishment of a school-based counselling research network. These are exciting times. ■

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How I became a therapist

Dilek Güngör

Dilek Güngör came to the UK from Turkey. Her wish to help other immigrants and refugees led her to confront her own losses and fears, and to psychotherapy

I was born in Turkey to immigrant parents. My mother is Turk/Mongol, my father's family root is Kurd/Kirmanji. My birth was a joy in the family. This is why my name is Dilek, which means 'desire'. My surname means 'enjoy life'.

I attended university in Turkey and obtained a BSc honours degree in 1977. I came to London in 1988, for personal, political and social reasons. In Turkey and then in the UK I worked as a nurse and teacher. It would be true to say that I really loved my job – the contact with so many people from such different backgrounds and a role that offered me a place in the community here.

But leaving my country was a traumatic experience. I cannot put into words the anguish of it. I turned to art during my early days in the UK because I could not talk and I carried on expressing my pain through my artwork. It was only after many frustrating years of painting, pottery making, drawing and painful progress that I discovered therapeutic work.

In my nursing and teaching work I observed people who were suffering as a result of being forced to leave their children behind when they came to the UK, usually as political refugees or fleeing imprisonment or arrest in their home country. I found out that attachment, loss, racism and separation from loved ones, especially their children, were the main themes in their lives. They were experiencing deep grief and suffering from guilt, as if they had committed some sort of crime. Some of them were suicidal.

During that period I realised that there was something about my job



that was limiting my engagement with these people and with my own sense of self. They began to draw my interest and attention, personally and professionally; they were triggering strong feelings in me. My growing interest also drew them to me, but I realised that I lacked the skill to do anything to help their obvious anxiety and sadness.

My decision to train as a psychotherapist came first from my real interest in these unhappy people, of whose condition I was clearly in total ignorance and whom I felt ill-equipped to help. Second, I recognised that my own mental health, if I was honest, needed attention. I could not go back to my country; I too was separated from my loved ones, and especially from my only child. I had neglected and denied these issues for a long time; now I needed to look at them. Being in a state of anxiety was necessary for my physical survival here but I needed to be able to control it; it should not control me.

This was a major transition in my life. It led me to enter individual and group analysis for several years. In 1992 I read *Intercultural Therapy*, edited by Jafar Kareem and Roland Littlewood. That was the turning point for me. Learning about one's self can be a scary experience. But I learned that trauma is not a life sentence; it is something that we can work on, recover

from and be happy. Through psychotherapy, I was able to build up strong emotional and mental muscles. As I grew emotionally, my internal and physical wounds did not go away but they became smaller in relation to my whole self. Learning to help myself, through 'emotional recycling', was not easy, but in the end my persistence paid off. Not only did I learn how to look after myself, but also how to conquer my fear of attachment, sadness and loss and separation.

It was my experience of the therapeutic process that inspired me to become a counsellor. I completed further postgraduate training in group analytic psychotherapy, and an MA in group and intercultural therapy. I also studied for a year at the Philadelphia Association and took a clinical supervision course at the Institute of Group Analysis, and completed three years of study towards a PhD.

At present I am surrounded with family and good friends. Now I feel I am really and truly able to offer help to distressed people, especially the ones who have had very traumatic life experiences. I now dedicate my life to working with people from all over the world and I enjoy what I do. I love London, I am grateful to have good jobs and good supervisors. I will continue to write books in Turkish, to do art and to enjoy an ordinary life surrounded by nature and people. ■

Dilek Güngör is UKCP registered senior psychoanalytic, intercultural psychotherapist and a clinical supervisor. She works at Nafsiyat, the Women's Therapy Centre and Family Action and has a private practice in north London.

Dilemmas

Drunk and disorderly

This month's dilemma

Aadi and Martha are trainees on their first year of a counselling diploma course. As they are both single and of a similar age, in a group where most of the students are in couples, they have become close friends. They often go out drinking together at the weekend. One night, drinking in a nightclub, they see their course leader, clearly very drunk, staggering around the floor and talking loudly and inappropriately. Aadi and Martha leave, rather embarrassed, but later wonder what they should do. They recognise that the tutor is off duty and therefore is not in a professional role, but they are concerned about the impact on them and the other students, should this become known. In particular, they are concerned that their own confidentiality may be at risk. What are the ethical issues inherent in this dilemma and what should Aadi and Martha do? Opinions expressed in the responses are those of the writers and not necessarily those of the column editor or BACP.

Phillip Houseby

Trainee counsellor

Aadi and Martha have a right to expect their tutor to have due regard for the BACP's guidance on good practice within the *Ethical Framework for Good Practice in Counselling and Psychotherapy*, which states that 'all training in counselling and psychotherapy should model standards and practice consistent with those expected of practitioners in the role for which training is being provided'.

However, Aadi and Martha will have been introduced to the ideal of being non-judgmental and they would do well to keep that at the forefront of their thinking. What they are seeing is their tutor in a potentially compromising situation but there may be more to the situation than meets the eye.

Aadi and Martha regularly go drinking themselves. They are in the same nightclub as their tutor. Could they say that they have never been drunk or never said something they regretted? Their tutor might be in that nightclub for the first time; maybe s/he is a guest at a celebratory function. Maybe Aadi and Martha happened to see their tutor at the one and only time s/he has been in this state. Their tutor's behaviour might be the result of not being used to drinking alcohol. If it was his/her first experience, s/he might now be aware of the risk that s/he might compromise his/her ethical responsibilities.

Talking loudly is not a crime. Talking inappropriately – although we're not told what was said or in what context – is far more of an issue for a counselling tutor, of course. Modelling confidentiality – a principle

'Everybody is entitled to a night out and everybody is entitled not to be judged on one perceived indiscretion'

that is paramount for any student on a diploma course – would be expected of the tutor within and outside the professional setting.

Not all diploma courses use students' own issues to model counselling theory and practice. My psychodynamic course uses role-play scenarios and discussion of real case studies, so my tutor would not know much about my personal issues.

Tutors are members of society and as such will frequent nightclubs, as they would any public meeting or leisure facility. They do have the added responsibility not to compromise any confidences. All tutors must be practising counsellors so they would be fully aware of client confidentiality as well as the confidentiality of their students.

Everybody is entitled to a night out and everybody is entitled not to be judged on one perceived indiscretion. Aadi and Martha will be expected to keep confidences and avoid disclosure unless necessary when they counsel clients; they should do so now. They certainly should not gossip to other students or share their opinions about what they saw. By so doing they will have demonstrated their understanding of BACP's 'personal moral qualities' of respect, humility and fairness.

If it were to come to light that the tutor's behaviour was not a one-off but was more

of a consistent pattern, then they could justifiably take this up with him/her or take the information to the course provider. If they deemed it necessary to take this course of action, Aadi and Martha would have demonstrated wisdom and courage.

Julia Segal

Counsellor and author

Whatever the students do or do not do, they will feel uncomfortable – which is why (unfortunately, perhaps) the behaviour of professionals in public is not a private matter, even when they are 'off-duty'. The students are concerned about the reputation of counselling, a profession they aspire to join, and that of their course leader, as a representative of their profession and as someone they want to respect as a teacher. Inappropriate behaviour is a threat to all of these, whatever its cause.

The students' concern about confidentiality may be realistic, but it may also have a more emotional aspect. Students identify with professional role models, tutors and leaders in their field; the course leader also represents some important aspect of themselves. This identification explains the feelings of embarrassment: the students have done nothing wrong, but they feel as if they have.

They are right to be concerned about the impact on themselves and on other students if the behaviour becomes a source of gossip – or if it becomes known to someone in a position to discipline the course leader. They may not want to lose him or her; the course itself may even be under threat. Unfortunately, if it remains a 'secret' that is known

only to a few, this also has an impact. Secrets have a corrosive effect on the free exchange of thoughts and ideas, particularly important emotional ones. These students may find it harder to share their emotions, or any thoughts or experiences that remind them in any way of the course leader's behaviour. The atmosphere of the course will be affected, whether the students discuss it or not. Confidentiality is indeed a problem.

Clearly the students do not know if the course leader regularly drinks to excess or is having a single bad night – or if s/he was ill (there are health conditions that cause this kind of behaviour). This makes it harder for them to know what to think and what to do. Making an unnecessary fuss about a minor, one-off misdemeanour is as bad as ignoring serious misbehaviour.

What they should do has to depend on their relationship with the course leader and other members of the staff. Keeping quiet means colluding in a cover-up. Raising the issue with the course leader might clear the air and be helpful, but could equally be very embarrassing and cause trouble for the students as well as for the course leader. Raising it with someone else could also be helpful, but might instead lead to the students feeling they have betrayed the course leader, or caused serious trouble for him or her. They might decide to wait – if the course leader does have serious alcohol or medical problems, these are likely to emerge in other ways too, and responsibility for challenging him or her would no longer rest with Aadi and Martha. 'Forgetting', however, is probably impossible.

If the students are in counselling themselves, they would be best advised to talk it through with their counsellors, in order (at the very least) to try to sort out what they actually saw, what they imagined and what they felt and feel about the incident, as well as its relevance to becoming a counsellor. 'Inappropriate behaviour' covers a very wide field, and their assessment of its seriousness may change through discussion. Their best course of action (or inaction) may become clear from such a conversation. Taking time to decide is probably wise.

Whatever they do, the course leader has put these students in a very difficult position and has jeopardised the value of the course.

Duncan Lawrence Trainer, equalities advisor and BACP Fellow

Working or training and actively socialising in the same area is a risk to personal privacy (and in this case a potential risk to the student-tutor-training centre relationship).

In this case the choices for Aadi and Martha are to tell no one; to tell someone else, or to let others take any action for them.

First, participating in an active social life cannot be 'regulated' (say, in this example, by the workplace, professional body for trainers, counselling training centre

etc) but, when ethical dilemmas arise, trainees need to consider carefully the options available to them, taking into account the immediacy and severity of risk of harm to themselves and others involved.

In some counselling and psychotherapy courses, there may be a 'course contract' that may cover situations such as this, making clear that, outside the course, the tutor's time is his/her own; it does not belong to the course. If so, Aadi and Martha, as adult learners, can simply choose to respect their tutor's right to privacy when 'off duty' (in the spirit of the course contract).

Following on, Aadi and/or Martha could additionally consider using their own personal counsellor and/or supervisor to work through and clarify their own feelings about what they saw and felt as a result.

It is important to note here that some supervisors may feel that, because of the potential for blurring the trainee-course leader relationship, once the trainee(s) have shared this information, it is the supervisor's duty to share the information with the course leader and/or training centre.

In an ideal world, a well-developed training centre would have explored this type of situation during staff inductions and potentially via CPD. If so, a tutor in this situation is working against advice and is exposing themselves to needless risks and exposing their current and prospective students, as well as current and potential clients to negative experiences of them (which could have many knock-on effects, such as loss of respect of the students and clients, loss of job etc).

Next month's dilemma

Angela is a faith leader who is coming to the end of her counselling diploma and counselling placement. She wants to continue gaining supervised counselling experience after she completes the course and it would be very easy to do this by counselling people from the congregation she leads. However, she is concerned that there could be a conflict of interest between her role as minister and that of counsellor. She is aware that this role conflict could lead to situations where confidentiality is at risk.

Is it ethical for Angela to offer counselling to people from her own local faith community or would it be better to approach a local agency where she can gain this experience with clients who are not members of her congregation?

