

# THERAPY TODAY

“  
Those tears  
should be mine,  
shouldn't they  
”  
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The voice of the counselling and psychotherapy profession



## WHO'S PULLING THEIR STRINGS?

The corrosive effects of coercive control

Working at relational depth // Therapist and journalist - confronting the ethical challenges  
Emotional burnout - the cost of compassion // Can counselling help people with dementia?

## I first heard the term 'compassion fatigue' when used to explain a dramatic drop in charitable giving just after Live Aid.

Apparently, the public couldn't bear to look at any more footage of the human fallout of famine, war and disease. Maybe they were self-caring?

Emotional burnout is particularly difficult for therapists because working with feelings and caring for others is why we chose this profession in the first place. As Dr Linda Dubrow-Marshall points out in our cover feature, "There can be shame in admitting that we are experiencing compassion fatigue, but we are human, and we are not protected from stress just because we have therapeutic skills."

I too have felt this way. Now, if I look at my diary and have to steel myself for the week ahead, I know I need to decrease my client hours when I can, increase my self-care and take a break asap. And breathe...

**Rachel Shattock Dawson**  
Consultant Editor



## Editor's note

The United Nations has designated 25 November International Day for the Elimination of Violence against Women. It also marks the start of a 16-day period of activism against all gender-based violence. We are all invited to 'orange the world', using the colour of the UN campaign to symbolise a brighter future without violence. This campaign influenced our decision to commission an article on coercive control for this month's issue. Coercive control is a relatively new crime, in terms of UK law, but an age-old and still widely misunderstood, pernicious form of violence, inflicted, largely, by men on women, within intimate relationships. But it is also found in other arenas, and used by women too - in cults, for example, and in modern-day slavery, and, indeed, in parent-child relationships, work situations and others where one person exerts power over others through emotional manipulation and threat. As the authors of the article point out, such clients are very likely to come to counselling for some quite other reason, and it's vital that counsellors are alert to the potential for this to be an underlying issue.

We have some very interesting letters this month in response to the articles in last month's issue on the closure of the counselling courses at the University of East Anglia and prescribed drug dependency. The letters pages are your forum for engaging with issues that concern you and adding to the debates. I know a lot of discussion goes on outside the magazine, on Twitter and in Facebook groups, but do please write to us as well.

**Catherine Jackson**  
Editor



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



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NICK LOWMDES/KON IMAGES

**'Here was a dignified woman in her early 80s, desperately holding on to herself, camouflaging deficits of memory, bewildered and frustrated, struggling to understand what was happening to her. In time, I answered my own question about what I could achieve.'**

**Sonia Khan meets her first client with dementia, at the start of a journey of profound learning**

**On the cover**  
**Unloving bonds**  
What are the signs that a client may be subject to the corrosive effects of coercive control?  
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# In the news

Our monthly digest of news, updates and events

## Gender identity concern

Attempts to change people's gender identity through psychological interventions are unethical, potentially harmful and not supported by evidence, leading psy-organisations and LGBTQI groups have said.

The groups, including BACP, UKCP, Pink Therapy, the Association of Christian Counsellors, the British Psychoanalytic Council and the British Psychological Society, have amended their original Memorandum of Understanding (MoU) on conversion or reparative therapy (November 2015), which referred only to sexual orientation. The revised MoU specifically includes gender identity.

It states that 'neither sexual orientation nor gender identity in themselves

are indicators of a mental disorder'. It also commits the signatories to work together to address the wider issues of raising public and professional awareness of the risks of conversion therapy, ensuring all new and existing therapists have training in these issues, and ensuring that the research evidence relating to reparative therapy is regularly monitored and reviewed.

Andrew Reeves, Chair of BACP, said: 'BACP in no way supports or condones the practice of conversion therapy and knows that the new memorandum will ensure individuals are protected from judgmental and uninformed therapy.'

The revised MoU can be downloaded from [bit.ly/2zkSjL2](http://bit.ly/2zkSjL2)



**51%**

of men would go down the pub if they wanted to talk to a friend about a mental health problem  
[bit.ly/2yze6kF](http://bit.ly/2yze6kF)

**49%**

of people who have had cosmetic surgery say their decision was influenced by social media  
[bit.ly/2zA3Gzo](http://bit.ly/2zA3Gzo)

**54%**

of primary schoolteachers don't feel adequately trained to help a child with a mental health problem  
[bit.ly/2gN4Tff](http://bit.ly/2gN4Tff)

**87,000**

people used Scotland's NHS 24 mental health first-response telephone and online support services last year  
[bit.ly/2yulYng](http://bit.ly/2yulYng)



### Mental health first aid campaign

The Government has announced a new, £15 million programme to train one million people in England in 'mental health first aid' skills.

The campaign will be designed and delivered by Public Health England, working with Mental Health First Aid England and other mental health organisations. The aim is to improve people's personal resilience and give them the skills and confidence to recognise and respond to others when they have mental health problems.

It will include an online learning module designed to improve the public's knowledge, skills and confidence about mental health so they can assess their own mental wellbeing and learn techniques to reduce stress, as well as feel better equipped to support others.

The campaign will launch next year and run for three years. [bit.ly/2yu7vHT](http://bit.ly/2yu7vHT)



## Doubts about couple counselling

Most couples don't think couple therapy works, a new survey by the charity Tavistock Relationships has found.

The YouGov survey of over 2000 adults found that 64% of people in long-term, committed relationships would not seek help from a couple counsellor if their relationship was in difficulty.

The most common reason, given by 43%, was that they didn't think that couple therapy would work.

However, 36% said they would try it if they were provided with evidence that it had the potential to improve their relationship.

'The idea that couple therapy doesn't work is simply not true - and the evidence is clear on this,' Tavistock Relationships Chief Executive Andrew Balfour said.

'We need to start a national conversation about the importance of getting help for our couple relationships. Many who need such help are not seeking it.

'The consequences of this are far-reaching for the adult partners involved as well as for their children and future generations.'

[bit.ly/2yw1DP4](http://bit.ly/2yw1DP4)



# Bullying and resilience

A new study has found that the harmful effects of bullying on children lessen over time, thanks to their own resilience.

The study used data on 11,108 children from the Twins Early Development Study (TEDS), based at King's College London, which allowed researchers to separate out genetic and environmental influences. Children and their parents filled out questionnaires about peer bullying at ages 11 and 14, and about mental health difficulties at ages 11 and 16.

The researchers found that exposure to bullying causes anxiety, depression, hyperactivity and impulsivity, inattention and conduct problems at the time, and that anxiety can persist for at least two years. But, by five years, all these effects have stopped, although 16-year-olds who have been bullied at age 11 remain more vulnerable to paranoia or cognitive disorganisation.

'While our findings show that being bullied leads to detrimental mental health outcomes, they also offer a message of hope. In addition to interventions aimed at stopping bullying from happening, we should also support children who have been bullied by supporting resilience processes on their path to recovery,' the study's lead author, Dr Jean-Baptiste Pingault, said.

[bit.ly/2ybPQ60](http://bit.ly/2ybPQ60)

## Depression in childhood

Parents can have a very different perception of their children's mental wellbeing to that of their children, new research reveals.

Researchers from the UCL Institute of Education and the University of Liverpool analysed data from the Millennium Cohort Study of 10,000 children born in 2000/01. Parents' reports of their children's emotional problems were roughly the same for boys and girls throughout childhood, increasing from seven per cent of all children at age seven to 12% at age 11. By age 14, 18% of girls were reported to have emotional problems, compared with 12% of boys. At this age, the children were invited to self-report their mental wellbeing, and 24% of girls reported symptoms of depression, but only nine per cent of boys.

Anna Feuchtwang, Chief Executive of the National Children's Bureau, which jointly published the report, said: 'Worryingly, there is evidence that parents may be underestimating their daughters' mental health needs. Conversely, parents may be picking up on symptoms in their sons that boys don't report themselves.'

The data also revealed clear links between family income and depression, and differences between ethnic groups. Children from better-off families were less likely to have depression at age 14. Girls from mixed and White ethnic backgrounds and boys from mixed and other ethnic groups were more at risk of depression; Black African girls and Bangladeshi and Indian boys were least at risk. [bit.ly/2hifDVJ](http://bit.ly/2hifDVJ)

## How do we know counselling works?

NICE should be drawing on a wider range of evidence, in addition to randomised controlled trials (RCTs), to inform its guidelines, a paper published in the BACP journal *Counselling and Psychotherapy Research* (CPR) says.

Written by BACP researchers Jo Pybis and Naomi Moller and Professor Michael Barkham of the University of Sheffield, the paper criticises both the evidence and the methods used by NICE to review its guideline for depression in adults, which is currently out for consultation.

There is, they say, a lack of high-quality RCTs directly comparing counselling with other treatments. They also argue that NICE should draw more widely on evidence such as the wealth of data on patient outcomes and experience collected by IAPT services, and on qualitative data from service users.

The paper reviews the evidence for counselling for depression, using these wider data sources, and finds that it is equally as effective as CBT. [bit.ly/2yvwXx7](http://bit.ly/2yvwXx7)

# Burnout

## ...the high cost of caring?

Burnout is an ever-present risk in the caring professions. **Sally Brown** talks to counsellors about their experiences, and how to avoid it

**E**mma,\* a London-based counsellor in private practice, realised all was not well when she found herself unable to make decisions. 'Even small, inconsequential decisions, like what to do at the weekend, began to feel overwhelming,' she says. Qualified for just six months, she decided to 'dip her toe' into private practice. 'People said it would take time for my caseload to grow, which suited me,' she says. But, within weeks she had 16 clients and was feeling overwhelmed.

'People would say, "You're doing great!" But it didn't feel great. It felt too much. I wish I'd been told to approach it like running a marathon - you need to build up to a large caseload, rather than aiming to get a full caseload straight away, because it is totally different to any other job in terms of the emotional and physical demands.'

Emma had what she calls a 'mini-breakdown', where she withdrew from her social life and felt increasingly anxious and fearful. She came close to giving up, but, after a planned holiday, put some changes in place, including reducing her client load and changing her working hours, which made it possible to carry on. 'It's not easy, as it's my sole source of income, but I realised

that the number of clients I take on can't be determined by finances,' she says.

We may be mental health professionals, but counsellors don't always 'walk the talk', and it's all too easy to focus on improving our clients' self-care and neglect our own. Even with an awareness of compassion fatigue and the impact of vicarious trauma, we can think 'it won't happen to me'. 'Counsellors find it hard to admit when they are struggling. It's similar to what I see in first responders and medical staff - there can be a shared culture of being strong, here to help others,' says Fiona Dunkley, BACP senior accredited counsellor and trauma specialist. 'We sacrifice our self-care for the greater cause.'

We can also fall into the trap of thinking that, because the lives of our clients are so awful, our needs pale by comparison, says Lisa Jenner, a BACP accredited counsellor and supervisor, who also delivers training on preventing vicarious trauma. 'We can be blind to the impact on ourselves until it's almost too late. It's often friends and family members who recognise that we are struggling before we do.'

Nor is it necessarily about size of caseload; a manageable caseload can

be tipped over into unbearable by just one client presenting with particularly acute or distressing needs.

Jenner herself didn't realise that what she dismissed as 'tiredness' and the effects of juggling full-time work and family life were the warning signs of burnout. 'People started to bring my attention to my memory and concentration problems. I was still able to be very present for my clients, but, outside the counselling room, I couldn't follow a conversation. It was disorientating, and I got very irritable with my family and people close to me. Then, when I was driving, I would suddenly forget which pedal did what. I saw my GP and ended up in an MRI scanner and being tested for Alzheimer's. Then, when everything was ruled out, it became clear I was suffering from stress and burnout.'

### What is burnout?

Burnout is a 'syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do "people-work",' explains Professor Christina Maslach, the US psychologist widely known for her pioneering research in this field and co-creator of the Maslach Burnout Inventory.<sup>1</sup> She first came across it in the late 1970s, when she was an assistant professor at the University of California, Berkeley, and researching how people in the emergency services, hospitals and psychiatric units responded to challenges at work. 'I stumbled across it in the interviews I was doing. A pattern emerged - people talked about

'People started to bring my attention to my memory and concentration problems. I was still able to be very present for my clients, but, outside the counselling room, I couldn't follow a conversation. It was disorientating, and I got very irritable with my family and people close to me'



‘If everyone else seems outwardly confident and competent, we look around and think, “I have to put on my happy face and not let anyone know I’m not doing as well”’

vicariously, you can find that you no longer have the capacity to absorb it in entertainment,’ says Dunkley. ‘I am very mindful of what I expose myself to in social media and TV. I am exposed to enough trauma in my work, so I have to watch what I absorb in my personal life. Trauma is very related to adrenaline, so you can become overloaded.’

For others, burnout shows up in the body - we find ourselves more prone to bugs and viruses, or physical symptoms. ‘We need to listen to our body as it holds a wealth of information,’ says Dunkley. ‘We might be telling ourselves to keep going, but our body will be telling us to slow down by creating physical symptoms, aches and pains or illness.’

### **The toxic environment**

But there is a danger in being too prescriptive about ‘typical’ symptoms of burnout, and therefore medicalising the condition, believes Maslach. ‘That was never the aim of my research. What worries me about making it into a “mental illness” is that it is essentially saying something about the individual - that they have a disease, they have a problem, so we have to fix the person. We should also be thinking about what is going on in the work environment. Burnout is a regular, chronic, everyday experience at work that wears you away, so that you can’t deal with stressors as you would normally.’

Maslach’s research has identified six factors that make burnout more likely: work overload, lack of control, insufficient rewards, breakdown of workplace community, absence of fairness, and value conflict.<sup>1</sup>

feeling overwhelmed, emotionally and physically exhausted, and losing their sense of compassion. But when I first wrote an article about it, it was for a magazine, not a journal, because no journal was interested in it. They dismissed it as “pop psychology”. But that article got sacks of mail from people saying, “this is happening to me.” A lot of people had been struggling on, thinking it was just them, and they couldn’t let anyone know. If everyone else seems outwardly confident and competent, we look around and think, “I have to put on my happy face and not let anyone know I’m not doing as well.” But once we become more open to talking to each other, we realise we aren’t the only one feeling this way.’

What differentiates burnout from exhaustion, depression or anxiety, is often the most devastating symptom for therapists - compassion fatigue: the loss of a sense of caring about clients, or feeling irritated by their problems. ‘There can be shame in admitting

that we are experiencing compassion fatigue, but we are humans, and we are not protected from stress just because we have therapeutic skills,’ says Dr Linda Dubrow-Marshall, BACP-accredited counsellor and lecturer in psychology at the University of Salford. ‘Admitting this means we can address these issues.’

Another insidious and undermining symptom is a sense of hopelessness about the efficacy of our work, says Professor Thomas Skovholt, educational psychologist at the University of Minnesota and author of *The Resilient Practitioner*.<sup>2</sup> ‘We can feel less intensity in offering hope for the demoralised client, and a loss of a sense of the work being meaningful.’

Other symptoms vary from individual to individual. I know I am becoming emotionally ‘knocked off balance’ by a client’s material when I lose tolerance for any other ‘drama’ outside the counselling room, including plot lines in TV programmes and films.’ When you have absorbed an amount of trauma

Organisational conflict is another risk factor, says Skovholt. 'Internal conflict, especially among senior management, increases the risk of burnout. I have come across this even in senior therapists – we are supposed to be experts on human development, and these people are fighting and hating each other. That can be really distressing for the counsellors they are managing and supervising. It's also hard when your values don't match those of the organisation you are working for. Anything that takes away the meaning of the work or the sense of fairness or justness increases the risk of burnout.'

For Helen,\* it was a sense of not being valued that undermined her wellbeing when she was working as a counsellor for a national charity. 'It seems crazy now I look back on it, given that the charity was national and high profile, but I didn't feel supported or that the work I was doing was valued. As an organisation, there was an awareness of vicarious trauma, but nothing was put in place to prevent it. I didn't have enough supervision and, as I worked out in the field, I felt isolated from my colleagues. I also wasn't paid very much, and that made me feel unappreciated. But it was my first job after qualifying, and I felt lucky to get it, so I didn't question the conditions. By the time I felt confident enough to think it wasn't right, the environment had undermined my resilience and I was finding it increasingly hard to deal with clients' material. I had nightmares about my clients, became exhausted, and stopped eating and sleeping properly. All I wanted to do outside of work was zone out in front of the TV. In the end, I felt I had no choice but to leave.'

Skovholt has also explored this, with his colleague, Michael Helge Ronnestad, in their book, *The Developing Practitioner*.<sup>3</sup> They describe how newly qualified practitioners in relationship-intense professions can easily become overwhelmed by the emotional demands of the work, especially in the early weeks and months, and can be driven to take an 'early exit', although most adjust and continue in their career.

