Therapy Today

For counselling and psychotherapy professionals

May 2013
Vol. 24 / Issue 4
www.therapytoday.net

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Pre-trial therapy

Working with cult survivors

When parents aren't good-enough

May 2013
Volume 24
Issue 4

Therapy Today is published by the British Association for Counselling and Psychotherapy
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ISSN: 1748-7846

Ten issues of *Therapy Today* are mailed free of charge to every BACP member between 15–20 of each month. There are no issues in January and August.

Buying the journal
Ten issues: £75 per annum (UK); £94 per annum (overseas). Single copies: £8.50 each (UK); £13.50 (overseas). Back copies of hard copy articles: £2.75 each. Visit TherapyToday.net to buy articles, e-issues or access the e-library dating back to September 2005.

Contributions
Therapy Today welcomes feedback, original articles and suggestions for features. For authors' guidelines see
W: www.therapytoday.net
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Advertising deadline
2pm on 19 June for the July 2013 issue.

Circulation figure
38,579 (from 1 January 2012 to 31 December 2012).

ABC

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British Association for
Counselling & Psychotherapy

The British Association for Counselling and Psychotherapy aims to:
- Promote the understanding and awareness of counselling and psychotherapy throughout society
- Increase the availability of trained and supervised counsellors
- Maintain and raise standards of training and practice
- Provide support for counsellors and those using counselling skills, and opportunities for their continual professional development
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Registered charity 298361

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- BACP Workplace.

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Sarah Browne
Editor

I am grateful to Peter Jenkins for guiding us through the complex area of pre-trial therapy, an area that we will surely be hearing much more about given the number of arrests of ageing celebrities currently being made for historic sexual abuse following Operation Yewtree. As Peter explains, pre-trial therapy is viewed in the criminal justice system as problematic because of its potential to 'contaminate' evidence. Despite there being clear guidance on pre-trial therapy for child and adult witnesses, in practice there seems to be much confusion about this. For example, in the recent tragic case of Frances Andrade who killed herself during the trial of her former music teacher, Andrade was allegedly warned by the police against having therapy even though she was clearly a reluctant and vulnerable witness – her husband has said that she had been completely distraught at the idea of the past being churned up.

In many cases, Peter writes, there is a lack of awareness even among therapists as to the specific requirements of pre-trial therapy. One mother of a six-year-old boy who was having nightmares and trouble sleeping was told by the police that her son could have counselling if he was really 'falling apart' prior to the trial. When she tried to engage a counsellor to work with him, however, they all refused saying that the police would not like it.

From the therapist's point of view there is the legal context of the therapy to consider, not least the issue of confidentiality – or, rather, the lack of it. Not only may the police and Crown Prosecution Service need to be kept closely informed but both the prosecution and defence solicitors have access to the therapist's records. However difficult and alien this work may be to counsellors, it would seem also to be terribly important if the voices of victims are to come to the fore.

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Time to Change misses targets

The Time to Change anti-stigma campaign has failed to convince the public of the effectiveness of psychotherapy to treat mental health problems.

The four-year Time to Change programme was launched in England 2007 with £16 million from the Big Lottery Fund and £4.5 million from Comic Relief.

It also received funding and support from the Department of Health. Its aims were to measurably increase public awareness of mental health and decrease discrimination reported by people with mental health problems.

But the evaluation of its social marketing campaign strand found that, while there was an increase in the numbers of people agreeing that 'psychotherapy can be an effective treatment for mental health problems' each time there was a media publicity 'burst', overall levels of agreement dropped over the period of activity.

Evaluations of all the strands of the programme were published in a special issue of the *British Journal of Psychiatry* in April. These found that Time to Change failed to achieve its target five per cent positive shift in public attitudes towards people with mental health problems and five per cent reduction in discrimination by 2012. There was no significant improvement in public knowledge; some initial improvement in public attitudes dropped back after 2009 and, despite some significant improvement in public intended behaviour there was no improvement in reported behaviour.

Service users reported a small reduction in discrimination from family, friends and in their social life, but no improvement in the attitudes and behaviours of mental health practitioners, or the police or housing, education and other public sector provision. Training medical students achieved only short-term improvement in their attitudes (less than six months).

Genetics and outcomes

A research team based at the University of Texas at Austin is to carry out a study into how genetic variation may influence outcomes from psychotherapy among adults with depression.

The study will use saliva samples to document connections between participants' genetic make-up and change in depression symptoms following online psychotherapy. The researchers believe the genes that influence serotonin may have a significant effect on how people respond to psychotherapy, as may genes that make people more sensitive to positive environmental changes.

The hope is that these kinds of studies in the emerging field of therapygenetics will eventually lead to the possibility of tailoring psychotherapeutic treatments for depression to match an individual's genome.

Cuts to Deaf people's therapy

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Deaf people in some parts of England may be denied therapy because of cuts in funding, the Deaf charity SignHealth has warned.

SignHealth's BSL Healthy Minds service employs psychological wellbeing practitioners (PWPs) who are fluent in British Sign Language (BSL) to provide one-to-one psychological therapy for Deaf people. SignHealth says that BSL Healthy Minds is having to make redundant some of their Deaf BSL therapists in the South Central and North West regions because Clinical Commissioning Groups have withdrawn funding from the service. In the North West, BSL Healthy Minds will only be able to offer treatment to half the 200 Deaf people currently using their service.

'Just as the Deaf community are becoming aware of the service, it is being cut. Deaf people will not get the therapy they need in a language they understand,' SignHealth Chief Executive Steve Powell said.

Assisted suicide poll

Over two thirds of people who identify themselves as religious support assisted suicide, a YouGov poll shows.

The poll was commissioned by the Religion & Society Programme for the 2013 Westminster Faith Debates. Overall, 70 per cent of the 4,500 people polled supported a change in the law to legalise assisted suicide. Just 16 per cent were against and 14 per cent were undecided. The main reasons for supporting legislative change included 'An individual has the right to choose when and how to die' and 'It is preferable to drawn-out suffering'.

Those against assisted suicide were more likely to be strictly religious but an overall majority (64 per cent) of people who identified with a religious tradition supported a change in the law, mainly because they supported a person's right to choose when to die.

Support for stroke patients

People with stroke are getting too little support to help them cope with the emotional impact, the Stroke Association says.

In a report, *Feeling Overwhelmed*, the charity says the emotional impact of stroke can be as devastating as the physical effects. Its survey of over 2,700 people affected by stroke found that 59 per cent felt depressed, 67 per cent experienced anxiety as a direct result of their stroke, 63 per cent feared a second stroke, 73 per cent reported loss of confidence and 48 per cent felt angry. Nearly half (42 per cent) felt abandoned by the health service once they were discharged from hospital and 79 per cent had received no information or practical advice to help them cope with the emotional impact of stroke.

Stroke also had a negative impact on relationships. Over half the stroke survivors (53 per cent) reported difficulties in their relationships with a spouse or partner as a result of a stroke, and nearly three in 10 had broken up with their partner or were considering doing so. Carers were also emotionally affected: 79 per cent reported anxiety, 84 per cent felt frustrated, 56 per cent were depressed and 57 per cent felt stressed.

The Stroke Association says the NHS should provide psychological treatment and emotional support to people with stroke and their carers, to avoid problems that could delay their recovery.

Mental health 'first aid'

Armed forces veterans and their families are to be offered training in mental health first aid (MHFA) to help them support colleagues with mental health problems.

The Government is providing £600,000 to pay for 200 veterans, family members and others working with Armed Forces veterans to learn the mental health equivalent of first aid skills. They will then go on to teach others the same skills so they feel confident to identify and help people in mental distress. The aim is to train some 6,200 people in the Armed Forces community by 2015.

The training will be designed and delivered by the community interest company MHFA England, in partnership with Combat Stress, the Royal British Legion and SSAFA – the Soldiers, Sailors, Airmen and Families Association.

Therapets aid stressed students

Edinburgh University Students Association (EUSA) has invited the dog charity Canine Concern to provide pet therapy for stressed students during the April/May exam season. Tickets for the two April sessions were sold out.

Pets are often used in care homes to aid residents' mental wellbeing. This is the first time they have been introduced in a university context in the UK.

Andrew Burnie, EUSA Vice President Academic Affairs, said: 'Therapets is an excellent new initiative for students who are struggling to cope with stress.' But some students have criticised the initiative. In a comment on the EUSA website, student Amie Robertson said: 'These dogs are being used purely to fit the needs of stressed-out students. EUSA would have spent much better time and money putting real dedication towards its counselling service and making it more accessible and dynamic to fit student needs.'

Depression 'contagious'

Vulnerability to depression may be contagious, a study of US 'freshman' university students suggests.

The study, published in the journal *Clinical Psychological Science*, assessed 103 pairs of roommates at one, three and six months for cognitive vulnerability, exposure to stressful life events and symptoms of depression.

Students sharing with a roommate with high cognitive vulnerability were likely to 'catch' their roommate's cognitive style, and vice versa: those sharing with a roommate with low cognitive vulnerability became less vulnerable over time.

The students who became more cognitively vulnerable in the first three months of college had nearly twice the level of depressive symptoms at six months than their less vulnerable peers.

Another US study, in the May issue of *Psychotherapy and Psychosomatics*, has found that some three in five people diagnosed with major depression may not meet the DSM-IV criteria.

Of 5,600 people receiving treatment in the community, just 38.4 per cent met the DSM criteria, falling to just 14.3 per cent of older people – one in seven. Those who didn't meet the DSM criteria tended to report less distress and better functioning and made less use of mental health services. But the majority of both groups were prescribed and taking antidepressant medication.

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Fixing to facilitating

Rachel Freeth

One of the aspects of my work that I value is its variety and particularly the fact that every person (patient) I encounter is different – indeed, unique.

In my view it should not be difficult (although too often it seems that way) to see beyond diagnostic labels to the person with their unique personality and unique set of past and present circumstances, whose experience and expression of mental and emotional disturbance and distress is also unique. This, in turn, should lead to a consideration of helping responses likely to best suit that individual. Clearly such an attitude and approach will create difficulties and challenges for helpers working in cultures and organisations where standardised helping responses and 'pathways' have become the norm and expectation.

While valuing the myriad differences between individuals seeking help, I also observe a feature that many have in common. This particular feature is far from universal but common enough to merit highlighting. I am referring to a patient's belief or assumption that it is my job as a psychiatrist to 'fix' mental health problems.

This notion of fixing can be construed in many ways, of course, and carries with it a potential array of other assumptions. Put simply, I am referring here to the assumption that I will be able to diagnose the 'fault' and then 'apply' a remedy, or at least know someone who can. It is an assumption that I have the answer and that I know what needs to be done.

This is a powerful position to be in. It is also, if I am honest, one about which I often have mixed feelings.

> 'This medical model paradigm of helping, where the expertise is located in the helper, creates considerable dissonance with how I have come to view mental distress'

On the one hand there is the seductive appeal of being considered an expert, and the satisfaction, esteem and status this can bring. But with this comes the sense of responsibility, pressure to perform the required task competently (for the stakes are often high), and the weighty burden of trying to meet expectations – one's own and those of others. Furthermore, for me this medical model paradigm of helping, where the expertise is predominantly located in the helper, creates considerable dissonance with how I have come to view mental distress and how individuals might best be helped and supported.

This simple notion that the job of a psychiatrist or other mental health professional is to fix people is, I suggest, strongly embedded both within healthcare organisations and in our wider Western culture. In fact, it is held to be so self-evident that it often goes unacknowledged, unspoken and therefore unchallenged. Perhaps this is what makes it so powerful.

I wonder in what way and to what degree therapists recognise these issues in their work? I also wonder how many clients enter counselling or psychotherapy with the assumption that the main expert in the room is the counsellor or psychotherapist, and with the expectation and hope that they, the client, will be fixed in some way? Clearly, how therapists respond to such expectations and hopes will be influenced by their philosophical orientation and therapeutic model.

I have been thinking about roles and expectations a lot lately because I am on the verge of returning to counselling practice. I have been imagining how different I might feel being with someone as their counsellor.

I am sure I will bring into the room just as great a sense of responsibility and desire to help as I do now as a psychiatrist. Undoubtedly I will also bring a certain level of knowledge, expertise and clinical experience. What I hope I will not be bringing is an internalised expectation that I can fix my client.

I anticipate that returning to work within a counselling setting will prompt me to re-examine many of my beliefs about human nature and human distress. I imagine that, without the medical lens, I will see people in a different way. Perhaps I will be more sensitive to my clients' innate resourcefulness and strength – their capabilities as human beings who, given the right conditions, can find their own way through their difficulties, using their own wisdom and expertise.

Most of all I imagine I will experience a sense of freedom from the burden of fixing people.

I will let you know whether fantasy and reality coincide. ■

A fish out of water

Angela Smith

I was involved in an accident on a college trip to South Africa with a group of students. The bus we were travelling in came off the road and turned over. A lot of us were severely injured and three of the students were killed. Even though I was hurt, I couldn't help but feel responsible. And I felt awful to have survived when others didn't.

I initially went to my doctor because of the flashbacks. I wasn't sleeping; I was very anxious and depressed. I lost my confidence. I had some facial scarring that I was really self-conscious about. I felt everyone was looking at me, saying 'She's the one involved in that coach crash'. My GP said I had PTSD and needed to see a psychologist. But there was a long wait list, so she suggested going to the Haven while I waited, and the counselling was working so well that I stayed there. It's a voluntary organisation; you give a donation, as much as you can afford.

I used to say to Mary, my counsellor, that I felt like a fish out of water. I was flopping all over the place, not able to function normally and not knowing what to do. I thought I was the sort of person who didn't need therapy. That is one of the most important things Mary made me realise – that how I was feeling was normal, and that I was safe now, and I could talk to her.

I felt almost embarrassed that I needed help still. It was almost a year down the line and I still couldn't deal with things and let it go and that wasn't like me. I was angry and I don't do anger. I'm a laid back person. I'd just go, 'It's happened, just get over it'. I'd never felt anger like this before, true anger, not even when I was a kid. It was physical as well as emotional. It was a rage, an inward rage. I couldn't tell anyone about it. I was angry with my dad, with the bus driver, with the police. I was angry with myself – why couldn't I do anything to help the others after the accident? I understand now that I was injured but I still can't help feeling I failed.

Mary picked it up quite early on. She said make an anger list of all the people you are angry at, and she saw I had scrawled really hard on the paper. I think it was the loss of control and not being able to understand what had happened.

I felt my dad wasn't there for me. That wasn't helping me get over things. I thought we were close but obviously it wasn't as strong as I thought. He would phone and ask how I was but he was just going through the motions; he wasn't really interested. I needed more from him. I needed him to be here. Things had changed since my mother passed away. He's more involved with his new partner now. My sister says he isn't there for her either but she's got the same mindset – 'Don't dwell on it.'

In therapy we talked and used some role-play and a lot of visual stuff. When I couldn't explain how I was feeling, we used sandplay. We created a timeline, which helped me process what happened and put me back in control. We practised grounding techniques so there was something I could do if I had a nightmare or flashbacks. We did a lot of writing work – writing letters to people about why I was angry, but not posting them. While we were on the trip I had kept a journal every day but I'd put it in a drawer and hadn't shown it to anyone. I couldn't face reading about the good times we'd had when it had ended so awfully. Mary encouraged me to share the journal with her. Then I was able to read it myself and, after we'd talked more, to share it with others.

> 'I was flopping all over the place, not able to function normally and not knowing what to do'

I saw Mary weekly for 12 months and then towards the end it was every two weeks and then every four weeks. I definitely feel more in control of my life, more confident, now. I've gone back to work. I've been able to accept what happened with the accident, and how things are with my dad. I have good days and bad days but the good days are more than the bad.

I don't feel 100 per cent ready to move on because the official investigation into the accident is still ongoing. I need to know what happened. I think the authorities blame the driver – that's difficult for me. We had got to know him; we had a bit of a relationship with him. Do I forgive him? Do I blame him for the rest of my life? So I might go back to the Haven to talk about that.

I had God on my angry list too but we didn't discuss that in counselling. When I am ready, I will seek help with that. I'm like that; once I've made up my mind, I do it. ■

Names have been changed to protect identities.

The Haven is a therapy and counselling service based in Leicestershire working with clients from any ethnic background and of any faith or none. It is a registered charity supported by contributions and donations and all its professional therapists give their time freely. Visit www.thehavenahsby.org.uk

Learning from my clients

Mel Perry

'For so long I've been battling my emotions, unseen terrorists that hide behind trees and around corners on sunny days – and then strike me down. But somewhere along the line I learnt not to fall over, not to show an inkling of this... somehow I'm beginning to realise that these terrorists are really my freedom fighters.'

This isn't one of my clients. Before I started out on my counselling course I used to have taped personal therapy and listening to this again reminded me of how I have both moved forward but also have moments of doubt. Brought up in this cognitive Western culture and having a difficult childhood had left me struggling to express myself. Three years on and I find that my clients are tutoring me in how to deal with these moments of doubt, these cries from the unconscious that need to be heard.

I've been counselling now for about eight months. Those first few terrifying sessions are out of the way and both counsellor and clients have survived relatively unscathed. I am slowly ditching the idea that to be a counsellor I first need to be 'sorted' myself. It's an ongoing process where I learn from my clients in every session and hold close to my heart the words of Barbara Somers: 'If ever we think we have the answer for another human being – or indeed for ourselves – we'd better pack it up and do something different.'[1]

'Janey', a 40-something woman, came to counselling because she had been identified as suffering from PTSD. In her early 20s she had been overpowered, held down and sexually abused. In our first session she talked non-stop. 'OK,' I figured,

> 'Three years on and I find that my clients are tutoring me in how to deal with these moments of doubt'

'it's the first session and this is what she needs to do, it's her space.' About 20 minutes in, I developed a very tickley cough (I didn't have a cough or cold). I tried to fight it down and keep the focus on her. It defied me; the more I tried to suppress it, the more it needed to come out. I had a serious coughing fit, but recovered. The session continued as it had started.

The second session was a repeat of the first, including the coughing fit. I knew that I felt overwhelmed and deskilled. When I did intervene Janey either listened politely or just talked over me. It felt out of control. When this happened again in the third session, and the coughing fit was so bad that she, parent-like, poured me a drink of water, I knew that I had to find out what was going on.

I mulled this over for a couple of days and then it came to me: the cough was happening because I felt I couldn't speak; the desire and need in me to 'do my work' was so strong that I was unconsciously interrupting the session. My ability to have a voice was being taken away from me to the extent that I felt useless and impotent in the sessions. My client felt powerful but I felt fearful. Indeed, it seemed I was feeling as she had felt during the attack – helpless, powerless. Once I had accepted this and reconciled my own feelings with what was happening in the room, the cough disappeared, I could hold Janey's feelings and was able to protect her space so she could test out her right to be and her potency.

Then there was 'Harry', a teenage lad who came in and told me that all the people he'd seen in the past (counsellors, child psychiatrist and other mental health professionals) had been 'f---ing shit, useless and patronising'. I'm sure you can imagine what was going through my mind at that point. Once I'd put my immediate feelings to one side, I could more clearly hear his message: I was going to let him down just as others had; he was beyond redemption.

Yes, I could accept how he felt towards himself but instinctively, of course, I could never concur with his own judgment. Yet I'd known that feeling and still do sometimes. I was sitting opposite myself; I heard my own beliefs and they were shocking. His wrath at the world that he directed inward so destructively was heartbreaking, yet it didn't diminish me; it allowed me to feel a deep empathy not only with him but with the younger me that still sometimes recklessly comes out to play.

By listening to my clients I've been able to start listening more to myself. Perhaps this is my experience of what the philosopher Heidegger meant by 'coming-into-the-nearness of distance'.[2] By being witness to the emotions of my clients, I've felt the deep sadness and frustration of their struggle and within it are echoes of my own. ■

The clients in this column are both composite case studies.

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Compare the market

Barry McInnes

April heralded the full implementation of the Government's new framework for commissioning NHS patient services. Control of the larger part of the NHS budget has now passed from Primary Care Trusts to some 212 Clinical Commissioning Groups (CCGs). These CCGs are GP-led, and Government ministers believe they will be more attuned to and therefore better able to commission care that meets the needs of local populations and individuals, as well as make the NHS more efficient and improve quality of care.

In the arena of primary care psychological health, the extent to which the new framework will live up to expectations and deliver more effective and efficient services to patients will be influenced by two critical and related factors. First is the Government's intention to establish parity between physical and mental health; second is the emergence of technology-based solutions to mental health problems.

Figures from the Psychiatric Morbidity Survey (PMS)[1] show that the proportion of the population likely to be suffering a common mental disorder (CMD) – anxiety, depression, phobias, mixed anxiety and depression – is around 15 per cent. Based on UK census data,[2] that would mean almost eight million people have a CMD. Even in the unlikely event that the IAPT programme reaches its target of treating 900,000 per year, this still leaves an enormous level of unmet need.

There will be no further resources in CCG budgets to achieve the required parity between physical and mental health, that much is clear. We cannot pretend that psychological therapy will fill the unmet need; there will need to be radical solutions, because failure to achieve something that looks like parity will not be an option. It will fall to CCGs to find creative ways to implement new solutions and extend their reach.

The NHS Confederation[3] advocates e-mental health as part of the answer – web-based platforms enabling the delivery of therapy to individuals and groups online, sites like the Big White Wall that offer self-help, peer support and online therapy, and apps, either as aids to patient management or as stand-alone solutions. For the latter, think of a digital version of books on prescription and you won't be too wide of the mark.

There are undoubtedly some people who, although significantly troubled, are nonetheless resourceful and will be able to benefit from a minimal level intervention, whatever that may be. What concerns me about the drive for parity is the form it will be seen to take, and whether our current imperfect system will be further compromised by the introduction of a range of new interventions whose effectiveness it may be difficult to properly evaluate.

What of counselling and psychotherapy in this brave new world? Forever the optimist, I believe there are opportunities. Setting aside the protection of vested interests, some commissioners will be prepared to buck the current trend and commission outside the list of NICE-compliant therapies if the alternatives offer demonstrable advantages (such as quicker access to treatment) for their patients. It is also likely that more therapies will be approved by NICE over time, giving greater meaning to the notion of patient choice. Whatever form these new therapies take, however, they will need to be demonstrably effective.