Email your responses (500 words max) to Heather Dale at hjdale@gmail.com before 28 June. Readers can send in suggestions for dilemmas to be considered for publication, but these will not be answered personally.

'The atmosphere of the course will be affected, whether the students discuss it or not. Confidentiality is indeed a problem'

The meaning in madness

Colin Feltham interviews psychiatrist *Joanna Moncrieff* about why the medical framework is not a helpful way to understand mental disturbance

Photograph by Jacky Chapman

What personal factors took you into the profession of psychiatry and the anti-psychiatry movement?

I was interested in philosophical and political issues, and these are central to psychiatry in a way that they are not in the rest of medicine. So, before I even started psychiatry, I had been reading Szasz and Laing and thinking about the meaning of madness and the functions that a medicalised notion of madness plays in our society.

For many of us, the subtleties of the anti-psychiatry world and its literature are themselves somewhat confusing. Can you say where you stand among figures like Foucault, Laing, Szasz, Dineen, Breggin and Bentall, and what significant shifts there have been?

Each of these figures has different ideas. Much of Laing's work focuses on the nature of the experience of severe mental disturbance and suggests that, however bizarre, it can be understood as a meaningful response to an individual's circumstances.

Szasz is an important and rather divisive figure. In my opinion, he is an important thinker because he articulates the fundamental issue at the heart of psychiatry and antipsychiatry – is mental illness an illness like any other? He argues that physical illness is an objectively identifiable, abnormal state of the body, whereas mental 'illness' is defined by a person's behaviour, and whether behaviour is judged to be normal or abnormal is a subjective, context-dependent and essentially moral and political activity. So mental illness is a fundamentally different phenomenon from bodily disease. Szasz suggests that representing unwanted behaviour as

illness is authoritarian, oppressive and infantilising; if the behaviour were represented as criminal, the accused would then at least have the opportunity to defend themselves. Szasz is often seen as uncaring because he appears to be critical of dependency, and he emphasises people's responsibility for their actions.

Foucault's ideas come from a different tradition of continental philosophy but nevertheless point to many of the same issues raised by Szasz and Laing. In *Raison et Folie*, he described how madness played a substantive and positive role in pre-enlightenment society before it was reconceptualised during the enlightenment as simply a lack of reason. He regarded the management of madness as essentially a process of social control that became overlaid in the 19th century with a medical patina, which is consistent with Szasz's ideas about the social functions of the medicalised notion of 'mental illness'.

Breggin focuses on drug treatment. I have written about how his theory of the brain-disabling effects of psychiatric treatments is close to my own theory of the 'drug-centred' effects of psychiatric medication.

I am not sure that there have been any consistent shifts in the antipsychiatry movement. Like other movements, it has lost the radicalism of early days, and most of us now are practising mental health professionals of some sort or another, accepting that there are problems that need to be dealt with and trying to find ways of working in a conventional health service setting. The philosophical and political issues these thinkers raised remain just as pertinent today as when they were first articulated.

In your many publications – for example, *The Myth of the Chemical Cure* (Palgrave, 2008), *A Straight Talking Introduction to Psychiatric Drugs* (PCCS, 2009) and your contributions to *De-Medicalising Misery* (Palgrave, 2011) – you have exposed some of the less than edifying practices of the medical and pharmaceutical professions. How much do you regard them as culpable rather than as doing their best but being mistaken?

I think the professions are culpable by neglect. The psychiatric profession could choose to investigate the overall effects of its drugs more thoroughly, for example, but it chooses to focus on this narrow disease model. I think it is also won over by the vast amounts of money that the pharmaceutical companies throw at the marketing of new drugs, and it is particularly vulnerable to this wooing because of its inherent insecurity about its status and its deep-seated desire to be seen as a proper medical speciality.

Psychiatrists and other professionals want to help people too, and that is also part of the motivation, of course. Applying a medical framework – that is, making a diagnosis and prescribing the right drug for the diagnosis – helps professionals feel they can do something in the face of what can be very challenging situations. The trouble is that this is a very simplistic approach to the complexity of mental disorders. It is not a framework that stands up to scrutiny and it is not one that I think is ultimately beneficial for the people it is meant to help, even if sometimes people find having a diagnosis, for example, brings some short-term relief.



For many involved in the talking therapies, anti-psychiatry, anti-psychopharmacy and the de-medicalisation of distress are very welcome, but psychotherapy offers the awaited panacea that should now be generously funded. I take it this is not exactly your view?

Although the recent initiative to widen access to psychological therapies is to be applauded for recognising that just doling out antidepressants is not often helpful, it adopts a medicalised framework of diagnosis and manualised therapy that undermines what is most useful about psychotherapeutic approaches. Each individual who is labelled as having 'depression' or 'anxiety', for example, has their own unique set of difficulties and a particular history. Once you give them a diagnostic label, you start to treat the label and not the individual. Instead of seeing depression as an emotional response to an individual's life situation, the medicalised approach simply focuses on the disease the person is thought to have. The manualised CBT that is delivered under the IAPT banner is like a prescription for a diagnostic label, rather than an attempt to understand an individual's situation.

It seems to me that the aim of decent society should be to empower people to deal with their difficulties themselves, without having to turn to professional services. As far as therapy helps people to find ways to help themselves, it is important and useful. There is a danger of promoting dependency, however, that therapists need to be aware of.

Most of us involved in experiences of acute or chronic mental distress, or caring for loved-ones who suffer, find ourselves 'passed around' services, meeting with inconclusive assessments and floundering among proffered but unsatisfactory medications, hospitalisations, therapies or on waiting lists.

Where can we look for inspiring examples of timely recoveries?

Experiences like this are common because the social and interpersonal difficulties that get labelled as mental illness are complex and often difficult to resolve. It would be better if services admitted their limitations more often, rather than giving people the impression that the right treatment lies somewhere out there, if only they can find it. I frequently see people who are taking two, three or four different psychotropic medications, without any real evidence that any of them is having a beneficial

effect, in an endless quest to find the right treatment.

The fact that people are told that they have an illness and require a specific drug to correct it is profoundly disempowering. People don't realise that very often it is their own efforts that have helped them get better. I also think that the medical framework encourages people to expect miracle cures, and to undervalue the small changes that quite simple interventions can make. Supporting people with severe mental conditions like psychosis or schizophrenia to cook for themselves, or to undertake some social activities, will not cure their schizophrenia but may make a significant difference to their quality of life and set them on a road to a more independent and fulfilling life.

To what extent is language critical here? Are terms such as patient, mental illness, diagnosis, treatment, recovery, psychiatric disorder etc to be avoided at all costs?

Good question! I think language is important, but I don't think you can change the system by changing the language. The medicalisation of madness and distress is deeply embedded within our society. It fulfils many social and political functions and roles and, until an alternative system of caring for people who are dependent and managing people whose behaviour is disturbing is devised, then nothing will fundamentally change.

And further on language and classification, we sometimes speak of everyone being somewhat disturbed (the human condition, or 'anthropathology'), of everyone being different and 'OK', of majority neurosis, of the personality disordered and those seriously disturbed or psychotic. Do these loose groups reflect reality or distort matters?

I think there are some broad patterns in emotional and behavioural disturbance. Hence there is something distinctive about people with what we call 'psychotic symptoms' or who are in a 'psychotic' state. I am not in favour of a continuum theory of mental disturbance. I think some states are categorically different from most people's usual experience of the world. But psychotic-type experiences are still enormously varied, and individuals who might be diagnosed with psychosis or schizophrenia are more different from each other than they are similar.

Depression, anxiety, personality disorder, on the other hand, are labels for the sorts of experiences and behaviours we all recognise and

have from time to time. This is where labels seem to me to be the most useless and most harmful, because they appear to provide an explanation for the emotions and behaviours described, but only actually provide a description and, because it is not an individualised description, it is an inadequate one.

You have, within the Critical Psychiatry Network and elsewhere, voiced your view that mental illnesses are meaningful reactions to various intolerable pressures, that solidarity is crucial and pragmatism necessary...

As I said, I go along with Laing. If you want to understand mental disturbance, you have to try to understand how it is a response to an individual's particular circumstances and history. But this is not the same thing as saying that our environment causes mental illness. Circumstances that are highly stressful for one person may be quite tolerable for another, and there are likely always to be people who find it difficult to lead a fully independent adult life. Having said this, I think there are ways of organising society that would help reduce mental health problems – reducing social isolation, subsidising or, indeed, providing stable and self-sustaining employment, curtailing our highly competitive and consumerist culture in some way and generally enacting measures that reduce the high levels of social disintegration and marginalisation that exist in many areas, especially in our cities.

Do you see signs of significant breakthroughs in our understanding of mental distress (eg Finnish claims to radical, new, humane treatments)?

I don't think there is a glorious future where there will be no mental disturbance. I think it is a fact of human life and what we can hope for is that we deal with it a bit more honestly and transparently, and hopefully a bit more humanely.

Are you still practising as a psychiatrist and can you say what future plans and hopes you have personally and for the psy-professions?

Yes, I work in a community recovery team in London. I think the main pressure we all face at present is cost cutting, and it is difficult to see real innovations in care taking place while reducing cost is such a prime motivator in service provision. However, there is an opportunity for independent providers to offer an alternative approach, and I hope they can do this without simply offering a cheaper service. ■

My side of the dilemma

I wanted to thank the three contributors who responded to the ethical dilemma 'Transgender disclosure', in the May issue of *Therapy Today*. A number of helpful and thought-provoking suggestions to the dilemma were presented.

I am Thomas, it is my dilemma, and I wanted to share my responses from a place of my felt sense, and not criticism.

I wanted to share that my initial response surprised me. I was aware of a sense of shame that emerged while reading responses from the first two contributors, Dominic and Alex. I somehow had got things badly wrong. I read that categorically I had used the wrong language; I had been wrong not to offer my female name and was somehow denying my femaleness; I had not been able to just let go of my internalised shame; I hadn't seen the client as being strong enough to be able to accept my fluid gender and really I should have just told them and allowed both of us to grow as a result.

My use of language was so inappropriate that one or more of the contributors felt the need to contact *Therapy Today* and persuade them to change it so that it would be more acceptable. I felt crap. I was relieved to then move on to the third contributor, Linda, who offered empathy, warmth, respect and a humility borne of not knowing but wondering. Unfortunately at that moment the shame felt solid.

I put the journal away and really wished that I hadn't bothered putting the time and effort into preparing the dilemma, along with lengthy negotiations with the column editor Heather

Dale over language and confidentiality. I thought that I would give myself time to process it and would sleep on it. I felt very disappointed and couldn't quite put my finger on why. After all, *Therapy Today* had invited two experts in the field to comment and so they must be right.

The next day I noticed a niggle in my gut that, when I focused on it, grew into a sense that my shame was not right and that how I was being defined was not right. I read the piece again and noticed that my shame became anger. I felt strongly that I needed to respond and reclaim my voice, my identity and, most of all, my power. A friend and a colleague who read the piece were fuming at what they experienced as the hijacking and redefinition of my situation as well as the professional journal allowing the rewriting of my language.

I felt that my language had been contaminated and redefined, that my language had been changed without reference to me. I was mindful and intentional about the language that I wanted to use. If I had wanted to use my female name I would have. If I had wanted to use 'her' instead of 'him', I would have, and there is no indication in the written dilemma that I am in the middle of transition.

My dilemma is not my gender, it is my practice, and to ensure that it is ethical and is guided by the BACP *Ethical Framework*.