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#### **Grief and uncertainty**

Aspects of the work itself can also put the counsellor at risk – notably, according to Skovholt, the 'accumulation of unresolved grief'. 'A therapist-client relationship is a human relationship. As therapists, we are always being left by our clients,' he says. 'We have to let go of them, but what do we do then? Do we think about them? And we also have to keep up the capacity for new clients. We have to keep making attachments but we are always losing them.'

Another key factor is feeling you are not making a difference with clients. 'Burnout is related to unclear, disappointing outcomes. It's hard to sustain work where the results aren't concrete,' he says. Dr Els van Ooijen, supervisor, trauma specialist, and writer, agrees that it's important to monitor your sense of 'doing a good job'. She says: 'Working outside of your experience and capability is extremely undermining. But, in organisations, counsellors can be in a situation where this feels unavoidable.'

There is also the ever-present element of anxious uncertainty from not knowing what work with a new client will involve. It can be particularly difficult if we have personal issues that are causing us distress when clients present with similar

issues, says Dubrow-Marshall. 'When my father died, I did not want to take on new clients who were coming to work on grief issues. Some family members were also demanding of me during that time, so I took a short break from working with very demanding clients, which allowed me to recover and heal. I also undertook personal therapy, and got outside input when I was ready to return to a more demanding and challenging practice.'

#### **Protection and prevention**

Babette Rothschild, in *Help for the Helper*,<sup>4</sup> suggests varying the intensity of empathy in sessions as a protective measure. Skovholt says counsellors should aim simply to be a 'good-enough counsellor', and know when a B+ effort is enough for a client, rather than A+. He says that experienced counsellors often operate with 'bounded generosity'. 'Being an effective therapist requires boundaries, but also generosity and willingness to give only so much,' he says. 'It's like the advice about oxygen masks on an airplane – you have to put on your own before you can help anyone else.'

Maslach talks about the 'detached concern' used by medical professionals as a burnout defence. Of course, detachment is more difficult for therapists, for whom 'putting ourselves into our clients' shoes' is core to our work. 'You can work with "one foot in, one foot out", rather than both feet in,' says Dunkley. 'With both feet in, you are too meshed with the client, and may not be the most effective in helping them.'

But it's not easy. 'I have experimented with Rothschild's "varying the intensity" with clients and it just isn't possible for me,' says Jenner. 'I can't focus on the client and also hold something back for my own self-care. In the past, I have got over-involved; I've followed clients' court cases to the point where I felt like I was also going through it with the client. I no longer do that. But I've realised I can't control my level of empathy, so my self-care needs to focus on what I do after sessions.'

'Care for self' is one of six core principles that underpin our work as counsellors; 'resilience' is one of



the 'personal moral qualities' we are advised to aspire to, defined as 'the capacity to work with the client's concerns without being personally diminished' in the BACP Ethical Framework. As Professor Tim Bond, author of the framework points out: 'Taking care of ourselves as practitioners matters to our clients. They need to know that we are sufficiently resilient to be able to work with them and to be able to withstand the challenges of that work.'

Effective supervision plays a key part, says van Ooijen. 'Supervisors need to get to know their supervisee well enough so that they can tell when they are not themselves. I spend some time with supervisees at the start of the session checking that they are OK. You need to develop a working relationship so they feel they can discuss honestly with you what is going on.'

Independent supervision can be particularly important for those working in an organisation, she believes. 'An independent supervisor is there as a check that your supervisee is not put into a position where they are working outside their level of experience and competence. That is where the Ethical Framework is helpful. I would advise counsellors to keep a copy with them at work and draw their employer's attention to it when necessary. We also need to encourage counsellors to do appropriate CPD, particularly in areas where they feel under-confident. It helps them have confidence in themselves by developing their own reflective and critical thinking skills.'

After taking a four-month sabbatical, Jenner made changes to reduce the

**'You need to find a way to symbolically shake off the energy that you have taken into your body. Sometimes I mindfully wash my hands, or do a simple breathing exercise, or some yoga moves'**

### Sally Brown About the author

Sally Brown is a counsellor and coach in private practice ([therapythatworks.co.uk](http://therapythatworks.co.uk)), a freelance journalist, and Executive Specialist for Communication for BACP Coaching.



risk of burnout in the future, including reducing her counselling days. 'My sabbatical reaffirmed that I loved being a counsellor, and I wanted to remain a counsellor, but doing it full-time wasn't sustainable for me in the long term,' she says. 'I now see clients on two days a week, and focus on training and writing on the others, which affect me in a different way.'

Multiple roles can give a sense of perspective, agrees Skovholt. 'Over the years I have thrived on doing teaching, supervision, therapy, research, and writing. But it doesn't work for everyone - for some, it just adds to their sense of being overwhelmed.'

We also need to give some thought to what we do in our leisure time, he believes. 'In my research, one of the things that has helped protect people from burnout is an element of "vitality" in their lives - having something in their personal life that really gives them a sense of pleasure, energy and high satisfaction. We are dealing with distressing, difficult things a lot of the time, so we need a contrast to that in our life, and for that to be ongoing. For one practitioner I talked to, it was absorbing herself in weaving.'

Dunkley recommends using a 'ritual' to ground yourself after a difficult session. 'You need to find a way to symbolically shake off the energy that you have taken into your body. Sometimes I mindfully wash my hands, or do a simple breathing exercise, or some yoga moves. Another therapist I know uses juggling balls. If you don't get rid of the energy, you risk bringing it into the next session, and then taking it home with you at the end of the day, which can spill into your personal life.'

Skovholt similarly sees value in rituals. He says he sometimes gets home from seeing several clients in a row in a state of what he calls 'emotional depletion', unable to think, listen or talk. 'It's a danger for the counsellor's personal and family life. Rituals can help with the transition from counselling work to personal life.'

For Jenner, a key change was scheduling longer gaps between client sessions. 'I make sure I do something physical in the break, such as stretching, or walking outside. It's such a simple change but it makes significant difference.' Dubrow-Marshall also suggests paying attention to the scheduling of clients: 'I used to keep Monday mornings free for my most demanding clients - usually the least personally motivated to change or the most disturbed or narcissistic ones - as I had more energy after the weekend. I sometimes saw these clients one after the other, because I got into the therapeutic space I needed to be in in order to work effectively with them.'

The most protective factor of all, says Maslach, from her four decades of research, is something that counsellors tend to be good at: human relationships. 'Research about work and psychology for decades has shown that we are better able as human beings to live life, do well and cope, and be generally healthy if we have good relationships with other people. The more people we have who are fun to be with, teach us, and support us, the better off we are. It's about keeping yourself grounded in the everyday and knowing you have people around who have your back.' ■

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# The month

**53** nominees have been shortlisted for this year's Mind Media Awards - the winners are announced this month [tinyurl.com/y9cceda9](http://tinyurl.com/y9cceda9)



## Theatre

### Barber Shop Chronicles

A scheme to tackle high suicide rates among black men by training barbers in basic counselling skills failed to secure funding. But it did spark playwright Inua Ellams to capture the role that the barber shop has played for generations in the lives of African men.

He spoke with men in barbershops in six cities across the world - London (Peckham), Johannesburg, Harare, Kampala, Lagos and Accra - and found common threads in all their tales: men working away from their homes; men cut off from their fathers; men in search of companionship. *Barber Shop Chronicles* returns to the National Theatre in London on 20 November following a successful UK tour.

[tinyurl.com/ygcx9f4n](http://tinyurl.com/ygcx9f4n)

## Radio

## Tune in

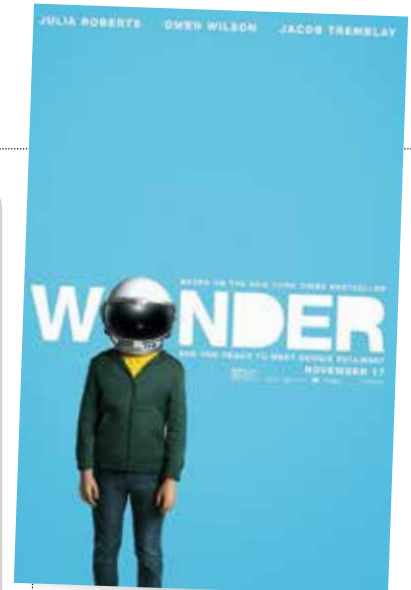
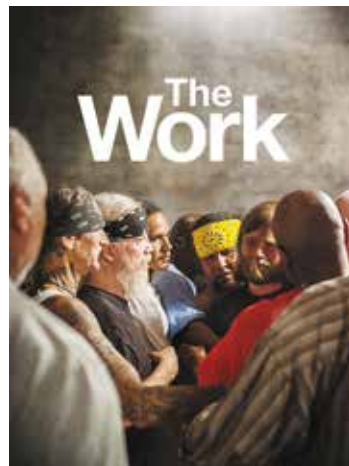
### A dose of nature

Depression narrows and internalises our view of the world around us. When we are outside, in a natural environment, we immediately widen our peripheral vision, and the awakening of other senses in response to sounds and temperature broadens our horizons still further. Spending time in a natural environment is becoming widely recognised as an essential aspect of recovery from mental ill health. Isabel Hardman, Assistant Editor of *The Spectator*, talks to psychiatrist Dr Alan Kellas about her experience of trauma-based anxiety and depression, and how important a dose of nature can be. *Isabel Hardman on Nature and Depression* aired on BBC Radio 4 in September and is still available on BBC iPlayer. [tinyurl.com/ybxwz12r](http://tinyurl.com/ybxwz12r)

## Film

### The Work

Rarely has group therapy been documented as powerfully as it is in *The Work*, which follows a group of prisoners serving time in northern California's maximum-security Folsom Prison. Taking part in a four-day therapy programme, alongside three volunteer civilians, the men endure the raw and revealing process of confronting their pain. The documentary film explores how hatred is both externalised and internalised in men who have spent a lifetime avoiding and repressing their emotions. Intense and moving, it gives a glimpse of what rehabilitation looks like when therapy is given a chance. *The Work* had a limited screening in cinemas in September and is currently available to download from several online stores.



## Film

### WONDER

August Pullman is a 10-year-old boy with facial disfigurement who is starting mainstream school for the first time. In an uplifting tale of difference and diversity, 'Auggie', played by Jacob Tremblay, meets bullies and makes friends in a film that makes a plea for acceptance, compassion and recognition of inner beauty. Based on the bestselling novel by RJ Palacio, and co-starring Julia Roberts and Owen Wilson, the film depicts how difficult it is for anyone who is in any way different to fit in with the standard norm, and challenges us to question how we support and make room for physical difference. *Wonder* is on general release from 1 December.



Don't miss

**Podcast**

**How to get angry**

The workplace is a hotbed of simmering anger and frustration, but expressing these emotions can lose you your job. What to do? Surviving Work is a website offering 'helpful stuff for human beings' - for healthcare and other workers trying, literally, to survive work. This three-minute podcast, *How to Get Very Angry*, offers a humorous and healthy take on handling anger at work by showing it as a powerful motivator, rather than something to be quashed. There are useful tips on how to let it all out in a safe place. [tinyurl.com/yahmsze2](http://tinyurl.com/yahmsze2)

**Television**

**Overshadowed**

Friendships can be intense during teenage years, but what if your new 'bestie' also happens to be your eating disorder? Vlogger Imogene posts videos of her life that chart how a sparky, outgoing teenager gets caught up in an escalating, destructive, internal battle with her eating disorder, personified in Caol, who becomes ever-more present and influential in this innovative and compelling drama. Irish writer and performer Eva O'Connor (who plays the eating disorder) based the series on her own experience and her award-winning play of the same title. *Overshadowed* is available on BBC iPlayer. [tinyurl.com/y8xm9eh9](http://tinyurl.com/y8xm9eh9)

**Exhibition**

**BRUCE NAUMAN**

The darker side of human nature is always centre stage in Bruce Nauman's art, where deep-seated fears, compulsions and our potential for violence are recurring themes. Tate Modern is showcasing a collection of some of the influential American artist's best-known work, in which he explores the power and nuance of language and communications through video, performance and neon pieces. Amusing and unnerving, the video works include *Raw Material Washing Hands* (1996) and *Violent Incident* (1986), where a disastrous and disturbing dinner party scene is played across 12 monitors. Bruce Nauman's work can be seen in the Artist Rooms space at Tate Modern, London until July 2018. [tinyurl.com/yc79nevf](http://tinyurl.com/yc79nevf)



**Know of an event that would interest *Therapy Today* readers?**

Email [media@thinkpublishing.co.uk](mailto:media@thinkpublishing.co.uk)

**Theatre**

**A Christmas Carol**

Dickens' festive tale of redemption and compassion rings many bells with the therapeutic process: confronting the truth, encouraging transparency, motivating change, and maybe a spiritual awakening to boot. You could say miserly Ebenezer Scrooge manages to complete the equivalent of a 12-step recovery programme in the space of one night. This new adaptation of *A Christmas Carol*, written by David Edgar for the Royal Shakespeare Company, stars Phil Davis and runs at The Royal Shakespeare Theatre, Stratford-Upon-Avon, until 4 February 2018. [tinyurl.com/y77apejt](http://tinyurl.com/y77apejt)



# The month



Read a new book worth reviewing? Email reviews@thinkpublishing.co.uk

## Reviews

### **Supervision in Psychoanalysis and Psychotherapy: a case study and clinical guide**

**Diana Shmukler (Routledge, £30.99)**



The subtitle accurately describes what is on offer here: a single case study through which Shmukler explores the role of supervision while working with one client, Jane, also a psychotherapist. The book chronicles the process and how the work finished, and ends by considering the theory that supported the therapy.

Patrick Casement, who supervised some of the more difficult aspects of the work, provides the foreword, and Andrew Samuels' afterword offers a sensitive reflection on the work, including the important point that it is possible to be 'warm and related - and also boundary, reflective and kind'.

Shmukler's approach allows the reader to experience moment by moment what was occurring from inside, and sometimes outside, the therapeutic relationship - one which was often under threat of disintegrating altogether. Both experienced and novice practitioners have much to gain from this fascinating, insightful account, particularly as it explores the struggles of the therapeutic endeavour and the challenges in finding the most appropriate supervisory support.

The theory is brought to life here in a way that is both challenging and satisfying. Shmukler bravely and openly explores the nooks and crannies of what seems to have been a challenging and troubling therapeutic relationship, and provides wider insights and learning for other practitioners about the tension held between difficulties and potential in our day-to-day (and, in this case, year-to-year) work.

**Steven Wells, psychotherapist, supervisor and trainer in private practice in south London, and a doctoral candidate**

### **The Political Self: understanding the social context for mental illness**

**Rod Tweedy (ed) (Karnac Books, £28.99)**

This fascinating collection of essays has been compiled at just the right time, as more clients (consciously or unconsciously) bring to therapy their anxieties, fears and stresses about how the external world is affecting their personal lives and internal worlds.

Contributors, including David Smail, Sue Gerhardt, Nick Duffell and Nick Totton, cover far-reaching topics, such as the social context of individual distress, the 'selfish society', boarding school survivors, pornography and sexual addiction. Each chapter has the same message at its core: that both our own and our clients' mental health and wellbeing are constantly being informed and shaped by the external (social, political and economic) world.

For me, the book's only weakness is its tone, which can be heavy-going. It is an important text, but it is not an accessible read. It is also on the expensive side for a paperback.



**Claire Kelly, integrative psychotherapist and counsellor in private practice in Manchester**

### **Mindfulness-Informed Relational Psychotherapy and Psychoanalysis: inquiring deeply**

**Marjorie Schuman (Routledge, £30.99)**

Here, Marjorie Schuman attempts to integrate the lessons of eastern mindfulness practice with western relational psychotherapy under the banner of 'inquiring deeply'.

The book is strong as an introduction to mindfulness. Schuman offers some useful techniques for transforming difficulties and a number of ways of re-approaching traditional psychotherapeutic practice. However, I found myself feeling restless. The book is light on psychoanalytical theory and doesn't do justice to previous crossovers between approaches. I began to feel that, in seeking to apply 'inquiring deeply' as an integrative solution, I'm already practising the attitudes Schuman identifies, while



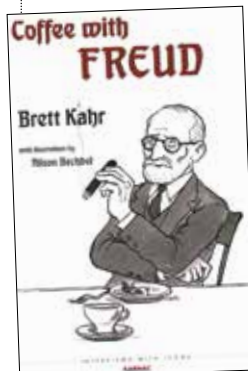
remaining in traditional western modes. At this point, the case studies lacked the depth of insight that I needed to convince me that integration was necessary.