> 'There will need to be radical solutions, because failure to achieve something that looks like parity will not be an option'

And remember that, while CCGs will control much of the NHS budget, it will be limited to around 60 per cent of the total. Individual GPs also have their own practice budgets, as the following example of a BACP member demonstrates.

The member in question has a contract for service with a GP practice that was due for review. The practice values her service in terms of speed of access and client feedback, but wanted to know how her outcomes compare with IAPT benchmarks. She was already routinely using both PHQ-9 and GAD-7 so, with a little guidance, she was able to work out the proportion of her clients who recovered, using the IAPT model.

In all, 77 per cent of her clients reached the criteria for recovery. The highest reported IAPT PCT recovery rate for which there were finalised data at the time was 72 per cent. Our member had broken the IAPT ceiling – albeit based on PCT mean recovery rates – by some distance. That's a nice message to be able to take to your commissioning GP. ■

To get in touch with Barry, email barrymcinnes@virginmedia.com

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The magical mystery cure

Richard Shrubb reports on controversial trials that use Class A drugs such as MDMA and LSD for psychotherapeutic purposes

A small number of pioneering psychiatrists, psychologists and psychotherapists are researching how certain Class A drugs can be used with very positive effect to help people with severe, chronic psychological and emotional health problems.

Despite the practical and legal difficulties, pilot trials are currently under way into the use of LSD, pure MDMA (ecstasy) and psilocybin (magic mushrooms) as an adjunct to conventional talking therapies for the treatment of post-traumatic stress disorder (PTSD) and in end-of-life care.

The therapeutic use of banned drugs has featured in the UK national media headlines in recent months, thanks to the outspoken David Nutt, Professor of Neuropsychopharmacology at Imperial College London and former Chair of the Government's Advisory Council on the Misuse of Drugs. He was sacked from the Advisory Council in 2009 after declaring that ecstasy was less dangerous than horse riding (in terms of adverse incidents per use). In a subsequent paper he classified drugs according to the harm they caused; alcohol and tobacco emerged as more harmful than ecstasy and cannabis.

In September last year, he, with Val Curran, professor of psychology at University College London, joined forces with Channel 4 to film some of the participants (including the novelist Lionel Shriver) in a study that used fMRI imaging to examine the effects of MDMA on the brain. In April this year, in his presentation to the British Neuroscience Association's biennial conference, he roundly condemned the British Government for blocking attempts to develop more effective treatments for depression with what he says are its 'irrational' drugs laws.

Nutt wants to research the use of the chemical psilocybin, the psychedelic ingredient in magic mushrooms, which he says can suppress activity in the parts of the brain that are overactive in severely depressed people. But, because magic mushrooms are a Class A drug, their active chemical ingredient cannot be manufactured without a special licence. Despite a grant of £550,000 from the Medical Research Council to begin a three-year project to test the drug on people with depression, Nutt and his team have been unable to progress because they can't get the comparatively small amount of the drug needed to conduct their trials. It isn't easy to find companies who can manufacture the drug and are prepared to stump up the estimated £100,000 and go through all the bureaucratic hoops to get a licence.

Nutt's research has already established that psilocybin appears to switch off the ruminative parts of the brain that are overactive in people with depression. 'We badly need more types of treatment [for depression] but we cannot pursue these because the Government is denying scientists access to powerful tools that could help people in need,' Nutt told the conference. 'The whole field is so bedevilled by primitive old-fashioned attitudes. Even if you have a good idea, you may never get it into the clinic, it seems.'

MDMA and PTSD

Post-traumatic stress disorder (PTSD) is notoriously difficult to treat, and a condition for which almost no drugs are being developed. Psychotherapy is generally regarded as the treatment of choice for the condition. NICE guidance recommends: 'All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused CBT or EMDR)'.

At the heart of PTSD is the issue of avoidance: the patient finds the experience too difficult to face and is therefore unable to process it. Clinical trials are being conducted in Israel, the US, Canada and Switzerland into the use of MDMA-assisted psychotherapy to treat PTSD. The trials are funded fully or in part by the US-based charity Multidisciplinary Association for Psychedelic Studies (MAPS), a research and educational organisation dedicated to promoting use of psychedelics and marijuana for therapeutic purposes.

South Carolina-based psychotherapist Michael Mithoefer is leading one of the trials. Mithoefer, a psychiatrist by training, believes that MDMA can open doors in the mind, whether the person wants it or not. The MDMA-assisted therapy sessions are eight hours long, with two therapists present – generally a male and a female so the client can talk to either, as they prefer. Though an apparently intense session – 45 minutes can be a lot for most patients in traditional non-drug psychotherapy – it is designed to be completely relaxed and without pressure.

It takes place in a non-clinical setting and, as the drug takes effect and the session progresses, the client finds him/herself talking naturally about the stressor that is causing them so much trouble. 'We have an agreement with the client that if nothing comes up during the session at a certain point, the therapist can engage them. This has never happened yet,' Mithoefer says.

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'By letting go I regained my mind'

Mikee (not his real name) was a Forward Air Controller for the US Army during the Surge in Iraq in 2006-07. He had to get artillery and air strikes signed off by officers. 'There were so many career officers in it for themselves that would not sign off strikes when I deemed them necessary that I had to sit by while 20 men were killed in six months whose lives I could have saved.'

PTSD is severely stigmatised in the US Army, particularly among elite soldiers like Mikee. Until he was medically discharged with a broken back, and his behaviour in civilian life forced his hand, he wouldn't admit his problems.

'As a soldier your mind controls everything. You live in the next five seconds in a structure that controls everything you do. In civilian life there is no control of your life,' says Mikee. He became violent on several occasions and had difficulty reintegrating with civilian life.

For Mikee, taking MDMA allowed him to let go of the control, which allowed him to understand what was going on for him. 'The feeling initially was extreme anxiety as I was about to come up on the drug, but when I became high I was only anxious when I had a thought about my past and didn't talk about it. When I talked about the thing, in my head I relaxed. By letting go and no longer being in control, I regained my mind.'

Asked how he has changed, Mikee says: 'I feel as if I have grown as a person. What doesn't kill you makes you stronger!'

Mikee is now going to medical school to learn to be a doctor. He wants to study psychedelics as part of therapy and help his former buddies cope with civilian life when they too leave the Armed Forces.

Few of the clients found taking MDMA an 'ecstatic experience', according to Mithoefer, and all have been able to both face the trauma and not be traumatised by doing so.

Outcomes to date indicate that MDMA-assisted psychotherapy is achieving results.[1,2] Twenty patients with chronic PTSD that had not responded to other forms of psychotherapy and drug treatment were randomly assigned to psychotherapy with MDMA or a placebo. The participants had suffered PTSD for an average of 19 years. Most of those who underwent the MDMA-assisted therapy had not relapsed 3.5 years later. Four out of five of the MDMA treatment group improved, compared with just one in four of those in the placebo group. The study found no evidence of drug-related serious side effects or adverse neurocognitive effects and concluded that MDMA can be given safely to people with PTSD, and may be particularly useful for those who have not responded to other treatments.[2]

Stephen Joseph, Professor of Psychology, Health and Social Care at the University of Nottingham, is sceptical. He has pioneered psychological techniques to treat PTSD and is the author of *What Doesn't Kill Us: a guide to moving forward and overcoming adversity*, on post-traumatic growth. He argues: 'In a nurturing, supportive environment, people can let go. If you rush them they will become more avoidant. You have to build up the client's trust over a couple of months.' Indeed, 'it is important to spend a lot of time not talking about their trauma'. Joseph is concerned about the use of any kind of drug to treat PTSD: 'PTSD is not a psychiatric disorder – it is more of a bereavement. You cannot medicate an existential crisis.' But he is prepared to be convinced: 'I'd be interested to see where we are when the research is complete in 10 years. I may well be surprised.'

MDMA and social anxiety

The US Food and Drug Administration (FDA) is currently considering an application from MAPS to conduct an MDMA-assisted psychotherapy trial for social anxiety among autistic adults.

Dr Berra Yazar-Klosinski, Lead Clinical Research Assistant at MAPS, says there is a lot of anecdotal data suggesting that MDMA can help with social anxiety, 'although there is little hard science on the subject'.

Put very simply, MAPS is arguing that MDMA can address social anxiety by reducing the individual's reactions to negative social interactions and enhancing the feel-good effect of positive interactions. The treatments are once or twice only, several weeks apart. There is no suggestion that people should be regularly dosed with MDMA, like an antidepressant or antipsychotic. The theory is that MDMA is a 'teacher', not a 'helper'.

Julian, a Londoner who has Asperger's, has taken MDMA at raves and confirms this effect: 'It seems to help filter out the signals you normally get, teaching you how others see social interaction.'

To help design the pilot study, MAPS brought in Nick Walker, who has autism and has taken MDMA recreationally. A teacher on the Interdisciplinary Studies programme at California Institute of Integral Studies in San Francisco, Walker says: 'Though MDMA is empathogenic for most who take it, the theory that autistic people lack empathy is complete rubbish.' He feels that social anxiety results from the power imbalance imposed on the autistic by 'neurotypical' mainstream society. 'Autistic people are generally bullied at school and

misunderstood as children. By their adolescence and adulthood they are traumatised from being taught they are somehow wrong. MDMA makes you warm and welcoming. It helps you get involved in others' interests. How do you share your interests? By getting over your social fear.'

LSD-assisted therapy

Dr Peter Gasser was able to practise psychedelic assisted psychotherapy in the 1990s under licence in Switzerland, as a member of the Swiss Association of Psychedelic Therapists. The licence was revoked when LSD and other psychedelics were banned even for medical use in 1993, but Gasser has since been given a licence to run a clinical trial into its use in end-of-life psychotherapy, partly sponsored by MAPS.[3] The results have yet to be published.

Taking LSD is a very intense and transformative, almost religious experience, according to research assistant Katharina Kirchner, who worked with Gasser and wrote her Master's thesis on LSD-assisted end-of-life psychotherapy.

Many writers over the years have likened the experience of taking LSD to Eastern mystic religious experiences. Kirchner challenges this: 'Those who have the language of the Eastern mystic experience speak of an LSD trip on those terms. An ordinary person from a village in Switzerland or Germany doesn't have that language to use, so describes their experience on the terms they have for reference.'

Kirchner practises meditation and describes the LSD experience as like 'taking a train to a peak meditative experience. You arrive in under an hour where through learning meditation it sometimes takes years to achieve that destination – not unlike walking'. One participant had a horrifying experience in the first trip, which they described as '... really black, the black side. I was afraid, was shaking [...] Really it was a total strain, no way out, no escaping.' They had reservations about taking the next trip but this proved more positive: 'Suddenly there came a phase of relaxation. Completely detached. It became bright. Everything was light. It is a pleasant feeling, a warm feeling. No pain. Almost like floating, like being carried, and together with the music... really wonderful...'

The protocol for the Gasser clinical trial explains that psychotherapy will take place before, during and after the LSD session. During the experience, 'as appropriate, the investigators will engage with the participant to support and encourage emotional processing and resolution of whatever psychological material is emerging. The investigators will also encourage periods of time in which the participant remains silent with eyes closed and with attention focused introspectively on his or her sense of self and life history in order to increase the psychological insights mediated by the LSD treatment'.

Very simply, there are two forms of experience, depending on the dose of LSD. A low dose is known as 'psycholytic' – it is still intense and transformative, but the client doesn't 'leave the planet' or hallucinate bright lights, for instance. The other dose is a 'psychedelic' experience and will result in complete release from reality. Kirchner says 300 microgrammes in most cases will bring about a psycholytic experience, depending on the person's body weight, health and stage of illness; 400mcg is the minimum needed to achieve a peak psychedelic experience in a healthy adult of a typical weight.

The therapy environment itself is similar to that for MDMA-assisted therapy: a calm, relaxing and non-clinical setting. The patient wears a blindfold and can choose to listen to music. They are given the LSD under the supervision of two therapists. Kirchner says: 'Therapists are there to guide you through the experience and help along the way.' After the trip has worn off, the client goes to bed and is left to sleep overnight – although a therapist is there for them to speak to if they wish at any time. Kirchner explains: 'Patients often just need time to process their experience and understand what they have seen and felt.' They receive talking therapy the next day, but again in a non-traditional way – the therapist is there simply to listen and help the person articulate what they felt, heard and saw, not to interpret or analyse it.

In her thesis Kirchner argues that LSD opens the individual's mind to a different viewpoint and way of thinking while they remain conscious, so they gain a different perspective on the seemingly intractable issue (for example, their impending death) facing them. Brad Burge, Director of Communications at MAPS, puts it more simply: 'With end of life therapy one comes to the understanding that "I do not end where my body ends".'

As the end-of-life research progresses, the hope is that enough scientific evidence will be gathered to break through the social and legal barriers that are currently blocking the therapeutic application of these and other so-called recreational drugs. ■

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Pre-trial therapy

Peter Jenkins outlines what the Government and Crown Prosecution Service are and should be doing to ensure victims and witnesses of crime have access to pre-trial therapy *Illustration by Clare Nicholas*

Investigation and court proceedings of alleged abuse seem to be a constant theme in the media, whether involving churches, schools, or high-profile media personalities. However, there is also increasing public concern about the levels of emotional support provided for witnesses giving evidence in such cases, following the recent tragic suicide of one such witness, in a widely publicised case. This led to accusatory headlines in the press and even to a leader in *The Times*, declaring: 'More help must be given to vulnerable witnesses unused to courtroom combat.'[1] MP Keith Vaz called for the revision of the guidance on support in such cases. Similarly, Keir Starmer, the reforming head of the Crown Prosecution Service, has issued a call 'to redouble our efforts to improve the criminal justice response to sexual offending' via a series of roundtable discussions.[2]

In an adroit and timely response, the Ministry of Justice has recently launched a consultation on a *Draft Code of Practice for Victims of Crime*, setting out new entitlements for vulnerable, intimidated and child victims.[3]

Pre-trial support

Support for victims and witnesses prior to a criminal trial can apply to a number of distinct groups. These include:

- children under the age of 18, who have been subjected to alleged *abuse*, including neglect or physical, emotional or sexual abuse, or who have been exposed to domestic violence
- adults who are *intimidated* because of their fear and distress about testifying in court
- adults who are *vulnerable* – ie they have a mental disorder or impaired intelligence or social functioning, or a physical disability or disorder.

It is important to distinguish carefully between the different types of support available: between preparation for giving evidence in court on the one hand, and ongoing pre-trial therapy on the other. It can also be important for support roles to be clearly demarcated, and for the different forms of support provided by different people to be distinguished. For example, support workers can provide practical help to a rape survivor, while a counsellor carries out the therapeutic work, to avoid any overlap or blurring of these roles and activities.

Pre-trial therapy guidance

Pre-trial therapy, whether for adults or children, has long been viewed as problematic and contentious within the criminal justice system. In the eyes of the law, it carries two main risks. First, unless carefully controlled, it may lead to 'coaching' of the witness, by unwittingly helping the client to rehearse and go over their evidence prior to its actual presentation in court. Second, there is the attendant risk that the therapy will 'contaminate' the evidence: that the client in therapy will incorporate their therapist's reflecting statements into their own understanding and memory of the events.

In response to these concerns, in 2001 and 2002 the Crown Prosecution Service (CPS) issued separate practice guidance on pre-trial therapy for child and adult witnesses.[4,5] These were later incorporated into *Achieving Best Evidence*,[6] which sets out clear standards for the provision of pre-trial therapy for both children and adults.

Therapists who take on pre-trial therapy with a vulnerable adult or child witness need to take account of a number of factors. They need to be fully aware of the legal context of the therapy being provided – that is, the relevant mental health and criminal law, court practice and rules of evidence. They also need to be aware of the tensions between the best interests of the client and the public interest in prosecuting alleged offenders. The criminal trial process affects the types of recording appropriate for this kind of work; it needs to be factual, accurate and contextual (referring to date, times and names of persons present at the session). Crucially for therapists, there are potential limits on confidentiality arising first from the need for close liaison with the police and Crown Prosecution Service and, second, from the requirement for both the prosecution and the defence solicitors to have access to the therapist's records.

The CPS practice guidance covers in detail the implications of the type of therapeutic approach used and the focus of the therapy for the viability of the client's evidence in court. The guidance outlines:

- the need to avoid any rehearsal of the client's evidence
- procedures for responding to the client making allegations of further, previously undisclosed, offences
- the need to avoid evidential problems inherent in attempts by the therapist to distinguish fact from fantasy in the client's account.

In effect, the therapist has to show a willingness to work as a member of a multi-disciplinary team that includes the CPS and police, with consequent clear limits to client confidentiality. In addition, an employer or agency that provides therapy under contract may be under an explicit obligation to provide reports to the CPS on the process and outcome of therapy.

The practice guidance sets out very clear parameters for therapy

that essentially explain its role as secondary and supportive to the criminal trial process. However, it also makes two crucial points: first, the CPS, and other bodies, do not have the legal power to veto therapy, either for adults or children; second, children have a right to a say in decisions about pre-trial therapy, under Article 12 of the United Nations Convention on the Rights of the Child 1989 (respect for the views of the child). Moreover, if the child's need for therapy conflicts with the needs of the trial, then the child's welfare must take priority and the trial should be abandoned.

Criticisms of the guidance

For therapists, if not for lawyers, the practice guidance is likely to make slightly strange reading. Psychotherapy and counselling are distinguished from each other as separate therapeutic approaches – a feat not generally recommended for the faint-hearted. There is also a rather curious list of therapeutic approaches to be avoided as likely to prejudice evidence for the trial. These include interpretive psychodynamic psychotherapy, group therapy, hypnotherapy, psychodrama and regression techniques. There is a marked preference for a therapeutic focus on improving self-esteem and self-confidence, using cognitive and behavioural techniques. Nevertheless, the guidance does represent some sort of accommodation between therapy and the criminal justice system, albeit very much on the latter's terms.

The original practice guidance is over 10 years old and, perhaps, badly in need of revision and updating. Given the predominance of NICE guidelines and evidence-based practice, it is striking that the list of problematic therapies rests simply on expert opinion, without a shred of an evidence base. Anecdotal evidence about its implementation in practice is also concerning. Numbers of counsellors report that the police and CPS still frequently refuse to allow therapy, despite the positive ethos expressed by the guidance. This is supported by some findings by Plotnikoff and Woolfson, drawing on data from Devon and Cornwall NSPCC: 'Some police officers are unaware of the guidance and families were advised that therapy could not take place until after the trial'.[7]

Overall, research into the detailed operation of the practice guidance is generally lacking. Jill Swindells researched this for her counselling degree dissertation, and found a general lack of awareness about the specific requirements of pre-trial therapy among her small sample of 10 therapists. She concluded that 'therapists must appreciate counselling has the potential to make or break a trial; without counselling, a trial may falter or fail; without a trial, the client has no chance of seeing justice done'.[8]

Research into pre-trial therapy

Most research into pre-trial therapy has tended to focus on the experiences of children, rather than adults. Plotnikoff and Woolfson explored the experiences of 50 young people involved as witnesses in criminal proceedings, and their parents.[7] The young people were aged between six and 17 years, with an average age of 12 years. Most described themselves as feeling 'very nervous or scared' before the trial. After the trial, only a minority of the young people and their parents were positive about the trial experience. Pre-trial therapy was offered to seven of the young people, although social services vetoed this for one of them. Post-trial therapy was later offered to another six young people but by then only two of them wanted it.

Lara (15) told the researchers: 'I was offered a counsellor after the incident by the police at the local hospital but when I called her to make an appointment she said she didn't really "do" children. The counsellor at school said she'd do it. She has been great.'

The mother of a boy aged six said: 'My main concern was that my son couldn't have counselling. The police said it might prejudice the trial but I could do it if he was really "falling apart". He was having nightmares and had trouble sleeping. I did too. I tried to follow up anyway but counsellors wouldn't touch him – they said the police wouldn't like it.'

Research into the STAR project (Surviving Sexual Trauma after Rape) found positive experiences of counselling among young people aged 14–16 years, but few had progressed successfully through the criminal justice system.[9] STAR separated the role of support worker from that of counsellor and established a database for tracking cases through the criminal justice system. Of 45 survivors interviewed, one third had contact with a counsellor, with most rating the counselling positively. Reasons for not using the service included not knowing it was available, support being obtained from elsewhere, or people thinking 'they could not be helped'. One finding may have wider implications for supporting this client group: 'Developing a positive counsellor/survivor relationship tended to be linked to a flexible approach where the survivor had control'.[9] These benefits of client empowerment were also reported in a multi-centre evaluation of counselling provision in sexual assault referral centres.[10]

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Consultations on provision

The adverse publicity arising from recent court cases has coincided, fortuitously, with recent consultations on the provisions for witnesses and victims of crime. In his foreword to the 2012 *Getting it Right for Victims and Witnesses* consultation document,[11] the Lord Chancellor Kenneth Clarke called for 'first class support, such as practical advice and counselling services'. This document set out two key principles underpinning the proposed nil-cost reforms of the criminal justice system:

- 'practical and emotional support should be given to those who need it most
- 'victims should receive help as and when they need it.'

However, none of the 66 questions posed in the consultation paper dealt directly with pre-trial therapy. In the Ministry of Justice response to the consultation,[12] Kenneth Clarke warmed to his theme of the centrality of emotional support: 'If any of these victims and witnesses come away from an investigation or trial feeling the experience has added to their suffering then we have let them down.' Criminal justice should therefore provide support services that 'aim to achieve the two outcomes of cope and recover' for such victims. The consultation response was geared to answering set questions, of which question 18 – 'What could be done to improve the experience of witnesses giving evidence in court?' – could perhaps be loosely linked to the issue of emotional support. However, the consultation responses to this question (paragraphs 86–94)[12] make no mention of pre-trial therapy.