What I found most interesting was that Linda's response engendered in me a sense of engagement with the dilemma presented and I have taken on board some of her ideas and in particular further exploration on the impact on me as a therapist and use of the personal qualities in the

Ethical Framework. Linda was not judgmental, was the least expert and stated that she had not knowingly worked with transgender clients. She felt gentle and thoughtful, as if she was able to be with the person and not the 'issue.'

I have gained much by taking the time to prepare and present this dilemma and have appreciated the time that has been given by those in responding to it and I sincerely hope that my voice is heard. There is a need for many voices in relation to gender and sexuality and some of that needs to be political and active but there is also a place for something gentle and accepting.

I guess that I wanted to put the record straight and to ensure that my voice is heard.

Thomas

Editor's note

Following publication of Thomas's original dilemma Therapy Today was contacted by Trans Media Watch who suggested that the dilemma was 'poorly presented' and that alterations might be made.

Class and connection

Like the three correspondents in the May issue of *Therapy Today* who responded to Daniels and Trier's article on class, we applaud that they have brought this issue into awareness. Daniels provides valuable descriptions of how disconfirming the establishment culture can be for a working-class child or adult. Their key point deserves strong support – that the counselling/therapy world needs to address the meaning of class in our work,

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especially as our setting is British culture, where the ramifications of class are still a greater shadow problem than among any of our neighbours.

However, we felt that the conversation fell short of a meaningful exploration of the experience of the 'privileged' child. Mike mentions (p16) that he was at boarding school, where there were issues of power and marginalisation among the children, but the matter is not pursued. It would be good to have a fuller account of how our class system hurts different children in different ways. We don't know at what age Mike went to boarding school but, for most children, being sent away for this kind of 'privileged' education involves a profound impact on their lives. Young children can only cope with boarding school by developing a set of defences that will profoundly compromise their development from that point; they evolve what Duffell (2000) has identified as a 'strategic survival personality'. Many boarders will go on to enjoy the senior and lucrative careers for which their schools prepare them, but this adaptation to the system is at the cost of their capacity to connect at depth with themselves or in relationships. Other boarders will be more profoundly damaged and if they come to therapy it is very important that they meet a therapist whose understanding of them is not based on a misunderstanding of class privilege. As Jane Barclay's letter in last month's pages conveys, this does happen.

Anne Power and Nick Duffell

Priced out of the market

In your April issue Simone Daniels called for BACP to challenge colleges about their disproportionate number of middle-class students and staff. Counselling courses are expensive and time-consuming. Working-class students have been priced out of the market, with even basic courses now costing thousands. If the course demands that the student is also in therapy, you can add another thousand or so to the bill.

Many courses expect a student to do a placement of up to half a day a week to demonstrate practical counselling experience, as well as their study hours and college attendance. After completing the course, there is little guarantee of work. This biases counselling courses against those struggling with low wages and full-time jobs. Within the present economic climate, I see counselling, unfortunately, becoming more middle-class.

Kevin Ryan
MBACP

Inclusive approach

It was with much interest, enthusiasm and a sense of identification that I read the article on class and counselling by Simone Daniels and Mike Trier in the April issue of *Therapy Today*.

It reminded me that I had a strong sense of the divide between classes during my earlier years. However, what I am acutely aware of now,

and what the article brought to my attention, is how my working-class background may be influencing my practice today re how and where I choose to practise.

I am aware that I feel much more comfortable working for a service, as opposed to working in private practice and therefore asking for payment for my services. I wonder if this is a common theme among those of us from a working-class background?

Simone mentions that she would like to see 'that colleges are proactive in recruiting students and staff from diverse backgrounds'. This made me think about the PG Dip counselling programme I chose. Although it is validated by a university and accredited by BACP, it had a very inclusive approach and all teaching/learning was held off campus, which really suited my still (at times) working-class hang-ups about being 'good enough'.

I would agree with what Simone says about the middle classes not always taking working-class people seriously, which can result in them not taking themselves seriously either. Although taking our clients and what they tell us seriously may seem basic and even simplistic, it could be that the client is experiencing being taken seriously for possibly the first time by someone in a professional role. What an absolute privilege that is and a potentially empowering experience for both the client and counsellor.

Thanks to Simone, Mike and BACP for highlighting this often overlooked issue. I look forward to the ongoing debate.

Lorraine Mackenzie
MBACP (Accred)

Power relations

I was interested to see the article on social class in *Therapy Today* (April 2013) as it is so rarely addressed.

What struck me was the structure of Mike and Simone's dialogue in that Mike said 688 words to Simone's 2,286 and he asked 10 questions to her one and that these asymmetries became more pronounced as the brief encounter progressed.

I think the structure is similar to a therapy session and exhibits the same power relations, although I can't be sure if this is mediated through class, gender or other factors such as age.

Nick Davis

Privileged but deprived

Although I'm not a counsellor, my attention was drawn by a counsellor friend to your pioneering article on class (*Therapy Today*, April 2013), and now the subsequent correspondence. Perhaps I could respond as a layperson who has written about the psychosomatic consequences of early boarding and upper-class child rearing customs, and the inadequacies of my lengthy psychoanalyses which did not address such issues.^{1,2}

I come from a similar background to Jane Barclay and, while I sympathise with what she experienced as 'prejudice' in the use of the term 'privileged' because it is quite possible, even likely, to be materially privileged yet emotionally deprived, I think

it is a mistake to see class simply as another category alongside age, gender, race etc. The power of the middle class and upper class in our society is supported by specific institutions of education (private day and boarding education – just look at the present Cabinet) and significant networks (old boys/girls) of influence. These realities are bound to enter the therapy space, whether acknowledged or not, and they are closely linked to the formation of our identities as human beings – problematic or otherwise.

As someone who has struggled to find an authentic self not deformed by my own class background (being sent to boarding school at seven didn't help; nor did being handed over to a nanny at a few days old), I very much welcome the initiative that Simone and Mike have taken, and that BACP has provided the space. I very much hope it can be pursued further.

Simon Partridge

Ex-analysand and writer

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In defence of crying

Following on from your recent article on therapists crying (News, *Therapy Today*, March 2013) and Alberto Pavan's contribution

(Letters, *Therapy Today*, May 2013), a recent edition of the BBC Radio 4 programme *All in the Mind* (7 May 2013) featured an item on 'Should therapists cry', based on the same study carried out by Amy Blume-Marcovici, a clinical psychologist at Alliant University in San Diego, US.

The radio programme presented a number of responses from practitioners and clients, ranging from understanding and discomfort to describing a therapist's tears as unprofessional.

As a practising psychotherapist/counsellor, I have personal experiences of 'shedding a tear or two' in the presence of a client, and over the years have given the pros and cons a lot of thought. I consider the topic in the context of my therapeutic approach. At the heart is the belief that integrative therapy attends to the person as a whole (on an affective, behavioural, cognitive, physiological and spiritual level of functioning); that it aids their personal integration process to create a cohesive personality and views human development as life phases with their own individual needs, crises and opportunities. For me, this therapeutic stance is underpinned by the importance of the therapeutic relationship between practitioner and client (the therapeutic process).

I regard 'being moved to tears' in response to some client presentations as a normal and very human way of being with another. For me, being emotionally closed to such responses effectively means that I cannot be fully present in the counselling room for the benefit of the client.

Now, what to do if I cry or shed a tear in the presence of a client? I have settled for looking at it on three levels – all based on constant self-awareness on my part.

1. What are my tears responding to? If the client's story raises issues connected to my own life (and there is nothing right or wrong about that happening), then I need to park these thoughts and emotions straight away and address them outside the client's session with my own therapist. Not doing so would be unethical.

2. If I am satisfied that I am authentically responding to the client's material, then what is the client's own emotional response, or lack of? Often clients have developed an emotional detachment in order to cope with traumatic experiences (understandably). I often find myself picking up viscerally emotions that the client may be holding back (eg crying). Working psychodynamically (ie aiming to make the unconscious conscious) I am aware that the client's 'unconscious emotions' are transferred to me in the therapeutic process. Therefore, my tears communicate something about the client – they are the client's tears.

3. How does the client feel about my tears? I always make a point (at an appropriate moment in the same session) of acknowledging my tears in front of the client and asking what that was like for them. I believe this goes towards integrating the event into the therapeutic relationship. Responses I get vary from discomfort and anger at me for being 'unprofessional' (or not leaving space for the client in what is their session) to looking at it as a sign of

empathy and understanding. I always stress that the client does not need to take care of me, that this is my responsibility and I am OK.

We may revisit this event at other points in the therapeutic work, as appropriate, and more often than not I have noticed a gradual reduction in discomfort in clients with regard to owning and displaying their own emotions and, indeed, needs.

In that scenario, working with a client relationally (ie using the therapeutic encounter as an opportunity to model a safe, containing, constant, boundaried and professional relationship), I can use my emotional response (which can be tears or even outrage on behalf of the client, who cannot yet own this emotion for themselves) to model that such a response is not necessarily a sign of weakness, that the client is 'not hurting me' or 'making me cry' and, moreover, that the client does not need to take responsibility for my emotions and take care of me.

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Wisdom of age

I was surprised to see no letters in response to the excellent article in the March issue on 'Retirement or renaissance?' I'd been going to write something myself but wanted to take my time about it to fully digest and process before writing. Perhaps others did the same? And I had some resistance to even looking at the subject, especially when I saw that one

of the therapists quoted had retired at 60. I'm 60 next year and retirement couldn't be further from my mind – I'm strong, capable and have all my faculties, and feel that I'm coming into a wisdom and depth of knowing that is after all of great value in our work.

As we age it is so important to employ that wisdom with ourselves as well as our clients – to work in a way that sustains us as well as others (taking rests between clients, giving time to really digest what has happened in a session, allowing our deep wisdom to speak to us, our inner knowing to surface). Perhaps this is equally true for our younger colleagues, though possibly more difficult to give yourself permission to take good time.

One of the issues not addressed by the article was not feeling able to retire for financial reasons. Perhaps the baby boomers and those elders quoted in the piece were better placed financially than those of us who haven't been able to afford expensive pension plans and are faced with the chipping away of older age benefits? Not to mention the sliding increase in retirement age!

Thank you for addressing the issue – an ongoing conversation with an ageing population I think!

Debbie Collins

Philosophy training

I enjoyed Alain de Botton's article, I have long thought that we therapists are secular society's new priests anyway.

The problem is that more often than not we have not really embarked on the

daunting task of thinking through the implications. We have not had the philosophical training to undertake this role, which is something that I think our training institutes need to take on board more fully. Even at MA level training, this challenge is largely ignored.

What is the 'good life' that we are trying to help our clients towards? What is the meaning for us and them that logically emerges from the increase in self-awareness and self-knowledge that we aim to foster? This is inextricably linked to the question of meaning in anybody's suffering and, ultimately, to the meaning of our death.

If, as therapists, we were more openly and consciously engaged in exploring these fundamental philosophical issues, then we would indeed have solid ground to stand on and be counted as secular society's priests. We are taking the role; we are helping people to find meaning in their lives, so it seems to me that we have a responsibility to take this on more consciously.

Maybe part of this could be having a regular philosophy section in *Therapy Today*?

Jim Robinson

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Therapy as commodity

When still in training years ago, I remember getting involved in endless, often futile discussions with acquaintances and friends. As some of them regarded the new world of therapy I was about to join with various degrees of diffidence – from uneasy distrust to downright

hostility – I felt I had to justify and defend my new profession. Things have moved on considerably since then. Nowadays, I rarely feel the need to defend my line of work and many would agree, I believe, that counselling and psychotherapy are largely accepted in our culture: going to see a therapist is no longer, on the whole, a mark of embarrassment or shame.