**Christopher Kidd, counsellor in private practice**

### **Coffee with Freud**

**Brett Kahr (Karnac Books, £14.99)**

Kahr has written widely on the history of psychoanalysis and its modern-day practice and has an encyclopaedic knowledge of Freud, for whom he has great respect



and admiration. What makes this book so riveting, as well as entertaining, is the very human portrait it presents of Freud at ease, discussing his achievements in the cosy setting of the Café Landtmann, but quickly becoming much less comfortable and co-operative when he suspects his own unconscious is under scrutiny.

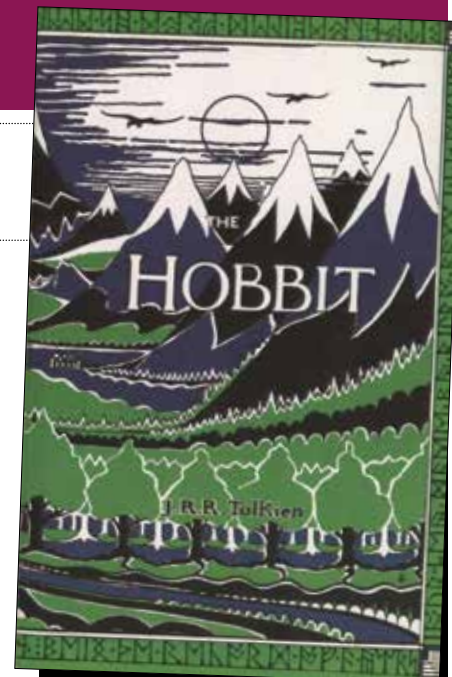
Kahr leaves the reader in no doubt about the huge contribution psychoanalysis made to the understanding and treatment of people who would previously have been shut away in asylums, or subjected to misguided and often cruel procedures by medical physicians keen to demonstrate their patent cures. But how does simply having a conversation about one's symptoms alleviate them? The answer is that, in therapy, the conversations are of a kind that isn't possible elsewhere.

**Jonathan Sunley, psychodynamic psychotherapist/counsellor**

### First lines

'I didn't know about the loaded gun hidden under his shirt, but the instant Captain Jason Fuller walked into my El Paso office on a summer day in 1980, my gut tightened and the back of my neck stung. War had taught me to sense danger even before I could explain why I was afraid.'

From *The Choice* by Edith Eger (Rider, £14,99)



### Previews

#### **Anxiously Attached: understanding and working with preoccupied attachment** Linda Cundy (ed) (Karnac Books, £14.99)

Cundy's contributors address the origins of anxious attachment in parent-infant relationships; research about developmental aspects; typical features and defences in adults, and how these may present in psychotherapy. Enmeshed dynamics in adult relationships, including the therapeutic relationship, are also highlighted - ones where threat of separation and loss activate intense attachment-seeking.



#### **How to Understand Your Gender: a practical guide for exploring who you are**

Alex Iantaffi and Meg-John Barker (Jessica Kingsley Publishers, £14.99)

This down-to-earth guide explores gender from its biology to its role in our relationships and interactions with family, friends, partners and strangers. It includes activities and reflection points designed to help people of all genders engage with gender diversity in relation to their own lived experiences.



#### **Pluralistic Therapy: distinctive features** John McLeod (Routledge, £14,99)

Pluralistic therapy is a flexible, integrative approach to counselling and psychotherapy that has also found applications in fields such as mental health, life coaching and careers guidance. McLeod is one of its co-founders. In this book, he offers an introduction to what is distinctive about this increasingly popular method and describes 15 theoretical features and 15 practical techniques for practitioners.

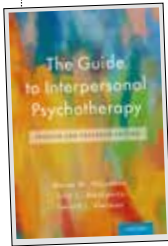


#### **The Guide to Interpersonal Psychotherapy**

Myrna M Weissman, John C Markowitz, Gerald L Klerman (Oxford University Press, £28.99)

This updated and expanded edition provides a definitive, practical guide to interpersonal psychotherapy (IPT).

Written by the originators of the approach, it features clinical examples and sample therapist scripts to explain how to use IPT to treat depression, bipolar disorder, anxiety disorders, eating disorders, post-traumatic stress, and other disorders.



#### **A book that shaped me** The Hobbit

JRR Tolkien (Houghton Mifflin)  
Although my mum and I are chalk and cheese, we share a love of reading. This is the only novel she ever insisted on reading to me, and I remember lying on the lounge carpet, night after night, being pulled into Tolkien's world. I remember the contrast between the safety of Bilbo's cosy home, and how one painful exploit leads to another for him.

I see parallels in my own life and in my work with clients, and often refer to the choices Bilbo has to make - returning to safe familiarity, or taking a more risky path for the greater good.

Jo Bisseker Barr, counsellor in private practice in the New Forest and writing for wellbeing practitioner at [www.writeyourmind.co.uk](http://www.writeyourmind.co.uk)



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

Email a few sentences to [reviews@thinkpublishing.co.uk](mailto:reviews@thinkpublishing.co.uk)

# Letters

Send your letters to the Editor  
at [therapytoday@thinkpublishing.co.uk](mailto:therapytoday@thinkpublishing.co.uk)

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

## Integrative or integration?

I am disappointed by the increase in the number of therapists describing themselves as 'integrative', without having an integrative framework with which to practise from.

As an integrative therapist myself, I often encounter fellow therapists who describe themselves in this way, having trained perhaps in person-centred counselling, and then gone on to develop an interest in, say, CBT. Without any integrative framework to base their approach on, it is not a true integrative approach; it is 'technical eclecticism' or 'assimilative integration'.

Integrative therapy has its own framework, such as Clarkson's 5 Relationship Model, or the Faris and van Ooijen Relational-Integrative Model (RIM). If we are to practise safely and ethically within the modalities we have adopted, the term 'integrative' should be reserved for this description only, rather than to describe 'cherry-picking' from other theories and models.

**Linda Harris MSc, Reg MBACP**  
Counsellor and psychotherapist

## Fostering dependency

I read Stephen Harley-Sloman's letter ('Patronising to clients', September 2017) with concern. It seems to me that his letter exemplifies a blind spot that I have come across before in some counsellors, who believe that if they promote their clients' autonomy and do not foster dependency, then dependency will not happen.

The reality is very different for many of our clients. Dependency develops because of early life experiences and inner-world configurations. It may be more likely to develop in a relationship-based therapy, but may be present in any therapeutic relationship, within which there is always a potential for a power imbalance. We may be present for just 50 minutes of a client's

week, but we need to be aware that we can, and often do, become very important to our clients. It is not patronising or rescuing to be mindful of how our clients perceive our breaks (the subject of Talking Point in July's *Therapy Today*). On the contrary, it is sensitive, thoughtful and empathic, and a bedrock of safe therapeutic practice.

**Frances Bernstein MBACP (Accred), UKCP (Reg), Cert Sup**

## Strangled by protocols

I would like wholeheartedly to endorse the sentiments expressed by Mark Emery in these pages ('Bureaucratic exercise', Letters, September 2017).

I acknowledge that finding a way to regulate our work and ensure a good-quality service is challenging, but the lack of trust and apparent expectation that we are doing wrong and need bringing to heel are increasingly dispiriting.

This seems to be a universal shift in human relations. I have been working for the NHS for over 20 years, and have witnessed the increase in bureaucracy and reliance on protocols and procedures to the point where they are now strangling almost all endeavours, creativity and compassion. Although this is usually attributed to financial issues, I experience it as mostly fear-based, and see its echo in BACP.

**Kim Pearl, Reg MBACP (Snr Accred)**  
Middlesex

“**We may be present for just 50 minutes of a client's week, but... we can, and often do, become very important to our clients. It is not patronising or rescuing to be mindful of how our clients perceive our breaks**”

## 'Weak moral relativism'

I read Nick Davis' letter, 'Shared despair', in your letters page (September 2017) with a visceral sense of shock, especially after having read the personal account by a counsellor of losing her beloved son in the Manchester Arena bombing in the same issue ('Picking up the pieces').

Nick Davis refers to the editorial by Rachel Shattock Dawson in the June issue, where she writes about 'senseless acts' of terrorism. He appears to imply that they do make sense if we view them 'systemically' and 'see that it is the bombers who are in deepest despair and enraged beyond endurance at the injustice and structural violence that is perpetrated daily' by our foreign policy. This, of course, may be so, but it is hard to see how acknowledging this despair through 'holding both sides of the relationship' would help bombing innocent people make sense to us in the west, even though it makes sense to those who do it. Rather, I would argue, it just leaves us embracing a weak moral relativism.

Of course, we can (and must) condemn the slaughter of innocent people in Manchester and place a very large full stop after it. We might then talk about the rights and wrongs of UK foreign policy in the Middle East.

Responding in this way does not mean that some deaths matter more than others - although I would argue that some deaths do matter more to us when they involve those we love. Rather, it suggests that, in the immediate moment, the shock and horror of the Manchester bomb demands an emotional reaction and not a political analysis, which Nick Davis offers by suggesting reading matter to help us understand the 'deeper context'.

Finally, I would like to point out that our 'drones' are not 'threatening death continuously above' many of these bombers' homes, as many of these bombers are born and bred in the places they bomb.

**Stella Williams MBACP**

## Dangers of prescribed meds

The important role that counsellors and therapists are playing in treating people whose lives and health have been damaged by long-term use of antidepressants and benzos is becoming more and more apparent.

You, as a profession, are the impartial, unbiased voice that can speak up and out on our behalf. As Sally Brown stated in the first paragraph of her excellent article ('What the doctor ordered', September 2017): 'The unmedicated client is becoming a rarity.' I imagine that there is another cohort of clients that you can also identify, who are, like me, some years away from long-term use of an antidepressant but whose health has been damaged, first by the trauma of drug withdrawal, and second by the ongoing, constant hyper-arousal due to unbalanced nervous and digestive systems.

The reason that your voices are so important to ring out on our behalf is that the NHS - the GPs, psychiatrists and specialist/consultants, to whom we turn to tell our stories - constantly deny our truth and reality. They are often the original prescribers and do not want to know that we have been harmed by the drugs. It is the final insult to be told by your GP that the symptoms that you are suffering, which bear no resemblance to anything you presented with when first prescribed the drug, are nothing to do with the drug at all but 'remission', 'the return of your original problem', 'your anxiety' or 'medically unexplained symptoms' (MUS).

We desperately need your support, particularly as the new focus on mental health will inevitably lead to the greater prescribing of antidepressants, unless something fundamental changes in the current system. We need you to speak out about your experiences of working with clients like us.

Sally Brown's article asks specifically 'What can therapists do?' She mentions the work being done by the All Party Parliamentary Group on Prescribed Drug Dependence, with the BMA, to have the problem of dependence recognised and appropriately supported and funded. In tandem with those initiatives, Marion Brown and the Recovery and Renewal independent self-help patient group in Scotland have raised a petition with the Scottish Government (now closed). I have also raised a similar petition calling on the Welsh Assembly Government to take action to recognise and support individuals affected and harmed by prescribed drug dependence and withdrawal. The petition is at <http://tinyurl.com/y8qyrqtq> and open until 28 November, so please take a moment to sign your name. Your support is a simple thing but would help us enormously. James Moore's campaign for tapering kits is mentioned in the article, with a link to his webpage ([www.jfmoore.co.uk](http://www.jfmoore.co.uk)).

Help us get our voices heard by raising yours and making a difference.

**Stevie Lewis (Mrs)**  
Monmouthshire

## Pernicious over-prescribing

I felt compelled to respond to your cover news feature ('What the doctor ordered', September 2017) about the over-prescription of drugs to clients, many of whom would have been better served by being directed to talking therapies. This seems to have elicited some rather angry push-back on social media from therapists who feel that meds are very useful and have been instrumental, for them,

in helping them through their own mental health issues. There has even been talk of 'pill shaming'.

I fundamentally disagree with this stance. I am a counselling psychologist and we, as a professional body, have long been worried about the pernicious effect that over-prescribing is having both on clients' ability to work through the issues and also on the therapy itself. Over the past 15 years, more and more of my new clients arrive

“  
**It is the final insult to be told by your GP that the symptoms... are nothing to do with the drug at all**  
”

either already on meds or having been offered them, and now it is the exception when they have either said no or their GP has recommended talking therapy. The article was not only extremely useful, but also very timely indeed.

**Ben Amposah MBACP (Accred)**  
Psychotherapist/consultant/  
coach/trainer

## Drop the disorder

Responding to Sally Brown's feature ('What the doctor ordered', September 2017), I just want to update readers on our campaign, 'A Disorder for Everyone!' (AD4E), which featured in the April issue of *Therapy Today* ('Just listen to their stories'). Since the first event, in Birmingham a year ago, we have held others in Bristol, Edinburgh and London, with attendances of 70 to over 100 people each time.

The events provide a space to critique the biomedical model and the narrative of 'diagnosis and disorder', and explore alternatives that can help people make sense of their experiences, however extreme. A participant at the Birmingham event told us, 'Now I feel empowered to offer the people I work with the option at least to explore alternative ways of understanding their pain.'

Contributors have included poets, academics, artists, researchers, activists, filmmakers, experts by experience, therapeutic professionals and more.

We have more events booked for Liverpool (7 December), Manchester (8 December) and Brighton (16 February). You can find out more at [www.adisorder4everyone.com](http://www.adisorder4everyone.com), follow us on Twitter @dropthedisorder and join in the discussions on our Facebook group, 'Drop the disorder!'.

**Jo Watson UKCP (Reg)**  
[www.adisorder4everyone.com](http://www.adisorder4everyone.com)  
[www.jowatsonpsychotherapy.co.uk](http://www.jowatsonpsychotherapy.co.uk)

“  
**As individual practitioners, we can express our dismay and anger at the erosion of relationship-based therapies and the associated ethical values that form the basis of our work, but we need a strong collective voice**  
”

## Coming off meds

I read 'What the doctor ordered' (September 2017) and want to highlight to readers the comingoff.com website, which contains useful information for people interested in learning more about coming off psychiatric medication in a careful, planned way.

The site includes topics such as alternatives to medication, a harm reduction guide and real people's stories. Professor Phil Thomas of the University of Central Lancashire, a former consultant psychiatrist, is among the website's advisers, and it was recommended in a 2008 Department of Health publication, *Medicines Management: Everybody's Business*.

**Zoe Gilbert MBACP (Accred)**

## Erosion of relationship-based therapies

Andy Rogers' reflections ('Standing on the edge', September 2017) on the University of East Anglia's (UEA) short-sighted closures of its internationally renowned person-centred training courses highlight the threat to our profession posed by neoliberal ideology and policies. We are told that the 'manualised, technocratic and instrumental' approaches that pertain at UEA are 'evidence-based practice', yet research consistently fails to show the superiority of one therapeutic modality over others.<sup>1</sup>

Recent research shows very poor long-term outcomes for clients of IAPT services,<sup>2</sup> yet the expansion of short-term, manualised models continues, seemingly driven by ideology rather than by 'evidence'. I, and many others, feel horrified at the ongoing, unjustified attrition of relationship-based therapies, both in the workplace and in training.

The Psychotherapy & Counselling Union played a central and recognised role in mobilising opposition to the closures at UEA, as we did previously (and more successfully) at Strathclyde University.

It seems clear that current policy makers have little understanding of, or interest in, non-instrumental approaches to human distress. As individual practitioners, we can express our dismay and anger at the erosion of relationship-based therapies and the associated ethical values that form the basis of our work, but we need a strong collective voice. The Psychotherapy & Counselling Union calls on BACP and the other professional bodies to take a more outspoken and active stance in defending counselling and psychotherapy, in academia, in training institutions and in the wider areas of social policy. This is both an ethical responsibility and a practical necessity for the future of our profession.

**Richard Bagnall-Oakeley  
UKCP (Reg), MBACP**

Integrative adult and child psychotherapist, Chair, Psychotherapy and Counselling Union (<http://pandcunion.ning.com/>)

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## We need dialogue

I appreciated Andy Rogers' article ('Standing on the edge', September 2017) expressing his thoughts about the closure of UEA's person-centred counselling programme.

It seems even more important to promote the humanistic talking therapies at this time when so many are feeling anxiety and distress, rather than the perceived 'quick fix' of CBT and/or medication.

I am concerned about the lack of dialogue within the counselling community on the range and reconfiguration of counselling

courses across the professional education landscape. I invite students, tutors, researchers and practitioners to reflect on Desmond Tutu's words: 'If you see an elephant sitting on a mouse and you say you're neutral, you have taken the side of the elephant.'

How can we hold open a dialogical space for critical thinking, and how can we help promote Rogerian qualities of difference and core conditions in our society? Can we come together to lobby for more optimistic approaches to health and wellbeing?

**Dr Salma Siddique UKCP (Reg)**

Psychotherapist and supervisor

## Interpreters' role

Prossy Kakooza's account ('Treat us like people', October 2017) of her experiences of counselling, mental health services and interpreters did not shock me. I know from our clients that these experiences are sadly too common.