Hopes may have been raised that it would be addressed in the second, follow-on consultation on the 2013 *Draft Code of Practice for Victims*.[3] The stated purpose of the draft code is 'to provide victims with a clear idea of the entitlements and services they can expect from the Criminal Justice Agencies'. It proposes that children and vulnerable or intimidated adult witnesses should be able to claim 'enhanced entitlements' beyond those available to other witnesses or victims. These include automatic referral by the police to victims' services within two days of making an allegation, and 'to information on pre-trial therapy and counselling where appropriate'. So child and adult victims would have a right to information about pre-trial therapy. But there is, as yet, no proposal to update or revise the practice guidance that governs its actual delivery.

Reforming pre-trial therapy provision

Given this welcome opportunity for revision and updating, the practice guidance should be based on evidence-based practice, rather than on simple assertion. It needs to include a much wider spread of therapeutic approaches with evidence of effectiveness. Jill Swindells suggests specialist training for counsellors in pre-trial therapy, with a register of suitably experienced and trained counsellors in this modality.[8] Research is urgently needed to check the extent of police and CPS compliance, or non-compliance, with the key recommendations of the guidance.

Any reform of pre-trial therapy provision also needs to acknowledge the thorny issue of funding. Currently, much of the therapy and support for child and adult victims and witnesses is provided by rape support centres and agencies that support vulnerable victims of crime, with government funding of around £40 million.[11] However, at least part of the burden of providing this support falls on hard-pressed statutory and third sector agencies, who lack dedicated funding for this purpose. One survey of young survivors of sexual abuse has estimated that 90 per cent 'do not receive any substantial subsequent support'.[13] In Austria, by contrast, local authorities are now legally required to provide therapeutic help for young people who have been physically or sexually abused, under legislation sponsored by their Children's Commissioner.

If the recent consultations really are going to provide 'first class support' for child and adult victims of crime, then adequate funding has to be a priority. But there is also a case for taking stock of the adversarial nature of the legal system itself, which dictates the skewed priorities of pre-trial therapy in the first place. New Zealand is now considering introducing elements of an inquisitorial system to address some of the constraints on victims' access to justice.[14,15] In view of the current media concern about vulnerable witnesses in abuse trials here in the UK, it would seem to be an opportune time to introduce some much-needed change to the provision of pre-trial therapy. ■

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Peter Jenkins will be running two BACP Professional Development Day workshops on 'Legal issues in therapeutic work with children and young people', on 31 May in Newcastle and 27 September in Manchester. For more details, see www.bacp.co.uk/events

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Working with cult survivors

Gillie Jenkinson describes the sophisticated techniques used by cults to manipulate members, and the lasting effects on their sense of self
Illustration by Clare Nicholas

In 1973, aged 21, I joined what I thought was a group of passionate, loving people. I had no idea that I would be trapped for years. It was the start of a lost decade for me. The group I joined was called 'The Love of God Community' (LOGC). It had little to do with love or with God.

I left the cult in 1980, and only when it imploded and ceased to exist. I have spent many years since processing my own experience and researching the experiences of others who also became involved in cults. After years of feeling convinced that my entrapment was somehow my fault, I know now that it is nothing to do with personal weakness or character defect; nor is it all about my childhood and family upbringing. Cults are powerful bodies that use potent psychological techniques to entrap their victims. People who are seduced into and abused in a cult deserve the same understanding as victims of rape.

For me, a good analogy is that of a frog in boiling water. If you put a frog into boiling water it will immediately jump out to try to escape the danger. But if you put it in cold water and then slowly heat it up, by the time the frog realises it is in danger, it is too late.

I initially joined LOGC because they offered free counselling and a radical form of Christianity that seemed more interesting than that on offer in most orthodox Anglican churches. Like many other young people then (and now), I was looking for meaning in my life. I wanted to feel less depressed, to make the world a better place and to belong. I turned to spirituality and Christianity to try to fill the void. Many of the people in LOGC were genuinely good and committed; a lot of love was shared; we had a vision. Looking back, there was little substance to our vision but at the time it was exciting. Many others have also described how this 'love bombing' drew them in.

At first it was a very positive experience. But, with the arrival of a new leader, the group changed; it became authoritarian, dedicated to a form of puritanical Christianity that demanded total obedience from its members, and used physical punishment and sexual abuse to exert control. We were all harmed psychologically and many were harmed physically by sexual abuse and beatings, which were described as punishments for 'sin'. I eventually managed to leave, but only because the group collapsed, and even then the controls and triggers stayed with me. I remained trapped in fear and cultic thinking for a further 14 years. I continued to look to authority figures to tell me what to do and assumed they knew me better than I knew myself – and that has been a hard one to break.

Why do people join?

No one knowingly joins a group that is going to harm them. People join a group because of the benefits it seems to offer them. Cults can be predatory and, like any predator, they prey on the vulnerable. They also tend to target people who are going to be of benefit for them, financially or otherwise. Anyone can be sucked in.[1] Research does suggest that vulnerability to cult recruitment is particularly high during key transitional periods,[2] especially from child to adulthood.[1] Family environment is not necessarily a significant factor in cult involvement,[3] although key periods of vulnerability are the 12 months following a stressful event, such as relationship breakdown, death of close friends or relatives, and failure in school or at work.

Cult leaders use highly sophisticated techniques to keep their members. Cialdini[4] lists the weapons of influence that are used powerfully in the hothouse atmosphere of a high demand group or cult. They include:


love
love
love
love
love
love

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What is a cult?

Langone defines a cult as 'a group or movement that, to a significant degree:[5]
a) exhibits great or excessive devotion or dedication to some person, idea, or thing
b) uses a thought-reform programme to persuade, control, and socialise members (ie to integrate them into the group's unique pattern of relationships, beliefs, values, and practices)
c) systematically induces states of psychological dependency in members
d) exploits members to advance the leadership's goals, and
e) causes psychological harm to members, their families and the community.'

Kendall[6] uses the term 'high demand group' to describe cult-like groups. This is a better description for cults that have a very high intensity but are not closed to outside influences. Another commonly used term is 'extremist authoritarian sect'.[6] Sociologists use the term New Religious Movements (NRMs) or New Religions, but not all cults are religious and not all new religions are cultic.

A cult can be any size. It can even be a one-on-one relationship where one individual has a hold over the other and uses spiritual/mental or physical violence to exert their power. Some domestic violence situations can be defined as cultic.

Cults can be spiritual, self-developmental or political. Psychotherapy cults can be some of the most damaging and toxic.[7]

A number of cases have been reported where a therapist has drawn clients and therapeutic group members into an intense relationship where the therapist controls and micro-manages their lives. In some cases huge sums of money have been extracted from clients. When a therapist evolves into a spiritual leader the dynamics of the 'therapeutic' and 'spiritual' can combine in a lethal mix to render their clients helpless, dependent, traumatised and psychologically imprisoned.

Contrary to common belief, cults are not an American phenomenon: there are an estimated 800 NRMs[8] and between 1,000 and 1,500 cults currently in the UK.[9]

- reciprocity – the pressure to repay what another person has provided. This rule can kick in from the very first contact with a cult when the victim is entrapped by the offer of spiritual enlightenment, a free meal, mystical experiences or simply love bombing
- commitment and consistency – once someone has been manipulated into making the initial commitment, they will be more ready to agree to further requests
- social proof – you are told that others, who may be role models, have done whatever they want you to do
- liking – people tend to say yes to requests from people they know and like, so cults will often present a friendly and loving face
- authority – Milgram's studies on obedience demonstrate how easily we will comply with requests from an authority figure
- scarcity – cults use high pressure sales techniques to persuade the victim of their privilege in being invited to become a member.

Many cults use thought reform to create totalitarian control.[10] Lifton identifies eight components of thought reform:[10]
- milieu control – communication, and often access to TV, newspapers, food, sleep and sex, are controlled
- mystical manipulation – contrived spontaneity creates mystique, which is then used to justify manipulation
- the demand for purity – who you were is of no account any more; you have to become 'pure' as defined by the group
- the cult of confession – recruits are pressured into confessing 'sins', 'lack of enlightenment' or 'negativity' and this is then used against them by the group or cult leader
- the 'sacred science' – it is only the cult leader or group that holds the ultimate moral vision
- loading the language – use of thought-terminating clichés that only members understand or think they understand
- doctrine over person – the belief system is more important than the reality and wellbeing of individuals
- dispensing of existence – the group or cult leader decides who has the right to exist and who does not – those outside are 'going to hell', 'part of the negativity', 'unenlightened'.

Other common techniques include provoking phobias and fears to enforce obedience and ensure that members are too frightened to leave, for fear that something awful will happen to them,[11] and separating people from all that is familiar, including family and friends. New recruits may be taken away on encounter groups or high intensity training courses in an unfamiliar place, which can very quickly destabilise them. Some cults move their members around the world; in some cases parents have not seen or heard from their adult children for many years.

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All of these psychological techniques create control and lead to identity loss and confusion, which in turn lead to the creation of a cult pseudo-personality.[1, 12] In West's words:[13] 'Individuals subjected to [prolonged stress] may adapt through dissociation by generating an altered persona, or pseudo identity.'

I underwent a complete change in personality after joining the cult. I had been feisty, flirtatious, depressed at times and 'quite a character'. When I left I was timid, cried a good deal of the time, was desperate to be 'a good girl' and terrified I would step out of line or upset others. I now see this as my 'cult pseudo-personality' and it is one of the major issues with which former members may struggle on leaving.[12] The development of the cult pseudo-personality can be seen as a form of introjection. It was only when I began to understand how these dynamics had worked on me in LOGC that I was able to start my walk towards freedom.

How therapists can help

People leave a cult for a number of reasons. Some are asked to leave (throw-aways); some leave of their own volition (runaways); some have mental breakdowns and are no longer useful to the group and are therefore thrown out (castaways).[14] It is difficult for anyone leaving a cult; throw-aways and castaways may feel rejected and a failure, alongside the feeling of relief at being out. Those who leave a large group that continues after their departure have particular difficulties, especially with self-doubt: if all those other people stayed, maybe I am wrong and they are right? Some people may be leaving family and friends behind in the cult – perhaps the only family and friends they have – which is both difficult and dangerous because they may be at higher risk of going back or even suicide.

Writing this article has been hard for me. Even though I have spent many years researching and working through my cult experience and now work therapeutically with former cult members, I still fear that people will judge me or think me stupid for joining a cult. This is why it can be so hard for former cult members to go to a therapist for help.[1]

You are likely to ask what drew me into a cult. This will leave me feeling even more foolish: I should have known better; obviously it was because I was so messed up. If you had asked me 'How does that feel?' I could not have told you, because I spent years learning not to feel. I (my cult pseudo-personality) was defined by others; they told me who I was and what I believed. I had to sever all emotional ties with friends, family and with my heritage.[15] I lost the ability to think my own thoughts and feel my own feelings. All I knew was what the cult taught me: that it was my fault.

You might move on to ask me about my family. You are likely to assume the cult was able to take me over because of childhood issues. That is what you are trained to do, but it just doesn't help.

The danger for therapists is that you may be unknowingly dealing with the cult pseudo-personality; you aren't reaching the pre-cult personality. The therapist needs to be able to provide information about cult techniques and how they work. This will help the client identify and understand what was done to them and the tricks that were used to lure them in and keep them in. You need to understand and be able to explain thought reform, to help the client identify how and where these influences are still dictating their life.

When I found a specialist counsellor who understood about cults and was able to give me information, I began to recover quite quickly. Once I understood about cultic dynamics, I was able to go into psychotherapy safely. The key for me was understanding the cult and how it operated; I think this is true for other former members.

With the right sort of support and therapy, former members can recover well. I find this work hugely rewarding as I see many former members gain clarity on, and make meaning of, their experiences and start to walk free. I use my personal experience to inform my work whilst ensuring I have necessary supervision and therapeutic support. I have a passion for this work and this fuels my drive to see former members' needs heard and attended to by the therapeutic community. ■

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The International Cultic Studies Association Conference takes place in Trieste, Italy, on 4–6 July 2013. See http://icsahome.com

Gillie Jenkinson will be running two BACP Professional Development Day workshops on 'An introduction to working therapeutically with former members of abusive groups and relationships' on 22 June in Bristol and 7 September in Manchester. For more information and to book, please visit www.bacp.co.uk/events

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Visit our website (www.therapytoday.net) to read Colin Feltham 'in conversation' with Gillie Jenkinson.

‘Practitioners need to find the balance between not being overly neutral when listening to atrocities and being open to people’s feelings of loss and grief’

Curiosity and willingness to learn

Linda Dubrow-Marshall offers advice to therapists working with former cult members

Establishing a psychotherapeutic or consultative relationship is a special challenge for people whose trust has been betrayed. People who have been in cultic groups and experienced ‘love-bombing’ and pseudo-intimate relationships, where sometimes people pretend to be similar to them in order to influence them, tend to feel that the professional relationship is cold and uncaring. Their experience of feeling special, purposeful, taken care of, and of living with rules stating exactly what to do can mean that clients pressure therapists to be directive. Some of the key tasks in working with current and former cultists are to help them to tolerate ambiguity and uncertainty, and to express and accept a full range of emotions, including existential angst, anger and grief. A return to critical thinking and the ability to make decisions is of paramount importance.

Practitioners need to find the balance between not being overly neutral when listening to atrocities and being open to people’s feelings of loss and grief when they leave the cult. These are the same skills needed to work with survivors of domestic violence where it may alienate the client to demonise their former partner. It is important for psychotherapists to acknowledge the client’s need to express the positive side of their relationships or what they may have learned or enjoyed during an otherwise traumatic experience, and to deal with personal anger and countertransference in supervision and consultation.

Psycho-education is a key element, whether working with individuals or their families, so that people can understand the experience and the principles behind undue influence. Lifton’s[16] model is extremely helpful in explaining the processes of being in a totalistic environment. As family members come to understand the power of undue influence, their anger towards their loved one’s withdrawal or disturbing actions rightly becomes focused on the destructive group.

The field has changed; in the early days there were some forced de-programmings where people’s families kidnapped them in a desperate attempt to get them to listen to another point of view. Voluntary exit counselling has emerged since, often delivered by former members who have a great deal of specific information about the practices of various groups. Exit counsellors can also be called thought reform consultants or mediators, and they may refer clients to mental health professionals if there are signs of psychological difficulties.

It is likely that counsellors will at some point work with people who have been involved in cultic groups. I have not been in a cult, although members of my family have. But I know what it is like to be influenced, manipulated and deceived, and I have done things under group pressure that made me feel uncomfortable. These are universal experiences that can help practitioners to work with individuals and families while displaying the core conditions of empathy, unconditional positive regard and congruence.

Good counselling skills, coupled with curiosity and willingness to learn about the psychology of cultic influence while listening carefully to the specifics of the person’s experience, will enable practitioners to be helpful, and they can refer to specialists for consultation as needed.

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Talking point
Care for the soul

Alain de Botton argues that therapists should be secular society's new priests

For centuries in the West, there was a figure in society who fulfilled a function that is likely to sound very odd to modern secular ears. He (for there were no shes in the role) was there to take care of that part of you called rather unusually 'the soul' – by which we would understand the psychological inner part, the seat of our emotions and sense of deeper identity.

I'm talking about the priest, who would accompany you throughout your years, from earliest infancy to your dying breath, attempting to make sure that your soul was in a good state to meet its maker.

Because, in many Western countries, the priesthood is now a shadow of its former self, a key question to ask might be: where have our soul-related needs gone? What are we doing with all the stuff we used to go to the priest for? Who is looking after it? The inner self hasn't given up its complexities and vulnerabilities simply because some scientific inaccuracies have been found in the tales of the seven loaves and fishes.

The secular response to the needs of the soul has tended to be private and informal: we find our own solutions, in our own time; we construct our own salvations as we see fit. Yet there remains in many a desire for more interpersonal, structured solutions to help us deal with the serious issues life throws at us. Probably the most sophisticated communal response we've so far come up with is psychotherapy.

It is to psychotherapists that we bring the same kind of problems that we would previously have directed at a priest: emotional confusion, loss of meaning, temptations of one kind or another and, of course, anxiety about mortality. Yet one could argue that there are a number of ways in which contemporary psychotherapy has failed to learn the right lessons from the priesthood and might benefit from a more direct comparison with it.

My suggestion is that society would benefit if therapists were more explicitly reorganised along the model set by the priesthood – that therapists should be secular society's new priests.

For a start, therapy remains a minority activity, out of reach of most people, too expensive or simply not available in certain parts of the country. There have been laudable efforts to introduce therapy into the NHS, but progress is slow and vulnerable. And the issue isn't just economic. It's one of attitudes. Whereas Christian societies would imagine there was something wrong with you if you didn't visit a priest, we tend to assume that therapists are there solely for moments of extreme crisis – and a sign that the client might be a little unbalanced, rather than just human.

A principally physical model of the self is popular, which leads to a preference for problems to be addressed by pills rather than interpersonal relationships. This isn't to say that drugs are not important in many situations; it is simply to make a supplementary case for therapeutic conversation with a sympathetic other.

> 'We bring the same kind of problems that we would previously have directed at a priest: emotional confusion, loss of meaning... anxiety about mortality'

There's also, in a serious sense, an issue of branding here. 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.

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 if the consulting rooms looked better and were more visible, to make a case for the dignity of the activity.

Modern psychotherapists' understanding of how humans work and what they need to cope with existence is, in my eyes, immensely more sophisticated than that of priests. Nevertheless, religions have been expert at creating a proper role for the priest, as a person to talk to at all important moments of life, without this seeming like a slightly unhinged minority thing to do.

Many people may well say that the pub and a few mates are all they need; after one or two big challenges, a great many more may feel that life is sufficiently complicated that they'd benefit from regular dialogue with a sympathetic third party in a stigma-free, reassuring location. For those interested in the challenge, there's a long way to go before therapy really plugs the gap opened up by the decline in the priesthood. ■

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When parents aren't good-enough

How do we help a child process the fact that their parents were unable to provide good-enough parenting? *Joanna North* offers guidance to therapists working with looked-after children

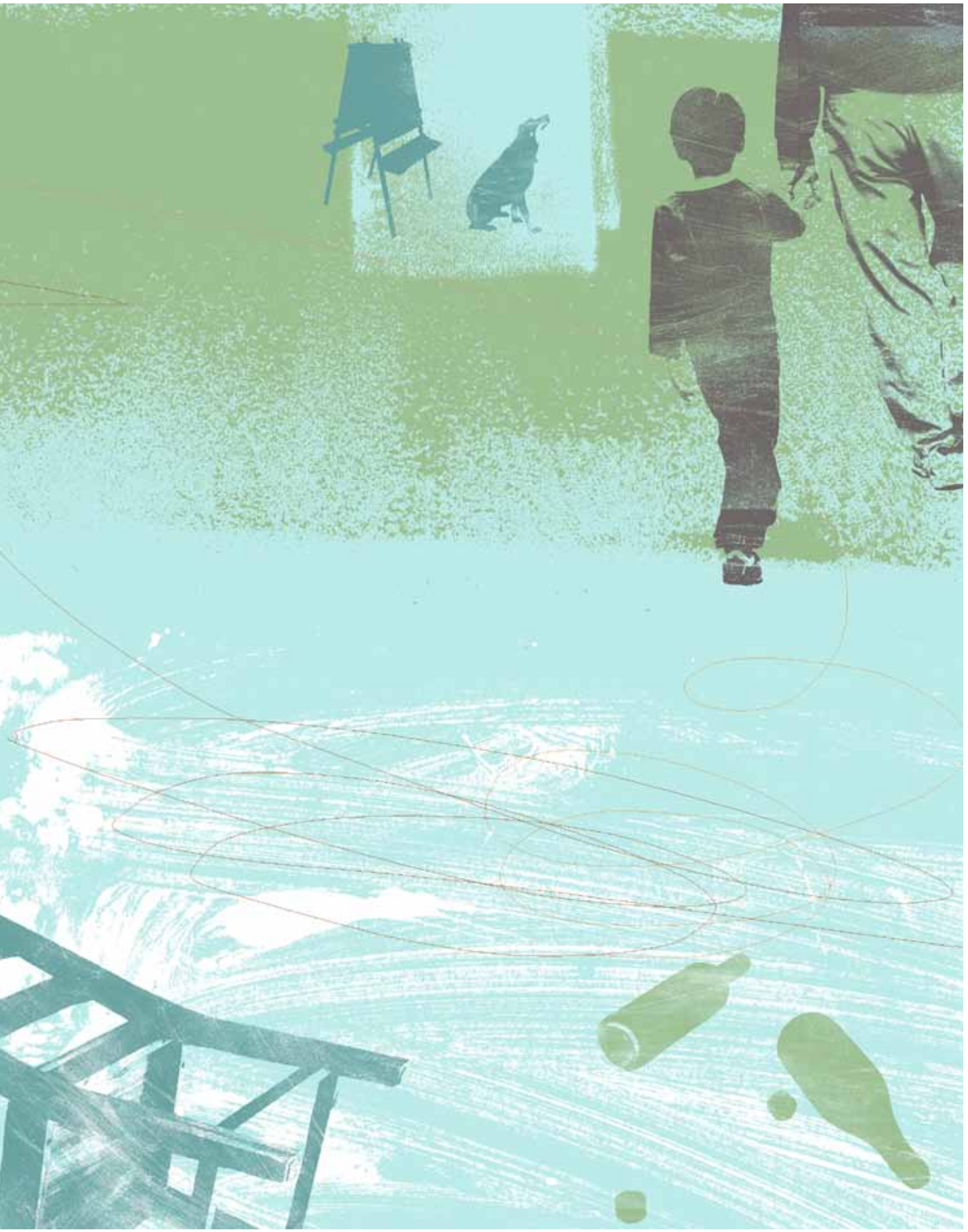
Illustration by Clare Nicholas

I have been reflecting recently on how we help children to make sense of the reality of a parent who has been abusive or unable to provide good-enough parenting, and the child has been taken into care. But, before we can do this, we need to understand why children are taken into care. What might have happened in their lives to precipitate this?