It was therefore with a sense of dismay and incredulity that I read Alain de Botton's piece ('Care of the soul', *Therapy Today*, May 2013). He declares, without a hint of irony: 'Imagine if seeing a therapist wasn't a strange and still rather embarrassing pursuit... Imagine if one could be guaranteed a certain level of service... Imagine,' he continues, as if parodying John Lennon, 'if the consulting rooms looked better and were more visible, to make a case for the dignity of the activity.'

Whether working privately or not, all the colleagues I know offer, as I do, a dignified, professional level of service in clean and salubrious settings that are conducive to the work we do. Where has de Botton been in the last 30 years? He refers to therapy as a 'minority activity', marred by an inability to solve 'issues of branding', before adding, again without irony: 'Therapists are hidden away. You don't see them on the high street. We don't make a place for them among other needs, like those for bread or electrical goods.' Personally, I don't want to metamorphose into a fashionable brand sold on the high street, with all the shiny accessories produced in some sweatshop. Maybe there is some value in therapists being slow on understanding

'issues of branding'. Maybe there is great value in not having to solicit shoppers in Oxford Street. Maybe there is value in being 'hidden away', as de Botton says. Maybe the nature of the work does not require glaring lights nor, I cannot resist saying, the trendy blankness of places like de Botton's shop, The School of Life in Bloomsbury. People I respect see de Botton and his School of Life as having the finger on the pulse of things. My concern is that this could well mean something worrying: ie the effective mirroring of the widespread commodification of life, now extending its claws to the therapy domain.

De Botton's point is part of a claim for a secular society – with its own temples and places of worship celebrating secular virtues; with its own secular priests, namely we counsellors and psychotherapists. Personally, I don't want to be a priest, secular or otherwise. My job as a therapist is not that of a secular or spiritual guide. 'I want to guide others, I want to help them,' when I hear that, in interviewing new candidates for a counselling training, it sends out alarm signals.

De Botton has made similar points in the past in relation to philosophy, with the unwitting and undesirable effect, in my view, of dumbing down what is a difficult yet rewarding discipline – turning it effectively into a consolation exercise. Philosophy is *not* consolation but deep engagement with the complexities of the human condition. I felt strongly about this, as I still do, on account of my previous training in philosophy – a field that still greatly interests me and is part of my professional

life. I teach philosophy part time and engage with philosophy in my writing. Much of my clinical work is informed by philosophy; its insights are tremendously valuable for therapy. Yet I would hesitate to call myself a 'philosopher' – a term I reserve for great innovators who brought philosophy to new heights. De Botton happily calls himself a 'philosopher' and, having attempted, in my opinion, to dumb down this rigorous discipline over the last few years, now appears to be attempting to do the same with therapy. Unlike my suspicious acquaintances and friends who were openly hostile to therapy, the author's intentions are well-meaning. At the same time, I find his views on therapy uninformed, oversimplified and resulting in a trivialisation of therapy. He seems unaware of the fact that therapists undergo a long and arduous training – a path of alternatively painful and elating personal discovery paired with the demanding integration of experiential skills and complex theoretical knowledge. As with philosophy, the dumbing down of therapy is a great disservice to our clients and the society we serve.

Manu Bazzano

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Needs of the soul

I am writing in response to Alain de Botton's 'Talking point' in the May issue of *Therapy Today*. Alain's words moved and encouraged me and I found myself agreeing wholeheartedly with his

sense of 'the needs of the soul' and the significance of 'therapeutic conversation with a sympathetic other'. As a trainer and counsellor in cancer care, I am afforded the great privilege of offering and engaging with many such conversations – conversations that are often profoundly and poignantly 'soulful'.

Influenced by my own spiritual heritage (some of which I experienced as abusive and some as deeply reparative), I hold a passionate belief in the importance, the demands and indeed the 'dignity' of caring 'for the soul'. Alain clearly sets us a challenge: a challenge to which I am uncomfortably aware I may fail to rise. For perhaps it is only those who are willing to remain on the threshold, encountering the chaotic rather than the coherent, who may truly discover the 'gap' of which Alain speaks and then – with an appropriate degree of trepidation – perhaps find creative and courageous ways of filling it.

Ruth M Bridges
MBACP

Paws against inaccuracies

We would like to comment on several inaccuracies in your news report entitled 'Therapists aid stressed students' in the May 2013 issue of *Therapy Today*. We were glad to see that our project 'Paws Against Stress' got a mention in the journal, but dismayed to note the fundamental oversight that the project was in fact the idea of the University of Edinburgh Student Counselling Service. It was

the Counselling Service who asked Edinburgh University Students' Association (EUSA) to partner up to host several therapist events for exam-stressed students, with experienced dogs provided by Canine Concern Scotland Trust.

The three two-hour events in April and May were attended by approximately 250 students and were considered a huge success by all concerned. Student evaluations are being analysed now and an article is being written for the BACP Universities & Colleges journal. There was a lot of positive press interest in the event – a news item on Scottish ITV, a BBC Scotland Radio interview and quite a lot of paper/website coverage, including in the national newspapers *The Scotsman* and *The Herald*.

The overwhelming reaction from the student body was positive. The negative comment quoted in the article from the EUSA website concerning the view that the dogs were being used purely to serve student need was very much a minority one, and was swiftly rebutted by many other student posts, who reminded the student writer that dogs also benefit from attention.

While we trust the best of *Therapy Today's* intentions went into covering this news event, let us hope that this kind of inaccuracy, which hides the multi-service initiatives that counsellors are often at the centre of, is a one-off.

Dr Jennifer Leeder
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Disparaging supervision

I can't let Scott D Miller's false characterisation of types of supervision other than his own as 'either administrative' or 'a kind of therapy for the therapist' go unchallenged (*The interview, Therapy Today*, May 2013). Dr Miller preceded his comments with 'Not to disparage the other type of supervision' but then goes on to do precisely this.

His comments about supervision bear no resemblance to my experience of being supervised in the UK over the past 20 years by a number of supervisors. All were clear about the difference between offering support to the counsellor in the context of supervision and offering therapy; none focused strongly on administrative issues, and all were able in different ways to 'stretch [you] beyond your current way of working'. Has Dr Miller read the works of Hawkins and Shohet, Proctor and others that have long influenced the teaching and practice of supervision in the UK? If he had he would see that supervision is a mature and diverse discipline that uses theoretical, structural and process models to fulfil its commonly agreed, supportive, developmental and normative functions.

Dr Miller may well have something to offer the supervision profession. However, to promote his own approach by misrepresenting the alternative positions is intellectually dishonest, and his interviewer should have challenged him on this.

Jamie Rance
MBACP (Snr Accred)

Sharing the joke

What made Freud laugh: an attachment perspective on laughter

Judith Kay Nelson
Routledge, 2012
232pp, £26.99
ISBN 978-0415998338
Reviewed by Mary Neave



Despite its title, this is not a book about humour; nor is it a psychoanalytic text. Nelson certainly does make use of Freud's writings on jokes, and the final chapter is about the transformative power of laughter in humour, comedy and wit. But this is essentially a book about the physical act of laughing itself, the many types of laughter, and its many meanings.

Nelson, an American clinical psychologist and attachment researcher, came to this study after spending many years researching crying and attachment. She discovered that there had been no research into what laughter contributes to the positive interactions between infant and caregiver. Infant research has shown that times of shared warmth and positive feeling between child and caregiver are of crucial importance for building a secure bond and for helping the child learn to regulate his or her feelings.

What is so impressive about this book is that it manages, within its 200-plus pages, to be comprehensive, detailed, lively and illustrated throughout with clinical material and family anecdotes as well as evidence from research.

The first part of the book is about types of laughter and theories about it as an attachment behaviour. I was interested to discover there are two major types of laughter, first identified by a 19th century French neurologist. Duchenne laughter is spontaneous involuntary laughter that suddenly erupts; non-Duchenne laughter is more low-key and conversational and can represent a very

diverse range of positive and negative feelings and meanings. It is also the one most often encountered in adult life; often we are not aware it has entered the conversational mix. It can sometimes be used in a bullying or cruel way.

The main body of the book is divided into three sections: on infant, child/adolescent and adult laughter. In each section I found much that was new and interesting. In the first section Nelson describes attachment theory and infant development with a special focus on laughter. Interestingly, she says that babies of eight months can use non-Duchenne laughter to show pleasure in what is going on (p64). In the following section, on children (who laugh more than any other age group), Nelson discusses the role of laughter in their development and how difficulties can affect this.

In both the child and adult sections there are chapters on laughter in the clinical hour, and how it can point to an interaction that is usually happening at an unconscious level. This is one of the key facts about laughter: that it is part of our non-verbal, intuitive ability to perceive and act without conscious thought. The contagious quality of laughter is because our bodies and minds react to its powerful unconscious stimulation.

This book has wide relevance – learning to be more aware of this aspect of non-verbal communication would be helpful for clinicians of all theoretical approaches. It is also fascinating to look in such close focus at a feature of human behaviour that is so rarely scrutinised. *Mary Neave is a psychodynamic counsellor*

A radical roars

Not a tame lion: writings on therapy in its social and political context

Nick Totton
PCCS Books, 2012
181pp, £16.99
ISBN 978-1906254483
Reviewed by Anne Gilbert



Written with passion and commitment, this volume is a collection of Nick Totton's writings over a period of years, exploring the relationship between therapy, politics and wider society. The author's main argument is that, to be effective, therapy cannot be risk-free.

The title is taken from the CS Lewis book *The Lion, the Witch and the Wardrobe*, and Aslan, the lion, who 'isn't safe but he's good'. This fittingly captures the unifying theme of this book, which is essentially about how the counselling/psychotherapy profession achieves a creative balance between safety and risk.

The book's four sections open with 'Personalisation and regulation', with chapters exploring the growing professionalisation of counselling and psychotherapy and the movement towards state regulation. Totton's opposition to state regulation is well known and, while not everyone would agree with his views, this section is both thought provoking and refreshing.

The next section covers the divergences between the various branches of therapy and their differing value bases. Totton argues in favour of pluralism, which accommodates both short-term, evidence-based practice and longer-term, self-exploratory psychotherapy without goals. Here he tackles issues such as boundaries, dependency and intimacy.

In the third section, 'Therapy in the world', Totton takes as his theme the inter-connection between politics and psychotherapy. He argues that all human activity is political, including psychotherapy, because it has very clear views on how we are and how we should be. I particularly enjoyed chapter 16, 'Can psychotherapy help make a better future?', which addresses issues such as conflict, trauma and eco-psychology, where psychotherapeutic ideas and practices are already contributing to wider societal wellbeing.

These themes are pursued into the final section – a short collection of writings on eco-psychology. The case studies in chapter 24 provide helpful practical examples from this emerging field.

While not agreeing with all of Totton's views, I greatly welcome this expression of radical polarity in psychotherapy today. The profession can only benefit from constructive, informed debate about these ideas and I would encourage all practitioners, and trainees, to read this book and engage with its arguments.