It is not always the case. I have also heard about much better experiences for clients. I have seen how our interpreters at Mothertongue can make a critical difference to clients' lives by the way they receive and relay distressing stories. Yet they have few outlets for the emotional impact this can have on them. Supervision groups provide a much-needed and appreciated space for interpreters to share their dilemmas and solutions, and be supported and challenged so that they can help their clients in the best way possible.

We have recently published a second volume of stories by interpreters from across the world, *In More Words*, and have made a six-minute film about interpreters' experiences of supervision, which can be viewed at [www.mothertongue.org.uk](http://www.mothertongue.org.uk)

**Dr Beverley Costa DPsych, UKCP (Reg)**

Psychotherapist, Chief Executive Officer and Clinical Director, Mothertongue



## Suicidal effects of drugs

I am writing to comment on the news feature on prescribed drug side effects ('What the doctor ordered', September 2017), and how research has shown that 60% of those prescribed antidepressants report side effects, such as impact on sex life, work and social life.

I have always been sceptical of such research, because these are the very effects of depression that the medication is attempting to alleviate, and we know that this medication is hit-and-miss in terms of benefit. I have not been able to examine the methodology of this research to understand how they have controlled for the underlying effects of depression in their study, but I wanted to share a more sinister and significant side effect of antidepressants that I believe affects a much smaller percentage, but has a far higher impact.

I experienced this close up when a friend took just one tablet during a period of postnatal depression. They said it was like 'the wheels were coming off' and they felt completely out of control. Needless to say, they didn't take any more, and recovered back to their previous state in about 24 hours, but it was a profoundly destabilising experience, where they felt suicidal and without the normal 'brakes' that usually kick in with such thoughts. Following this, I did a bit of internet research. There are several well-publicised cases of suicide in similar circumstances, and commentary from other professionals. The worrying part is that, in some cases, GPs will just prescribe a higher dose, rather than recognise the situation, which I can only imagine could have dire consequences.

Although I believe this adverse reaction only affects a small proportion of those taking this medication, the impact is enormous and one that seems to be not well known. It took a personal experience to jolt me out of my complacency.

**Justin Havens FdA BA BEng MSc  
MBACP (Accred)**

Psychological therapist

## Men and suicide

Following on from the June article on muscle and masculinity, 'Muscle-bound man', it was good to see Phil Mitchell's article 'Boys can be victims too' in the October issue. Phil highlights the male fear of his masculinity being questioned, and therefore keeping quiet about sexual abuse. This article is set in the context of a changing western world where male and female roles are much less clearly defined, and yet the ancient, traditional role of man as provider and protector is still deep in the psyche of many men. If a man admits to any kind of weakness, he fears ridicule.

It was sobering to see the national statistics on male suicide highlighted in the October news pages - 'Of the 6,188 suicides registered in the UK in 2015, three quarters were male', and shocking to read Phil's closing comment that, for some men, 'death can be preferable to being seen as less of a man'.

Thanks for highlighting male needs in a journal supporting a disproportionate number of female to male counsellors, Phil.

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## Duty of care

Therapy today takes place within the context of the perceived need to safeguard against undesirable outcomes. Many agencies and practitioners have become risk averse. 'Difficult' clients are increasingly excluded. Is this compatible with the ethical 'duty of care'? What happens to such clients?

A person with suicidal ideation, for example, may well be weeded out at the assessment stage. Good reasons can always be found for such a course of action. The canny would-be client may be aware of the risk of stating his or her true level of distress, and then the whole issue goes underground.

What happens to the client who has been taken on by the agency or private practitioner and is then discovered to have a serious mental health issue? Is he or she to be 'cast off' or 'abandoned'? The reason given for this action is often that it is unethical to work with anyone beyond one's level of competence.

This raises many other questions. Those seeking therapy often cannot afford to go to a highly qualified practitioner in the private sector, but they may be greatly helped by an agency volunteer working in a humanistic way, backed up with effective supervision.

How would it feel to be told one is 'too difficult' to be a client? The suicidal person is likely already to believe that they are a burden to others and that it would be better for everyone if they were dead.

One of the EAPs for whom I work seems to me to adopt a refreshingly clear position on this issue. On a sheet given to every client, they state that they would not break confidentiality in the event of self-harm, and would 'not act on a client's behalf or intervene when there is a threat of suicide'. The person is given responsibility for him or herself, but within the context of at least short-term therapy. I do not wish to convey that I think all would-be clients can be suitably held within the framework of one session a week. However, I do think that there is too much fear of recrimination and that the therapist or agency may have swung too far in the attempt to keep themselves safe. Is this risk-averse attitude really in the interest of the client?

**Elizabeth Garsten MBACP  
(Snr Accred)**

Private practitioner

**“ Many agencies and practitioners have become risk averse. 'Difficult' clients are increasingly excluded. Is this compatible with the ethical 'duty of care'? ”**

# What can I possibly achieve?

**Sonia Khan** describes the unique challenges and huge rewards of working with people who have dementia

**Y**ou walk into the reception to welcome your client and are met with a blank stare. Despite having had numerous sessions, your client has no recollection of who you are or what you have previously discussed.

I was an eager trainee therapist when I was first allocated a client with dementia. I knew nothing about the condition, other than its associations with memory impairment, and had neither personal nor professional experience of it. I shared my sense of hopelessness and futility with my supervisor, asking, 'What can I possibly achieve?' He encouraged me to at least meet the client.

My initial session with Helen affected me profoundly. Here was a dignified woman in her early 80s, desperately holding on to herself, camouflaging deficits of memory, bewildered and frustrated, struggling to understand what was happening to her. In time, I answered my own question about what I could achieve. As psychotherapists, we do not aim to 'fix' our clients' problems but to create a space where they can safely explore their world view and express themselves; this also applies to working with clients with dementia. I learnt not to see people with dementia as dementia sufferers, but as people who have dementia; to see the person and not just the condition.

I developed an interest in the subject, researched it and continued to work with clients with dementia. Inspired, I wrote my MA dissertation on psychotherapists' experience of working with clients with dementia,<sup>1</sup> and this article draws on this research. It is based on the experiences of Edward, a Gestalt therapist; James, an integrative therapist who draws on humanistic approaches; Anna, an existential therapist, and Emma, a counselling psychologist. I too am an integrative therapist. None of us, at the time of the research, had received any specialised training in working with clients with dementia. All names have been changed, as have any identifying details of the clients mentioned in this article.

## What is dementia?

Dementia may be viewed as a group of symptoms, including memory impairment, reasoning and communication problems, and fluctuations in mood. Alzheimer's disease is the most prevalent and well-known form of dementia, although other conditions may cause dementia.<sup>2</sup> Diagnosis of dementia is imprecise and certainty can only be achieved by dissection of the brain post-mortem. It is a progressive condition and currently there is no known cause or cure for it.<sup>3</sup> According to the Alzheimer's Society,<sup>4</sup> currently there are approximately 850,000 people with dementia

*'As long as I see in the eyes there is something there, they've got an awareness, that's it for me, and even if it's for split seconds that something is taken on, who are we to say that's not of value?'*

in the UK. These figures are predicted to rise to one million by 2025 and to double to two million by 2051. Psychotherapy for people with dementia is becoming much more common than it was.

Since dementia brings loss of memory, which creates loss of continuity and process, the efficacy of psychotherapy for people with dementia has historically been questioned. The progressive nature of dementia dictates the way a therapist may work. In the early stages of dementia, when memory is

reasonably intact and occasional forgetfulness is experienced, clients may be struggling to come to terms with the diagnosis. Therapy may help affirm a sense of identity, provide emotional support and an opportunity to communicate emotions, revive order and meaning, and restore a sense of mastery.<sup>5</sup> As the condition progresses, the psychotherapist may serve as an auxiliary memory, as Sinason<sup>6</sup> describes: 'One of the functions of working with a deteriorating patient was to hold their memory, their knowledge, their choice of words.' Reflecting on her personal experience of Alzheimer's disease, Dartington, a psychotherapist, writes:<sup>7</sup> 'I also spend time feeling sad, and sometimes I think about death. I work with a psychoanalyst to reflect on the feelings I have and the changes I am experiencing.'

According to Bonder,<sup>8</sup> as words are gradually lost, verbal psychotherapy may become unsuitable and expressive therapies, such as art and music therapies, may be more beneficial. In addition, psychotherapeutic interventions such as reality orientation, validation therapy, reminiscence disorientation therapy and resolution therapy have been developed, particularly for this client group. Research into outcomes of these methods is limited and comprises mainly anecdotal evidence.

To those who question the point of offering therapy to people with dementia, Cheston's<sup>5</sup> comment offers a sharp riposte: 'Dementia must be understood as a personal tragedy... it is unacceptable that its most immediate victims should so often have to struggle unheard and unheeded against personal disintegration and social isolation.' This very much reflects my research participants' views. Edward told me: 'I've not worked with a client where it was so difficult that we couldn't communicate with each other... Never at any point did I think, "What am I doing here and what is the client doing here?"' For James, psychotherapy



LESLIE MURRAY / ALAMY STOCK PHOTO

provided his client with: '... just this kind of glow of, I suppose, comfort in his own skin. And I think, if I can introduce that into the room for 50 minutes once a week, then I think that's a pretty good justification for my presence really.'

For Anna, there was value in the brief containment and validation she could offer: 'I can't necessarily take that strong emotion of isolation away but I feel, if I just can give them, for some moments, just a feeling that things are OK, or contained, [if I can] contain

it just for a few seconds... I think there's a value already in that, even if I can't make something happen long term.'

She continued: 'As long as I see in their eyes there is something there, they've got an awareness, that's it for me, and even if it's for split seconds that something is taken on, who are we to say that's not of value?'

#### **From 'you and me' to 'we'**

Bond, interaction, collaboration, alliance; fellow travellers, analyst/analysand.

Psychotherapeutic literature abounds with phrases to define and describe the therapeutic relationship.

Working with this client group means engaging with clients who may forget to attend sessions, get lost en route, or rely on someone to accompany them. They may carry no recollection of content (thus negating process), lose track of what is being said mid-sentence, and even forget who their therapist is. How then can a therapeutic relationship be established, deepened and maintained? ►

For Clarkson, the therapeutic relationship is a central feature, the factor 'that determines the effectiveness of psychotherapy'.<sup>9</sup> Norcross writes: '... the most common of common factors, the most convergence amongst the professional divergence, is the therapeutic relationship.'<sup>10</sup>

Research on the therapeutic relationship with clients with dementia is scarce, but, drawing on their research with nursing home staff and residents in the later stages of Alzheimer's disease, Williams and colleagues<sup>11</sup> acknowledge the impact of the characteristics of dementia but conclude: '... most participants spontaneously shared their feelings and concerns and... many remembered their nurse, looked forward to her visits, and were saddened by termination [of the relationship].'

In the early stages of dementia, the therapeutic relationship may follow a traditional course. As memory evaporates, the therapist too fades away, and specifics of content and words disappear. However, even when explicit memory diminishes, implicit memory may enable clients to retain a 'felt' sense of the therapist. I found that, as cognition failed and content and process dissipated, the therapeutic relationship in fact became the cornerstone of the work. Clarkson writes: 'The person-to-person relationship is the dialogic relationship or core relationship. It concerns the authentic humanness shared by client and therapist. It has also been referred to as the "real" dimension of the therapeutic relationship.'<sup>9</sup>

Daniel was 80 when we first met. Accompanied by his wife, he came regularly and punctually for sessions. Dapperly dressed and always smiling, he would wait for me in the reception and 'recognise' me when I walked in, although he rarely remembered my name. When he did, he used it repeatedly, almost as if to prove that he 'knew' me, just like any other client. As our relationship developed, he told me he would wake up in the night, frightened and anxious, and imagine my face; this reassured him. In a world that was rapidly disintegrating, I offered a measure of stability and security.

For Emma, the therapeutic relationship offered a 'relationship where they know I'm interested. Because I think the client group often has been marginalised by other people, depending on the extent of the dementia.'

I used to see Helen at the provider organisation's rooms but, due to her health issues and difficulties with the journey, she increasingly missed sessions. Finally, after consulting with my supervisor, I decided that the only way to continue the work was to offer home visits. Every time I visited Helen for these sessions, thanks to a timely reminder from her daughter, she would open the door immaculately dressed, usher me in to her pristine living room and graciously offer me a cup of tea. Most days she did not remember my name but 'recognised' me and vaguely recalled the purpose of my visit. Over time she spoke of her past and the loss of her husband, and shared photographs and memorabilia with me. Gradually I felt she grew to trust and accept me. One day when she opened the door she was in her dressing gown, having missed her daughter's reminder. The mask of the gracious hostess dissolved and her frustrations with

## 'Dementia may lead to the creation of a false self, to disguise failings of memory and to protect against feelings of shame and embarrassment'

her memory and anger at herself emerged. Dementia may lead to the creation of a false self,<sup>12</sup> to disguise failings of memory and to protect against feelings of shame and embarrassment. In that moment, we met as two human beings: one with something to say, and the other someone she could trust to hear her without fear of judgment or derision.

James described a similar process as his client's cognitive abilities declined. He too would go to his client's home, and, although his client did not recognise him: 'He knows that I'm a friendly face. He knows, he has that facial recognition.' As the therapeutic relationship evolved, James inferred that his client saw it as a supportive relationship in which his authentic self could be revealed, where he didn't have to hide his frailty and impaired memory.

According to James: 'My interpretation is that I'm someone with whom he can relax enough just to be himself in his home environment.'

### Attunement

As the therapeutic relationship evolves, therapists meet their clients' changing needs and clients learn to trust that their therapist will meet them where they are. The following vignettes from my research illustrate how that could still happen with a client with dementia.

- *Time:* Traditionally psychotherapists adhere to 50-minute sessions and the responsibility for punctuality lies with the client. Edward's client struggled to come for sessions: 'He would get lost or he would be late.' To accommodate his client, Edward extended the session time when possible, not something he would normally do. Yet, by doing so, he created opportunities for the therapeutic relationship to mature and deepen: 'When [the client] was late, he would think of me sitting on his shoulder and he would remember my words.' Edward's flexibility provided an opportunity for their relationship to flourish, whereas a rigid attitude may have stifled it.
- *Place:* The therapy room serves as a container that holds both therapist and client, and when the frame changes shape, it impacts on the therapy in unexpected ways. As described above, several of us at some point had agreed to visit our clients for sessions in their own home.

- *Approach:* To facilitate communication and connection as his client's words disintegrated, James, although not an art therapist, used his innate artistic abilities to integrate facets of art therapy into his work. 'I would bring things in... chalks and pastels and things like that. And we would sit down together and get creative. I'd write on bits of card, just words, very simple words that would give off an image, and then we'd both draw, or paint something abstract, which reflected that.'

Edward described his client 'realising that he may have said things to me that he'd said maybe minutes before'. Emma had found a very simple way to deal with this: 'Where people have struggled with words, I've said, "Do you want me to just wait for you to remember it, do you want me to try and prompt you?"'

When words evaporated, Emma too used other means to communicate. 'One

## 'I had to let go of my assumptions and meet my clients where they were. I also had to let go of aims, objectives and goals'

client wanted to show me all the pictures in her house and show me her garden... It felt appropriate for her to show me things rather than struggle with speaking them sometimes... In more advanced stages, like... a woman who particularly liked knitting, I took in some... knitting wool and we sorted it out together while we were talking.'

• *Process:* I learned that I had to let go of my assumptions and meet my clients where they were. I also had to let go of aims, objectives and goals, and any sense of achievement I might experience. My original question, 'What can I possibly achieve?' became irrelevant and meaningless. The focus became the encounter. Our relationship had to transcend words, content and process.

Buber writes about the rarity and meaning of moments of connection: 'These moments are immortal, and most transitory of all; no content may be secured from them, but their power invades creation and the knowledge of man, beams of their power stream into the ordered world and dissolve it again and again.'<sup>13</sup> His words seem remarkably appropriate in the context of dementia.

### Challenges and rewards

Working with these clients presents huge professional and personal challenges. Forming an alliance with a client with dementia means eventually being forgotten. James succinctly describes the impact of this: 'We're all human and therapists are more human in many ways - more feeling, than the average person... and so there's a little bit of upset.'

Because memories of the therapist fade away, it becomes necessary to re-establish the alliance at every session. I gently remind the client what has happened in past sessions and attempt to convey a sense of intimacy and ease non-verbally.

Much has been written about the power imbalance in the therapeutic relationship, even with cognitively sound clients. This issue becomes even more complex when working with clients with dementia. What happens if the client does not recall giving consent for therapy or what was agreed about areas to explore? And who decides when therapy ends? In my own work, I regularly ask clients if they would like to continue seeing me and if they are comfortable to talk about the topics we are touching on.