When a parent's care has resulted in or is 'likely to' result in significant harm to a child, he or she will be placed into the care of the local authority and the state becomes their parent. Contrary to media myth, it is not possible for a child to be taken away from a birth parent without a robust amount of evidence produced in court to prove that their care is not good-enough.[1]

We're not talking here about families going through a period of adversity when parents become bad tempered and illogical and take their minds off the job of parenting for a while. This can happen in any family system and these days parents are frequently stressed by the competing demands of earning a living in a recession and supporting children to grow into happy and well-balanced young people who participate fully in the social world. Families are often short on time as well as money. They are stretched to their limits but are able to take good-enough care of their children: to keep them safe, help them to feel loved, and give predictable and consistent levels of care.

In my work as an expert witness in family court cases, I see many parents who do not manage a good-enough level of care; they can be divided into two categories. The first is when harm



is based on cruelty and intent; the second is when harm arises from multiple conspiring circumstances, such as when a child's needs are neglected because of very poor parenting skills. I have come across very few cases in the first category, where parents are intentionally cruel and harmful, but plenty of such cases do exist. These cases become matters for criminal law, and children will be placed in local authority care. Our work in this field is often about helping a child to integrate the trauma of harm in their young and impressionable mind.

The second category is most common, and comprises about 90 per cent of the cases with which I deal. These are cases where a constellation of factors has conspired to reduce the circumstances of the parent and the overall quality of care. These factors include stress, undiagnosed and untreated mental health conditions, low income, learning difficulties, problems with drug and alcohol addiction and domestic violence. It is also highly likely, but not always the case, that the parent will have an insecure pattern of attachment from their own childhood, when they experienced a lack of containment, safety, love and care. A parent's childhood neglect crosses the generations and is mirrored and replicated in their care of their children. Parents are often completely unconscious of neglectful tendencies stored in their memory systems. More usually, they have no idea of the developmental needs of their child. They may expect the child to be more independent and to be able to take care of their own needs, and so ignore their need for support. Frequently, older children in the family are expected to take care of the needs of the younger children, which places a burden on the older siblings and erases fun and play from their own lives. Parents often have had insecure backgrounds themselves or may struggle to read their child's communications and distress signals, culminating in great anxiety for the child.

We may think it would be easy for such parents to change their behaviour but they often struggle with these problems and are unable to find the right amount of help within the given time frame, and so lose their children to the care system.

How can we help?

So, given that we are unable to prevent children entering the care system in the first place, how do we help a child think about a parent who has not been good-enough in any of these ways?

We are often faced with a paradox in therapy, which can be stated as: 'I love my parent even if they hurt me.' Life cannot get more confusing for a child – or for an adult. I observe many children and adults who struggle with their preoccupation with this dilemma. Separation from a parent, even if they are a harmful and neglectful parent, will always be a scar across the mind of a child and cause a deep sense of sadness and loss – and probably some despair. It will form part of their life story and, at some stage, depending on the care or therapy that they receive, it will fall to an adult to help a child to integrate that unfathomable experience into their mind in order to bring some resolution.

These conflicting tensions of love, fear and harm can often disturb a child so deeply that it affects their learning, disorganises their behaviour, makes them afraid of relationships with carers and/or pushes them into psychotic states. Children in the care system are frequently trying to live with unresolved trauma resulting from harm; it pervades their dreams and makes them afraid to sleep. They can be left full of anxiety and unable to envision goals or experience happiness – let alone get on with the developmental tasks of childhood through play and forming relationships. Yet somehow the damaging and pathogenic parenting relationships remain precious in the child's mind. So, what can we do to help?

Tread carefully

First, tread carefully around the representations that a child may have of their abusing or less-than-good-enough parent. The representations will usually idealise the parent and paint them as benign. We cannot take that safe haven away from a child. However the child will also frequently blame someone else for the sense of harm or fear with which they are left. Because they are likely to act out their fear, it is often the substitute carer who has to organise the waves of emotion that threaten to overwhelm the child's life and the carer's relationship with the child.

A child will commonly internalise abusive experiences: they will lock away an experience in their mind and all the time view themselves as the cause of the problem and blame themselves for what has gone wrong. It is easier and more comfortable for the child to hold him or herself to blame for what has gone wrong than to accept that their parent has been harmful to them. This redirecting of psychic energy then triggers a pattern or system that erodes the child's self-belief and undermines their self-esteem. They are bad – therefore they deserve

'Separation from a parent, even if they are a harmful and neglectful parent, will always be a scar across the mind of a child and cause a deep sense of sadness and loss'

bad things. This is why we have to tread carefully around their misconceptions.

Pick up unconscious communication

I have spent many hours trying to come up with constructive ways to help a child find peace of mind in relation to pathogenic parents. The most helpful and hopeful starting point is where the practitioner is able to pick up on the unconscious communication of the child. This will often mean that the therapist is affected by the child's fears or disturbance. But it is at the point where we can feel that despair or where we can fear for and with the child that we can begin to show them that we understand their struggle. This is the signal that we are engaged in a healing process. It is also why therapists need supervision and why they may find this job difficult. I don't know of any other profession where being helpful involves the deeply unsettling act of being disturbed by the disturbance of another.

This might be described as 'the use of empathy as a therapeutic tool' or reading the transference material. It is that – but it is more. It reflects, in my view, the depth of communication that is possible between human beings – whether that communication is joyful or full of despair. Initially, we at least have to be open to these communications. As therapists, we therefore need a good store of information in our heads about this unique and primitive process of communication if we are to help a child with the processing of these difficult states of mind.

Create the right environment

On the other hand, it's worth noting that human beings are very efficient at hiding the effects of trauma and abuse both from themselves and from those who care for them. So it is our job to create an environment where sharing thoughts and feelings about difficult things is deeply acceptable and praiseworthy, so that ultimately we make it possible for children to share their worst fears or their worst secrets, their painful dreams and their negative emotions.

It is also our job to begin to imagine how unimaginable this is for a child. The best carers that I know, who get the best results in terms of helping children to settle, are those who can find ways to share the hidden or unconscious story with the child and can organise it in their own mind before helping the child to integrate it into theirs.

Never name and blame

If the first rule is to be open to the communication, the second rule is not to name and blame the parent. How tempting it is to get mad at parental harm or incompetence. It is natural, and part of the journey of protecting the child, to want to condemn such a parent, but we cannot allow ourselves to fall into this trap. We have to be able to tolerate various states of mind and emotions until we reach our destination, which is to help the child with integration, and this is often achieved by a deeper understanding of ourselves and our own processes. We might, for example, be hampered by our own worst fears; our own defences may get in the way and inhibit the child's flow of emotional information.

Name the experience

Good professionals find various positive ways to begin to talk about the parents who have failed their children. We can hardly say to a child 'You drew the short straw there!' or 'Nobody said life was a level playing field'. It may be tempting to be over-sympathetic to the point of sentimentality. But the best stance I have found is one of being able to name the experience. So it could be both helpful and accurate to say 'Your parents loved you but did not know the rules of being a parent or have the skills to look after you, and they did not understand how children think'. These descriptions tend to invoke discussion at an age-appropriate level and at least they separate out the manageable from the unmanageable. Besides, the statement is true. I have never yet met a parent who lost their children into care who did not say 'I love my kids, they mean everything to me'. When parents say this, they really mean it. The inconvenient truth is that parents who harm their children or fail to care for them to an acceptable standard frequently adore them. And so, often, they are left with the mind-numbing task of integrating (usually for the rest of their lives) the terrible thoughts of how they failed their child and lost them.

Help rewrite the script

The next part of the process is for us as professionals to find ingenious and creative ways to rewrite the script in a way that helps the child make sense of their story, by breaking it up into digestible pieces. This is like putting pills in jam so that the child doesn't taste their bitterness. I often begin 'I knew a child who had that experience…', so that young people can realise they are not alone and that other children also have these experiences. Our stories can give children a foothold into their own world.

'It is at the point where we can feel that despair or where we can fear for and with the child that we can begin to show them that we understand their struggle'

'Did I ever tell you about a boy I knew called Danny? He had to go and get looked after by someone else because his mum got cross too much and it frightened him and upset him. One day, his teacher noticed that Danny was frightened and upset at school and he could not go home to his mum that night as the teacher called a social worker who wanted him to go to someone safe.' A small child might ask, 'Jo, do you see other kids here or is it just me?' Part of the child wants to be really special, but it is a perfect opportunity for me to make up a story about another child just like him or her who also struggles with painful thoughts. From then on, the child realises fully and quite excitedly that our time is all about sharing their thoughts.

This flow of information can be achieved through any medium that best suits the child. Children can be engaged in art, music or dance. With older children, some plain talking and well-crafted counselling skills can be just the right approach. A child can also resolve these issues through work with animals or caring for pets. What is clear from the latest neuroscience is that our state of mind will have the biggest influence on the integration of difficult states in a child's mind. It is our kindly, secure and sensitive responses that will dictate whether or not a child opens their mind to resolution – or closes their mind in the hope of stopping the flow of their story.[2] As practitioners, we have to be in a psychologically and emotionally fit state to achieve this.

Let them choose the time

We have to be wise enough to know that a child has every right to close down their story for as long as they wish – and we have to be informed enough to notice the signals that suggest that they want to share their story, or a bite-sized piece of it, with us. The right environment is important and so too is the right time, in relation to the child's developmental stage, combined with their sense of security. Sometimes enough information has to be fed into the hippocampus (the information-sorter in the brain) for the trauma to be released and processed. And when a child is dealing with recall of trauma, we may have to lower our expectations of their ability to cope with everyday life, so that they can re-process and recover from the trauma.

Concluding thoughts

To help children to integrate and come to terms with the idea that their parent really did not get things right for them, first we have to be willing to engage in a process that may affect our own mind deeply. I recently presented this as the Five Rs – our capacity to 'receive, resolve, respond, repair and repeat' the communication with the child.[3] Second, we have to learn not to judge the parents who failed in the job and bear in mind that they always would have preferred not to have failed. A compassionate response is our only option, and information processing on our part can frequently help this journey along (back to supervision again). Finally, we give that story back to the child in an age-appropriate and digestible format so that he or she can metabolise the story for now and make sense of their experience.

Of course, children will often revisit the story as their lives progress. A story accepted at the age of five can be reprocessed in a dramatically different way when the child is 10 or 15 – or even in adulthood. The wonderful thing about the mind is that it will process and organise mental material into a tidy cupboard when given the opportunity for reflection and the right amount of information and psychological and emotional support. As practitioners, we are really helping the mind to do its job of self-organisation. Ultimately, our minds are capable of a flow of energy that enhances life. Freeing children's minds from the difficult circumstances of their parent's not-good-enough care is one more step towards helping them along to an equal playing field with children who come from ordinary and well-balanced homes where no one is threatened by harm – deliberate or otherwise. ■

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A version of this article was first published as 'Thinking about the bad mum or dad' in the BACP Children & Young People *journal (March 2013; pp14–19). For more details, visit www.ccyp.co.uk/journal.php*

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'I have never yet met a parent who lost their children into care who did not say, "I love my kids, they mean everything to me." When parents say this, they really mean it'

How I became a therapist
Eugene Ellis

Eugene Ellis describes how his journey to become a therapist put him back in touch with his whole self

What made you decide to become a therapist?
In the mid 80s and early 90s I spent a lot of time thinking about what had shaped me as a person. In therapy, and in other self-development contexts, I developed a realisation that it was possible to make contact with forgotten parts of myself and bring them more to life. Slowly I turned what felt like my grey world into a world of colour.

I was working in the music industry as a sound engineer at the time, which was a mesmerising place for a young man. After a while, however, I became aware of how narrow my life had become. I thought I would take a six-month break, which turned into a two-year break. In that time I began the process of training to become an integrative arts psychotherapist.

My strongest recollection of my own therapy was the feeling of being attended to, of being seen, of internalising this as my human right and recognising the simple notion that validation is an essential part of attaining self-worth.

What were your hopes when you became a therapist?
I have always been fascinated with the power of personal and cultural stories. The stories we tell each other and ourselves are the genesis of all our actions, our reference point for prioritising how we use our resources. My cultural heritage is from the Caribbean and as a colonised people we have absorbed many stories of being seen as less than. My hope as a therapist was to create a reflective space for new stories, especially stories of our culture; stories that move us from blame, shame

and denial to understanding, empathy and wisdom.

What do you think makes a good therapist?
For me, the most important parts of being a therapist are keeping contact with ourselves as therapists through self-reflection of our thoughts and behaviours and keeping at the contact boundary with our clients. For me this means taking time away from ordinary life to slow down, meditate and become mindful of myself and my patterns with others.

What is the best advice you have received?
It was while I was stressing with getting to the end of my psychotherapy training; I was told that it wasn't really the end I was working towards but the beginning – the beginning of the real journey to becoming a therapist.

What do you enjoy about being a therapist?
I really honour being a witness to that moment when clients begin to process, make sense of and integrate aspects of their personal or cultural stories – when their perception of themselves changes and I know their life will be changed.

What do you find most challenging?
That the general therapeutic community does not yet have enough practitioners who feel confident in working with the interpersonal dynamics of cultural or race issues, which can make therapy a bit hit or miss for some black and minority ethnic clients. Fortunately my first encounter with therapy was a positive one, but there are many for whom this is not the case.

What values do you hold dear?
Respectfulness – being open to seeing people in new ways and integrity, where my actions are in harmony with my conscience.

Which books have inspired you?
Currently I'm reading a lot around the neurological impact of trauma and working with trauma and the body. This has opened up many possibilities for treating the many traumatised children that I work with in adoptive/foster homes or in residential care. Authors like Pat Ogden and Brian Post really inspire me. A book that still sits with me, however, is Ben Okri's *A Way of Being Free*.

Has becoming a therapist changed you?
I feel my work has aligned me to my values and as a result I feel less conflicted and I am now able to put myself into roles of leadership that do not come easily to me. I set up the Black and Asian Therapist Network shortly after I qualified in 2004. I wanted therapy to play more of a part in the lives of Black and Asian people in the UK and to create a community that would make this more of a reality. That is still my aim. ■

Eugene Ellis is an integrative arts psychotherapist and founder of the Black and Asian Therapists Network (BAATN). He has a special interest in body-orientated therapies, including mindfulness, and facilitating dialogue around race and culture.

Dilemmas
Transgender disclosure

This month's dilemma

Thomas is an experienced and accredited counsellor in private practice, working in rented accommodation just outside a small town. He is a female identified trans therapist who works as Thomas but has times when he prefers to dress and live as a woman. He has not been through any reassignment surgery or hormone treatment.

Thomas has been working with a client, Angela, for about a year, and they have worked on deep and sensitive issues that she is just beginning to resolve. Some of these issues are around anxiety.

Last week, Angela told Thomas that she is going to move to an area very near to where Thomas lives as she is starting a new job. Thomas is concerned about the kind of self-disclosure that this might entail should he run into Angela in female clothes. ***Although heavily disguised, this is a dilemma sent in by a reader who specifically asked to be addressed using the male pronoun. The wording in this dilemma has been revised since its publication in April's issue of* Therapy Today*, in the light of feedback from contributors. Opinions expressed in the responses are those of the writers and not necessarily those of the column editor or BACP.***

Dominic Davies
BACP Fellow, Director of Pink Therapy

This case is very problematic and sensitive. It raises many points that could be made and I'm going to address just a few of them here.

My initial reading of the dilemma, as originally presented in the April issue of *Therapy Today*, caused me considerable concern over the language used and the way the dilemma was framed. Thomas's gender identity became a noun, 'Thomas is a transgender', which immediately set my guard up. This has since been amended. Thomas is 'a transgender person', or Thomas is 'transgender'.

However the pronouns used are entirely male, and we are not given Thomas's preferred female name. As Thomas's preferred identification appears to be female, this feels as if her identity is being denied. One of the first things one learns when working with someone who is gender variant or where their gender is ambiguous is to enquire how they would prefer to be referred to and, if they are clearly presenting as the other gender, to use pronouns relevant to the gender presented.

The dilemma also appears to make an implicit assumption that to be a 'real' trans person one should undergo hormone treatment or surgery or both. It should be born in mind that this is not possible or desirable for many trans people.

How Thomas chooses to live her life is her own business and she is afforded some protection under the law in the Single Equality Act 2010 and the Human Rights Act. As a therapist, Thomas will want to be mindful of the principles in the BACP *Ethical Framework* and, while many colleagues (including, perhaps, Thomas) might consider non-maleficence as the core principle, I'm also aware that there are other principles to balance out here. We should not assume that the client is too vulnerable to be able to manage this information as that denies Angela's own autonomy and the chance to grow and learn and demonstrate her own compassion and so autonomy is worth Thomas's consideration. Not to disclose to Angela is perhaps doing her and their therapeutic relationship a great disservice.

> 'It is important that we don't infantilise our clients or collude with prejudiced views under the guise of "protecting the vulnerable"'

As Thomas is being mindful of their personal boundaries and psychological health, the principle of self-respect is relevant. Exploring the situation in supervision and planning how to share this information, especially if Thomas is considering a full-time transition to a female or more explicitly transgender role, is also important.

I think most therapists have experience of dual relationships and the possibility of meeting my own clients in social settings is something of which I'm always mindful. I think this is best dealt with at the beginning of the relationship, by agreeing how we will manage any outside contact. In this case, I think it is relevant for Thomas and Angela to discuss briefly how it might be for Angela if she were to meet Thomas *en femme* in the neighbourhood.

Alex Drummond
Writer and therapist

It strikes me that 'Thomas' (and we don't have her female name here) is in the early stages of her transition. It is understandable for her to feel highly anxious about the process of transition, yet we know from the experience of other trans therapists that it can be more straightforward than she might imagine.

First, medical intervention (surgery and hormones are mentioned) is not a requirement for protection in law from discrimination, and it would be prudent for Thomas and other therapists to become fully acquainted with the Single Equality Act 2010, since there is an ethical principle of justice here.

Second, it is important that we don't infantilise our clients – or collude with prejudiced views under the guise of 'protecting the vulnerable'. This was the argument Richard Littlejohn inappropriately used in the Lucy Meadows case and we know the tragic outcome there. If a client is homophobic or transphobic, then a positive experience of interacting with an LGBT therapist can serve the greater good: prejudice is borne of unfamiliarity so we serve an ethic of beneficence towards both client and society.

While clients retain the ethic of autonomy to act out on their prejudice (and that could equally be because they perceive the therapist as too young/old, too middle-class, too culturally different), we should not as a profession be guilty of the same.

My suggestion, given that Thomas is currently living a dual-role identity, is that she lets go of the internalised shame and embraces a congruent trans identity: upfront in a straightforward, matter-of-fact manner. Simply saying to the client, 'Coincidentally, I'm transgender and, although you'll read me as male, I identify as female so when I'm not working I present as female,' can be included in the generic 'If you meet me in Tesco's' conversation that we may have in initial contracting.

It would benefit Thomas to network with other transgender counsellors and psychotherapists to gain support and insight into best practice, to serve the ethic of self-care, and in the greater good of the profession.

Counselling and psychotherapy philosophy are built on ideals of self-actualisation, self-acceptance, congruence and the quest for connection with and expression of the true self. As an openly and 'out' transgender therapist, one has the potential to demonstrate this as an achievable aspiration and my experience two years post-transition is that clients both recognise and respect this. As clients have remarked: 'You obviously know what you are talking about.'

Counsellors are great at talking the talk – I'd say it serves the ethic of fidelity in the profession when therapists can actually show they walk the walk too.

Linda Aspey
BACP Fellow, executive coach and coach-therapist

The possibility of meeting clients outside of the counselling room is something most of us will have considered at some stage, probably during our training. What if we see a client on the street or in the supermarket? Do we acknowledge them or not, and if we do, will that make our professional relationship obvious to people they're with? What if we see aspects of their lives we didn't know about and what if they see aspects of our lives that we haven't disclosed?

It would be a normal part of the contracting process to discuss some of the 'what ifs', especially for a counsellor working in a local community, such as 'Do we say hello or not?'. So I hope that Thomas would already have considered, perhaps with his supervisor, the possibility of meeting his clients outside of work. However, we don't know if Thomas's supervisor is aware of his transgender identity, or if Thomas is prepared to share that.

Working with transgender clients or colleagues is not something I knowingly have experience of. I certainly would encourage Thomas to talk this through with a supervisor who has expertise in this area. This is not only a boundary issue that might affect his relationship with Angela and impact on her anxiety; it may happen with other clients. If unresolved, Thomas's concern could become anxiety, impair his own wellbeing and impair the quality of care he is able to provide.

> 'If Thomas doesn't disclose now and waits until he bumps into Angela, might she feel betrayed by his secrecy, or confused?'

Thomas may be completely at ease with his transgender identity. However the dilemma may be compounded by the often-held stigma about and misunderstanding of transgender issues. Thomas and Angela have probably built up a high level of trust over the year. If Thomas doesn't disclose now and waits until he bumps into Angela, might she feel betrayed by his secrecy, or confused? Might she feel indifferent, accepting or rejecting? Might it impact on her wellbeing? Thomas needs to guard against making any assumptions about Angela's reactions.

And from Thomas's perspective, while being transgender is part of his identity, he may resent the idea of having to share it, and possibly feel forced by circumstances. Has he felt compelled to keep it secret at work and also in his wider life, or has he made a considered choice of privacy? It may be something he's already explored. If not, he may find it useful to do so with a suitably trained counsellor who has a sexually affirmative stance.

If he considers the personal qualities of the therapist to which the BACP *Ethical Framework* encourages us to aspire, this may provide rich ground for his thinking: empathy, sincerity, integrity, resilience, respect, humility, competence, fairness, wisdom and courage. What would each of these mean in relation to this situation? When Thomas has considered all of these and other aspects, ideally in supervision, I think he will be in a better position to decide what to do.

Next 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?
Email your responses (500 words max) to Heather Dale at hjdale@gmail.com before 29 May. Readers can send in their own dilemmas to be considered for publication, although these will not be answered personally.