Anne Gilbert is a gestalt psychotherapist and supervisor

Groupwork and loss

Setting up and facilitating bereavement support groups

Dodie Graves
Jessica Kingsley
Publishers, 2012
160pp, £18.99
ISBN 978-1849052719
Reviewed by Trish Staples



Following on from her first book on the art of communicating with bereaved people, Dodie Graves has produced another readable guide, this time on setting up and running bereavement support groups in a range of different settings. An experienced bereavement services co-ordinator in a UK hospice, Graves is able to draw on a wealth of knowledge and insight gleaned from the many groups she and her colleagues have facilitated over the years.

The book's five chapters cover setting up a group, the different types of group, the facilitator's role, group dynamics, and the difficulties a group may encounter. Each chapter is illustrated with examples, suggestions, case studies and dialogue, all of which add depth to their content but also a sense that Graves is writing here about real people, real distress and real – sometimes very problematic – interactions. The appendices include templates for leaflets, evaluation and record keeping, and there is a

brief section listing references, further reading and other resources.

Graves acknowledges in the introduction that her book 'will disappoint those who are looking for a theoretical framework' (p15), and indeed the book may not appeal to experienced group leaders seeking more in-depth literature to develop their practice. It is, however, the perfect resource for practitioners who are considering setting up and facilitating a bereavement support group. Here you will find the comprehensive guidelines, information, tips, advice and resources you need, as well as very clear messages on the importance of good preparation and clear ground rules as the bedrock of ethical and safe practice.

Among the book's attractions are its messages about the perils and joys of facilitating these groups: 'Facilitating a group can be an adventure, fraught with dangers and perils for the unsuspecting, unprepared and unskilled,' Graves warns (p114); 'It can be gut wrenching to sit with those whose hearts are literally breaking with grief, but a hug and a kiss are not the solution and it might lead to misunderstanding' (p144); and the simple yet obvious, 'You may not be able to satisfy everyone in the group' (p153). These are things that no facilitator should ever forget.

Trish Staples is a counsellor/trainer and bereavement volunteer

REFERENCE:

1. Graves D. Talking with bereaved people: an approach for structured and sensitive communication. London: Jessica Kingsley Publishers; 2009.

Reflective writing

Transformation through journal writing

Jane Wood
Jessica Kingsley
Publishers, 2012
240pp, £15.99
ISBN 978-1849053471
Reviewed by Jeannie Wright



First, a declaration of interest: I am a life-long journal keeper, a writer on the back of anything that comes to hand and a strong proponent of the view that writing transforms. Surprisingly, given Jane Wood's long involvement in writing for reflective practice, I had not come across her work before. Our allied fields of practice – homoeopathy, shiatsu and other complementary therapies in her case and counselling and psychotherapy in mine – seem to inhabit separate silos. However we evidently share a passion for self-reflection through writing.

Among this book's gifts to readers are Jane Wood's three-line, poetic introductions to each chapter. Here is the one on page 210:

*'In her hands
the bunch of yellow daisies
brightens her smile.'*

They, and the illustrations, provide a kind of refreshment break as you work your way through the book.

Wood has tested all of the material with complementary therapies practitioners, and it shows. The instructions for the writing exercises are detailed and encouraging.

The examples of journal writing are rich and the reflections that follow each example would give even those who just don't 'get it' a way into reflective writing.

I started to imagine how I might go on a retreat for a few days and use the suggested exercises as a structure. There was certainly enough that was exciting and new for me to want to try it out.

This is a practical rather than a theoretical book, and intended for students, although it would be equally useful to more experienced practitioners. There are some gaps in the literature – on current research in adult learning and reflection, for example. I could live with these but some talking therapists might not want to make the necessary adjustments. Overall, in its 10 chapters and 235 pages, my feeling is that there is much here that could be adapted for our discipline. *Jeannie Wright is Director of Counselling and Psychotherapy Programmes at the University of Warwick*

Unburdening the soul

The psychology of feeling sorry: the weight of the soul

Peter Randall
Routledge, 2013
278pp, £25.99
ISBN 978-0415600477
Reviewed by John Eatock



Appropriately this book arrived on my desk on Shrove Tuesday, the traditional day

for people of the Christian faith to consider relieving themselves of the 'weight of the soul' by confessing their sins and receiving an assurance of forgiveness.

Peter Randall's book is a magisterial overview of current research and discussions of the way in which that very common human emotion of 'feeling sorry' is experienced. Time and again, having weighed the research evidence and with various caveats, Randall comes to the conclusion that religious faith and practice can contribute significantly to mental health and general wellbeing.

As the title implies, the focus is a consideration of every aspect of the emotion of 'feeling sorry'. The nine chapters begin with the stirrings of conscience in early childhood and the development of moral emotions. This is followed in chapters two and three with a discussion of interpersonal relationships and betrayal, and religious and spiritual development and the instinct for vengeance. Counsellors working with children and also ethicists will find a mine of thought-provoking information here.

Discussions of the impact of shame and guilt and remorse in the next two chapters are illustrated with some very pertinent case studies. Chapter five, on remorse and criminal offending was fascinating, especially the sections on the relevance of a conversion experience to the decisions reached by judges and their juries. This is expanded on in chapter six, which examines the influence of religion

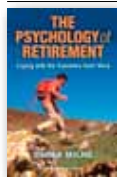
and spirituality on both victims and perpetrators. Forgiveness, with all its many facets, is explored in chapter seven and is placed alongside the possibilities, or otherwise, of reconciliation. Remorse, empathy and forgiveness as they relate both to victims and perpetrators are tremendously painful issues, and often the stuff of therapy, and chapter eight, similarly, contains revelations. Finally, Randall addresses that critical point at the end of life, and the difficulty of the final unburdening of the heaviness of the human heart – 'the weight of the soul', in the book's title.

This is a powerful book, a bountiful gathering up of research, and the work of a lifetime and 40 years of diligent practice. You will be returning to it many times. *John Eatock is former BACP Lead Advisor for Spiritual and Pastoral Care and Counselling*

Recipe for retirement

The psychology of retirement: coping with the transition from work

Derek Milne
Wiley-Blackwell, 2013
192pp, £19.99
ISBN 978-0470972663
Reviewed by Mary Russell



This book explicitly reframes retirement not as the retreat from the world of work but as a transition from paid employment to a new life phase, with new challenges and opportunities. Milne

makes the point that it is important to take the transition to retirement seriously. He estimates that approximately one quarter of people who retire will experience it as a stressful, complicated transition and the book is intended to provide a 'recipe' for managing this. The recipe becomes an acronym for the book's contents: Resources, Exercise, Coping strategies, Intellectual activities, Purpose and Engagement.

One problem with a recipe, however, lies with what it leaves out and the implication that, provided you follow the instructions, a successful dish (or retirement) will result. This leaves no room for shades of variation and difference and, for me, the book fails to acknowledge the complexity of the issues involved. For example, Milne ignores the possible origins of the vulnerabilities that render us more susceptible to the negative effects of retirement. Yet it is precisely the examination of these issues that may be very important after retirement, as previous defence strategies (displacement through work, for example) may no longer be available to us. Similarly, there is no mention of where we might find help to explore this stage in our life, from counsellors, coaches or support groups.

There is also very little exploration of cultural and ethnic differences in how people manage retirement. Case studies should have been drawn from a variety of ethnic groups, to better reflect our society. In the chapter on relationships there are no gay or lesbian case studies and the terms 'partnership' and 'marriage'

are used interchangeably, so that gay and lesbian couples are excluded.

The book does have strengths; by bringing together the various philosophical approaches, research findings and case study materials, it adds to the resources currently available on this topic, and could be useful to both counsellors and their clients, provided they are aware of its limitations. It is, however, likely to be most useful to the sort of person who finds clear structures and strategies (mainly related to CBT) helpful. *Mary Russell is an accredited counsellor working in private practice and adult education*

Unbounded lives

Broken bounds: contemporary reflections on the antisocial tendency

Christopher Reeves (ed)
Karnac, 2012

141pp, £15.99

ISBN 978-1780490373

Reviewed by Karen Minikin



This book brings together the series of lectures on the theme of 'the antisocial tendency' hosted in 2009–2010 by the Squiggle Foundation, an organisation set up to study and disseminate the work of Winnicott, with a particular emphasis on its application to practice. The contributors come from psychiatry, psychotherapy and social work. Their contributions here are thoughtful,

considered and politically and socially topical.

The lectures were intended to inform the wider public about how to think about the difficulties of antisocial experience and delinquency, as well as what needs to be done at a practical level. Some of the pieces help contextualise Winnicott's work as a product of his time but there is also ample illustration of the relevance of his writing today. Alongside the clear explanations, critiques of and discussions about Winnicott's work, the contributors write movingly about the lives of children and young people, the suffering and despair they encounter in their work, and the possibility of recovery, if the right help can be provided.

This book is a very 'real' read. By that I mean that the contributors write genuinely from the heart about the complexity of the social, political and psychological difficulties that litter the route towards meeting the needs of children and young people who have been deprived of adequate responsiveness and communication from their caregivers. The chapters are touching in their descriptions of how children and young people's antisocial presentations can provoke a hardening attitude in authority figures and organisations that, in turn, produce a similar response from the young people themselves. The contributors share the ways in which they have managed to break this cycle, both in their thinking and in how they work with their young clients.

The lectures were intended to appeal to a varied audience, and the style is both readable and accessible. This is an

informative, interesting and, I think, important book, with relevance to counsellors, psychotherapists and social workers, and also, potentially, to foster carers and adoptive parents of children with attachment difficulties.

Karen Minikin is a supervisor and psychotherapist in private practice in East Sussex

Insidious addiction

Understanding and treating sex addiction: a comprehensive guide

Paula Hall

Routledge, 2013

206pp, £19.99

ISBN 978-0415691918

Reviewed by Yvonne Farley



Many professionals disagree over whether 'sex addiction' really exists but, as the author of this dynamic book asserts, 'what really matters is its definition, not its name' (p9). Paula Hall presents a well-researched and thorough, evidence-based treatise on how to diagnose, treat, manage and recover from unwanted patterns of sexual behaviour that can corrupt, intimidate and destroy people – and those around them.

Hall specialises in sexual addiction and runs her own recovery course, and is thus extremely experienced and knowledgeable in the field. She presents her ideas clearly and cogently as she leads us assiduously through a field 'fraught with complex ethical and legal dilemmas' (p22), drawing in the latest

neuroscientific research, new theoretical models and a plethora of behavioural and experiential exercises.

Historically, sex addiction has been linked to trauma or to attachment injuries but Hall points also to the effects of new technology – access to the internet has resulted in an increasing number of clients who present with 'opportunity-induced addiction' (p27). Although this may seem too reductive – is opportunity really sufficient on its own? – it is reassuring that the thinking around sex addiction is developing and that there appears to be some movement towards updating sex education to include awareness of these emerging risks (p36).

The style of the writing is chatty and colloquial; for me this belies the profundity of experience and learning evident in this work but I can see that her intention was to make it feel fresh, accessible and inclusive. This does not excuse the pervasive grammatical and spelling errors, however, nor the incorrect placing of St Augustine in the third century, which mars the opening sentence of the introduction.

However, do not be put off by these details – this is a new, vibrant UK voice in a hitherto US-dominated field. This comprehensive book would be equally useful to therapists and their clients, or to anyone seeking to understand more about this subject. It does not shy away from the sometimes insidious complexities of sex addiction but it is also infused with compassion – and with hope. I recommend it heartily. *Yvonne Farley is a BACP and COSRT accredited relationship and psychosexual therapist*

From the Chair



Paving the way to the future

The role of BACP Chair is about putting in place the infrastructure to support future development, writes *Amanda Hawkins*

It's been 18 months since I started as Chair; sometimes it feels like only yesterday and at other times it feels as though I have been doing it forever. But half way through is a good time to pause for reflection.