Anna finally decided she could not continue the therapeutic relationship with one client who repeatedly forgot sessions and who was unable to recall who she was or why she was there. She initially switched the sessions to the client's home, but the client continued to forget she was coming or who she was. 'I had to ring in the morning before I arrived there... and I rang 10 minutes before I rang the doorbell. When I rang the doorbell, she didn't know anyway that I was coming.' Finally, she decided not to continue: 'I have actually got now feelings of guilt... I could have gone [on] but yet I felt I couldn't contain it anymore. I felt so many boundaries were broken I couldn't contain it.' Therapists working with these clients sometimes have to make some very hard, ethical decisions. Good self-care and supervision are vital.

Not least, working with dementia forces us to confront our own fears of cognitive decline, as Emma explained: 'Maybe the fear that we'll get it, you know... that that's a mirror, and just because we're therapists doesn't mean we wouldn't get it.'

Yet, the relationships I have forged with clients with dementia stand out for me. The depth, candour and authenticity I encountered enabled us to meet without masks. I always felt that my clients held on to a 'sense' of me and our time together, even though they lost the specifics. At times, it was difficult to enter a relationship, knowing what lay ahead, but I knew too that, for it to be helpful, I had to drop my defences and allow my clients to matter to me, so long as, at every step, I looked for ways to care for myself.

Ultimately, I was the one left remembering the moments we had shared: the laughter, the quiet words and the averted gazes. 'Our' history was left with me to hold and cherish; the moments of connectedness remained with me. ■

### Sonia Khan About the author

Sonia Khan has an MA in counselling and psychotherapy and an ADIP in integrative psychotherapy from Regent's University, London. She works in private practice in St. John's Wood, London. She also volunteers at St. Joseph's Hospice, Hackney, a large, inner-city hospice.



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# WHEN YOUR LIFE IS NOT YOUR OWN

**Linda Dubrow-Marshall**  
and **Rod Dubrow-Marshall**  
urge counsellors to be alert  
to signs that a client may be  
subject to coercive control

**G**ina appeared to be a little depressed and anxious and was frequently on the verge of tears. She had been persuaded by her course tutor to make an appointment with the college counsellor as she had been missing her adult education classes for several weeks; her tutors were concerned - it wasn't like her. Friends at college had also noticed that Gina wasn't going out so much and didn't hang out with them at weekends. She was always rushing home to be with her husband, and they didn't see her for weeks on end. Gina, a mature student with a professional career behind her, had re-entered higher education to retrain to work alongside her husband in his business. Why was she acting in this way?


At the first counselling session, Gina was not very forthcoming. 'I'm OK, I'm just struggling a bit with everything right now... but I'm OK, really, I'm OK.' Everything was OK with her husband and family too. 'Yes, yes, it's all really, really great - my husband is so supportive. I don't know where I would be without him. I worry sometimes that I don't measure up to his standards, but I do my best and I will get better. I don't know what he would think about me snivelling in your office like this and I'm not sure whether I really need your help - I'm really well supported at home and I'll be fine.'

Gina, it turned out, was a victim of coercive control in a psychologically abusive relationship. This article highlights how such clients may present in the counselling room and the signs counsellors and psychotherapists need to be alert to if they are to identify and support people who are affected by, or have survived, this hidden form of abuse. Very often a client may present with anxiety and depression or a problem that is seemingly unrelated to their 'perfect' relationship; it can take time and trust for the real picture to emerge.

An estimated one in four women and one in six men will experience domestic abuse at some point in their lives.<sup>1</sup> The Office for National



GETTY IMAGES



Statistics reports a 10% increase in domestic abuse-related offences for the year ending March 2017 (a total of 464,886 offences), with the increase attributed in part to improved recording of these crimes.<sup>2</sup> There are ongoing challenges in recognising domestic abuse and coercive control for what they are, and this is partly because the perpetrators do their best to convince their victims that they are actually the recipient of benign protection and loving care; hence the abuse is not reported and is often not spotted by loved ones and friends. This is similar to the 'Stockholm Syndrome',<sup>3</sup> where a hostage/captive is psychologically manipulated into identifying with and loving their captor, at the expense of their own identity and wellbeing. This difficulty in identifying when coercive control is a factor makes it vital that counsellors understand its psychological features and dynamics across different contexts, and are equipped with appropriate strategies for helping this particularly vulnerable and sometimes misunderstood client group.

### Psychological subjugation

Stark broke new ground when he drew a clear distinction between coercive control as a form of 'subjugation' within relationships and well-recognised models of domestic violence.<sup>4</sup> The concept is now, after long campaigning, enshrined in UK law, under the 2015 Serious Crime Act (see box).<sup>5</sup> Significantly, the Serious Crime Act explicitly recognises psychological abuse, or 'controlling and coercive behaviour in an intimate or family relationship', as a criminal offence when there is no physical abuse (this was traditionally the evidence standard used for taking action against perpetrators of domestic abuse). While physical abuse sometimes accompanies, and often follows, a long period of coercive control, the Serious Crime Act, by establishing clear definitions of controlling and coercive behaviour, allows professionals to identify it and intervene as appropriate before it manifests in physical violence.

In 2017, 4,246 offences of controlling and coercive behaviour were reported across the 38 police forces for which data were available.<sup>2</sup> The types of behaviour cited include 'isolating a person from their friends and family', 'monitoring their time' and 'taking control over aspects of their everyday life, such as where they can go, who they can see and

when they can sleep'. 'Gaslighting' is another form of manipulative behaviour, where one person tries to exert power over another by making them doubt their own judgment to the point that they question their sanity (the name comes from the 1940 film with that title).<sup>6</sup>

### Warning signs

One of the difficulties in identifying coercive control is that relationships extend along a continuum of healthiness, and can be seen from a range of viewpoints (the individuals concerned, family, friends, counsellor, psychotherapist, GP). This can make it difficult to assess whether an unhealthy relationship has become actively abusive. An unhealthy relationship can, for example, involve a lack of trust, respect or communication, without necessarily being abusive, but these factors can also tip into abuse, and counsellors and psychotherapists need to be aware of the warning signs, so that they can offer their clients appropriate support.

The signs can include missed counselling appointments within an overlying pattern of increased isolation, emotional withdrawal or numbing, dissociation, increased anxiety and nervousness, depression, and a change in personality or behaviour patterns. A number of organisations that work with survivors of domestic abuse and violence have produced taxonomies that describe the continuum of healthy through to abusive relationships.<sup>7</sup> The Duluth healthy/unhealthy relationship wheel<sup>8</sup> is a useful illustration of how an apparently healthy relationship can develop unhealthy and abusive aspects over time.

The main psychological features of controlling and coercive behaviour also exist in other contexts where people are subjected to coercive or undue influence. These include human trafficking and modern slavery (including sex trafficking), gangs, and extremist groups or cults, of which an increasing prevalence has been reported recently (there were 3,805 recorded victims of modern slavery in 2016, a 17% increase on the previous year<sup>9</sup>). Importantly, there can also be an overlap between trafficking, domestic abuse and cultic practice, as in the case of Maoist cult leader Aravindan Balakrishnan, who was jailed ►

The Serious Crime Act (2015) defines controlling and coercive behaviour as follows:<sup>10</sup>

*'Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour'*  
*'Controlling behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'*

for 23 years in 2016 for keeping prisoner two women and his own daughter in a flat in Brixton, and subjecting the women to rape and sexual abuse over a period of more than 40 years.

Research has identified the common psychological processes involved when people become controlled and psychologically dependent on an abusive partner or lead figure in a business, gang or cult. These are outlined in Lifton's<sup>11</sup> model of 'thought reform', which describes eight themes processes whereby an abusive and 'high-demand' relationship takes over the mind of the victim, resulting in a 'totalistic identity'.<sup>12</sup> They include 'milieu control' (control over the person's environment), 'doctrine over person' (whether from a partner or by a group leader) and 'dispensing of existence', where the influence over the person becomes bound up in a powerful, totalistic form of identification with the abuser or abusive group. It is the coercive control and the resulting totalistic identity that effectively trap the person in an abusive relationship and environment where it can be hard for anyone, including the victim themselves, to recognise the problem and that they need to seek help.

### Disconnection and isolation

It is often family members who first report concerns about a loved one. A family member will notice that their loved one is becoming disconnected from them and is changing in subtle - sometimes less subtle - ways. It is common for the loved one themselves to report that they are blissfully happy in their relationship or group, and it is therefore vital that counsellors and psychotherapists are able to spot when a healthy obsession or devotion has tipped over into coercive control and abuse. The signs can include a change in personality, a change in appearance, isolation from family and friends, lack of access to financial resources, being driven everywhere by their partner and not going anywhere by themselves, a change in emotional state, such as increased anxiety and depression, and apparent increasing dependence on a partner, group or relationship. Of course, these can also signify other difficulties; a holistic assessment is required, which will take time, and can be augmented with feedback from other people, whether reported indirectly by the client or directly to the therapist. A particularly strong indicator of coercive control is when the person's mobile phone is being tracked by a partner or group so that their whereabouts are always known.

When Julie and Keith first began to be concerned about their daughter Natalie, they were, like many parents, afraid that they were being overly anxious, or even a little judgmental about their daughter's new partner, whom they liked but felt they did not know really well. Natalie had graduated with a first-class degree a few years before and had surprised her parents when she announced she was going to get engaged to Ben, her boyfriend from university, and stay on in the town (some 100 miles from her parents' home) where they had been studying. Her happiness and excitement initially consoled Julie and Keith, but their feeling of disconnection from their daughter grew, as did their concerns about some of Natalie's decisions, which seemed 'a little out of character'.

For example, Natalie had decided to invest her savings in Ben's business, which was a small but apparently growing consultancy offering mindfulness and yoga training. Both Natalie and Ben were increasingly devoting all their time to the business and to an expanding but close-knit group of friends. Natalie's plans to start a family, take a postgraduate degree and pursue other hobbies (she was a talented cellist) had gone

by the wayside. In addition, when Julie and Keith saw Natalie for her birthday, she looked gaunt and tired and was only really interested in talking about Ben and their 'vital work' to save humanity through yoga and mindfulness. What concerned them most of all was when Natalie announced that she and Ben would be going to South Korea for the summer, abandoning their earlier plans for a family holiday together.

### Supportive dialogue

We have worked with many families like Natalie's, through the organisation RETIRN/UK (the Re-Entry Information and Referral Network), and have developed the Strategic and Personal-Oriented Dialogue (SaPOD) approach to help families and concerned others get through to people who they think are subject to coercive control and undue influence. Rather than using a confrontational approach, which may push the person further away, SaPOD uses a motivational interviewing approach,<sup>13</sup> which supports and extends dialogue, is empathetic toward the person's perspective, and gently challenges them to resolve their own ambivalence when openings (such as doubt) present. It also allows for an emphasis on harm reduction, which might mean that, while the person may not leave the relationship or group, they may adapt their involvement in a way that reduces the risk of harm.

Psychotherapists and counsellors can use these same types of strategic interventions when working with people who are currently experiencing coercive control. They need to balance the ethical principles of autonomy - 'respect for the client's right to be self-governing' - and beneficence - the 'commitment to promoting the client's wellbeing'.<sup>14</sup> This can be very challenging when the practitioner recognises dangerous signs of coercive control that threaten the client's wellbeing but the client does not understand that she is subject to coercive control, or is too frightened to question the relationship or consider leaving. Gina, the university student, was unable to recognise that she was having any problems when she first came for university counselling, but she returned when she failed an assessment, and, in further counselling sessions, began to acknowledge the effect of her relationship on her studies. This illustrates how laying the foundation for a trusting and respectful therapeutic relationship can have future pay-offs that are not immediately realised. Patience and understanding are often required with clients who have been subjected to coercive control and need time to build up trust before they can express their hidden doubts and fears.<sup>15</sup>

Another warning for practitioners is to be sensitive to issues of power in the therapeutic relationship. They should avoid temptations

'Vulnerability to coercive control is not restricted to any particular socioeconomic status, age, religion, culture, level of education etc, or gender or sexual orientation (although women, as with domestic abuse, are more often the victims, and men more often the perpetrator)'



to provide answers for clients, or otherwise impose standards of behaviour, and instead aim to help them to identify their motivations and needs, and make appropriate changes that they feel ownership for. It is helpful for practitioners to be aware of their own emotional reactions to working with clients who have been subjected to coercive control, and to practise good self-care, particularly with regard to their emotional reactions to the painful material presented by their clients.

Vulnerability to coercive control is not restricted to any particular socioeconomic status, age, religion, culture, level of education etc, or gender or sexual orientation (although women, as with domestic abuse, are more often the victims, and men more often the perpetrator). Power in relationships is negotiated over time, and anyone is vulnerable to an imbalanced relationship that can fall somewhere toward the coercive end of the continuum. There are many cases where men are affected (with a woman as perpetrator), and it also features in same-sex relationships. It is important that counsellors keep an open mind to the range of controlling and coercive behaviour that sadly exists.

There is also more work being done to identify and support victims and survivors of elder abuse. As with other forms of coercive control, elder abuse can be physical but often includes psychological abuse, where the elderly person is drawn into becoming dependent on a particular person (relative or acquaintance), loses their sense of self and autonomy, and is coerced into becoming acquiescent, gives over their money, moves house, and gives up or restricts their activities and contact with others. Elder abuse sometimes overlaps with financial abuse, where the perpetrator takes over the person's finances so they have no control over their own income. Financial abuse can be hard for practitioners to detect and may only be revealed in counselling as an adjunct to other matters.

### Recovery

Recovery work with people who have left coercive relationships and groups can include helping them to understand the principles of coercive control, which can help reduce their feelings of personal shame and guilt. However, they must also understand the personal dynamics that have played a contributing role, so they can avoid becoming involved in subsequent relationships that may be overly controlling. People who have escaped a controlling group or relationship may need help with practical issues, such as housing and employment, and may have safety needs if the former partner or group is threatening them. They may experience an existential void and struggle to establish their sense of identity outside the relationship and the control that has dominated their life for so long.

These issues may present quite obviously in clients who have recently left a coercive relationship or environment, but they may be camouflaged by presenting symptoms of depression and anxiety, which a client may not associate with their earlier abuse. Practitioners can integrate this specialist approach with standard work to help clients develop self-awareness and self-esteem. Supervision with someone experienced in working with coercive control may be very useful, as well as self-care (see above). It can be very painful to enter the phenomenological world of a person who has experienced coercive control and to relate empathically to their 'powerlessness'. So counsellors and psychotherapists have a vital role in supporting clients to grow in their confidence to form authentic relationships and overcome longer-term effects of coercive control and abuse. The value of training and continuing and professional development cannot be underestimated. ■

### Linda Dubrow-Marshall and Rod Dubrow-Marshall

#### About the authors

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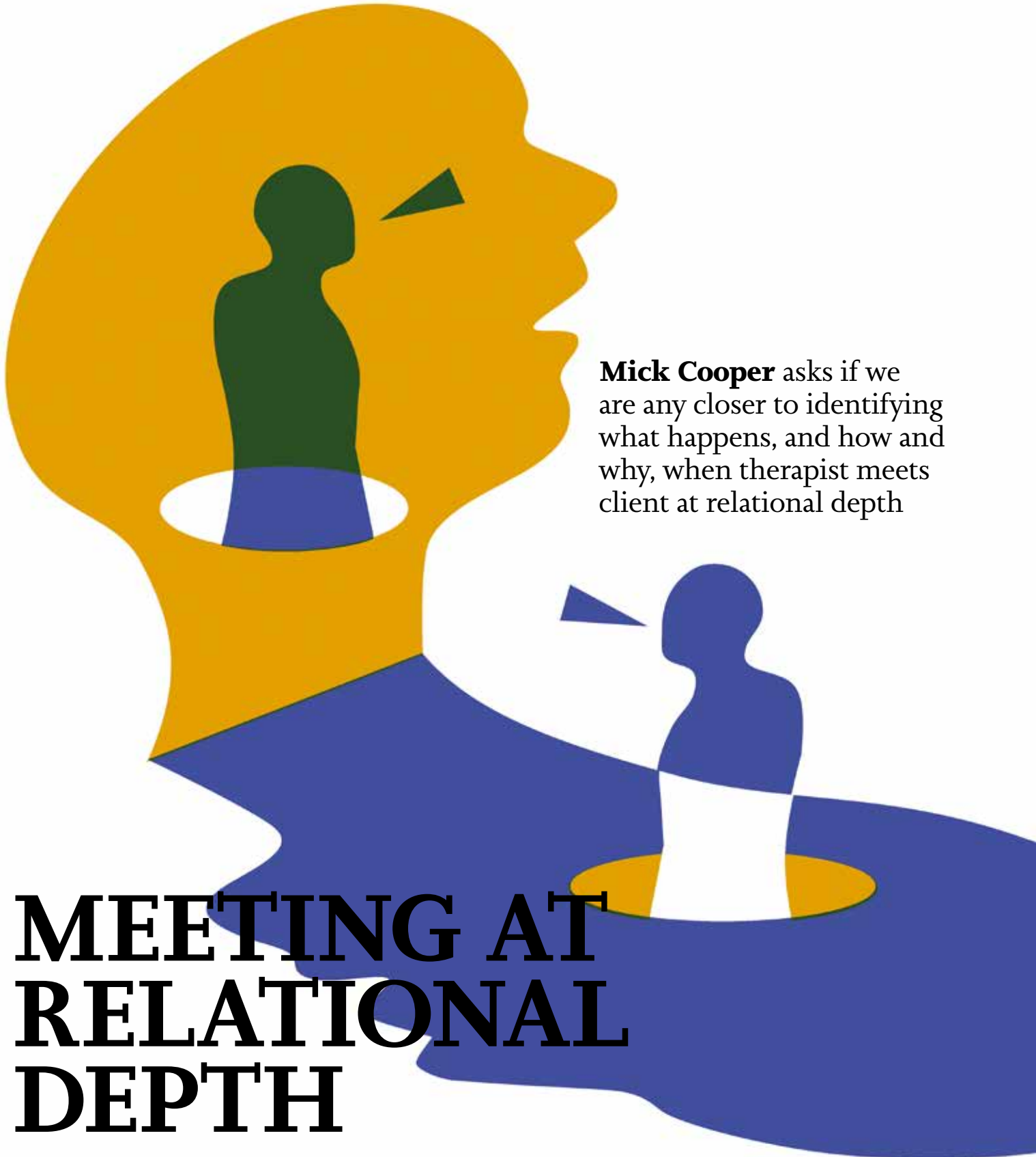


Linda is also the Programme Leader for the MSc Applied Psychology (Therapies) programme at the University of Salford. Rod is a social psychologist who has been researching the psychology and aetiology of coercion and undue influence in cults and extremist groups and relationships for over 20 years. He is a member of the Board of Directors of the International Cultic Studies Association and is Co-editor of the *International Journal of Cultic Studies*.