Excellence in therapy

Scott D Miller, founder and Director of the International Center for Clinical Excellence, talks to *Colin Feltham* about what makes a good therapist great

Colin: Can you tell us how you came to be involved in psychotherapy?
Scott: I think it's due to a series of fortunate accidents and run-ins with remarkable people. I started university at 18 as an accounting major. I grew up in a family of meagre means and the idea was that, even if I couldn't make much money, I could be around other people's money. I changed to experimental psychology and had a professor called Hal Miller, a protégé of BF Skinner. I loved Hal – he was inspiring and very stimulating. I wanted to be like him! I discussed my future with him, thinking of becoming an assistant professor, and he suggested broader avenues such as clinical work. Michael Lambert was in the department; I met him, changed to a clinical focus, and the rest is history.
Colin: What are your views on assessment and diagnosis?
Scott: I've always found the diagnostic code baffling – not very useful or informative. I've found myself more interested in the differences between my clients than in the similarities. That's where the work takes place, tailoring it to the unique characteristics of clients. The truth is that clients tend to get the kind of therapy their therapist knows how to give. Perhaps this will change someday. Until then we can take some satisfaction in knowing that the average treated client is better off than 80 per cent of the untreated sample.
Colin: You've said that 'most therapists do good work' but also that 'most therapists have an inflated assessment of their own competence'. Can you explain this?
Scott: It's confusing on the face of it but if you compare the services of psychotherapy with, say, medicine, therapy's outcomes are either as good or better. Plus, we have a far better side-effect profile. I'm surprised a) at the amount of money that's spent on medicine, b) how much positive press it gets, and c) how little positive press psychotherapy gets. Psychological services are often on the chopping block compared with medicine. That said, what we do is good but it can be better. Like other professional groups, we vastly over-estimate how effective we are, by 65 per cent on average. Additionally, our outcomes have remained fairly level for some time now.
Colin: Daniel Kahneman, in *Thinking Fast and Slow*, says that clinicians work well in the moment, working intuitively, but are not so good at seeing their limitations in the longer view.
Scott: Absolutely. I love that book. I tell people, 'Don't read my book, go and read Kahneman's.' In reading that we'll see where we need to go and why we haven't got much beyond where we were 30 or 40 years ago in terms of outcomes. I think experienced practitioners find that you gradually move from working in a way where you ponder every step to a much more intuitive way, but if you want to improve your work further you need to move into Kahneman's System 2 (deliberative, evaluative), which is very time-consuming. Client feedback measures give you an idea of where you should shift into a more deliberative process. As for therapist reluctance to use certain measures, we are like medical staff inundated with accountability procedures; it's amazing that so many can be required without having any effect whatsoever.
Colin: I understand you now use the term feedback-informed treatment (or therapy) – FIT?
Scott: Yes, this is to distinguish what we're now doing from the CDOI (client-directed outcome informed) label. I was never comfortable with that, honestly. Why? I'm not interested in telling therapists how to work. There's a ton of gurus and model developers from whom to learn. What I can do is help clinicians identify when what they're doing isn't engaging the client or leading to progress. FIT is a 'six sigma' (continuous effort to improve success) approach to clinical practice.
Colin: As well as running many FIT workshops, you also apply it to clinical supervision (feedback-informed supervision, FIS)?
Scott: We're holding an FIS workshop this summer in Chicago, actually. You can check that out on my website: www.scottdmiller.com. We show how the feedback data can be looked at in supervision to improve the therapy process. Not to disparage the other type of supervision, but much of it is either administrative (did you do your paperwork?) or a kind of therapy for the therapist. Another type is model-based (seeing that you're doing this therapy the right way), which is what I want to avoid. FIS is about using the feedback measures to identify where you as a therapist need to stretch beyond your current way of working.
Colin: Does that fit with the ethos of the International Centre for Clinical Excellence, where therapists from all over can discuss how they're working with clients?
Scott: Yes. I don't believe expertise resides in people like me. Expertise resides in the local community, but practitioners seem to have fewer and fewer opportunities to rub shoulders

with people who understand clients' nuanced characteristics and contexts. Expertise requires close, near-knowledge, deep, domain-specific ability, and I can't do that from here with someone in, say, Sheffield. I can help them identify when they're not engaging with clients and then put them together with a community that has something useful, interesting or different to say. Excellence never emerges in a vacuum.

Colin: You travel the world giving talks and workshops. When Americans use language like supershrinks, superior results and mastery, the British tend to recoil. Is that your experience?

Scott: We are not known for being an understated people! But we've known for decades that certain therapists achieve better outcomes. It's not about all becoming supershrinks but about learning the underlying processes that lead to superior results.

Colin: So it's about helping people to be the best they can be. But on the other hand, about training and selection, there is the question of suitability. I'm thinking of James D Guy's work on therapist personalities and the fact that therapists come from those who are self-selecting.

Scott: I couldn't agree more. But Anders Ericsson's research on expert performance and deliberate practice indicates the selection process isn't as important as the training process. There are identifiable processes among musicians that suggest, regardless of where you start, you can achieve world-class performance levels. The expertise process also applies to therapists. For some time we didn't have any way of understanding superior performance, even from data from thousands of therapists. We looked at within-session phenomena to try to understand this. But it's *before* and *after* sessions where you see what makes the best great – they simply spend more time in reflection, planning, preparing, reading and reviewing.

Colin: You've written about the 'heroic client' with innate resources. Is that something you genuinely believe – that all clients, given the right therapist, can change, or are some hard to help or so-called non-compliant?

Scott: Bringing up my former work reminds me of looking at my prom pictures. I had a good time, *at the time*, but can't help but be embarrassed by how I looked! The same is true of my prior writing. It was good *at the time*. We used to talk about client strengths and resources because of our work on the common factors, which indicated a significant portion of the variability in outcome was attributable to client characteristics. However, and importantly, it borders on presenting the common factors as a *model* of therapy when you say 'focus on the client's strengths'. We know from 30 years of research that there's no difference between approaches – solution-focused or problem-focused. What's critical is having a choice or alternative as a therapist. When I'm working with a therapist whose outcome indicates the client isn't engaged, it's probably an alliance problem. The key is for therapists to listen for how clients talk about their lives. If your therapy isn't working, you can listen for the *clients'* views, goals, strengths and resources.

Colin: You've written in *Escape from Babel* and elsewhere about the problems of therapy models and their languages and you recently reported on the Swedish experience of CBT not living up to its research-grounded hopes. What was going wrong there?

Scott: I think the CBT folks in the mental health community got their act together long before others. They saw that clinical trials were likely to have currency, they got them done, and as a result were able to claim they were in some way better. The Swedish Government took this evidence seriously and funded CBT, as in the UK. But the Swedes found a CBT monopoly made no difference. The Western world is embedded in a medical perspective that thinks that effective care is finding the right treatment for the specific disorder. This is *not* what evidence-based practice is about, however. The correct and accepted definition is, 'using the best evidence delivered in the context of clients' needs, preferences and characteristics, informed by *ongoing feedback*'. Let's insist that our leaders and regulators stick to the accepted definition.

Colin: Take a polar opposite to CBT, like primal therapy from the 1970s, sometimes now written off as a dangerous or 'crazy therapy'. Is almost any therapy model and training OK if the therapist uses feedback?

Scott: Our field has done some wild and experimental stuff, but far less than other fields, like medicine, where thousands of people die annually from medication errors alone. In the US we whipped kids' tonsils out and prescribed antibiotics for ear infections – both at great risk and cost and with little effect. So, let's get some perspective. How many people were really damaged by primal therapy? There isn't a single therapy in an RCT that has reliably produced negative effects. I think therapists and our field are a remarkably sane lot.

Colin: There's a lot of concern with medication and the de-medicalisation of distress. Are there any signs that psychotherapy is winning this battle?

Scott: I'm hugely optimistic but I don't see it in terms of battle. I think we're a conservative species and things simply evolve very slowly. Our models are representations, bound by current culture and understanding. The ideas we embrace today will have to be jettisoned in the future. This won't occur quickly, but it will occur.

Colin: And sometimes things have to get bad enough to change. Perhaps sometimes crisis pushes evolution?

Scott: I've just been reading about the history of phrenology, which was once influential in both our countries in determining people's lives. Although hugely powerful, it was completely bogus. And how about pre-frontal lobotomy? It had virtually no evidence of success – complete rumour – before it was stopped, and there are still speculations about psychosurgery. But human beings are hopeful and it takes time for ideas to be adopted and, when necessary, rejected. The key is transparency. I'm hopeful, in part because social media serves to level the playing field a bit, giving voice to a wider group of people.

Colin: You come across as a high-energy, optimistic person. Is that in your nature, or do you have to push yourself?

Scott: Ha! I love what I do, especially the exploration. If I suddenly found out what the secret was, the whole field would lose its allure to me. More important, I think, is that I'm driven. This may sound old-fashioned but I'm interested in the truth, the narrative that brings the parts together, helps me make sense of the world and know what to do in my work.

Colin: What's next on your agenda?

Scott: I'm convinced expertise is nothing to do with the measures we've developed. Some people I've worked with are obsessed by them. This misses the point, and risks turning measurement into another treatment model. Indeed, claims are being made that their use is 'the most effective intervention created in the history of psychotherapy'. Bullshit. The measures are a prop, a tool. What really matters is the therapist, their desire to grow and willingness to push beyond their current realm of reliable performance. ■

Research in practice

Practice research networks (PRNs) form the vital bridge between frontline practice and academic research, argue *Joe Armstrong, Amanda Hawkins and Mhairi Thurston*

This article grew out of our experience of facilitating the pre-conference workshop at the 18th Annual BACP Research Conference in Edinburgh in May 2012. The workshop, 'Practice research networks: promises, pitfalls and potential',[1] generated lively debate not just about the practicalities of setting up and maintaining practice research networks (PRNs) but about their role and purpose as well. We thought it would be worth sharing a flavour of the discussion here.

The aim of the workshop was to engage participants in reflection and discussion about the value of PRNs as a vehicle for facilitating practitioner engagement in research, and their potential to contribute to building an evidence base for the effectiveness of counselling and psychotherapy. We structured the workshop around two brief presentations that outlined our own involvement in two PRNs (see the side bar overleaf), which we used as case studies to prompt discussion.

Over 50 researchers, academics and practitioners attended the workshop, from the UK, the US, Australia, New Zealand and other countries.

What is a PRN?

PRNs originated as a basic system for recording morbidity rates in primary medical care settings, and are now established in mental health and psychological therapy services in the UK and elsewhere.[2,3] Essentially, a PRN provides an infrastructure for practitioners and researchers to work together to conduct research that is practice-based and relevant to everyday practice.[4] Examples of PRNs in psychological therapies include the Pennsylvania Practice Research Network,[5] the Human Givens Research Network (www.hgiprn.org), the Supervision Practice Research Network (SuPReNet), and Schools-based Counselling Practice Research Network (SCoPReNet) – information about the latter two PRNs can be found on the BACP website at www.bacp.co.uk

There appears to be a growing interest in PRNs currently because this research model holds the promise that it may narrow the so-called research–practice gap,[6,7] facilitate practitioner engagement in research and cultivate a more vibrant research culture in the counselling profession. However, while the PRN paradigm may offer the promise of such things, there are also significant challenges, all of which featured in the themes that arose during the workshop

Two UK networks

The Scottish Voluntary Sector Counselling Practice Research Network (SVSC PRN)

The SVSC PRN is a new collaborative project that is funded and supported by the University of Abertay Dundee and COSCA.[8] It aims to enhance understanding and practice of voluntary sector counselling in Scotland by pursuing a research agenda that is generated and shaped by the concerns of the Scottish voluntary sector counselling community and derived from issues that emerge from routine counselling practice within voluntary organisations. A primary function of the network is to facilitate collaboration between practitioners and researchers in order to generate knowledge from practice-based research.

For further details, visit the SVSC website at www.svscprn.abertay.ac.uk or contact Dr Joe Armstrong, SVSC Co-ordinator, University of Abertay Dundee, at svscprn@abertay.ac.uk

The Vision Impairment Network for Counselling and Emotional Support (VINCE)

VINCE was established to provide a national network to:

- support the development of collaborative working between counsellors, emotional support service providers and commissioners of services
- provide a forum to share good practice, service developments, evaluation and research outcomes
- influence the development of counselling and emotional support services for adults, children and families affected by sight loss
- support the 2008 UK Vision Strategy outcome for the provision of emotional support for blind and partially sighted people.

The VINCE research sub-committee includes representation from the major sight loss charities, service providers and academics. It focuses on providing a national network for relevant research. The VINCE research sub committee is chaired by Amanda Hawkins.

For further information, please contact Mhairi Thurston, VINCE Chair, University of Abertay Dundee, at m.thurston@abertay.ac.uk

discussions, as the remainder of this article will report.

Engaging practitioners in research

One of the first issues that emerged in our discussions was the challenge of engaging practitioners in research. A potential pitfall associated with PRNs is that they may struggle to engage a broad spectrum of practitioners and end up being 'enthusiasts' clubs' for a small group of therapists and academic researchers. In fact, many practitioners regard research as time-consuming, complicated or even boring.[9] One workshop participant commented that lack of funding and increased demands on voluntary sector counselling agencies, for example, meant that survival was the order of the day, leaving little if any time to focus on research. Clearly, there are obstacles to be overcome to engage practitioners in research. So the question of what would motivate practitioners to take part in research is important and must be addressed for a PRN to be effective.

There was consensus amongst workshop participants that it was essential to convey the importance of research to practitioners and to work at creating a stronger research culture within the profession. More specifically, if practitioners are to be enthused to 'buy into' taking part in research within a PRN, they need to have a sense of ownership of the research strategy, and the research questions themselves must be derived from, and meaningful to, their everyday practice. This 'bottom-up' approach may tap into practitioners' intrinsic motivation and curiosity about how to improve their practice. The imposition on practitioners of a less collaborative, 'top-down' approach to research or service evaluation is unlikely to harness their enthusiasm and commitment.

It was also noted that incentives may be needed to engage practitioners in a PRN project. One popular suggestion that emerged from our discussions was to offer CPD training events on topics related to research and issues that are pertinent to their practice. As we don't have a comprehensive understanding of the factors that facilitate or obstruct participation in PRNs in different practice contexts, this is an area that could be researched further.

Where should we focus our research?

While workshop participants acknowledged the importance of promoting practitioner research within the profession, there was some debate about where the focus of our research activities should be. Participants questioned the value of practitioner research per se (which can be seen as fragmentary and idiosyncratic) and the extent to which counselling research should be about fulfilling the demands of the evidence-based agenda and influencing policy.

A concern was expressed that practitioner research within the context of a PRN may not really contribute to addressing important strategic questions for the profession (eg questions of efficacy/effectiveness). Another concern was that practitioner-researchers may lack the methodological expertise and resources to conduct more sophisticated studies. There are, clearly, important methodological and strategic issues that need to be addressed within a PRN. On the one hand, there was a strong argument for facilitating practitioner research, and on the other a recognition of the need to conduct research that is more methodologically sophisticated, in order to establish, among other things, an externally credible evidence base for counselling.

In relation to these issues, workshop participants raised several questions. 'How can practitioners/counselling agencies turn routine audit and monitoring data into something more useful?' Is it possible to conduct more sophisticated, rigorous research (eg random controlled trials) within a PRN? 'Which should come first? Practitioners coming together and deciding the methodology, or do we design the methodology first, then recruit practitioners (ie *practice*-research network versus *research*-practice network)?' We didn't come to any firm conclusions during our discussions, but these and other questions deserve more detailed consideration and debate.

This debate may be particularly important given the current concerns that, unless the profession engages with the evidence-based paradigm, there is a very real danger that some counselling approaches may be sidelined in favour of therapies with a much stronger research evidence base for their effectiveness.[10,11] We are sympathetic to this view but, as many of our workshop participants reminded us, it is important not to lose sight of the value of conducting research that makes a more general contribution to knowledge and understanding of our profession.

Disseminating research findings

We had an interesting discussion about disseminating research findings. One workshop participant described their experience of disseminating research related to their agency through targeted public awareness campaigns that emphasised the human 'story' of their clients' engagement in counselling. The advantage of this kind of reporting is that it makes a clear link between counselling research and people's experience of counselling and its social impact.

A number of important points emerged about how we communicate these kinds of research stories to our different audiences. When communicating with members of the public, funding bodies and policy makers, it was considered essential to:

a) use a range of targeted media formats to raise awareness of the problem or particular issues affecting a client group (or groups)

b) highlight the extent and pervasiveness of the problem and its negative psychosocial effects, and

c) make a case for the benefits of counselling in alleviating the problem.

In short, the message is, 'There is a real problem here; it's worse than you think; counselling can help.'

This use of research stories is something that Joe and the Advisory Group for the SVSC PRN hope to use to engage voluntary sector counsellors in Scotland in research and disseminating findings from their network's research activities. One idea they are currently working on is to disseminate research stories through the PRN website (www.svscprn.abertay.ac.uk) and its quarterly newsletter. For example, they are encouraging network members to submit brief 'research biographies' in which they describe their own experiences of being a researcher or conducting a specific study. They are also planning to disseminate findings from their research through the same media in a way that is more accessible to practitioners with little or no research experience. The hope is that this will stimulate counsellors' interest in research and show, through the stories of other researchers, that participating in research can be a rewarding and empowering experience.

There is clearly a need to ensure that counselling research is published in professional and research journals. However, no less important is the dissemination of findings in appropriate forms to front-line practitioners who may not always use research to inform their practice, and to a range of different audiences, such as the general public and policy makers.

Other issues

Other issues that emerged during the workshop included the importance of leadership and effective organisational structures within a PRN to facilitate collaboration and communication among members. We also discussed how we engage clients in research and agreed that data collection methods should be practice-friendly and should not unduly burden clients.

Further important issues were the productivity and potential impact of any given PRN on practice and policy. For instance, Amanda and Mhairi's work with VINCE (see sidebar) suggests that, despite its strong membership, funding and expertise in counselling for sight loss, it continues to struggle to make an impact in the sight loss clinical world. In part, this may be because funding for research into the effectiveness of emotional support services tends to go to sight loss clinicians rather than counselling researchers. It seems that counselling has not yet gained credibility in this sector. Their experience with VINCE raises important questions about the structures and models that would maximise a PRN's potential to have an impact on policy and practice.

Conclusion

Essentially, the PRN model can be seen as an important way to embed research in practice and develop a practitioner-led and client-led research agenda for the counselling profession. PRNs have the potential to bridge the so-called research–practice gap by linking research to practice and vice versa. But, as we have noted in this article, there are challenges: in engaging practitioners and clients in research, in developing a coherent research strategy, in disseminating research findings effectively and also, more practically, in the funding, organisation and co-ordination of a PRN's activities. Notwithstanding these issues, the PRN model represents perhaps the most viable model for developing research capacity among counselling practitioners, in collaboration with academic researchers. Counselling practitioners are in the best position to engage counselling clients in research, to report their experiences of therapy and the outcomes they achieve and, in turn, to generate knowledge and improve awareness of our profession. ■

'PRNs hold the promise that they may narrow the so-called research–practice gap, facilitate practitioner engagement in research and cultivate a more vibrant research culture in the counselling profession'

Dr Joe Armstrong is a lecturer in the Division of Nursing and Counselling, University of Abertay Dundee. He is co-founder and Chair of the Scottish Voluntary Sector Counselling Practice Research Network.

Amanda Hawkins is Senior Manager, Emotional Support at the RNIB and Chair of BACP.

Mhairi Thurston is a lecturer in counselling at the University of Abertay Dundee and Chair of the Vision Impairment Network for Counselling and Emotional Support.

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Letters

We need to talk about class

I thoroughly welcomed the inclusion of the 'Class and counselling' piece in the April issue of *Therapy Today*. It raised important points about our role as a profession in acknowledging the impact that social, political and class issues can have on our clients – not least because of what we ourselves bring into the room with us.

I am very much the white, educated middle-class counsellor and my first training placement was in a local inner city community counselling service. It was very striking to me how so many of my clients had issues that directly related to or were severely impacted by poverty, both in terms of money and opportunity. I found myself thinking 'There's nothing I can do about this' and so classed it as 'not relevant' to our work.

Over the years, as these issues have persisted in popping up regularly with clients, my position and practice on this has changed dramatically. Some of my current clients have been directly affected by the changes in the benefits system and I have seen first-hand how uncertainty about future finances can exacerbate pre-existing symptoms of depression and anxiety and how the social scapegoating of those with long-term mental health conditions can intensify feelings of shame and alienation. I believe it is possible to acknowledge the impact of social/political circumstances on a client's life as a real obstacle and barrier to wellbeing without colluding with a stance of 'You're a victim and you have no responsibility for what has happened to you'.

I am acutely aware that, as counsellors, we are in a position of power that, from my own experience as a client, can be strongly felt between a client and counsellor who belong to the same social class. I am sure that the working-class client must be at risk of feeling this more acutely with the double whammy of professional and societal power being present before them. While I have a passion for learning and don't see any shame in pursuing a Master's or Doctorate, I do believe that, as a profession, we are over-valuing academic prowess at the expense of essential core personal attributes such as capacity for attunement, humanity and self-reflection – qualities that can be found among all sectors of society.

This area is vast and complex but I do think a good starting point would be further conversations, like Simone and Mike's – particularly during training – in safe, non-judgmental spaces, about self-identity, class, assumptions we make about others, the social make-up of counselling trainees generally and potential/actual impact of counsellor background on different client groups. Class issues certainly seem to permeate every area of my life on a day-to-day basis and it would be good to hear more from our profession on this and great for BACP to take a lead in facilitating it.

Rachel Shepley
MBACP (Accred) counsellor and student mental health mentor. Email rachel.shepley@gmail.com

'I do believe that, as a profession, we are over-valuing academic prowess at the expense of essential core personal attributes'

Rendered invisible

Thanks for a great discussion article ('Class and counselling', *Therapy Today*, April 2013). Mike and Simone are much-needed pioneers!

It reminded me of an experience I had when I offered to volunteer as an (unpaid) counsellor for a local staff counselling service. Another black woman and I were selected for interview. At the group interview the three white senior counsellors who managed the service gathered. The Head of Counselling started: 'Let me tell you why you are here: all our paid staff are white so we are looking for a black volunteer.'

Said without a flicker of understanding, thought, empathy or sensitivity (let alone any grasp of equal opportunities policy and law). I really felt the sensation of not being 'seen' at all. I was struck by the fact that the majority of their clients are women from ethnic minorities and I wondered about the possible impact on clients of such a stance.