We've got through registration, and the process of becoming registered is growing and maturing. At one point, at the beginning of my term, it still felt a long way away and there were times I couldn't believe that we would ever get there – but we did. Our challenge with this process now is to ensure that the standards stay high, and that being registered means something very real to our clients and the public – that it gives them a sense of quality and assurance.

Of course, going through the registration process has thrown up questions about the wide variation in our training, as well as the focus of our accreditation scheme. The onset of registration has changed the context and landscape we inhabit. Again, we need to pause and reflect and work out which way forward from this point. We have become a profession that is very public facing. It's time we looked at these issues and found solutions that work for us in this new landscape.

Our media profile as a profession has grown. On Saturday 25 May I found myself on Sky News, having been asked to comment about the bereavement processes of Drummer Lee Rigby's family. I really didn't want to have to comment on such issues, and certainly not in such tragic and awful circumstances. But it was good that the role of counselling was being

recognised and that counsellors are increasingly being regarded as an 'expert' service that can offer people very real help at such times of terrible grief and confusion. Over the last 18 months we have had the opportunity to comment in the media on many issues; this is another big step in the right direction, a sign that our public profile and respect for our professionalism are growing.

The international scene has become important to us at BACP, especially in the context of the development of online counselling. We can't rely on our own jurisdictional parameters any longer, when clients and their counsellors can be based thousands of miles apart, in different parts of the world. It forces us to negotiate and work with our sister organisations and fellow practitioners as an international community, to ensure both our own safety and the safety of our clients. It's becoming increasingly important to have a set of common international standards and there is much work to be done here. At least we have made a start.

I think what I have realised and learnt in my first 18 months as Chair is that I am one very small part of the construction that is our profession. I have had the luxury of being able to build on some very strong foundations laid down by some excellent previous

Chairs and Boards of Governors. I can only hope that the bricks I lay down will have relevance and strength and support the profession's continued growth in ways and directions that meet the needs of the public and clients we serve.

So what about the next 18 months? Apart from continuing to support and work with staff, members and relevant stakeholders to facilitate all the above, there are always areas to reflect on... it's a constant and ever-evolving process.

Inclusivity is another difficult but important issue for us. As a profession, we are predominantly white and female, and over the years that I have been involved I haven't seen this change very much, despite the best efforts of all involved. I was very interested in the Canadian Counselling and Psychotherapy Association's (CCPA) approach to ensuring their indigenous population is included. Aboriginal practitioners have their own chapter within the Association. The chapter works hard at making counselling available to their population in culturally sensitive ways that incorporate old traditions and new. The CCPA Board has also nominated one place that is always held by an aboriginal member, thereby ensuring that their expertise and opinions are heard throughout the whole organisation and community.

While our population here in the UK is very different, it did get me thinking about what more we can do to encourage a more inclusive representation of our profession at all levels. Here too there is so much to do and all of it is always important. ■

'What I have realised and learnt in my first 18 months as Chair is that I am one very small part of the construction that is our profession'

New logo for BACP registrants

BACP has created a new logo for members who have joined the Register. The logo is only available to BACP members who appear on the BACP Register for Counsellors & Psychotherapists. Members who are already on the Register, having transferred over or successfully completed the Certificate of Proficiency (CoP), can download their logo free from the members' area of the BACP website. The logo will carry their unique registration number.

The logo reflects the accreditation of the BACP Register by the Professional Standards Authority. BACP has also

updated its Advertising Policy. The policy states that registered members should use their unique logo on all advertising material, including websites, promotional leaflets, business cards and printed advertisements, to demonstrate to the public that they are legitimate and have achieved the required standard of training and experience to qualify to join the BACP Register.

There are different logos for registered members, registered accredited members and registered senior accredited members. The logos are all trademarked, which means they can only be used for the purposes



The logo for accredited members on the BACP Register

described in the revised and updated BACP Advertising Policy, and cannot be amended or changed in any way, other than size.

The *BACP Advertising Policy* also explains how registrants and members can describe themselves in promotional materials and correspondence, depending on their category of membership.

'This is another great benefit for BACP registered members. We urge all our members to take the necessary steps to join the Register as soon as possible,' said Sally Aldridge, BACP Registrar.

The BACP Advertising Policy – May 2013 can be downloaded free from www.bacp.co.uk. For a hard copy, call Customer Services on 01455 883300.

Numbers of BACP registrants continue to grow

BACP's Register is the first psychological therapists' register to be accredited under a new scheme set up by the Department of Health and administered by the Professional Standards Authority for Health and Social Care. BACP is in the process of assisting all practising BACP members to meet the requirements for entry onto the register. Once this process is complete, BACP will be advising anyone who is seeking therapy or employing a therapist to make sure that their counsellor or psychotherapist is on the BACP Register.

The numbers of BACP members who have transferred onto the BACP Register or who have successfully completed the Certificate of Proficiency (CoP) and are now eligible

to join the Register continue to grow steadily.

The CoP is an online case study-based assessment for BACP members who have not completed a BACP accredited course and/or are not BACP accredited and who wish to go onto the Register.

BACP is rolling out a national programme of CoP events where members can complete the assessment. Events have been held at nine venues to date, in London, the North, the Midlands and the South West. The pass rate so far has been 90 per cent and the feedback suggests the assessment is as close to real practice as it could be. New dates and venues are being organised each month (for details, visit www.bacpregister.org.uk). Members should check the itinerary and book early,

as places are limited. And please be sure to turn up so a valuable space isn't wasted.

BACP is also running special CoP assessments on-site for BACP accredited services who have a large number of counsellors.

To join the Register, please follow these simple steps.

Accredited members

Go to the prospective registrants' area of www.bacpregister.org.uk and sign up through the fully electronic process. Don't forget to renew your registration when you renew your membership.

MBACP who've completed an accredited course

Go to the prospective registrants' area of www.bacpregister.org.uk and sign up through the

fully electronic process. (You may be asked to upload a certificate, which we will then need to verify before you proceed.)

MBACP Certificate of Proficiency (CoP) holders

Go to the prospective registrants' area of www.bacpregister.org.uk and sign up through the fully electronic process.

MBACP who have not completed a BACP accredited course and/or are not BACP accredited

If you wish to go onto the Register you will need to take the BACP Certificate of Proficiency (CoP).

If you need any help, please contact 01455 883300, email enquiries@bacp.co.uk or visit www.bacpregister.org.uk/faq

BACP comments on *DSM-5*

Clinical diagnoses can be useful but reducing complex human experiences to a checklist of symptoms may not be helpful to people with common mental health problems, BACP has said in a statement on the publication by the American Psychiatric Association of the latest, fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

In its statement, released on 22 May, BACP warns that classifying normal human behaviour into

mental disorders ‘risks over-medicalising common issues and may lead to an increase in prescribing at a time when our drugs bill is higher than ever before and when we know that patients often want counselling rather than drugs’.

‘Instead of medication, many people with anxiety and depression could benefit more from counselling,’ said BACP Chair Amanda Hawkins.

The statement also stresses the importance of treating the whole person, not just the diagnosis. ‘Taking a

whole person approach and considering the underlying issues can help people make sense of their lives and build resilience,’ BACP says. It also sounds a note of warning about the inclusion in the *DSM-5* of a number of new diagnoses that critics have said come within the spectrum of ordinary human experience, such as grief, shyness and temper tantrums in children.

‘This new publication raises a serious question about the labelling of

specific behaviours and the treatment of mental health,’ Amanda Hawkins said. ‘Broadening diagnoses suggests that a wider range of conditions will be immediately treated with drug therapy, when in fact counselling should be the first treatment option for many of them. If a client is experiencing depression following a bereavement for example, this is a natural reaction when dealing with loss and can be treated with talking therapy, as opposed to medication.’

Supervision coverage in *Therapy Today*

Therapy Today’s Associate Editor for Supervision, Bernice Sorensen, has stepped down after five years in the position.

‘Bernice has made an invaluable contribution to the journal,’ Sarah Browne said.

Therapy Today is taking the opportunity to review how it covers supervision in its pages. It plans to introduce a new, monthly column that will look in depth at issues arising in and relevant to supervisors and the supervision experience.

Anyone interested in writing the new column should contact the Editor, Sarah Browne, by emailing sarah.browne@baccp.co.uk

Anyone wishing to contribute longer articles on supervision issues should in future email their article to the Editor, at therapytoday@baccp.co.uk

APSCC has new Executive

APSCC, the BACP Association for Pastoral and Spiritual Care and Counselling, has announced its new Executive Committee. The Chair is Melody Cranbourne-Rosser. Executive Committee members are Gillie Jenkinson, Valda Swinton, Manda Moyo-Ncube and Kathryn Kinmond.

Along with Salma Khalid, BACP Lead Advisor for Spiritual and Pastoral Care, the Executive team will continue to develop and promote initiatives and projects relevant to the division and its members.

Members of the Executive will be at the next BACP Making Connections event, in Edinburgh on 9 July, where members and potential members can meet them and find out more about the division and its work.

Two of the current BACP Professional Development Days (PDDs) have a focus on topics linked to spirituality. Gillie Jenkinson is leading two one-day workshops

on working with former members of abusive groups and relationships, in Manchester and Bristol. Guy Harrison is leading two workshops on pastoral care in counselling and psychotherapy, in Edinburgh and Bristol. For details of dates and venues and to register, please visit the BACP CPD Directory at www.baccp.co.uk/cpd

APSCC has three Counselling with Spirit (CwS) networking groups where members interested in spirituality can come together with colleagues to discuss ways to integrate spirituality into practice and the many ways in which spirituality can be expressed and experienced. Others are being planned for launch later this year. The CwS groups meet on 21 June (South Wales), 21 July (East Midlands) and 14 September (West Midlands).

For further information, please visit the APSCC website: www.apscc.org.uk

CYP members to vote on new Executive

Five BACP Children & Young People members have now been nominated for one elected position on the BACP Children & Young People Executive Committee. Their election addresses are printed in the June issue of the *BACP Children & Young People* journal, which also includes a ballot paper insert.

BACP Children & Young People members will have until 9 July to choose a candidate and to complete and return the ballot paper. The successful applicant will be announced in the September journal.

The June issue of *BACP Children & Young People* includes articles on cultural competence training for young people’s counsellors, setting up a counselling service for third-culture children, compassion in counselling and altruism.

Research methods for trainers

Places are still available on a unique series of four CPD workshops on research methods that have been designed to meet the professional development needs of experienced trainers and lecturers.

The 'training the trainer' workshops are intended to help trainers and lecturers develop their skills in teaching research to counselling and psychotherapy students. The workshops are interlinked but can be taken singly or

together. They take place at Shelter Training in London on 24 June and 21 October 2013 and 10 March and 20 October 2014. The workshop leaders are Professors Robert Elliot, Sue Wheeler and John McLeod. All three are experienced academics who have played a leading role in developing counselling and psychotherapy research.

The workshop topics are as follows:

- Workshop 1 (24 June 2013) – introducing research into the curriculum, overcoming

resistance and teaching students how to set up process-outcome monitoring

- Workshop 2 (21 October 2013) – doing good qualitative research
- Workshop 3 (10 March, 2014) – case study research
- Workshop 4 (20 October 2014) – finding research questions and supervising students.