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**Mick Cooper** asks if we are any closer to identifying what happens, and how and why, when therapist meets client at relational depth

# MEETING AT RELATIONAL DEPTH

**W**hat do you remember about your first-ever session with a client? I remember the shabby, homely furnishings of the youth counselling centre in which it took place. I remember being really anxious about whether or not the client would show: my first two hadn't turned up, and I was beginning to take it personally. And I absolutely remember the shy, thoughtful young woman who turned up, well ahead of time, and told me about the problems she was having with her schoolmates and her over-intrusive father. Most of all, though, I remember coming out of the session feeling that I had experienced some really powerful, deep, profound connection with this young woman. More than that, I sensed that there was something about this in-depth connection that was right at the heart of what was healing in the therapeutic work.

From 2003 to 2005, I had the privilege to be able to explore these experiences and ideas in more depth with Dave Mearns, co-author of the much-loved classic, *Person-Centred Counselling in Action*. Dave had been writing about 'relational depth' since the mid-1990s. When his publishers, Sage, asked counselling trainers what books they would like to see, several had suggested a more detailed exploration of this topic. For Dave, 'relational depth' was a way of pulling the Rogerian 'core conditions' (empathy, congruence and unconditional positive regard) back together again. As a counselling trainer himself, Dave had seen how trainees and trainers could end up seeing each of these conditions as separate techniques that got 'implemented' at separate times ('Now I'm doing empathy';

'Here's a bit of congruence'; 'This one's unconditional positive regard'). Dave wanted to say that it is really all one thing: when you are there for a client, you are relating in a way that is 'empathically-congruently-accepting', and you cannot pull these core conditions apart like strips of

string cheese. What, I think, Dave also really wanted to say is that, in the counselling world, we have become so concerned about getting 'over-involved' with our clients that we have forgotten about the dangers of being under-involved: of providing them with a relationship that is so cold, impersonal and detached that it can end up doing more harm than good.

The result was *Working at Relational Depth in Counselling and Psychotherapy*, which we first published in 2005. I was, I confess, surprised by how warmly it was received. It became one of the highest-ranked texts on the Amazon.co.uk counselling bestsellers list a few months before publication, and has pretty much stayed there ever since. The book, of course, has its critics. For instance, some members of the person-centred community felt that our perspective was too directive and confrontational. But we held conferences on relational depth; it was the focus of a special issue of the journal, *Person-Centred and Experiential Psychotherapies*, and the book served as a key text in the emergence of a 'relational', 'dialogical' approach to person-centred therapy.

For me, one of the most gratifying outcomes of the book was the number of research studies that followed, mostly conducted by doctoral or master's level students. Of course, in trying to research relational depth, there is always the danger of destroying it: like catching a butterfly and inadvertently crushing it in the process.<sup>2</sup> But I also think that research has a very important function here, because, like relational depth, it is about learning and growing and being open to change. So, as the second edition reaches the bookshelves (it's

published by Sage this month), this seems a good time to review what we've learned since its first publication in 2005.

### The experience of relational depth

One of the first things that a lot of the research looked at is what is it like to relate deeply to another person, either in therapy or outside it. Most of this research found that the experience of relational depth could be described in terms of four main areas: what people felt inside, how they experienced the other, what the relationship was like, and how the atmosphere around them was.<sup>3</sup>

In terms of internal feelings, people described feeling energised and focused at these times of relational depth, yet also safe and calm. They often talked about relational depth being a very physical experience (for instance, electrifying or tingly feelings), and also a level of emotional intensity. They also said that, at these times, the 'other' was experienced as very genuine: real, human and present - coming from the 'core' of their being.

In terms of the relationship between them, people described powerful feelings of connection, closeness and intimacy at these moments of relational depth, and talked about this in very evocative terms: for instance, a 'heart to heart' meeting, or 'like electricity flowing one from the other'. Feelings of mutuality and equality in the relationship were also very common, and people often said that relational depth happened without words. In terms of the atmosphere, they often described feeling in some kind of altered state, or that there were changes in their perception of time: for instance, long periods of time

**'... people described feeling energised and focused... yet also safe and calm. They often talked about relational depth being a very physical experience... and also a level of emotional intensity. They also said that, at these times, the "other" was experienced as very genuine: real, human and present'**

seemed to go by in a flash. Some people also described these experiences as spiritual.

The striking commonalities in how these experiences of relational depth were described – both across participants within the same study and across studies – suggest that the phenomenon of relational depth is a real and distinctive occurrence. Initial research suggests it also extends beyond western cultures, but more cross-cultural studies are needed. However, we have also found some differences in the experiences of relational depth, particularly between therapists and clients. For instance, consistent with their roles, therapists are more likely to experience feelings of respect and empathy for the other at these times, while clients are more likely to describe feelings of being known, understood, cared for and accepted.

### For therapists

All the studies conducted so far suggest that the vast majority of therapists experience moments of in-depth connection with their clients. For instance, one survey found that around 98% of therapists could identify at least one experience of relational depth.<sup>4</sup> Interview studies with therapists have found similar prevalence across orientations and client groups. In terms of frequency, one survey found that therapists experience relational depth somewhere between 'sometimes' and 'often' in their therapeutic work.<sup>5</sup>

Surprisingly, perhaps, there is no difference in the degree to which therapists of different orientations report experiences of relational depth. There are also no differences across age, ethnicity or gender. However, more experienced therapists seem to report more experiences of relational depth. Also, perhaps not surprisingly, while therapists have reported experience of relational depth in short-term therapies, long-term therapy relationships appear more conducive to a greater depth of connection.

### For clients

But is relational depth something that therapists just imagine happening; does it have any bearing on what clients really experience in the therapeutic work? The research suggests that clients do, also, have this experience. In one study, around 80% of clients reported experiences of relating in depth with their therapists, and clients in most qualitative interview studies have reported

something similar.<sup>6</sup> Nevertheless, in some studies clients have not reported experiences of relational depth, and, overall, they seem significantly less likely than therapists to report it. In addition, one study found that young people really struggled to describe any such moments of connection with their therapists.<sup>7</sup> They could identify important moments in therapy, and were certainly able to talk about therapists' relational characteristics, such as their warmth or supportiveness. But the notion of experiencing moments of closeness or relational intimacy with their therapist appeared alien to the way these young people thought about the counselling process.

Across studies, there are some indications that clients may experience less relational depth with psychodynamic therapists than with humanistic therapists. Clients also report more depth of connection with female therapists. Interestingly, this seems to be particularly true for male clients: the deepest levels of connection are between a female therapist and a male client; the shallowest between a male therapist and a male client.

### Shared relational depth

One question that has always fascinated me is whether the client and therapist experience relational depth at the same time. I tested this myself, in a study in which pairs of practising and trainee counsellors were asked to conduct 20-minute 'counselling' sessions with each other, and, at every minute, to rate their own sense of depth of connection in their respective roles.<sup>8</sup>

I didn't expect to find much match, given the body of research showing that therapists' and clients' perspectives are typically very different. However, there was an overlap of around 45%. This varied a lot across the pairs: in some cases, the therapists and clients were really closely matched in their assessments of the degree of connection; in

others, the therapists and clients seemed to be experiencing quite different 'journeys'. Although the design of this study was somewhat artificial, other studies in which participants have rated their depth of relating after the session have found something similar.

Interestingly, the more experienced therapists did not seem to be any better at matching their clients than the trainee therapists. However, female therapists did achieve a better match than male therapists.

### The impact of relational depth

Does achieving this connection have any actual impact on the therapeutic work and the client's outcomes? The best evidence here comes from a study using the Relational Depth Inventory. This asks clients to identify a particular helpful moment or event in therapy, and to rate how accurately 24 items associated with relational depth fit with this experience (for instance, 'I felt a profound connection between my therapist and me').<sup>9</sup> This demonstrated that experiencing a depth of connection was associated with a striking 10-30% of the overall positive outcomes: that is, the more that clients experienced relational depth in a particular moment of therapy, the more they improved.

In support of these findings, interview studies also indicate that a majority of clients feel that moments of relational depth have a significant positive impact: both immediately and in the longer term.<sup>6</sup> In terms of immediate effects, clients describe these moments of meeting as facilitative, healing and changing, and also describe a positive impact on the therapeutic process itself. In the longer term, the most commonly reported impact is an increased connection with their own selves. Clients also report feeling more powerful, feeling better, and developing improved relationships with others.

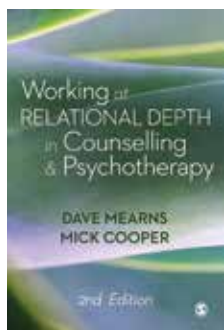
**'In terms of immediate effects, clients describe these moments of meeting as facilitative, healing and changing, and also describe a positive impact on the therapeutic process itself. In the longer term, the most commonly reported impact is an increased connection with their own selves'**

## What blocks it

Clearly, a meeting at relational depth is not something that can be made to happen. By definition, it's a spontaneous encounter, and it's also a deeply human and respectful meeting - so not something that a client can be manipulated into. Nevertheless, there may still be things that therapists can do to make its occurrence more likely.

When therapists are asked how this connection occurred, they most often mention 'taking risks': in particular, taking the risk of saying to a client how they are experiencing the therapeutic work. They might say, for instance: 'I sense that you are feeling a bit disconnected today', and then follow that through to a more honest and authentic dialogue.

However, clients say that moments of relational depth are most likely to happen when their therapists are offering something 'over and above' what they would expect from a professional relationship: a genuine, very real commitment and care.<sup>6</sup> Closely related to that, they talk about their therapists being really real and human: genuine, themselves, and not faking things or putting themselves on a professional pedestal. So, for instance, one client said: 'I think I had only expected to receive from her professional self... [I]t felt like she was giving from her core.' Clients talk about the therapist's ability to create a welcoming and safe atmosphere; their patience; their ability to act in a way that is trustworthy, reliable and professional. Interestingly, too, the clients emphasise how the therapist feels really on their side: not just a neutral, non-judgmental presence, but ►



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## SOMETHING WONDROUS HAD JUST TAKEN PLACE

'Grace' was a 39-year-old woman who worked with counsellor Anne Deacon for over two years. Throughout her childhood, Grace was regularly beaten by her parents and mentally tormented in the most sadistic of ways.

Anne writes: 'Grace learned early in her life to keep her feelings under control and never show any emotion. Every waking moment was fearful for her as she never knew what might provoke another attack.' Grace did not know what her feelings felt like because she had not been allowed to experience them. 'Even fear had been replaced by a void of nothingness.'

For the first few months of counselling, Grace and Anne worked together to help Grace recognise what her feelings were and put labels to them. 'Then came the day when she was telling me of yet another beating and, as my eyes filled with tears as I listened, she suddenly stopped mid-sentence and said to me: "Those tears should be mine, shouldn't they." I nodded. Grace continued to look at me and then I saw her eyes beginning to fill with tears as well. (This was the first time in 18 months that she had shown emotion). She continued to look at me as if she needed to be connected to my tears to allow hers to flow. Time seemed to stand still, quietness seemed to descend on the room, there was nothing happening, yet there was so much happening. Grace

continued to look at me and the enormity of her pain was tangible. Then her tears came, at first slowly, as she blinked hard as if to force them out of her eyes. Then she was sobbing, her body shaking with the force. She looked at me now with panic in her eyes as she experienced for the first time what it felt like to cry for her self. I leaned closer, her tears now were falling on to her arms and clothes, and the noises she made came from deep within her very soul.

I asked softly if she wanted me to sit next to her. She nodded. I moved slowly across to the settee and sat down, half-facing her (touch was something she was afraid of, so I needed to be extremely sensitive), and then made my hand available to her. It seemed a while before she very slowly moved her hand towards mine. I made no movement and gradually she touched my finger with hers. All the while her sobbing continued. Suddenly I was aware she was carefully and gently starting to hold my finger.

'When I felt her finger touching mine I was careful not to make much movement. I was aware of the courage it was taking for her to touch me. The way she was touching me was so tentative and uncertain and instinctively I didn't respond straight away; I waited until she was holding my finger more securely. I then very slowly held her back and we sat like that for what seemed

an eternity. The contrast between her fragile touch and her racking sobs seemed a chasm apart.

'I didn't feel any sense of a need to comfort her in any way. I felt a deep empathy for her, and, in that moment, I was willing to just sit alongside her in that dreadfully painful and terrifying place she now found herself in. (In the past to cry would have resulted in a beating.) She was not only crying for the first time, but she was touching another human being. To me, in that moment, she was saying, "I trust you with my tears and with my touch."

'My chest cavity was full to the brim with emotion and it felt difficult to breathe. I no longer felt any desire to cry for her pain. But the effort of just staying close was intense.

'Eventually her crying subsided. Just as gently and slowly as she had first held my finger, she now began to release it, and, as if in slow motion, we took up our original positions facing each other. She looked into my eyes again, and in that moment, we knew that something truly wondrous had just taken place.'

Anne continued to work with Grace for a further eight months. At the end of her counselling, Grace decided that she would pursue her love of art and enrolled on a course at the local university. Her first year was a success and she went on to take the degree course.

*(Adapted from: Knox R, Murphy D, Wiggins S, Cooper M (eds). Relational depth: new perspectives and developments. Basingstoke: Palgrave; 2013 (Chapter 1).*

## 'If therapists want to deepen their levels of relating with clients, then it would seem important that they allow themselves to express a genuine care and concern for the people they are working with'

someone who actively values them, and sees things in their way. Mostly, however, clients say that the emergence of a meeting at relational depth is less about their therapist and more about them. For instance, they talk about their own readiness and desire to engage at depth; how relational depth is something that they very proactively entered into: a deliberate choice to take the risk and open up. One client, for instance, said: '[I]t was a very definite thing within myself that happened, that I allowed myself to be so open, and let my defences down enough... it was almost as if I'd got to the point... of no return and I thought, "I'm going to go for it".'<sup>6</sup>

If therapists want to deepen their levels of relating with clients, then it would seem important that they allow themselves to express a genuine care and concern for the people they are working with. This is not about pretending that we care; it's about expressing our natural warmth, compassion and humanness. Of course, boundaries are critically important for therapy. But what the research on relational depth suggests, as Dave Mearns originally argued, is that, if therapists implement boundaries in an impersonal, detached, uncaring way, then it has the potential to act against the helpfulness of the therapeutic work.