I can appreciate Mike's discomfort at Simone's use of the word 'perpetrator' as it suggests a concrete action against another rather than an unfortunate circumstance. However, I certainly experienced the Head of Counselling as someone spearheading inequality within their organisation (albeit unconsciously) and hence as a perpetrator of oppression.

It is great that Simone is suggesting that we actually change these structures by improving training standards. Ensuring that courses imbue all aspects of counselling

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training with understanding of the reality of issues such as racism, class issues, sexism, homophobia and poverty, for example, is crucial. Quite often those themes are the backdrop to all other issues a client may bring to therapy. In my opinion, it is crucial that each and every therapist considers his or her own issues around class, gender, race, sexuality, disability, transgender and creed, before we inflict ourselves on our clients or colleagues.

As the very brave and admirable Mike and Simone's important discussion shows, if a therapist is worried that they may be viewed as a perpetrator, then what can ensue is a battle between client and therapist, re-enacting the painful battles that go on in other aspects of a client's life. This battle can be a challenging but sometimes useful exploration for both parties, but in my opinion, it is not the client's role to educate the therapist.

In response, I turn to *In Our Own Hands: a book of self-help therapy* by Sheila Ernst and Lucy Gooding.[1] The quoted section below is about racism, but the writers note that you could work with other issues, such as classism or sexism.

'This exercise is based on the idea that in order to have become oppressors... we were ourselves first badly hurt: the racism masks grief. By starting from a position of pride in who we are and a sense of unity with all oppressed people (by recalling how we are or have been oppressed), we can discharge the grief and let go of the racism [...]

- Stage 1 – How was/am I oppressed? (Get in touch with a particular incident) [...]
- Stage 2 – When was there a time I stood up against racism? (If you can't remember, make up a fantasy with yourself as hero/heroin)
- Stage 3 – When was there a time I colluded with racism and did not stand up against it? (Describe a specific incident)
- Stage 4 – Re-tell Stage 3 as a fantasy the way it should have happened.'

Akum Uwahemu
MBACP (Accred). Twitter: @akumefulee

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Meaningful debate

I have just read your article on class and wanted to thank you as it helps me to delve deeper into this topic with my student colleagues. I am a second year CYP training psychotherapist, with a social work background. I always leave my experiential groups with a deep sense of frustration, as my colleagues cannot acknowledge that black/working-class people tend to have different experiences of the external world. It probably doesn't help when the facilitators enact this lack of understanding by terming my responses 'angry' or 'prejudiced'. They too seem unable to make 'space in their minds' for this idea.

Just to highlight that I am the only working-class, black female in a year group of 20. There are no lecturers reflecting this demographic. How do I support a meaningful debate among my colleagues who will be working with young, working-class black CYP without being labelled as a 'trouble maker'?

Name withheld

History of oppression

I was interested to read the debate about class in April's issue of *Therapy Today* as it touched on many of the themes I found when researching this topic. I agree with Simone that class is a neglected issue when compared with other aspects of client–counsellor difference such as gender, sexuality or ethnicity. Social class has its own powerful history of oppression that, as counsellors, we cannot afford to ignore.

In 2005 I carried out a research project (for an MSc in counselling) into how clients' experiences of perceived differences in social class between counsellor and client affect the therapeutic relationship.[1,2] I interviewed five clients who identified as working class (and who identified their counsellor as middle class).

The imbalance of power in the relationship that Simone talked about (pp16–17) was mentioned by all the clients. One client described it as: 'It felt like she [therapist] was the figure of authority and I was this wee person that needed help.' Another client described it as a huge barrier in the room that was never acknowledged. These feelings effectively disrupted the therapeutic work for the clients, as they were unable to trust the therapist.

As Simone mentioned, clients' conditions of worth were linked with their background: one client felt ashamed when she did not understand a word the therapist used; another felt unable to cry in therapy, for fear that this would confirm to the therapist the shortcomings of her working-class upbringing. One client described how she took great care to dress well when she attended a counselling session. Alternatively, another client's pride in her background meant that she adopted a more combative attitude to the therapist and refused to cry in sessions, as it might seem like 'capitulation' to the power of the middle-class therapist.

All the clients spoke of how being working class felt like another world for their (perceived) middle-class therapist, and one client reported how his therapist found his values quite novel, and expected him to educate her on what it was like to be working class. The therapists could not or would not move outside the 'protective bubble' that Mike describes in the debate. Inside this bubble everything is secure and cannot be challenged; as one client said, to be middle class is to be 'on safer ground' than to be working class.

While I agree with Simone that more diversity among trainers would be welcome, I also feel that, as therapists, we each have a personal responsibility to address class for ourselves and become aware of how it affects the political values we bring (albeit subconsciously) into the relationship with clients. It is all too easy to take refuge in the feeling that 'helping people' is non-political and ignore the covert assumptions that clients may be making about how we speak or where we live (if the counselling is in the therapist's home); these assumptions may in turn affect what the client voices or withholds in therapy.

When I asked the working-class clients if they would

prefer to have therapy with a counsellor of a similar class, most of the clients expressed a wish rather for their counsellors to be aware of the difference and acknowledge it. In this way, the power dynamic can be addressed in the relationship, rather than covertly reproducing old patterns of oppression.

Jane Balmforth
PhD; MBACP (Accred)

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Relationship and class

I was so pleased to see 'Class and counselling' as the main headline on the front cover of April's *Therapy Today* – this subject has been of particular relevance to me in my personal process – and so I was disappointed to find but one article.

Only when I read Simone's answer to Mike's question 'How should class be looked at in training?' did I fully engage with her and her viewpoint (up till then, disliking her stance as victim). As much as I appreciate the importance of looking at *how our identity affects the way we experience the world*, looking at *how the way we experience (and have experienced) the world affects our sense of who we are* seems equally important.

To assess anyone's background, including one's own, as privileged or under-privileged is surely subjective and loaded with prejudice. Indeed, it was hearing my therapist utter the word 'privileged', after I'd disclosed my private boarding school education, that unleashed my fury at being utterly misunderstood about this very matter – which started the lengthy process of my identity deconstruction-reconstruction.[1]

All aspects of relationship contain power dynamics, class no more no less than age, gender, race etc. Raising this as a separate issue is valuable but only as part of integrating this particular aspect of selfhood with the greater whole, so it doesn't remain split off as the 'green-eyed monster' of our culture and society.

Jane Barclay
MBACP; AHPP; therapeutic counsellor

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They've seen enough tears

I wonder why such a little report on therapists crying (News, *Therapy Today*, March 2013, p5) had such an impact on me. Maybe it's because recently I saw one of my clients, who comes to me as his drug counsellor, and he told me about what a freak he felt when he told his life story to a private therapist and she burst into tears.

When this client told me his story, I felt tears forming in my eyes. I went to a great extent to keep my eyes dry, but wanted to let him know that I was very moved by what he told me. I had just managed to express this when he told me about his previous experience with the crying therapist and how that made him lose trust in her. He never went back.

His said that if an experienced therapist, accustomed to all sort of stories, situations and life dramas, felt so sad for him to the point of crying, what kind of freak did that make him? Was she not concerned for how he was feeling?

Perhaps he also felt that, if she could not contain herself and get a grip on her emotions, how would she be able to contain him?

I am not sure this demonstration of emotions has a helpful effect in a therapeutic relationship. Many of my drug-using clients look at me as a solid and rational agent in their tremendously chaotic and emotionally charged lives. I feel that it is not my place to feel the comfort of expressing my own emotions. Many of them have seen enough tears.

I would be happy to be challenged. I may be missing something. Maybe spontaneity has more room than I give it credit for in a therapeutic setting and a client could see the therapist's tears as the humane side of the profession. I am not sure. I will try, however to keep my eyes dry for the time being.

Alberto Pavan
CBT counsellor

Multilingual client study

I was pleased to see Dick Blackwell's letter in *Therapy Today* (March 2013) in response to Lysanne Sizoo's article (October 2012), where she comments on her decision to allow therapists only to work in their mother tongue. I run a multilingual and multiethnic counselling service called Mothertongue. All our counsellors and therapists are multilingual and they work in their native languages as well as in other languages. Not only are they able to work fully in a range of languages; they raise a different issue about training.

Multilingual therapists interviewed for a recent research project[1] mentioned the problems of training in English and then working clinically in their native languages where they did not have access to the professional vocabulary or experience in relating professionally in their native language. Therapists who answered an online questionnaire identified that there were also potential benefits of working in an additional language.

There will of course always be those who share Perez Foster's concerns that work in English with non-native English speakers could be 'a "pseudotherapy" which simply sides with the patient's resistance to the mother tongue and the mother era, or a "quasitherapy" where the essential material is lost in the complex cognitive traffic of bilingualism...'[2]

We are currently collecting information for a research project on the experiences of multilingual clients and would welcome input from anyone who is interested in improving services for people from diverse cultural and linguistic backgrounds. The questionnaire can be found at http://bit.ly/Questionnaire_Patients

Beverley Costa
CEO and Clinical Director, Mothertongue multiethnic counselling service

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Counselling hearing loss

It is estimated that 150,000 individuals have 'profound or severe' hearing loss (July 2011, Action on Hearing Loss). These individuals have lived in the hearing world and have gradually or suddenly lost their hearing due to a variety of causes. The impact of this loss can be likened to being at the centre of an earthquake, when everything that has been taken for granted is no more. The sound of a loved one's voice, music, traffic, the wind blowing through the trees and the easy ability of being able to communicate with another are no longer available to them and this is often combined with difficulty with balance.

It is not only the individual who is subject to this impact but also those closest to the epicentre of that shock wave of change. This means their partner, family members and friends all experience the loss of the familiar and the ordinary. The loss of hearing is life-changing for all involved and can be regarded as a hidden disability.

Hearing Link is a UK-wide charity that responds to the needs of the deafened, their partners, family and friends through support and advice and, significantly, through the provision of a week-long residential rehabilitation programme. The Intensive Rehabilitation Programme (IRP) offers an opportunity to explore ways of overcoming the difficulties presented by the loss of hearing. An integral part of the IRP is the opportunity for participants to use the services of a counsellor. It is acknowledged that there are limitations to what can be achieved through these sessions. But often it is the first opportunity made available to people with hearing loss to talk through their experiences so, while it may well be just the one session, this short input can still be of great value.

The need for 'deaf aware' counsellors has become apparent through our work with Hearing Link and it is our wish that this be addressed. BACP is exploring the possibility of setting up a sub-section of their directory to identify counsellors who would be able to respond to this need.

[Editor's note: And also a sub-section of counsellors with particular experience of working with people who are visually impaired.]

Equally Hearing Link would be pleased to receive names of those counsellors who have experience of working with the deafened and, also, would be pleased to hear from those who would be interested in attending deaf awareness training. If you are interested please make yourself known to BACP or Laura Turton, Head of Services at Hearing Link, on 0300 111 1113 or email laura.turton@hearinglink.org

Caroline Bickerton
MBACP (Accred); RSLI
Dick Hill
MBACP (Accred); MA

Moira Walker (1948–2013)

All of us who knew Moira in person, which is a great many people, or through her writing, will be saddened to hear of her death on 25 March.

Throughout much of the time I have known Moira she was Head of the Counselling Service at the University of Leicester and a major contributor to BACP committees and initiatives, particularly around supervision and ethics.

One of the delights of working with her on ethical issues for BACP was her warmth, sense of fun, insight and thoughtfulness around a wide variety of topics.

Her contributions combined creativity with good judgment. Her style was to understate the significance of what she was offering, so I often found myself reflecting on what she had said after a meeting as its significance continued to grow. She was a very easy person to like, instinctively friendly and collegial, and a lot of us liked her a great deal.

Moira also published extensively, authoring over six books, including one with her husband Michael Jacobs, and made many other contributions to edited collections and journals. She is probably best known for *Women in Therapy and Counselling: out of the shadows* (Open University Press, 1990) and *Surviving Secrets: the experience of abuse for the child, the adult and helper* (Open University Press, 1992). *Surviving Secrets* was shortlisted for the Mind Book of the Year and is now in its fourth reprint. Moira also founded the charity Dorset Action on Abuse.

Moira died after a long illness. In his email informing BACP of her death, Michael talked about her struggles with her illness before slipping away peacefully. He concluded: 'She was a fighter to the end, this time for herself, having over her lifetime fought for so many others.'

Tim Bond

Getting with the beat

Freud's lost chord: discovering jazz in the resonant psyche
Daniel Sapen
Karnac, 2012
240pp, £23.99
ISBN 978-1780490120
Reviewed by Chris Payne

When I became interested in jazz some years ago, I realised it had parallels with psychotherapy, in that we know where we start but don't know where the interplay will take us. Thus, we are creative. This book deepened my appreciation of those parallels, which are present in both music and therapy, based on the pulses, rhythms and breaths that form our earliest experience in the womb.

This book is bursting with ideas and references – occasionally to excess for me but better that than insufficiently challenging. Daniel Sapen devotes the first chapters to the art of therapy, moves on to 'resonant space' and then to fundamentally musical ways of seeing the work of the therapist. He describes the post-Freudian progression from a focus on repressed drives towards an emphasis on potential and change. He points to the great overlap and interplay between music and emotion. He holds out the musical model 'as a field of resonance into which much of the psychoanalytical tradition then enters on a new basis' (p182).

He is both interesting and clearly well versed in Jung ('Freud's first nemesis') and Bion, but also refers across philosophy, science and the intersubjective field. He then discusses the jazz process of Miles Davis and John Coltrane, who illustrate 'a particular marriage of disciplined form and affective, aesthetic freedom which serves as a musical cousin of Bion and Winnicott's analytic aesthetics' (p156). He goes on to consider analyst-musician Steven Knoblauch's fascinating ideas on expanding clinical attention,[1] and comes down to earth with Ellen's case history in the final chapter, 'The musical and the clinical'.

For all Sapen's learning, this is a modest and human account of a therapeutic journey. It led me to consider anew the idea of music in clients' voices, in the rhythms of sessions and groups of sessions and repetitive choruses. It gives me, too, a way of considering the tenor of my own responses.

You may find yourself carrying *Freud's Lost Chord* around for six months, still having only absorbed half of its ideas. I recommend it.

Chris Payne is a transpersonal/psychodynamic psychotherapist and counsellor

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Spirit and psyche

Psychotherapy and spiritual direction: two languages, one voice?
Lynette Harborne
Karnac, 2012
153pp, £17.99
ISBN 978-1780490182
Reviewed by Caz Binstead

Lynette Harborne is Chair of the Association for Pastoral and Spiritual Care and Counselling and both a psychotherapist and a spiritual director. This is her bold attempt to critically examine the two disciplines of psychotherapy and spiritual direction in their own right, and also to encourage greater co-operation and understanding between them.

The book begins by looking at their shared roots: how each arose from spiritual settings, with psychological insight at their heart, and how they developed uniquely from this. Chapters three and four then consider how successfully psychotherapy now deals with spiritual issues, and spiritual direction with psychological concepts. The subsequent chapters focus on ethical practice, and the contribution to this of the training in each of the disciplines. Harborne ends by asking the reader to look beyond the differences and their own professional remit to appreciate, respect and learn from the other. While there may be differences between them in *nature*, they share a common functional *purpose*, she argues – and that purpose is one of 'healing'.

This is not purely a book of appreciation; one of Harborne's aims is to challenge both disciplines. She encourages therapists to engage with spiritual issues more readily in their work, arguing that clients will bring spirituality into the room whether we like it or not, and that therapists need to be less fearful of working with their clients' beliefs. Equally, she asks that spiritual directors engage more with psychological thinking. Issues such as the underlying dynamics in the client/practitioner relationship or the possibility of unconscious process must be taken seriously, she argues.

Chapter 10 asks, 'Can spiritual direction be considered a modality of psychotherapy?' This is Harborne's 'heretical question'. I find it an

interesting consideration, but remained unconvinced. Given how many religions/denominations there are, and their myriad doctrines of varying authoritarianism, there will inevitably be incompatibilities with what is considered ethical practice in the psychotherapy world. Harborne herself points to the lack of training in diversity in spiritual direction programmes, in glaring contrast to the importance accorded to culture and diversity in psychotherapy trainings.

But this is a valiant attempt to address a complex subject. Harborne's passion for giving clients the best possible service drives her arguments. This book is an invigorating mixture of opinion, challenge and advice for the psychotherapist and spiritual director alike.

Caz Binstead is a qualified, integrative counsellor and writer, working in private practice in London

Is grief a diagnosis?

Complicated grief: scientific foundations for health care professionals
Margaret Stroebe, Henk Schut and Jan van den Bout (eds)
Routledge, 2012
332pp, £29.99
ISBN 978-0415625050
Reviewed by Ruth Malkinson and Simon Shimshon Rubin

This book is a welcome addition to the literature. Professors Stroebe, Schut and van den Bout are well known in the field of research on bereavement. With the controversy around the inclusion of the diagnosis of 'complicated grief diagnosis' in the *DSM-5*, its publication is particularly timely.

The scepticism about the need for a bereavement diagnosis and professional intervention following loss is shared by many professionals, as well as the general public. This book addresses the many questions about the scientific, clinical and societal implications of healthcare professionals dealing with complications of response to loss, from theoretical, empirical and applied perspectives. Readers will appreciate the scholarship and knowledge it contains and its contribution to the in-depth consideration of the issues.

The list of contributors is impressive. The chapters also contain expected and unexpected topics. An example of the former is 'Prolonged grief disorder as a new diagnostic category in the *DSM-5*', by Boelen and Prigerson; 'Complicated grief: philosophical perspective' by Cooper is an example of the latter.

The book is divided into six sections. Section I outlines the goals of the book, and contains an overview by the editors. Section II, on 'The nature of complicated grief: conceptual approaches', addresses conceptual, cultural, clinical, and philosophical issues. Taken together, they provide the reader with a range of viewpoints and frames of reference for thinking about complicated grief. Section III, 'Diagnostic categorization: scientific clinical and societal implications', presents arguments for and against the diagnosis. Section IV, 'Contemporary research on risk factors, processes, and mechanism', provides a deepening and broadening understanding of our understanding. Section V, 'Treatment of complicated grief', explores a range of approaches, including cognitive-behavioural, family therapy, internet-based bereavement interventions and group therapies. In the final section the editors close by stressing the importance of interdisciplinary collaboration, especially between researchers and practitioners, as the best way to develop our understanding of the complexity of complicated grief.

The book provides an up-to-date, state-of-the-art focus on complicated grief. It is addressed to researchers, practitioners and policy-makers whose work brings them up against the controversies. While any number of issues resurface time and again in different chapters, the overall effect is not one of unnecessary repetition but rather of a deepening and broadening of understanding. This book makes it clear that the focus on the complications of grief has been positive and has accelerated the understanding of loss, grief and mourning in both the professional and public spheres.

Ruth Malkinson is Director of Training Programs at the International Center for the Study of Loss, Bereavement and Human Resilience, University of Haifa. Simon Shimshon Rubin is Director of the International Center for the Study of Loss, Bereavement and Human Resilience and Chairman of the Clinical Psychology Program

Whole-earth healing

The life of things: therapy and the soul of the world
Bernie Neville
PCCS Books, 2012
203pp, £18.00
ISBN 978-1906254469
Reviewed by Caroline Frizell

This is a significant contribution to a growing body of work that questions the egocentric and anthropocentric assumptions framing a conventional approach to psychotherapy. Neville's scholarly writing draws on a wide range of works as he seeks to discover an ecological-mindedness in person-centred therapy, specifically in the writings of Carl Rogers. Neville suggests that, at close scrutiny, we find that Rogers offers a perspective on the process of actualisation that brings individual healing into an intimate alignment with the healing of a whole-earth community.

One of the main strengths of this book is the breadth of material covered; each chapter is packed with a density of ideas, including the mythologies of the classical cultures, philosophical perspectives, science, depth psychology, 'right-brain', transpersonal therapies and ecology. This book is one of a number of recent publications that have begun to map the landscape of ecopsychology and through which a new language for therapy is emerging. It challenges

us as therapists to reframe the nature of our work and to operate from a place that is simultaneously client-centred and planet-centred.

The book may appeal to established professionals who want to reconsider the nature of 'things' through which relationships flow, such as consciousness, empathy, communication, memory, imagination, cognition and soul. Neville argues that this flow is part of a universal becoming, experienced as a felt sense. He demonstrates how, for Rogers, the actualising tendency, rather than being a specific characteristic of the human experience, is a 'formative tendency at work in the universe as a whole' (p60). Whitehead's notion of the universe and Gendlin's thinking on the focusing process both serve to support an argument for psychic growth as a cosmic event in which we participate, rather than a private matter. We (humans) are some of the many 'things' that make up the body and soul of that universe.

Towards the end of the book, the chapter entitled 'Self-realization and the ecological self' draws on the work of Jungian analyst Jerome Bernstein to discuss the indigenous wisdom of the Navajo, in which the sacredness of life itself is literally central. As we explore the concept of the 'borderland', the incongruence between our culture and nature becomes apparent. Profound healing can occur, it seems, when we shift away from a preoccupation with the ego towards a sense of our ecological self.

This book challenges therapists to become agents of change for our culture – to adopt an environmentally sensitive professional practice that honours individual pain and planetary suffering simultaneously.

Caroline Frizell is a practising dance movement psychotherapist and ecopsychologist

Winnicott revisited

Donald Winnicott today
Jan Abram (ed)
Routledge, 2012
408pp, £29.99
ISBN 978-0415564885
Reviewed by Eileen Aird

Donald Winnicott's unique contribution to the development of psychoanalysis has been in the ascendancy for some time. This volume is a welcome addition to the growing body of commentary and scholarship available.

Divided into three sections, the book brings together published work from Marion Milner's 1972 paper 'Winnicott: overlapping circles and the two way journey' to Christopher Reeves' 2012 paper 'On the margins: the role of the father in Winnicott's writings', an illuminating extension of Winnicott's formulation of the significance of the father.