Prices start from £85 per workshop for BACP members. For more information and to enrol, visit www.bacp.co.uk/events

Professional development workshops

Pastoral care and coaching are just two of the topics of the 2013 BACP programme of Professional Development Days (PDDs).

PDDs were first introduced by BACP Events in 2012 and have been very popular. Nearly 50 of these one-day specialist workshops have been run, offering practical learning opportunities on a wide range of topics.

The days are designed to provide participants with the opportunity to gain valuable CPD. They are led by expert tutors and limited to a maximum of 25 participants.

Full details of the programme can be found at www.bacp.co.uk/events. Topics in the 2013 programme include 'Pastoral care in counselling and psychotherapy: the challenges and opportunities of working in a dual role', led by Guy Harrison, which runs on 8 July in Edinburgh and 24 September in Bristol, and 'An introduction to building a coaching approach', led by Carolyn Mumby, on 2 July in Southampton and 16 September in London.

Further PDD topics and dates are planned for October onwards. 'Our plan is to run a PDD programme continuously throughout the year. We'll repeat the more popular titles already in the programme and also develop new, innovative and relevant titles,' said Richard Smith, BACP Event Development Manager.

BACP Universities & Colleges conference

The BACP Universities & Colleges conference 2013 takes place Monday 24 June to Wednesday 26 June at Sheffield University.

The conference, titled 'A world of difference – embrace and respond', offers a wealth of presentations and workshops of interest to counsellors working in further and higher education settings. On Tuesday 25 June keynote speaker

Dr Keon West will deliver a presentation on 'Diversity, prejudice and privilege post-2000', which will explore current research on diversity, difference, prejudice and privilege in contemporary society.

On Wednesday 26 June Salma Khalid, BACP Lead Advisor for Spiritual and Pastoral Care, will deliver a paper on 'In search of the psyche: lost in translation',

exploring the challenges that practitioners face when working with spiritual and faith issues in a multicultural society.

Details of the complete conference programme of workshops and presentations can be found on the BACP website at www.bacp.co.uk/events, where you can also register, or call Customer Services on 01455 883300 or email enquiries@bacp.co.uk

BACP Coaching Executive seeks new member

BACP Coaching is seeking a new member to join its Executive Committee to replace Dr Trish Turner, Executive Specialist for Networks, who is stepping down. Laura Bennett, BACP Lead Advisor for Coaching, is also leaving.

'The BACP Coaching Executive extends its greatest appreciation to both: Trish Turner

for supporting the local network groups to thrive and flourish, and Laura Bennett for embedding coaching into the internal BACP environment,' said Jo Birch, Chair of BACP Coaching. 'I'm so sorry to see them go. Trish and Laura have contributed a fantastic amount to the growth of the division. I'm so proud to have worked alongside them both.'

The Executive is seeking someone to take on the role of Executive Specialist for Networks up until 14 July. For details of how to apply, see www.bacpcoaching.co.uk/opportunities.php. To apply or to arrange an informal conversation, please email Jo Birch at jo@jobirch.co.uk. Details about the Lead Advisor position will be released shortly.

Research/Professional standards



BACP Research Foundation

The BACP Research Foundation is supporting frontline practitioners and clients by developing a much-needed evidence base

By Nancy Rowland

As reported in last month's BACP News, the BACP Research Foundation has recently announced its first distribution of funds to a research study. The Foundation has commissioned the Centre for Psychological Services Research at Sheffield University to conduct a randomised controlled trial comparing Counselling for Depression (CfD) and CBT.

The Sheffield PRaCTICED trial (see pp18–20) is the Foundation's first major commission and will, we intend, be followed by many others to add to the evidence base for counselling and psychotherapy interventions. This particular study is especially significant as it will test the effectiveness of an approach that, if successful, would mean clients who present in primary care with depression have a genuine choice of evidence-based therapies.

In the words of BACP Chair Amanda Hawkins: 'NHS commissioners expect hard evidence of effectiveness, and we owe it to our clients to research it. It is fantastic news that the Foundation has made its first investment in such a bold but necessary piece of work.'

The BACP Research Foundation is unique in its focus on promoting and funding innovative research into the efficacy and effectiveness of counselling and psychotherapy.

Conducting research into counselling and psychotherapy is the only way to establish how practitioners can best provide ethical and effective therapy. It's also important to assess the cost effectiveness of therapy: apart from the emotional toll of mental health problems

on individuals and families, the cost to society of picking up the pieces is enormous. The Research Foundation aims to support studies that will evaluate how counselling can promote resilience and prevent chronic mental health problems by helping people to manage their mental health problems in a better way.

Research into counselling and psychotherapy is currently woefully underfunded, as is all mental health-related research: some £90 million is spent each year on mental health research in the UK, compared with £1.6 billion on health-related, predominantly medical research.¹ The priority of the BACP Research Foundation is to support research that is directly relevant to practice. Our interest is in what works – what will make a real difference to practitioners and their clients, and how to improve counselling and psychotherapy services.

The Foundation is deliberately and specifically independent from BACP; the £455,000 for the Sheffield PRaCTICED study has been financed by BACP as a pump-priming investment. This clear separation of the two bodies is important because robust research starts from a position of equipoise and it has to be seen to be completely independent of any organisation that might have a vested interest in its outcomes.

The Foundation's decisions about which studies to fund are taken by its independent Scientific Committee, chaired by Professor Else Guthrie, Consultant in Psychological Medicine at Manchester Royal Infirmary and Honorary Professor at the University of Manchester. The full list of committee members is

on the Foundation's website: please visit www.bacpresearchfoundation.org.uk

Else has kindly agreed to answer some brief questions for *Therapy Today* about the Foundation, its work and its vision for the future.

Therapy Today: Why did you take on the role of Chair of the Foundation's Scientific Committee?

Else: Because it seemed an exciting and novel project. It's quite a bold move on behalf of BACP to prioritise research into counselling. It shows a commitment from the organisation to expand and develop the scientific base, which can only be a positive thing. I would also like to thank Nancy Rowland for her commitment to this project as, without her drive, enthusiasm and tenacity, the Foundation would not have been formed.

TT: What are your views on the state of counselling and psychotherapy research generally today?

Else: It's a tough old world as far as research funding is concerned. All research on psychological treatments relies on funding from either government or charities, which means competition is fierce, and resources are relatively scarce. Most psychotherapies and counselling are playing catch-up with CBT, which has developed quite a large evidence base and is in a strong position to access research monies. Of course, far more funding goes into research into pharmacological treatments, via the powerful pharmaceutical industry, and it's difficult to produce high quality work without adequate funding. We are in an age of austerity, where

many people are seeing their benefits cut and there is an increasing pressure on public services. I am mindful therefore of the current environment and the scarcity of even basic social and medical care. If counselling and/or psychotherapy are to be delivered by the NHS, it must bring about benefit for people. It is reasonable that funders expect evidence of benefit and this should be provided. I applaud BACP for its commitment to research and its recognition that the evidence base regarding counselling and psychotherapy needs to improve.

TT: What do you think should be the Foundation's priorities for research topics?

Else: The main priority has been the funding of the Sheffield CfD trial of counselling in primary care, which is being carried out by highly respected, independent researchers following a rigorous tendering process. Evaluating the efficacy/effectiveness of counselling is a key area at the moment. More generally, I would also like to see the Foundation supporting smaller innovative research projects, the kind of projects that would be unlikely to be funded by government bodies.

Nancy Rowland is BACP Director of Research, Policy and Professional Practice and a member of the BACP Research Foundation Scientific Committee.

Reference

1. UK Clinical Research Collaboration. UK health research analysis 2009/10. London: UK Clinical Research Collaboration; 2012. <http://www.ukcrc.org/researchcoordination/healthresearchanalysis/ukanalysis/>

Newly accredited counsellors/ psychotherapists

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

Jane Anghelatos
Vicky Ashraf
Laura Baines
Kate Barnes
Ursula Barnes
Lisa Berg
Mina Blair
Aidan Bond
Bernadette Boyle
Ian Bradshaw
Geoff Britton
Melanie Broadley
Anne Brown
Karen Brown
Lynn Campbell
Susan Channing
Justine Colley
Debbie Dawson
Emily Deakin
Teresa Debney
Johanna Dickie
Angela Dierks
Susan Draper-Todkill
Louisa DuBarry-Hennessy
Justin Duwe
Susan Egan
Reyad El-Imlahi
Ellie Enston
Helen Fairhurst
Karen Ford
Philomena Forsyth
Linda Fox
Jaine Fraser
Norma Gardner
Della Gawthorpe
Jacqueline Gibson
Gillian Gibson
Paula Gibson
Georgina Greenway
Tracy Harbage
David Hargreaves
Kathryn Hawkins
Margaret Heap
Annie Heining
Angela Hoey
Patricia Holliday
Tina Holt
Christine Hopfgarten
Henrietta Hutton-Potts
Sarah Jegou
Sinclair Jenkins
Mary Jones

Sheila Kelly
Debbie Keys
Denise Knowles
Justin Lee
Andrea Lucas
Jacqueline Mallon
Gillian Marsh
Vivien Marsh
Jane Martin
Peter McCammon
Sarah McCartney
Mandy McDermott
Sharon McIntyre
Anne McLeod
Alan McNaughton
Colin McWhirter
Yolanda Medina
Teresa Moloney
Laura Morris
Sally Mortimer
Nigel Nicholas
Mona Noblett
Charlotte O'Dell
Susan Oakley
Norma Patterson
Elishka Penfold
Tim Poole
Emma Raymode
Annette Rushton
Michelle Seabrook
Rundeep Sembi
Philippa Standley
Rachel Stephens
Sylvia Sterling
Amanda Stewart-Harries
Phillip Stone
Bill Swindlehurst
Catherine Swinhoe
Kim Synclair
Andy Taylor
Caz Taylor
Stephen Thomas
Heather Tilley
Dawn Tinning
Jenny Trainor
Chris Walsh
Sarah Williams
Jenny Willsher
Rachael Wright
Duane Yon

Newly senior accredited counsellors/ psychotherapists

Michael Bryant
Mervyn Clemmitt
Max Eames
Helen Greenaway

Colleen Long
Linda McCartney
Claire Moor
Sonya Steller

Newly senior accredited supervisor of individuals

Anthony Wynne-Jones

Newly accredited counselling/psychotherapy services

- Community Counselling (North Yorkshire) Ltd (formerly Ryedale Counselling Service)
- Youthline Ltd
- Rape & Sexual Abuse Support Centre (Rape Crisis South London)

Successful service re-accreditations

- Open Door Youth Counselling Service
- Aston University Counselling Service

Members whose accreditation has been reinstated

Lin Gates
Phil Kenny
Helena Keogh-Stevens
Catherine Lawson
Sandra McDermott
Susan Widlake
Elizabeth Wood

Members not renewing accreditation

Annick Arjol
Pamela Ashford
Ellen Davis
Susan Flahey
Jane Haslam
Anna Miniham
Janet Needham Jackson
Gill Pearce
Elisabeth Raymond
Lisa Rodbourn
Louise Seear
Julie Spencer-Purvis
Deborah Toksvig
Glynis Unwin

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

BACP Annual Research Conference

Over 180 delegates attended on each of the two days of the BACP 19th Annual Research Conference on 10–11 May.

The conference, ‘Synergy in Counselling and Psychotherapy Research’, was co-hosted with the Irish Association for Counselling and Psychotherapy (IACP).