So, rather than looking at how we can make relational depth happen, it might be more useful to look at what stops us, as therapists, from relating more deeply with our clients. A concept that may be useful for this is that of chronic strategies of disconnection, developed by relational-cultural therapist Judith Jordan.<sup>9</sup> This describes strategies we may have developed as children to protect ourselves from interpersonal hurt, but which have now become self-defeating. For instance, as children, we may have gone quiet and passive when we feared others were going to hurt or reject us, and we may still do this

in arguments with our partner, even though we know it makes things worse. So, as therapists, we need to ask ourselves: 'What are my chronic strategies of disconnection? Are there ways in which these might leak into my therapeutic work? What might I do about this?' (A recent study found that around 50% of

therapists' chronic strategies of disconnection leaked into their therapeutic work, at least to some degree.<sup>10</sup>)

### Beyond the visible

This is just some of the new evidence informing an understanding of the role of relational depth in therapy. There are also new findings in the social neuroscience field, showing how in-depth relating can have a positive effect on the brain, and health studies research showing that the quality and quantity of interpersonal relationships are among the strongest predictors of mortality. But the research reviewed here comes specifically from our own field of counselling and psychotherapy, and tries to put relational depth right into the centre of an understanding of therapy processes and outcomes.

There is an old adage about a policeman who sees a drunk looking for something under a street lamp, and asks him what he has lost. The drunk says he has lost his keys, and so



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For resources and training on relational depth, visit [mick-cooper.co.uk](http://mick-cooper.co.uk).

they both look under the street lamp together. After a while, the policeman checks with the drunk whether he has definitely lost them there and the drunk says, 'No, I lost them in the park, but this is where the light is.' So it is with research into relational depth: we can look under the street lamp, at easily definable and measurable phenomena like therapists' techniques, but we may be focusing on only the most visible and surface-level agents of change. We need to take a torch into the park to see more of what's out there.

Of course, we will never 'catch' relational depth, hidden behind a bush like some scurrying mouse, but at least we can learn more about its habitat, its terrain. And maybe, in some fleeting moments, we will catch a glimpse of it, and stand in awe of its power, profundity and beauty. However evasive, however hard to find, those experiences of deep relational connection may be the most meaningful in life, and the most significant in the therapeutic healing process. ■

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‘Better to talk about it in the session with the client than for it to come back into their minds in the middle of the night, when there is nobody to listen’



**I had been working as a counsellor** for a few years, and had been to a seminar where a colleague had described working with a boy who had cancer. The boy spoke about buying a motorbike when he came out of hospital, and driving it really fast. I was surprised the therapist hadn't asked him whether he wanted to kill himself; the therapist had said the boy wasn't ready, that he 'couldn't take it'. I would have asked him immediately, but I now worried that perhaps I would have done some harm.

I told Hanna Segal, an older, more experienced psychoanalyst, that I still worried about saying the wrong thing to clients - what if I put an idea into their heads that they hadn't had before? She said two things that stayed with me. First, 'if it has occurred to you in the session, it will already have occurred to them'. She said that pupils of Melanie Klein (like herself) were taught to be more concerned about 'leaving patients alone with a worry'. Better to talk about it in the session with the client than for it to come back into their minds in the middle of the night, when there is nobody to listen. 'Defences are raised against frightening ideas that are always worse than reality; you can help reduce them to a realistic level,' she advised.

Putting this into practice was a revelation. Time and again with clients, a clear idea has come into my mind that to me seems literally unspeakable - thoughts about a client being crazy; a client dying because nobody loved him enough; a mother not loving her daughter. Time and again, Hanna Segal's words have

come into my mind, and I have taken a deep breath and managed to speak these thoughts, although hesitantly, and as a question. In every case, the atmosphere has changed, there has been a palpable sense of relief, and the work with the client has taken a huge step forward. It has been clear that I have understood something that has worried them for a long time, but they have felt unable to share it with anyone. The thoughts have in themselves been frightening, but they have become less terrifying to the client after we have talked them through. Defences are indeed raised against fantasies or ideas that are worse than reality, not against realistic ones. The client and I have sometimes been left needing to grieve for real losses, but there has also been a huge relief at the disappearance of the exaggerations.

**I now see this as part and parcel** of counter-transference or projective identification. Normally, when we share ideas with a client, there is a natural to and fro of unconscious communication that recognises and acknowledges shared understanding. But these particularly powerful ideas are blocked by the client because they have some kind of terror attached to them. As a result, I think, we attribute them to ourselves alone, as if they had nothing to do with the client. It is this that makes them hard to say. That is where the input of a more senior therapist is helpful; first in supervision, but later, in our own minds, we need to hear their voices casting doubt on our most disturbing assumptions and giving us confidence in our role and capacities. ■



#### About Julia

Julia Segal has worked for 35 years as a psychoanalytically informed counsellor, lecturer and trainer, and is an author of numerous books. She currently works in north-west London as a counsellor for people affected by neurological and other physical health conditions. Her latest book is *The Trouble with Illness: How illness and disability affect relationships* (Jessica Kingsley, 2017).

# ON THE SPORTING COUCH



**Gary Bloom** describes how his roles of therapist and journalist combine and collide in his radio show, *On the Sporting Couch*

**T**he guest radio studio at Swansea Sound is small and far from glamorous or show-biz. However, the sound engineer beamed with pride. 'The equipment might be dated, but it works just as good as the new-fangled stuff. You'll have a decent show.' He was right.

Rugby referee Nigel Owens was running late. He couldn't get his car out of his rural driveway as a tractor had blocked him in. Nigel is probably the most famous rugby union referee in the world these days, after officiating in the last World Cup Final. He's only about 5ft 7in tall, but his witty put-downs of rugby players who tower above him on the pitch have become a YouTube phenomenon.

When he arrived, I noticed he was wearing an anti-bullying wristband. As the recording of our conversation progressed, he became tearful as he described his early life when he was bullied at school and how he struggled to come to terms with his sexuality while growing up in rural south Wales. It was an extraordinary recording, during which he finally broke down as he explained how he bitterly regretted the attempt he had made on his life because he couldn't deal with the shame of telling his parents he was gay.

I'm a sports journalist and practising psychotherapist. I was in Swansea to record a programme I've developed with talkSPORT radio called *On the Sporting Couch*, which aims to replicate as far as possible a 50-minute therapy session. Nigel was the first guest I'd

recorded outside the cosy confines of the talkSPORT studio on London's South Bank.

I had mixed feelings as the recording progressed. First, I realised I was party to an emotional outpouring with which many listeners would connect. I hoped the ancient equipment was working. I also felt the pressure to deliver a memorable piece of radio. There would be no session two next week, as there normally is in therapy, and these are not therapy sessions in the usual sense, as they are self-evidently not confidential. Nor are they really interviews. Think *In the Psychiatrist's Chair* - the popular BBC Radio 4 programme hosted by Anthony Clare - but more relational, and my subjects are all sporting celebrities.

In truth, there was very little about sport in the show with Nigel Owens. His shame about not 'coming out' dominated the programme, and by the time we had finished, I felt close to tears myself. It was a strange goodbye. He was whisked away into the Swansea Sound newsroom to record an item on Welsh rugby. I was left struggling for words after such an intimate disclosure.

## Talking feelings

I first had the idea for the programme after spending a lot of my training hours in a men's therapy centre in Oxford. A recurring theme with my clients was: 'As a bloke I find it difficult to talk about my emotions', yet many men talk freely and with great emotion about sport. Just listen to any football phone-in on a Saturday

evening. I approached talkSPORT with the idea of the programme, and they said, 'Find a guest and we'll commission a pilot.'

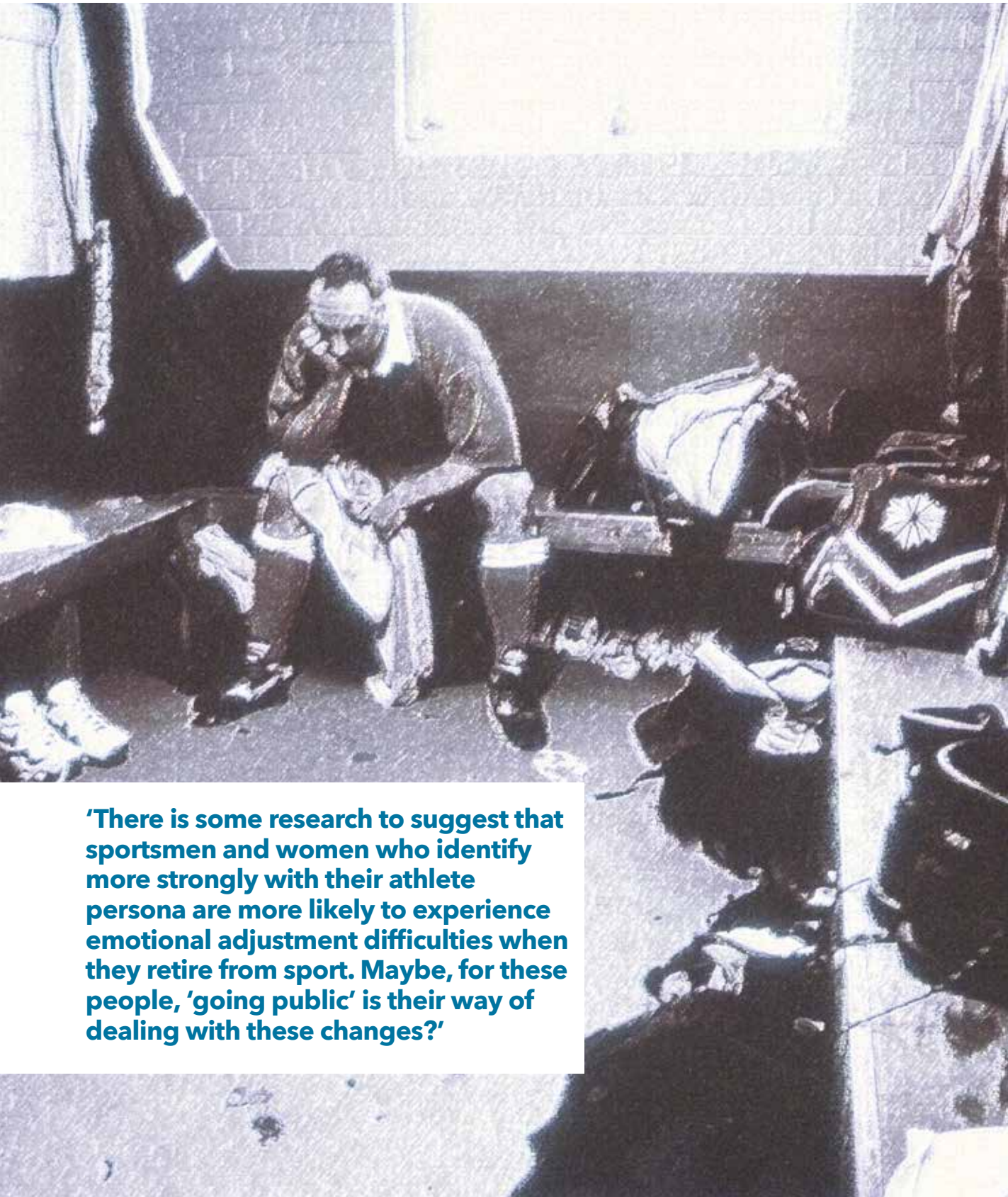
I approached a former Premier League player with whom I had done some broadcasting work in the past. He'd had his fair share of ups and downs and I thought he'd support my idea for the radio show. He was polite, but said he didn't know of any players who'd be prepared to go public. After putting the phone down to me, he called another commentary colleague of mine and reportedly said: 'If Gary Bloom thinks he can find a sportsman or woman to go on the radio and admit they have mental health issues, he's \*\*\*\*\*g mad.'

I was not deterred. Boxing legend Sugar Ray Leonard once said, 'Nothing could satisfy me outside the ring... there is nothing in life that can compare to becoming a world champion.' Leonard would later suffer from depression after retirement from boxing, and he made numerous attempts to reignite his career. Could I find my Sugar Rays?

There is some research to suggest that sportsmen and women who identify more strongly with their athlete persona are more likely to experience emotional adjustment difficulties when they retire from sport.<sup>1</sup> Maybe, for these people, 'going public' is their way of dealing with these changes?

So why not ask them? I did, of course, and every one of my guests turned out to have a different motive for appearing on the show. ▶





**'There is some research to suggest that sportsmen and women who identify more strongly with their athlete persona are more likely to experience emotional adjustment difficulties when they retire from sport. Maybe, for these people, 'going public' is their way of dealing with these changes?'**

VC/CHRIS RYAN

Most of the guests said they just wanted to pass on the message, 'Don't suffer in silence.' Some wanted to give this message without having to be too open about their personal struggles with their mental health.

### **New territory**

My first guest was former England and Bath rugby prop forward Duncan Bell. I got in touch with him through Cognacity, the London clinic where I work. This was to be the pilot show. If it went well, and talkSPORT liked it, there might be others. I was nervous, but not as nervous as Duncan.

My fears were many and varied. I was worried about what my supervisor might say about me conducting an on-air therapy session; what my tutors at my training college would have said, and also what might happen if my regular clients heard the show. Should I tell them about it, even? I took these concerns to supervision and was told, 'This has never been done before with sports people. Create the rules, based on your training.' So I did.

## **'I always carry in my memory something my supervisor once said to me back in my early days of training: "Gary, you must wait with your clients at the bus stop. Don't pick them up in a taxi!" So I waited'**

At the start of the recorded interview, I told Duncan he could stop the session at any time, and if he was uncomfortable with the recording, he could say so. Five minutes in, I asked him about his family. 'Can we move on?' he said. I capitulated. A therapist colleague later told me she wished I hadn't.

Duncan went on to talk about what it's like to live with anxiety and depression as a professional sports person, and how, when he eventually told his club and country, they supported him unequivocally. His message was clear - without that support and the right people to talk to, he probably wouldn't still be around to tell his story.

The pilot show was aired in December 2016, and had such a good response that talkSPORT asked for six more shows. Now the radio station took over booking the guests and used the show with Duncan Bell as a 'calling card' to give an idea of what would happen to prospective guests. We hoped some would open up on air, but I never demanded that.

I prepared by reading a guest's autobiography (if there was one), and then visiting them to make sure they knew what they were letting themselves in for. As with a therapy session, I didn't plan any set questions, and this allowed the radio shows to meander in the same way a therapy session would, so it sounded less like a formal interview. If a guest started talking about his or her schooldays, I'd go with that. I always carry in my memory something my supervisor once said to me back in my early days of training: 'Gary, you must wait with your clients at the bus stop. Don't pick them up in a taxi!'

So I waited.

Former England cricketer Marcus Trescothick was my next guest. He, like other sports people who came on the show, each for their particular sport, has become an ambassador for mental health in cricket, working with the Professional Cricketers Association. Our pre-interview chat took place at the Oval in London. Marcus, immaculately turned out, struck me as someone who presented a good public image for the work he was doing to promote mental health.

At the peak of his cricketing career, Marcus had been hit for six by debilitating anxiety about travelling abroad, which culminated in an incident at Heathrow airport, when he couldn't bring himself to board a flight to Dubai with the rest of his Somerset team colleagues. He'd had an idyllic childhood in Somerset, with Mum, Dad and sister, regularly travelling to local cricket games. Dad was a handy cricketer himself, and Mum made the teas.

During the recording, I tried to discover why Marcus had these anxieties. He was evasive. I had previously re-acquainted myself with Bowlby's attachment theory, in readiness for our meeting, but Marcus was ready for me. He answered all my questions politely, but without opening even a chink in the well-developed armour he had constructed. Nor did he display any real curiosity about his condition. I might have been asking him why he had dark hair. With time running out and the recording

## **'It's been a recurring tension in these interviews: the broadcaster and therapist in me were sometimes at war; what makes good radio versus what is good therapy practice'**

drifting. I wondered if he simply didn't want to know. What came next was, for me the core of the whole session. I told Marcus that I felt like a bowler, and that each time I bowled a ball, he simply held up his bat in a block stroke. 'I just don't want to know what's wrong with me - what good would it do me knowing?' he said. I said it might help him reduce his anxiety and depression. He dismissed me with an 'OK'.

I had the overwhelming feeling that I was threatening to disturb a carefully constructed mechanism that had helped him keep his game together, and allowed him to continue to play competitive sport. I was instantly reminded of our basic ethical principle as therapists: 'First, do no harm.' I felt I was in danger of breaking down something that was very necessary and important. I let it go.

Later, as I began to deconstruct the interview with Marcus in my head, I wondered why he'd agreed to do it. He's an ambassador for mental health for cricket and maybe he was willing to do as much as he could. Many would shy away from that role, and Marcus has my respect and admiration.

The post-interview response was once again hugely positive, but I was left feeling that I had failed listeners by not pursuing my questions about his mental health. It's been a recurring tension in these interviews: the broadcaster and therapist in me were sometimes at war; what makes good radio versus what is good therapy practice.