The three sections, 'Introductory overviews', 'Personal perspectives' and 'Late Winnicott studies', each begin with one of Winnicott's own papers: each a reminder not only of the exploratory and daring nature of his work but also of the direct way in which he addresses his audience.

Jan Abram's introduction argues that Winnicott's work 'creates a huge advance in the concept of subjectivity' (p2). She delineates some areas of agreement with Klein but sees Winnicott's thinking as essentially an extension of Freud's, although she does point out that Winnicott's starting point was different – the ill baby with the presenting mother. Winnicott himself seems disarmingly disengaged from the notion of continuity of influence and association that books like this strive to establish: 'With me, just as with other people, the development of thought has been along the line of something that has to do with growth, and if I happen to be like somebody else, it just turns up because we are all dealing with the same material' (p33).

On his part,Winnicott is clear about his early debt to Klein. He argues that her concept of the depressive position (a phrase that he didn't like, replacing it with the stage of concern) ranks with Freud's concept of the Oedipus complex. Where he diverges from Klein is in his belief in the initial unity of mother and child as the source of development. Klein's emphasis was much more on the individual baby.

There are many important papers in this volume. Particularly noteworthy are Kenneth Wright's 'The search for form' and Marion Milner's paper mentioned above, which emphasises the significance Winnicott saw in preliminary chaos as the first part of the creative process.

Eileen Aird is a psychoanalytic psychotherapist and supervisor

Practice-based theory

The presenting past: the core of psychodynamic counselling and therapy (4th edition)
Michael Jacobs
Open University Press, 2012
288pp, £26.99
ISBN 978-0335247189
Reviewed by Colin Feltham

Michael Jacobs remains one of the leading figures in psychodynamic counselling and this book has been a central and reliable source since 1986. It's important to note that, a prominent trainer and writer for decades, Jacobs has also maintained a clinical practice and this is the key source of his own theorising. In other words, this text is characterised by the insight and authority of practice-based evidence rather than being primarily theory applied to practice.

It is also written accessibly, with sometimes difficult psychodynamic concepts rendered into plain but elegant prose.

Most readers will know from previous editions that the book rests on the principle that an individual's past, particularly in its unresolved conflicts and limitations, continues to exert an influence on present life, acutely so in the therapeutic setting. But the present also affects perception of the past. The three parts of the book are 'Trust and attachment', 'Authority and autonomy', and 'Cooperation and

competition'. Jacobs draws on the developmental theories of Freud, Erikson, Winnicott and Rayner, as well as Klein, Bowlby, Stern and others. He has taken due care in this fourth edition to progress from early stage theories to developmental themes, and a major aspect of the book is to demonstrate what practitioners' tasks are in relation to the key themes presented in counselling and psychotherapy.

Convincing case studies are used throughout and summaries helpfully link practice issues with theory. Jacobs shows how early ambivalence, the internalisation of parental control and Oedipal configurations, among other psychodynamic phenomena, are understood and skilfully worked with.

This edition is thoroughly updated and revised so as to avoid unwieldiness. It is hard to see how such a succinct and authoritative text can be improved on. Mainly for those undertaking psychodynamic training courses, the book will also be useful to those working in other theoretical approaches and experienced practitioners, since the author clearly has such a wealth of clinical experience and wisdom himself.

Colin Feltham is Emeritus Professor of Critical Counselling Studies, Sheffield Hallam University

Romanticism and analysis

Uncertainties, mysteries, doubts: romanticism and the analytic attitude
Robert Snell
Routledge, 2012
£24.99, 217pp
ISBN 978-0415 543866
Reviewed by Gillian Ingram

Robert Snell is an analytic psychotherapist and his book is a timely reminder in these days of brief, economically driven therapy of the need to stay true to the basic psychoanalytic stance of respecting the client by maintaining an 'evenly suspended attention' – an undirected, actively receptive listening that involves bearing not-knowing and not foreclosing. Snell explores various Romantic art forms that he feels can offer a parallel experience of this 'analytic attitude'.

The quote from Keats in the title leads into his initial exploration of the extent to which Romanticism was an essential part of Freud's cultural heritage. Snell starts with the Spanish artist Goya, claiming his work can help the analyst 'stay alert to forms of aliveness, even unwelcome ones, in the deadest of material' (p65). Goya forces us to confront 'what lurks in the shadows: the repressed and denied, rage, perversity, malignant narcissism' (p65). Snell looks in detail at a series of etchings entitled *Los Caprichos* (1779), which he considers were deliberately opaque, so that the viewer is forced to puzzle out their ambiguous riddles, inevitably beyond interpretation. Can we, like the analyst, allow ourselves to float in this sea of signs?

Through next exploring the German writers Hölderlin and Novalis, Snell argues both writers 'might help attune therapists to the importance of the particular word spoken – this word, not that – and to that fact that the word is always contingent and inadequate' (p65). Impenetrability in the poetry has to be tolerated, just as it must be tolerated in the analytic session, until some sense, unforced, begins to emerge.

The chapter on Baudelaire links the poet's persona as a *flâneur* to 'free-associative wandering, a way of bearing lostness and disconnection at the same time as allowing experiences and a hope for meanings in' (p129). The poet must also, like the analyst, hold himself together in such a free-floating multiplicity, Snell argues. Snell moves on to exploring the 'proto-analyst' Dr Noir in de Vigny's novel *Stello* (1832) and then the detective Auguste Dupin in three stories by Poe (1841–43). The latter's 'lateral mode of thinking adumbrates that of the working psychoanalyst' (p152).

When he finally, movingly, engages with Keats, Snell admires his courage in struggling to maintain 'negative capability' and stay true to his belief that it is not a poet's role to soothe (just as it is not the analyst's) but rather to demonstrate 'how necessary a World of pains and troubles is to school an Intelligence and make it a soul' (1819).

As a practising therapist I found the second chapter of the book, which provides an overview of the historical development of 'the analytic attitude', the most helpful. Intellectually, the consideration of Romantic art forms was intriguing but tended to drift into the over-detailed and esoteric. Those of a more disciplined intellectual bent might, however, 'be challenged to invent [their] own ways of reading' (p150) by adopting a free-floating, non logical and intuitive approach to the works Snell suggests.

Gillian Ingram is a BACP accredited psychodynamic counsellor and a clinical supervisor

From the Chair

Direction of travel

Suicide confronts us with our powerlessness and our purpose, writes *Amanda Hawkins*

Sometimes things happen that change the way your life is going in a split second. This week I had one of those experiences. I was on the train back to London, from a meeting in Manchester. Just past Salford, the train hit something. At first I thought it was a bit of debris – the train seemed to keep going despite the loud noise of the collision, but eventually it came to a halt.

I noted the train manager swiftly but calmly walking through the train, on her way to see the driver. The sun was shining (uncharacteristically for this year), and I wasn't too concerned about the disruption to the journey. I didn't need to be anywhere fast. I carried on writing my emails.

Then there was an announcement that unfortunately there had been a fatality on the line – that a person had thrown themselves in front of our train. It took a few minutes for my brain to comprehend what had happened, to reprocess some of the sounds that I had heard and to make sense of them. Then the horror set in, the empathy with the driver and the realisation that (and I am sorry if this sounds dramatic) I had just witnessed the end of someone's life in the most horrific of circumstances – a thought that won't stop running in my head.

I have to say, the train crew and the train company handled the situation very well. I felt held, understood and looked after in my own reaction to the incident. The train and all its passengers were held up for quite some time until the initial police enquiry was completed.

While waiting on the train, I had a number of reactions. Obviously there was shock – I wanted to reach out, have someone tell me that what I was feeling was normal, because it all felt very confusing, very surreal.

My iPhone allowed me to make contact with my loved ones, who reassured me and gave me a sense of safety. A little while afterwards I felt a sense of loss – the loss of this person's life. I didn't know who they were, but I couldn't understand why they would take their life in such a violent way. Then I (and this is the bit that surprised me) felt a sense of failure and responsibility in relation to our profession; I wondered how matters had got so bad that this person couldn't access help. It felt overwhelmingly sad. I went to a place where I had to question what I was doing in my job and whether it was really helping anyone if things like this can still happen.

Ultimately, however, the experience has left me with a renewed sense that what we do is vitally important; that it does save lives; that my role as BACP Chair, right here, at this time in relation to this profession, is to make sure that as many people have access to good, safe therapeutic support as need it. And it reminded me that sometimes life gives you what you need, even if it isn't always what you want.

Taking us away from this sad topic, I wrote, a few columns ago, about my relief that BACP has successfully achieved accreditation of our voluntary register with the Professional Standards Authority, and that we can now move on to other issues. But, I admit, I was premature; for you, our members, there's another stage still to be completed.

> 'I wondered how matters had got so bad that this person couldn't access help. It felt overwhelmingly sad'

We've had a very good initial response to our communications about the need to join the Register. many members who are BACP accredited have made the simple transition; many who need to complete the Certificate of Proficiency (CoP) first have done so, or have booked their place at one of our regional events. The feedback from BACP's Making Connections events is that the CoP is relevant, meaningful, and possible!

Are you BACP accredited? Have you gone onto the BACP Register website and signed the terms and conditions to join the Register? If you aren't BACP accredited, have you signed up to take a Certificate of Proficiency test? You'll find all the information you need at www.bacpregister.org.uk

I urge you to do this now – don't wait until your membership renewal date comes up. It's important for you as a professional and practitioner, for the counselling profession as a whole, and for our clients above all. The Register is part of our continuing campaign to drive up standards, ethical practice, safety and our professional profile. Employers increasingly will be looking to see that you are on it. The standards of protection and ethical practice it enshrines put us on a par with our professional colleagues in the health and social care arena. Let's all take this great step forward together! ■

Are you registered?

BACP is in the process of assisting all its practising members to meet the requirements for entry onto the BACP Register, writes Registrar *Sally Aldridge*

While many of you have already been to the BACP Register website and signed up to the terms and conditions, some members haven't yet done so.

The Register is the first psychological therapists' register to be accredited under a new scheme set up by the Department of Health and administered by an independent body – the Professional Standards Authority for Health and Social Care (the Authority).

The Authority is working with the Department of Health to ensure that quality-assured registers are promoted as the first port of call for members of the public, employers and commissioners.

Being on the BACP Register demonstrates that a counsellor or psychotherapist exceeds the minimum level of competence that a client has a right to expect from a practitioner. We are in the process of assisting all BACP practising members to meet the requirements for entry onto the BACP Register. Once this process is complete, we 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.

So sign up today!

Sally Aldridge

Accredited members
Go to the prospective registrants' area of the BACP Register website and sign up through the fully electronic process. Don't forget to renew your registration when you renew your membership.

MBACP who have completed an accredited course
Go to the prospective registrants' area of the BACP Register website 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 who have passed the Certificate of Proficiency (CoP)
Go to the prospective registrants' area of the BACP Register website and sign up through the fully electronic process.

MBACP who have not completed a BACP accredited course and/or are not BACP accredited
To go onto the Register you will need to take the BACP Certificate of Proficiency (CoP). This is an online, case study-based assessment. Details of the venues currently available can be seen on the map below and by visiting the BACP Register website.

Visit the BACP Register website at www.bacpregister.org.uk. If you need further clarification, please contact 01455 883300 or enquiries@bacp.co.uk or visit the Frequently Asked Questions at www.bacpregister.org.uk/faq

Certificate of Proficiency

The Certificate of Proficiency (CoP) is a computer-based assessment of ethical practice, decision-making and knowledge, which gives eligible members a way onto the BACP Register of Counsellors and Psychotherapists. The CoP provides a route to registration for members who aren't BACP accredited and haven't done a BACP-accredited course.

To be eligible for the CoP, members need to be either an Individual Member (if they have joined this category since 1 April 2013) or MBACP.

CoP events are being held across the UK. We will continue to add to the itinerary of dates and venues and, once the venues are confirmed, you will be able to book your place online at www.bacp.co.uk/events/conferences.php

The map opposite shows new locations that have been recently added to the CoP itinerary.

You can find out more about the CoP and check your eligibility status on the Register website at www.bacpregister.co.uk/prospective/CoP.php

Frequently asked questions

1. Why should a counsellor be on the BACP Register?
Being on the BACP Register demonstrates to the public, employers and peers that a practitioner exceeds the minimum level of competence that a client has a right to expect from them.

2. Will counsellors have to raise their standards in order to join the BACP Register?
The majority of our members are already practising at the high standard of competence required of them in order to join the BACP Register. We are working to advise and assist those members who have not reached those standards.

3. Are all current members of BACP moving onto this new register?
Accredited members and those who have passed a BACP accredited course have already demonstrated and evidenced the required level of competence to join the BACP Register, and have been invited to sign up to its terms and conditions. All other practising members in the eligible membership categories will have this opportunity on achieving the Certificate of Proficiency (CoP).

4. Will new members automatically join the BACP Register?
Some members, such as those who have passed a BACP accredited course, are already eligible to sign up. All other practising members in the eligible membership categories will have this opportunity following achievement of the CoP.

5. What does the CoP assessment involve?
The CoP is delivered through case studies and is designed to reflect competent practice. It is derived from the competences developed for the National Occupational Standards in psychological therapies. There are systems in place to make sure that the assessment is varied and covers a range of areas, including ethical practice, establishing the therapeutic relationship and use of supervision. During the assessment, candidates need to make appropriate choices based on their experience and the information that they are given. Members have three opportunities to pass the CoP.

6. How are you conducting the assessments?
We have booked venues across the country where our members can take the assessment at a time and location convenient to them. As of 7 May 2013, 1,579 members had completed the CoP assessment at sessions in 17 different towns and cities across the UK, and 92 per cent of these members achieved the level required and became eligible to join the Register. Members who have not yet booked their CoP assessment can find out more about the process and book their session at www.bacpregister.co.uk

7. What are the implications for a counsellor not on the BACP Register?
Following the transition period, BACP would not recommend seeing a counsellor or psychotherapist who has not exceeded the minimum level of competence required to join the BACP Register. This safeguard provides a vital benchmark to help potential clients to find their way in an increasingly busy marketplace.

8. What about companies and organisations that employ counsellors?
As with potential clients, we would urge all employers of counsellors and psychotherapists to only employ practitioners who are on the BACP Register.

9. What about BACP's accredited counsellors? Are they better than those on the Register?
The BACP Register also recognises members who have achieved a substantial level of training and maturity of experience, as assessed by BACP. We refer to them as accredited BACP counsellors and psychotherapists. These BACP members have additional areas of expertise, skills and knowledge, on top of their original training. We recognise them as the 'gold standard' within the profession.

10. So what does accreditation by the Professional Standards Authority mean?
It means that our Register meets the Authority's high standards in respect of governance, standard-setting, education and training, management, complaints and information.

11. How does the Register help protect clients of therapy from malpractice?
As well as having proved that their practice exceeds a minimum level of competency, all Registrants are bound by the BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy* and, within this, our Professional Conduct Procedure.

12. Don't we already have a register? Why do members need to sign up to this one?
BACP has reviewed its existing register to more closely align it to the Authority's standards. Being on the Accredited Voluntary Register demonstrates that a practitioner exceeds the minimum level of competence that a client has a right to expect.

13. Didn't BACP previously oppose a voluntary register?
BACP has long campaigned for tighter regulation of the industry to provide protection to both the public and practitioners. We believe that the Authority's accreditation of our register will assist us in our goal to advance standards within counselling and psychotherapy and are proud to have been one of the first professional organisations to be involved in the scheme.

Walking the talk

A BACP award-winning initiative has transformed the counselling service at the Hospice in the Weald, reports *Catherine Jackson*

Martin Riley says the changes have radically increased patient contact

'Medical and nursing colleagues saw us as very much sitting upstairs in our ivory tower. We were, essentially, waiting for referrals to come to us. It wasn't how we felt we should be working.' So says Martin Riley, Head of Counselling Support Services (CSS) at the Hospice in the Weald, one of the winners of the BACP 2012 Improving Access to Counselling and Psychotherapy Award.

The Hospice in the Weald is based in Pembury, Kent. Surrounded by orchards, deep in the Kent countryside, it serves a 400-mile catchment area, and offers a Day Therapy Centre, a Hospice in the Home Service, carer support, and respite, palliative and end-of-life care in its 17-bed inpatient unit (IPU). Its counselling service works with patients, families and carers, and includes outreach counselling in the community and bereavement counselling. The counselling team has always been well established: Martin currently manages four permanent counsellors (one full-time, three part-time), 18 volunteer counsellors, a part-time music therapist and a full-time administrator.

Two years ago Martin, then a counsellor in the team, launched a review of how they were meeting needs on the inpatient unit (IPU). 'My sense was that counselling was seen as detached, removed from the hands-on day-to-day work of the IPU,' he says. The nurses were also having to hold patients' emotional distress, simply because they were there with the patients, day and night. 'For us the issue was how could we better hold some of the pain and alleviate some of the anxiety of the nurses' role and how could we make ourselves more accessible. If a nurse felt a patient would benefit from counselling they had to fill out a form, email it to us, and they had no control over how quickly we responded.'

Another challenge was the stigma attached to counselling. 'We wanted to normalise emotional support, to convey the message to patients that having counselling isn't a sign that you aren't coping or that you're mentally ill. There are a lot of false beliefs about counselling and, while we need to recognise that counselling isn't for everyone, we also need to communicate that we are there to support people through what is a normal response to their situation – who wouldn't be upset if they had a terminal diagnosis?'

Martin initiated a review of how the counselling team worked in relation to the IPU. He set up separate focus groups with the hospice doctors, IPU nursing staff, with the chaplain, occupational therapist and physiotherapist and with the counsellors. He also interviewed the Nursing Director. He taped and analysed the hour-long discussions and from the transcripts identified the key themes, which he used to inform his recommendations for change.

A major theme was access to and availability of counselling: how did the IPU multi-disciplinary team (MDT) deal with situations where they felt a patient might benefit from counselling but refused it; was there a way in which the counselling team could offer less formal support that might be more acceptable to a patient? How too could it better support non-counselling colleagues who were fulfilling this role informally? Nursing staff in particular talked about the necessity of being able to work with patients' psychological needs when they arose. Multi-disciplinary team (MDT) members talked of their anxieties about 'opening a can of worms' if they engaged with a patient's psychological distress.

Formal referral to counselling was largely considered too slow and difficult; the nurses said the counsellors felt 'a long way away' and 'strangers on the ward'. The clinical staff wanted a less formal introductory/referral process.

There was also recognition that the counsellors had much of value to contribute to the wider MDT and its holistic approach to care. There were comments about 'psychological aspects being missed in MDT', and 'Counsellors will give a bit

of insight into somebody that helps us all'. One nurse commented: '... we do hear some quite sad and worrying things... We probably go for a more clinical point of view rather than a psychological point of view, so support there would be helpful.'

Increased ward presence

Based on the feedback, and drawing on the research and reports of good practice in other palliative care organisations, Martin developed a new way of working. Counsellors would be allocated to the ward on a six-week rotation and would attend the MDT weekly meetings and the weekly ward rounds. This was piloted over four rotations: one for each of the counsellors. After each rotation the counsellor was interviewed and feedback was invited from IPU colleagues via a questionnaire. When all the rotations were completed the MDT team was re-interviewed collectively about the benefits of the new way of working and ideas for further improvements.

Counsellors said they liked feeling part of the wider team and working more closely with clinical staff. They felt they now had a better understanding of the IPU, how it operates and how decisions are made about patient care. They felt that the proactive approach relieved clinical staff of the responsibility for deciding who might benefit from counselling.

There was a mixed response to attending handovers and MDT meetings: some counsellors saw this as an opportunity to learn more about the needs of the patients; others felt less comfortable and confident in a clinical team context. However, routinely attending ward rounds was seen as advantageous in improving MDT working. The counsellors also felt that patients were more receptive to the idea of counselling if they met the counsellor in person, rather than being given a referral to an anonymous service.

The IPU clinical team welcomed the contribution of the counsellors to ward rounds, and in particular when they offered to take the lead or stay behind to talk with patients and relatives if something came up during the ward round. They also welcomed the increased presence and availability of counsellors.

There was clearly some emotional impact on the counsellors from being on the ward and in closer and regular contact with patients and relatives; the ad hoc role was more demanding. The traditional 50-minute counselling session had, effectively, been replaced by a Monday to Friday, 9–5 counselling week, the counsellors pointed out.

The quantitative results from the questionnaires and from patient contact statistics told a similar, positive tale. In 26 returned questionnaires, the benefit listed by most was the improved MDT working and holistic care, followed by the speed and ease of access. The majority felt that the amount of time that the counsellors now spent on the ward was 'just right'. And, in comparison with the same periods in 2009 and 2010, the counsellors recorded seven times more contacts with patients and relatives – an average of 22.75 face-to-face contacts over the six-week rotation, compared with 3.5 in 2009 and 3.75 in 2010.

Removing the stigma

Dr Helen McGee, the hospice's Medical Director, is delighted with the changes. 'It always was a very accessible team but it did feel as though you had to make a formal referral. Now, with the counsellors on the ward round, it's much more informal and it removes that stigma – that sense that if a patient needs to see a counsellor there must be something wrong.'

A major benefit is that the anxiety about dealing with patients' emotional distress has been lifted. 'It really helps me out when I find myself outside my comfort zone, if we are exploring lots of emotional issues with a patient. Doctors are used to asking questions, finding out what's wrong and fixing it. Here you can't fix everything so it's good to have the counsellor there, if you do take the lid off.'

There has been, she says, an overall improvement in the emotional articulacy of the MDT. 'Sometimes we'll come out of a patient's room and have a little debrief. Having the counsellor there helps us acknowledge that sometimes it's not all about what we have or have not done; sometimes it's about where the patient is now.'

Paula Wilkins, Nursing Director, is similarly happy with the way the counselling service now operates. 'The role of the counselling service on the ward has become far more embedded since the project. It's helped to demystify their role and given staff more confidence in their own skills and abilities.'

In response to the feedback, the counsellors now do a four-week rotation, not six, in recognition of their more emotionally demanding role. Says Martin: 'The work can be very draining, very intensive. It's important not to underestimate the impact of this way of working.'