The event started with a pre-conference workshop led by Michael Lambert, Professor of Psychology at Brigham Young University, on ‘How to use clinical support tools to enhance counseling outcomes’. The workshop encouraged delegates to question their intuition regarding a client’s progress.

Professor Lambert opened the first day’s proceedings with a keynote presentation following on the theme of the pre-conference workshop and titled ‘How to double client outcomes in 18 seconds: using mental health vital signs

feedback and problem-solving tools’. He demonstrated how therapists are so optimistic about their effects on clients that they overlook negatively responding clients, and suggested that a simple measure of mental health functioning, along with knowledge of typical patterns of change, enables therapists to focus their attention on negative treatment responders, to the benefit of these patients.

On the second day the conference opened with a thought-provoking keynote presentation by Professor Roz Shafran titled ‘Psychotherapy for perfectionism: research and clinical practice’. Professor Shafran holds the Charlie Waller Chair of Evidence-based Psychological Treatment at the University of Reading. In her presentation she discussed the issue of perfectionism and its

association with a variety of mental health problems. She provided practical clinical information for counsellors and psychotherapists who come across perfectionism in their practice and made us all question to what extent we are perfectionists.

The papers, symposia, workshops and posters were of a high standard, and offered a mixture of methodologies and a range of topics. These included culture and race, training, body image and stigma, relational depth, children and young people, outcome measurement and supervision.

The friendly, welcoming and encouraging environment of the conference was evident throughout, with new researchers presenting alongside renowned experts in the field.

The research team and BACP would like to thank

everybody involved for making the conference such a great success. We appreciate your continued support, and would like to say a special thank you to those who travelled far to be with us.

Abstracts from this year’s conference are available at www.bacp.co.uk/research/conf_archive/2012.php

We are now inviting papers for the BACP 20th Annual Research Conference, ‘Researching the special relationship’, which will be co-hosted with the American Counseling Association. The conference will take place on 16–17 May 2014 (venue to be confirmed). For more details about the venue or to register interest as a delegate, email katy.hobday@bacp.co.uk

The deadline for abstracts is Friday 9 November 2013. For further details about submitting an abstract, email angela.couchman@bacp.co.uk

New seedcorn grants available

BACP’s research strategy aims to help build research capacity in counselling and psychotherapy. This directly links to providing seedcorn funding to BACP members to support them in undertaking a small research project.

This year the BACP Board of Governors has approved funding for seedcorn grants for research projects in three separate categories:

- any area relevant to counselling and psychotherapy (deadline 8 November 2013)
- specific to counselling children and young people (deadline 27 September 2013)

- specific to counselling for older people (27 September 2013).

Each award is worth £5,000. The research could be a pilot project that may lead to a larger study in the future, or a small study that can be undertaken within a budget of £5,000. Any BACP member is eligible to apply and BACP is especially keen to encourage research proposals from practitioners.

For further details about applying, see www.bacp.co.uk/research/resources/seedcorn.php or contact Dr Jo Pybis on 07850 203151 or email jo.pybis@bacp.co.uk

BACP research surgery

Do you need to talk to someone about a research project or research dilemma in counselling and psychotherapy? The BACP Research department holds a regular research surgery to support members who do not have access to research supervision and have a research dilemma, question or problem.

The research surgery sessions are via telephone with Andy Hill (Head of Research) and Jo Pybis (Research Facilitator). If you would like to book a 30-minute session, they are offered throughout the

year and are available to any BACP member, whether you are new to research or an experienced researcher.

The next surgeries are on Wednesday 26 June and Wednesday 24 July. To book a session, contact Stella Nichols in advance: email stella.nichols@bacp.co.uk or telephone 01455 883372. You will need to supply your question and a telephone number where you can be contacted. BACP will call you up to five minutes before the agreed scheduled time for your slot. The slots are limited so please book early to avoid disappointment.

Around the Parliaments

Her Majesty the Queen set out the Government's legislative programme for the 2013–14 session in the Queen's Speech on 8 May. The 20 proposed pieces of legislation include Bills on care and crime, and nine further areas for future attention.

Mental health was the subject of a parliamentary debate on 16 May, when MPs from all political parties raised a wide range of issues (see below). In addition, MPs have tabled several questions about mental health. Prisoners, body image, debt, workplace and young people have all been subjects raised with Health Ministers. Labour MP Chris Ruane continued his prolific questioning of

the Government around therapy, asking about treatment for patients who have not yet developed a mental illness but are in danger of developing a mental illness in the future. Replying for the Government, Public Health Minister Anna Soubry said that in 2012 IAPT services treated 43,280 patients who were below clinical caseness at assessment – the equivalent to just below 12 per cent of total treatment completers.

BACP has also been in touch with MPs in the past month. Continuing its work to promote school-based counselling, BACP is pressing the Liberal Democrats to deliver on the motion passed at their 2011 Autumn

Conference that pledged: 'England has some counselling available to students, but in the other three nations of the United Kingdom counselling is or will shortly be available in every post-primary school. Schools in England should make the same commitment.'

BACP has also promoted counselling in the workplace with the Shadow Work and Pensions Minister Ian Austin MP after he raised the issue of support for people suffering from mental health issues in the workplace and how they are encouraged to seek treatment.

BACP also submitted written evidence to the Health Committee's Inquiry into the Management of Long-Term Conditions

(LTCs). BACP's response focused on the interaction between mental health conditions and long-term physical health conditions and the use of psychological therapies to ameliorate the impact of psycho-bio-social problems.

Over in the Northern Ireland Assembly, counselling has been the subject of Parliamentary debate, with questions about counselling for nursing home residents and for prison staff. On the subject of dementia, the Government came in for criticism from the SLDP, with Health Spokesperson Conall McDevitt MLA suggesting there are 'concerns about the Government's willingness and ability to properly deal with this disease'.

MPs debate mental health

On 16 May MPs took part in a House of Commons backbench debate on mental health. This followed last June's historic debate on the same subject where many MPs openly discussed their own experiences of dealing with mental illness.

In advance of the May debate, BACP prepared a briefing for MPs who were expected to contribute, outlining BACP's positions on the IAPT programme, school-based counselling, Children and Young People's IAPT, mental health and older people and NICE guidelines and evidence.

The debate covered a wide range of topics. Former Care Minister Paul Burstow (Lib Dem) focused on the

importance of parity of esteem between physical and mental health. There was also discussion about reducing the stigma attached to mental ill health and improving services for people from BME communities, those in the criminal justice system and in the armed forces and those with severe conditions such as schizophrenia.

Other issues raised included access to employment for people with mental ill health and work capability assessments. The debate also covered the role of local authorities in delivering public health.

A video of the debate can be seen at www.parliament.live/tv/Main/Player.aspx?meetingId=13101&st=11:33:49

New mental health commission

Liberal thinktank CentreForum has launched a 12-month mental health commission. The commission will be chaired by former Care Minister Paul Burstow MP.

Led by experts from across the sector, the commission will examine the progress made by the Coalition Government's mental health strategy in ensuring parity of esteem between physical and mental health. It will present its findings to the Government, NHS and local government commissioners, providers and health and care professionals in 2014.

Welcoming the launch of the commission, Paul Burstow said: 'Placing mental health on a par with physical health, in training,

in commissioning, across our public services and beyond, is essential to improving people's wellbeing and delivering significant improvements in the way our health services work.

'I look forward to working with a distinguished team of commission members to offer a practical and thoughtful agenda of action in the next parliament and beyond.'

The Commission has published a call for evidence from all sections of the mental health community.

BACP has welcomed the launch of the Commission and will be looking to engage with it and contribute to its evidence-gathering exercise.

ESA found in breach of Equality Act

Three judges have ruled that the procedure currently used by the Department for Work and Pensions (DWP) to decide whether unemployed claimants are eligible for Employment and Support Allowance (ESA) is in breach of the Equality Act 2010.

The judgment, which was made public at a High Court hearing, is the result of a judicial review brought by two anonymous claimants with mental health problems.

The charities Rethink Mental Illness, Mind and the National Autistic Society supported their case with evidence from the experiences of their members and supporters.

The case centred on the process used by DWP officials to gather evidence for the controversial Work Capability Assessment (WCA), which determines whether someone is fit for work. The judges found that the current

procedure for the WCA puts some groups at a substantial disadvantage because it relies on the ability of the applicant to obtain information to support their claim from their GP and social worker. Providing this information is not mandatory but it can help a claim.

The judges said this put people with mental health problems, learning disabilities and autism at a disadvantage as they may find it more

difficult to obtain this information, and that the DWP was in breach of its duty to make 'reasonable adjustments' in recognition of applicants' disabilities, under the Equality Act 2010. They said the DWP must do more to ensure this sort of evidence is collected and taken into account for all applicants.

The Department for Work and Pensions has said it disagrees with the ruling and will appeal.

Sanction compliance

Linda Saltwell

Reference no 530430

Brighton BN1

BACP received a submission which verified that the requirements of the sanction have been met. As such, the sanction reported in the November 2012 edition of this journal has been lifted. The case is now closed.

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

Re-entry to membership

Pennie Aston

Reference no 699102

London N3 3DR

Ms Aston submitted an application for membership which was considered under Article 12.3 of the Memorandum & Articles of Association, her withdrawal of membership having been previously reported in the November 2010 edition of *Therapy Today*. BACP was satisfied that Ms Aston had sufficiently demonstrated her learning to warrant acceptance of her re-entry

into membership, subject to conditions.

BACP Professional Conduct Hearing

Findings, decision and sanction

Nigel Summerton

Reference no 542072

Plymouth PL2

The complaint against the above individual member was heard under BACP's Professional Conduct Procedure 2010 and the Professional Conduct Panel considered the alleged breaches of the *BACP Ethical Framework for Good Practice in Counselling and Psychotherapy*.

The Panel made a number of findings and it was unanimous in its decision of finding professional malpractice in that Mr Summerton failed to provide an adequate professional service on the grounds that he entered into a personal and sexual relationship with Ms B at a time when he was her supervisor, avoided taking the issue to supervision and continued with this dual relationship for three months against his better judgment.

Mitigation

Mr Summerton gave honest answers and tried fully to assist the Panel. He showed contrition in the way he presented himself and did not make excuses for his conduct. Over the two years that have elapsed since the events giving rise to this complaint, Mr Summerton has reflected on the issues, acknowledged his errors of judgment, cooperated in trying to resolve the issues locally with organisation A, increased his supervision sessions and made the decision not to take any new clients in the period when he was the subject of this complaint. He provided a detailed report from his supervisor, which confirms he has used supervision to think deeply about and learn from the issues giving rise to this complaint. His supervisor states that he is a thoughtful, experienced and competent practitioner who offers a compassionate and ethical counselling service to a wide range of clients. The Panel was satisfied on the evidence of both Mr Summerton and the written evidence of Ms B that there was no

abuse or exploitation and the relationship with Ms B was entered into by consenting adults and is continuing. There was no evidence that damage has been caused to any of Ms B's clients or to organisation A as a result of Mr Summerton's dual relationship with her between October and December 2010.

Sanction

The Panel considered the full range of sanctions available to it and what would be fair and proportionate in the unique circumstances of this case, where it found that the personal and sexual relationship was consensual and non-predatory and Mr Summerton had made an isolated error of judgment. After very careful consideration, the Professional Conduct Panel decided that Mr Summerton had shown sufficient learning and, in the particular circumstances of this case, it was not appropriate to impose a sanction.

Full details of the decision can be found at http://www.bacp.co.uk/prof_conduct/notices/hearings.php