What made such a radical change possible? 'Right from the start it was a collaborative endeavour – we thought it through very carefully; we consulted with our MDT colleagues to find out what they felt and wanted,' Martin says. 'This was about how we all contribute to get the best outcomes for our patients.'

For more details, email martin.riley@hospiceintheweald.org.uk or visit www.hospiceintheweald.org.uk

Labour signals policy review

Labour leader Ed Miliband has said that integration of health and social care will be essential so that the 'NHS can be made financially sustainable and provide a better service for the future'. Milliband was speaking at the launch of an Independent Commission on Whole-person Care, which the Labour Party has asked to explore ways to integrate health and social care. Whole-person care looks set to be one of Labour's key policies for the 2015 election.

The commission will produce recommendations to achieve Labour's vision of 'whole-person care', bringing together physical health, mental health and social care into a single service to meet all of a person's care needs.

Early Intervention Foundation launched

BACP was represented at the launch on 15 April at 10 Downing Street of the Early Intervention Foundation.

The Foundation has been designated by the Government as the 'What Works' lead body on early intervention, working alongside the National Institute for Health and Care Excellence, and the Education Endowment Foundation. It was formally launched by the Prime Minister with the backing of Liberal Democrat leader Nick Clegg and Labour leader Ed Miliband, in a show of cross-party support.

Speaking at the launch, Chair of the Early Intervention Foundation Graham Allen MP said: 'All parties have supported the drive towards early intervention and the creation of an independent Foundation to promote it. Now the serious work begins on delivering our three 'As – Assessment, Advice and Advocacy of Early Intervention.'

David Cameron said: 'I am committed to improving the life chances of every child, but especially those who come from troubled backgrounds. I look forward to seeing the Foundation get to work, not only assessing which programmes make a difference but giving people working in this field clear and practical advice about where money can be most effectively spent.'

The Foundation will:

- advocate for early intervention as a serious alternative to late intervention, which it argues is more expensive and less effective
- assess what programmes work – to determine both the best early interventions available and their relative value for money
- advise local commissioners, service providers and potential investors on the best practical, evidence-based interventions for supporting children and families.

The Foundation will focus initially on programmes in England but will also engage with partners across the UK and internationally.

More information is available on its website: www.earlyintervention foundation.org.uk

Support for adults with multiple needs

The Big Lottery Fund (BIG) has announced a £100 million programme to promote multi-agency collaboration to support people with multiple, complex needs. The £100 million will be shared between 10 partnership projects in England to fund collaborative work to address problems including homelessness, mental ill health, addiction and reoffending. The programme is backed by Channel 4 news presenter Jon Snow and Mitch Winehouse, father of the late singer Amy Winehouse.

The aim is to bring together organisations and public bodies to work to support people with multiple and complex needs to lead better lives, reducing offending and drug use, improve their mental health and have stable accommodation.

Each of the 10 successful partnerships will receive £50,000 in the first instance to put together a business plan on how they will improve and better coordinate services, with the prospect of a further £10 million should their plans prove robust and effective.

Around the Parliaments

It has been a quiet period for Parliamentary activity as the four Parliaments of the UK have been in recess over the Easter period.

Charles Walker MP, Chair of the All-Party Parliamentary Group for Mental Health, in a parliamentary question asked how the Government is going to measure the delivery of its commitment to create parity of esteem for physical and mental health. Responding, Norman Lamb MP, Minister of State for Health, said the Government will assess whether NHS England is meeting the objective 'by its practical actions, by whether its overall programme of work demonstrates that commitment, as well as progress on the relevant outcome measures in the NHS outcomes framework, and the delivery of other mental health commitments in the mandate'.

In response to a question from Conservative MP Eric Ollerenshaw about mental illness in young people, Norman Lamb MP affirmed that the Government is investing £54 million over the four-year period 2011–15 in the Children and Young People's IAPT programme.

In the Northern Ireland Assembly, Chris Lyttle MLA (Alliance) asked about the provision of counselling at primary school level, its impact and its funding. The Minister's reply was that state-funded counselling is provided to primary school-age pupils as part of a critical incident response package but that primary schools can also provide counselling from within their own resources.

Date confirmed for 2013 BACP AGM

BACP's next Annual General Meeting (AGM) 2013 will be held on 16 November at the London School of Economics, in London.

Governor and AGM Business Sub-Committee nomination forms are included with this (May) issue of *Therapy Today* (see also over page). Ballot papers for Governor elections and forms inviting member resolutions for the AGM will be circulated with the July journal. The full AGM agenda, postal/proxy voting forms and the Association's financial statements will all be sent out with the October mailing. Members will be able to access and return completed postal/proxy voting forms electronically. Further information on this option will be included in October BACP News and on the BACP website.

Questions relating to the AGM should be directed to jan.watson@bacp.co.uk or call 01455 883383.

BACP Universities & Colleges election

BACP Universities & Colleges is looking for a new Chair Elect for the division.

This is a one-year post at the end of which the Chair Elect takes on the role of Chair for a two-year term, followed by a further one year 'mentoring' role as Past Chair. Nominations are being invited from the BACP Universities & Colleges membership for the Chair Elect, who will take up the post as soon as possible after 24 June 2013. Current Chair, Charlotte Snoxall, will continue in the post for one more year until June 2014, when the Chair Elect will take over and Charlotte will become Past Chair.

To request a nomination form for the post of Chair Elect, email BACP Divisional Officer, Julie Camfield, at julie.camfield@bacp.co.uk

The BACP Universities & Colleges annual conference takes place 24–26 June 2013 at Sheffield University. The title is 'A world of difference, embrace and respond'. For further information about the conference, please visit www.bacp.co.uk/events or www.bacpuc.org.uk

Making Connections

BACP is holding two Making Connections events this summer: on 3 June in Leicester and on 9 July in Edinburgh.

For further details of venues and programmes visit the Events webpages at www.bacp.co.uk/events

Conference attendance costs

Members who wish to attend national and international conferences are entitled to submit a request for financial assistance to the BACP Conference Attendance Working Group (CAWG) for consideration.

Requests will be considered for conferences that are of strategic importance to the profession and where the applicant feels they can contribute from their own experience and expertise.

Applications should be submitted not less than six weeks before the event and prior to booking.

For further information, please contact Wendy Davis at wendy.davis@bacp.co.uk

BACP Connect redesigned in website overhaul

BACP has overhauled the design of the members' website portal to allow a more comprehensive and fluid integration of BACP Connect.

BACP Connect provides a secure place where members can build networks with friends and colleagues to share insights, ideas or concerns. The new design is intended to offer a more streamlined, consistent and user-friendly experience, which will underpin all future changes to the website.

Other improvements to come include an improved search function and a more collaborative news feed and active social network presence. If you have any feedback or suggestions, email ict@bacp.co.uk

Coaching round table

Barry White, BACP Coaching Executive Specialist for Professional Standards, has been representing BACP Coaching in round table discussions with the leading coaching organisations across Europe and beyond.

The Coaching Bodies Round Table (CBRT) UK has just set up a new website to begin to demonstrate the collaborative work they are doing.

Barry says: 'My role has been to hold open a space for BACP as an organisation committed to standards and good practice with its counselling members and now also its coaching members. I have taken part in helping formulate commonalities and have also looked at other ways in which we could be of help. To that end we have a fledgling website for the coaching bodies, which at the moment is simply a snapshot of all the differing attendees but in time we hope will be a vibrant "place to go" if you want to know anything about coaching.'

For more information about the Coaching Bodies Round Table, please visit www.coachingbodies.org.uk

2012 AGM Open Forum responses

Question about attendance and the third sector
Val Potter commented on the low member attendance at the AGM, despite the importance and value of members being present and taking the opportunity to vote on the important changes that were being brought for approval. She also commented on the lack of communication in the context of the Third Sector Forum/Reference Group and the increasing difficulties faced by the third sector through service and funding cuts. Val asked how the Association intended to support and represent members and the third sector in the future, and also queried the position with service accreditation.

BACP response
All members receive notification of the AGM date and venue through the Association's journal and a personal communication, which includes all AGM details and papers detailing the business of the meeting.

Other AGM-related information is normally made available through *Therapy Today* and the BACP website. The ongoing Divisional and Forum Review, which includes the Third Sector Reference Group, is considering future resourcing and a field of strategic imperatives in order to form a view on how to support and represent members from the Divisional and Forum perspectives. Support for, and representation of, the third sector will be incorporated within this review. A consultation event with Accredited Services was held in October 2012 on the proposed changes to criteria. The focus of the scheme was reconsidered in light of feedback from that meeting. The criteria have been further reviewed and we are now in the process of starting consultations with BACP Divisions prior to launching the new scheme.

Question about reviewing how the AGM is publicised
A member present acknowledged the difficulty in getting members to attend AGMs and suggested reviewing how it was publicised in future and making more use of electronic communication.

BACP response
Electronic communication and the BACP website will be used more widely to advise and remind members of the date and business of the 2013 AGM, as well as continuing the traditional notices in the journal and circulation of the various documents in line with legal requirements.

Further comment
A further comment, not requiring response, was offered by Liam Lally, Chair of the National Association for Pastoral Counselling and Psychotherapy in Ireland. He welcomed the opportunity to attend the AGM and congratulated BACP on a very successful year.

Nominations invited for BACP Board of Governors

Nominations for the vacancy for an elected Governor on BACP's Board of Governors are invited from the membership.

BACP continues to grow and thrive, with approximately 40,000 members, 125 professional staff and an annual turnover in excess of £6 million. The organisation is complex and the role of a Governor is equally complex, holding a balance between the needs of the organisation, the needs of members, the needs of those who use our services and the public perception and reputation of counselling and psychotherapy.

It is important to be aware that Governors do not represent any particular modality, sector or interest within membership. The Trustees' focus, in accordance with legal requirements, is on the following key areas:

- achievement of the Association's vision and mission within its Charitable Objects and strategic objectives
- ensuring probity, particularly financial probity, in the management of the Association's activities
- development of policy and strategy and monitoring implementation
- holding accountability, as required by Charity and Company Law, for the Association's activities to and on behalf of the membership, and ensuring due compliance with Charity and Company Law.

The time commitment Governors can expect to give is, on average, two days a month, in addition to attending approximately six Board meetings a year. There may be tasks required between these meetings, which can involve reading, consulting, writing papers, attending other BACP Committee meetings, meeting with members and other constituents and tele-conferencing.

To support and facilitate continuity and succession planning within the Board of Governors, the maximum term a Governor may serve, without a two-year break, is nine years. This is broken down into three elected terms, each of three years, and there is no requirement for any Governor to commit to the full nine years when first standing for election.

If, after reading the nomination form mailed with this issue of the journal, you have any queries or would like any further information, please contact Jan Watson, Assistant to the Chief Executive, on 01455 883383 or jan.watson@bacp.co.uk.

Completed nomination forms must reach the Chief Executive/Company Secretary in Lutterworth by 5pm on Monday 10 June 2013.

BACP AGM Business Sub-Committee election

An AGM Business Sub-Committee consisting of three members of the Association, and not members of the Board of Governors, shall be elected (for a three-year term) by postal vote supervised by the Company Secretary to advise on the conduct of the business of the AGM. There is currently one space available for election to this Sub-Committee, which is concerned solely with the AGM. On behalf of the membership it:

- ensures that the AGM runs in accordance with the Association's Articles of Association
- advises on the conduct of the business
- prepares and agrees the timetable
- manages and facilitates the smooth running of the meeting, and
- is responsible for voting that takes place at the meeting.

As well as attending the AGM, which will be held on 16 November 2013, the Committee meets, either face to face or by telephone once a year (usually in September/October) for approximately three hours. Any other contact and communication is managed by telephone, letter or email.

Nomination forms for the vacancy on the Sub-Committee are included in this mailing. For further details, please contact Jan Watson on 01455 883383 or jan.watson@bacp.co.uk

Newly accredited counsellors/psychotherapists
Azeem Ali Khan
Julie Armitage
Samantha Biswas
Jacqueline Bock
Aine Bourke
Allison Bowden
Toni Buffham
John Campbell
Stephanie Cass
Alison Cathcart
Loretta Collins
Stephanie Compton
Marcia Corlis
Deborah Crookston
Lisa Cross
Julie Crowe
Mabel Doole
Carole Edwards
Linda-Jayne Elliott
Sharon Evans
Gillian Finn
Nigel Gibbons
Tara Gibson
Carol Green
Yvonne Green
Pam Hall
Paul Harris
Oya Hassan
Sylvia Hemingway
Ilse Herlihy
Marian Hilditch
Christopher Hollis
Kate Holt
Caterina Husbands
Martyn Hutchings
Stephanie Hutchinson
Fiona Hutchison
Lilas Javeed
Sharon Johal
Pam Laurance
Carrie Lindsay
Karen Lloyd
Maureen Long
Barbro Magnusson
Tiki Martel
David McAvoy
Terry McCourt
Catherine McEvoy
Sarah McMichael
Delores McPherson
Ivan McStea
Lynne Milman
Caroline Mitchell
Jeanette Moore
Ian Mounsdon
Celia Murchan
Catherine Muston
Claire Parlane
Jayshree Pattni
Lucy Pedrick
Kathryn Pierrepont
Barbara Prager
Beverley Price
Elizabeth Pycroft
Andrew Quarmby
Catherine Quinn
Christine Roberts
Madi Ruby
Karen Savage
Ann Scanlon
Jane Short
Rajwinder Sidhu
Sue Simpson
Alison Smyth
Linda Steele
Pamela Stocker
Claire Taylor
Paul Toft
Roland Tolley
Marianna Urdhin
Faye Walters
Elizabeth Welch
Rick Wilson

Newly senior accredited counsellors/psychotherapists
Karen O'Neill
Lesley Shrapnell

Newly senior accredited supervisors of individuals
Emma Redfern
Wendy Somerville

Newly accredited counselling/psychotherapy service
Ryedale Counselling Service

Members not renewing accreditation
Fernanda Barros
Pauline Bauer
Eleanor Braterman
Lesley Brewerton
Elaine Brooker
Heather Brown
Karen Burnett
Elizabeth Calvert
Claudio Calvi
Alan Carter
Tony Cashman
Elizabeth Colley
Madeleine Comben
Ann Davis
Caroline Day
Clare Dodgson
Prunella Doherty
Sue Edmans
Mary Edwards
Margaret Evans
Amanda Fox
Caroline Fry
Hilary Gallacher
June Goble
Maureen Goodson
Dorothy Graham
Patricia Grant
Susan Griffiths
Anne Gurd
Ann Hall
Rose Hall
Judy Holman
Florence Jackman
Maureen John
Andrew Leatham
Pamela Lockett
Gillian Loveday
Rhoda Luzio
Yvonne Mahoney
Jody Mardula
Ann Newbould
Richard Noble
Michael Partridge
Jean Potter
Maria Rhodes
Anita Roberts
Caroline Russell
Hilary Sheath
Judith Taylor
Lottie Taylor
Linda Wellens
Christina Wheatley
Julie Wilde
Gill Wilkinson
Tricia Young

Please note: details of members whose accreditation has been reinstated and successful service re-accreditations have been held over until the June issue due to limited space in the May issue.

2013 research award winners

The BACP Equality and Diversity Research Award (£500) has been awarded to Beverley Costa and Jean Marc Dewaele, from Mothertongue multi-ethnic counselling service, for their research into 'Psychotherapy across languages: differences between monolingual and multilingual therapists', which was presented at the BACP Research conference earlier this month. This study explored and compared the ways in which monolingual and multilingual therapists work with clients whose native language is not English, with the ultimate aim to improve access to therapeutic help for non-native speakers of English.

The PCCS Student poster prize (£500) has been awarded to Coral Russell and Anne Napier and colleagues from Lewisham Counselling and Counsellor Training Associates, for their poster presentation 'Person-centred counsellors' experiences of working with sex-addiction', which was also presented at the BACP research conference.

The *CPR* New Researcher Prize (£500) has been awarded to James McElvaney, from Trinity College Dublin, for research undertaken as part of his PhD into 'Clients' experience of therapy and its outcomes in quantitatively "good outcome" and "poor outcome" psychological therapy in a primary care setting'.

Revised CYP counselling review published

BACP has published an updated review of counselling and psychotherapy with children and young people. The review, 'Research on counselling and psychotherapy with children and young people: a systematic scoping review of the evidence for its effectiveness from 2003-2011', is written by Colleen McLaughlin, Carol Holliday, Barbie Clarke and Sonia Ilie, from the University of Cambridge.

BACP's first review of the effectiveness of therapeutic interventions with children and young people was published in 2004. The updated review investigates whether counselling and psychotherapy are effective for children and young people, what types of counselling and psychotherapy interventions are effective, and which are effective with which problems and which client groups.

The review can be downloaded for free from www.bacp.co.uk/research/Systematic_Reviews_and_Publications/ccyp_update_2013.php

BACP research surgery evaluated

BACP Research contacted BACP members who have used its research surgery service over the past 12 months to ask what they found helpful, what other support they had accessed and what future plans they had for their research.

Respondents said that it was helpful to be able to discuss methodology in a consistent and systematic manner and that the surgery helped them with structuring research questions and with literature searches. The amount and variety of additional support accessed varied considerably and included academics and supervisors, peers, textbooks and the internet.

Some members had published their research in *Therapy Today*, or had plans to. Others had reached the point of obtaining ethical approval to undertake their research. One had submitted findings to a large national charity, which plans to use the findings for a benchmarking project.

Research surgery sessions are offered throughout the year and are available to any BACP member, whether new to research or an experienced researcher. The sessions last 30 minutes and should be pre-booked.

The next surgery dates are Wednesday 26 June and 24 July. To book a session, contact Stella Nichols in advance on 01455 883372 or stella.nichols@bacp.co.uk. Slots are limited so book early to avoid disappointment.

Training the trainers

In 2007 BACP and the University of Leicester won funding from the Economic and Social Research Council (ESRC) researcher development initiative to develop and enhance research capacity in counselling and psychotherapy. As part of this project a training manual and DVD were produced, *Training counsellors and psychotherapists in research skills: a manual of resources*, which is now the best-selling BACP publication.

Alongside the manual, there was a five-day summer school to train the trainers in research methods, which was so successful it was repeated in 2008. The trainers were Professors John McLeod, Robert Elliott and Sue Wheeler.

As reported in the April issue of *Therapy Today*, off the back of the success of these previous events, BACP will be running four one-day workshops, led by Professors Elliott, McLeod and Wheeler. Each workshop will be linked to elements from the research skills training manual. The workshops are aimed at lecturers and trainers of counselling and psychotherapy. They will take place at Shelter Training, London on 24 June 2013, 21 October 2013, 10 March 2014 and 20 October 2014.

Workshop prices start from £85 each for BACP members. The manual can be purchased for £30 for BACP members (£35 for non-members).

For further details and to book, visit www.bacp.co.uk/events/conferences.php or contact BACP Customer Services on 01455 883300.

Youthhealthtalk on eating disorders

Youthhealthtalk.org, the youth health website, has launched a new section on young people and eating disorders.

The section covers early signs and symptoms of eating disorders, where to get help, different treatments, thought patterns and physical symptoms, impact on social life, education, family and how it feels to recover.

The pages are based on research with young people conducted by the Health Experiences Research Group, University of Oxford. Funded by Comic Relief, the research comprised video interviews with 39 young men and women aged 16-27 across the UK. The young people had a range of different eating disorders, including anorexia nervosa, bulimia nervosa, binge-eating disorder, EDNOS, ED-DMT1 and disordered eating.

In the extracts on the website, they talk about the experience of living with and recovering from an eating disorder. They highlight the many barriers they face to accessing the services and support they need because of lack of awareness and poor understanding of the illness and its effects among health professionals and the general public.

Ulla Räisänen, a senior researcher who conducted the study, said: 'Eating disorders are common and many go undiagnosed for a very long time. The longer eating disorders are left untreated, the more serious they can become and the harder it can be to treat them. It is paramount that we increase awareness of the issues and get rid of the barriers that young people face. We need to make it easy for them to speak up and get help.'

For more details, see www.youthhealthtalk.org/young_people_Eating_disorders

BACP Professional Conduct Hearing

Findings, decision and withdrawal of membership
Damien Black
Reference No 641919
Mid-Glamorgan CF31 2JG

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. The Panel noted that these findings involved the exploitation of a vulnerable client and that compliance with paragraph 17 of the *Ethical Framework for Good Practice in Counselling and Psychotherapy* is mandatory ('Practitioners must not abuse their client's trust in order to gain sexual advantage'). Accordingly the Panel was unanimous in its decision that these findings amounted to Serious Professional Misconduct and contravened the ethical and behavioural standards that should reasonably be expected from a member of the profession.

Sanction

The Panel was unanimous that Mr Black's membership of BACP should be withdrawn and took the view that, on the findings reached, any lesser sanction would be wholly disproportionate.

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

BACP Professional Conduct Hearing

Findings, decision and sanction
Mark Wheeler
Reference No 651980
Harwich C012

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 that these findings amounted to professional malpractice in that Mr Wheeler showed incompetence in his understanding and use of the Counselling Directory website.

Mitigation

Mr Wheeler expressed his sincere regrets and took full responsibility for his errors and lack of understanding. He took immediate steps to rectify the entries on the website as soon as these were pointed out to him by contacting both the Counselling Directory and BACP. Mr Wheeler is undertaking further IT training. He stated that he has learned a valuable lesson and would be very careful in future to ensure that information about his counselling and other qualifications were accurate. The Panel was satisfied that Mr Wheeler had demonstrated significant and sufficient learning from these events.

Sanction

The Panel carefully considered what sanction, if any, would be appropriate and proportionate in the circumstances.

As a result of the learning and understanding demonstrated by Mr Wheeler during the hearing and as referred to above, the Panel considered that, in the particular circumstances of this case, it would not be appropriate to impose a sanction.

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

Withdrawal of membership

Damon Bachegalup
Reference No 611906
Bolton BL1 6PU

A sanction was imposed on Mr Bachegalup following a Professional Conduct Hearing.

Mr Bachegalup failed to comply with the sanction and consequently his membership of BACP was withdrawn. Any future application for membership of BACP will be considered under Article 12.3 of the Memorandum and Articles of the Association.