### **Revealing**

In a later show, one of the world's leading darts players, James Wade, talked openly about his social exclusion as a child and his fury at the failure to diagnose his bipolar disorder and ADHD. He talked with extreme frankness

about his less than perfect childhood and how his excellence at his sport had made a huge difference to his life. However, as with all the sportsmen and women I interviewed, being at the height of his sport brought intense mental pressure that was hard to bear. He clearly felt misunderstood by the Professional Darts Corporation, and that many of his brushes with them over his conduct could have been handled better had there been a greater understanding about his diagnoses. As a therapist, I wondered if his anti-social outbursts were more of a message that no one was listening to him.

The recording with James was arguably the most powerful of the series, and probably the closest I managed to get to the essence of what an on-air therapy session would be like. I had visited James in Cardiff a fortnight before the recording, to give myself a chance to get to know him better without the pressure of the recording light being on. There was a real connection between us, and this was replicated when we met again in the recording studio two weeks later. The response on social media was hugely positive. James has a huge following and there were several messages of support from Twitter users who also have ADHD and bipolar disorder.

I wondered whether the radio show was therapeutic for James. He had been constantly told to 'shut up' by his teachers and his darts organisation. The disclosure seemed to be part of coming to terms with something unresolved. From my perspective, this recording was by far the easiest.

One of the hardest interviews was with former footballer Keith Gillespie, whose motivation for doing the show was to warn young players of the temptation of gambling addiction. Keith managed to fritter away £7 million on gambling during his time as an elite player. He put it down to being both 'bored and lonely'. But every time I tried to open up an emotional landscape for him, he quickly closed it down. It reminded me of a first session with a client who is ambivalent about being in therapy, and who isn't particularly curious to look at their own material. Keith didn't display any real curiosity, and I left the studio feeling a bit flat and wondering if the recording had been worthwhile. My producer was positive: 'His reluctance to open up is the story,' she said.

She was right. So many things had happened to him and he didn't really

understand why, and nor did he want to understand. I was left with the sense that, if I could have worked with him for longer, in a more private setting, maybe it could have changed things for him.

Another guest was former Olympic swimmer Rebecca Adlington, who talked about the online trolling to which she was subjected about her physical appearance. Rebecca is now running learn-to-swim clubs, as well as forging a new career as a TV presenter. I was intrigued to understand why she chose such a very public career, given the online abuse she had already received.

Contrary to my male guests, 'Becky', as she insisted I call her, didn't strike me as in any great need of therapy. She's bright and confident about who she is, has good insight into her feelings and motivations, and only wanted to be involved in the show to help other young women who were facing online trolling about their appearance.

The recording took place in her home, in her upstairs lounge. 'This is my private space,' she said, before we began. I wondered if being in her home would alter the dynamic between us, and listening back to the broadcast, I felt I was slightly more friendly and chatty, rather than therapist-like. Or perhaps I didn't feel the need to challenge her thinking, given she does that already, and is open to understanding more about herself.

Nearly all the people I interviewed had a message to impart: 'Don't suffer in silence.' That is exactly why I undertook the project. Eighty per cent of talkSPORT's audience are men, the majority of them aged 35-44 - the demographic most at risk of suicide. My hope is that a few of them might listen to the show and think, 'You know what, therapy isn't so daunting.' ■

**'Former Olympic swimmer Rebecca Adlington, talked about the online trolling to which she was subjected about her physical appearance. She is now running learn-to-swim clubs, as well as forging a new career as a TV presenter. I was intrigued to understand why she chose such a very public career, given the online abuse she had already received'**



**Gary Bloom**  
About the author

Gary Bloom is an integrative psychotherapist working in Oxford and at his Harley Street clinic in London. He also works in schools in the south-east using a sport-based therapy to challenge behavioural and academic underachievement in adolescents.  
[www.abc-education.org.uk](http://www.abc-education.org.uk)

**On the Sporting Couch has just won bronze at the Arias national radio awards in the Best Sports Programme of 2017 category, and has been nominated in the Radio category for the Mind Media Awards 2017. Past programmes can be heard at [talkSPORT.com/sporting-couch](http://talkSPORT.com/sporting-couch)**

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# STUDENT COUNSELLING - WHAT IS ITS FUTURE?

**Liddy Carver** reviews current research on the complex challenges facing student counselling services today

**F**urther and higher education is driven by 'marketisation' principles - primarily, the need to maximise student numbers and minimise costs. This month's Research into Practice examines the role of counselling services

**in supporting these goals. With ever-increasing numbers of students coming to them with more complex emotional and mental health support needs, how do counselling services fulfil this role, and should they even be trying to?**



**Liddy Carver**  
About the author

Liddy Carver is a BACP-accredited counsellor. She works as a counselling educator at Wrexham Glyndwr University, volunteers at a student counselling service, and is Managing Editor of *Counselling and Psychotherapy Research*.

## Current challenges

A very recent paper from a research team at Sheffield University helpfully sets the scene with its comprehensive survey of the challenges facing embedded higher and further education counselling services across the UK, and how they are responding.<sup>1</sup>

Brogia and colleagues conducted an online survey of heads of UK counselling services (113 out of a potential 160 responded), to obtain comparative data on staffing, attendance at counselling sessions, uptake of different kinds of support, and the use of new technology as an alternative to face-to-face therapy.

A wealth of information emerged from the responses (the article is Open Access, so readily available). A finding of immediate interest was that the current spike in student demand appears to coincide precisely with the introduction of student fees and consequent increase in student debt. The survey also produced data to support the hypothesis that widening student participation has in itself led to increased demand

for mental health support, as more students from more disadvantaged backgrounds, with poorer mental health, are attending university.

These students all bring higher needs, necessitating high-intensity therapies, and are now likely to have much higher prevalence of mental ill health than the general population. More preventive programmes are needed to help vulnerable students manage their emotional health, Brogia and colleagues report. But there is an optimistic assumption here that universities are a natural place to locate student mental health support. Many students with complex and risky presentations need secondary care level services but, with thresholds so high in the NHS, they don't get access until they are seriously unwell. University counselling services can't be expected to plug the gap in the NHS by default.

The authors say all services need to be using validated clinical outcomes measures in order to inform service development (not all were). There was, they say, 'an absence of a culture of evaluation and a lack of strategic implementation that would enable

collected data to be best used'. Looking to alternative ways to meet student need, the survey found a growing interest in online peer support communities and mobile phone apps, but warns there is currently no national system of quality assurance for the latter: 'Users could benefit from having professional guidance on the appropriate use of apps.'

## Quality improvement

As in the UK, US universities and colleges have also been trying to find cost-effective ways to tackle escalating demand from students for their counselling services. Maffini and Toth<sup>2</sup> are enthusiastic proponents of quality improvement (QI), frequently mistrusted by practitioners (ironically) as management bean-counting that sacrifices quality for quantity. Certainly, as their article points out, QI is rooted in the corporate sector (notably, the Ford Motor Company).

They describe a programme instituted at a large, midwestern US university, and the paper offers some good examples of 'clinician-friendly' QI strategies suitable for the further/higher education sector. The university embarked on a 20-year programme, led by a QI co-ordinator who spent some 6-8 hours a week introducing QI strategies into routine clinical counselling practice and to overcoming clinicians' suspicions, anxieties and resistance.

The service now has an ongoing programme of user satisfaction surveys, outcome studies, chart reviews, evaluation surveys, and special intern research projects.

The satisfaction questionnaires have resulted in a reduction in wait times to two days maximum, and provide evidence to support requests for additional funding to meet unmet need. Outcome measures provide clinicians with important feedback about effectiveness. Chart reviews examine how well counsellors

**'...the current spike in student demand appears to coincide precisely with the introduction of student fees...'**

document diagnosis, treatment and planning, and are now completed by the majority of clinicians. The requirement for all pre-doctorate students to complete a QI project as part of their studies has produced some very useful data, such as how international students view the service and its cultural sensitivity, which led to successful efforts to reach out to these groups.

Overall, Maffini and Toth conclude, clinician resistance to QI measures may be inevitable, but it can be overcome through open and non-judgmental dialogue. QI is 'about curiosity and exploration,' they write. Start small, with a 'doable' project that addresses a particular interest or concern for the service, and let the data gathered lead its subsequent growth and direction.

### Ethics of student retention

In another US study, Kyle Bishop<sup>3</sup> explored the ethical tension facing university and college counselling services who may feel under an obligation to support their college's primary aim to retain students when it might be a better personal choice for a student to leave: 'A primary issue that college counseling centers face is that their principal goal is not, and should not be, the retention of students. It would be unethical for counselors to attempt to retain students who were disrupting the college community or emotionally unable to succeed in the college environment.'

Bishop's study goes to the heart of this ethical dilemma by exploring four questions: the impact of counselling services on retention; at what points might high-risk students benefit most from extra, targeted counselling support; the differences in retention rates for high-risk students who use counselling

### 'A primary issue that college counseling centers face is that their principal goal is not, and should not be, the retention of students'

services and those who do not, and whether students without diagnosed mental health problems benefit equally from counselling.

From previous research, Bishop defines high-risk students as those who are the first in their family to attend college, are from lower socio-economic backgrounds, and with poorer academic performance in school.

The study recruited 429 students. Low-risk students who received counselling were significantly more likely to complete their studies than high-risk students who received counselling. However, high-risk students who had counselling were no more likely to complete their studies than other high-risk students who did not. Nor did having more counselling sessions reduce risk of drop-out among high-risk students. Interestingly, there were no changes - no clear spikes - in risk throughout the students' college careers where intervention might be most helpful.

Several messages emerge. One is that, even with counselling, high-risk students are more likely to drop out than low-risk students. The reasons may be several, Bishops says: '... high-risk students may have lower resiliency, may be less responsive to counseling intervention, may be facing more severe issues, or may be less proactive about seeking counseling intervention than their peers.' Ethnic and cultural variables have also been shown to affect retention

rates. The overall conclusion, Bishop says, is that students at high-risk of drop-out may be less likely to seek help and that university counselling services have a clear duty to reach out and actively promote counselling to those likely to be most vulnerable.

### Online options

If counselling services are to meet escalating need within reduced resources, inevitably the most cost-effective methods for delivering counselling will be needed. Most university counselling services have introduced online alternatives of varied kinds, from instant messaging to online video and computerised, self-help CBT packages. Terry Hanley and colleagues joined forces with the youth counselling service, Kooth, to compare what young people aged 11-25 gain from online and face-to-face counselling.<sup>4</sup>

The researchers used an exploratory mixed-methods design to examine the therapeutic goals identified by the young people using the Kooth counselling services, whether online or face to face. Data were taken from the organisation's Counselling Goal System (CoGS), which encourages clients to set goals for counselling and enables their progress to be assessed quantitatively.

More personal growth goals (46.05%) were identified online than in face-to-face counselling (28.85%). Emotional wellbeing goals were more frequent in face-to-face counselling (35.58%) than online (16.32%). Most online issues related to improving relationships with friends (61.80% versus 24% face-to face), while the most common goal in face-to-face counselling was improving relationships with family (76% versus 21.35% online). None of the young people in face-to-face counselling set goals related to

intimate relationships, compared with 16.9% of online clients. Under the 'intrapersonal goals directly related to others category', 16% of online goals related to the 'fitting in' subcategory, but none in the face-to-face counselling.

The study concludes that online counselling can avoid the stigma often associated with seeking therapeutic support, meaning that it can reach young people who might otherwise struggle to talk about their problems face-to-face with a counsellor. But as to the direct comparison of the two approaches: 'Young people utilise online and face-to-face counselling to address different types of therapy goals [and as] a way to access other types of support.' What matters then, is surely that they have that choice.



### Get in touch

If you're interested in continuing this debate or suggesting papers for these pages, please email Liddy Carver at [research@thinkpublishing.co.uk](mailto:research@thinkpublishing.co.uk)

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# THIS MONTH'S DILEMMA:

## The police have requested access to my case notes

**D**oug comes from an abusive family and presents in therapy with difficulties in his marriage. He repeatedly gets angry with his wife, and has hit her on several occasions. He believes she provokes the attacks by belittling him and talking back. However, he admits that he has a 'short fuse', and he feels remorseful after each incident. Doug's wife is now pregnant. She has told him she will leave

him if he doesn't change. He thinks things will settle down once they have the baby.

Doug's therapist, Ruth, who is in private practice, has been keeping thorough records, including details of the abusive behaviour, and has filed these in his case notes. She explained this when she contracted with him, and told him the records were strictly confidential

Eighteen months into the therapy, and six months

into the pregnancy, after a particularly violent argument, Doug's wife leaves him and reports the incident to the police. Subsequently, Ruth receives a request from the police to see her case notes.

Ruth thinks her primary duty of care is towards Doug. She also fears that, if she releases his case notes without his consent, this will rupture their therapeutic alliance.

### WHAT SHOULD RUTH DO?

Please note that opinions expressed in these responses are those of the writers alone and not necessarily those of the column editor or of BACP.

### Missed opportunities

#### Jill Swindells MBACP

Person-centred counsellor in the criminal justice system (victims and offenders) and pre-trial therapy trainer. In my experience, from my training workshops, therapists and supervisors are often involved in forensic practice without realising it. We need to recognise that clients (victims, witnesses or offenders) who disclose criminal behaviour might become involved with the criminal justice system and subsequently appear in court. How we subsequently work needs to be carefully considered, reassessed and possibly re-contracted around, with a potential trial in mind. Unfortunately, opportunities were missed over the 18 months.

Neither supervision nor CPD provided Ruth with a better understanding of the issues and inherent risks for Doug, his wife or herself. For example, SafeLives' *Quick Start Guidance* suggests physical violence often worsens during pregnancy.

There is no specific guidance from the Crown Prosecution Service (CPS) for working therapeutically with clients who disclose their own or others' crime(s). However, I believe it is advisable to follow the CPS guidance on pre-trial therapy for vulnerable or intimidated adult witnesses.

In particular, as it is not our role to investigate, we should avoid both extensive discussion of events and making detailed records. Ideally, we should document first disclosures verbatim, and thereafter make

brief factual session notes to avoid the risk of inaccuracies.

While we have a duty of care to our clients and no legal duty to report, we need to balance these against protecting others from harm. Ruth's client contract should have included the possibility that she might need to break confidentiality, both to protect others and if required by a court of law. Ultimately, refusing an access request from either the police or the CPS is likely to result in all notes and records being subpoenaed, so neither Ruth nor Doug would have

any choice in the matter. Hence, we can never guarantee strict confidentiality. In doing so, Ruth failed to achieve appropriate and fully informed consent. Therefore, a rupture in their therapeutic alliance may be inevitable.

### Seek legal advice

#### Vernon Cutler MBACP (Accred)

Counsellor and psychotherapist in private practice

My first advice to Ruth is to contact her insurer with a view to seeking legal advice, and ask that they recommend a solicitor and meet their fees.

Beyond that, however, is the issue of Ruth's initial contract with clients. When I contract with clients, I make it clear that, while I will respect their confidentiality, which includes any notes that I keep, ultimately, I will not disobey a court order. My advice to Ruth would be to seek legal representation and to resist the police request to access her records until her legal position is clarified or she receives a court order demanding the release of her case notes.

Hopefully, if Doug is able to recognise that Ruth has defended his confidentiality to the best of her ability, then the therapeutic relationship need not be ruptured. But, ultimately, Ruth cannot disobey a clear legal requirement. Moreover, to do so would not only compromise her professional position, but, by implication, her relationship with her other clients.

*'We can never guarantee strict confidentiality. In doing so, Ruth failed to achieve appropriate and fully informed consent. Therefore, a rupture in their therapeutic alliance may be inevitable'*

## Working beyond her competency

### Anne Embury MBACP (Snr Accred)

Counsellor and Suicide Liaison Service Lead, Outlook South West  
My concern is that Ruth is working outside of her skills and competence levels. In seeking to build a therapeutic alliance by demonstrating the core condition of unconditional positive regard for her client, Ruth may have unintentionally colluded with Doug's belief that his wife's behaviour is the cause of his violence towards her.

I am also fearful for Ruth's personal safety. As Doug's belief has been that Ruth's notes were strictly confidential, he could be justifiably angry with her. He has a known history of violence and admits to having a 'short fuse'. Ruth works in private practice. She needs urgently to seek advice from her supervisor to support her and provide guidance, and she should also review her personal security.

### Safeguarding priority

### Ellie Luscombe MBACP

Integrative counsellor in private practice in London  
This dilemma immediately brings to mind the first session I have with clients, where I talk about confidentiality and the potential breaches to it: serious risk of harm to self or others. In this case, this applies to Doug's wife and unborn child. There is a clear professional obligation here to breach confidentiality, as the safety of Doug's wife and baby are at risk.

The consequences for Doug in this scenario are the loss of important relationships with his wife and unborn child. Maybe experiencing this could be a turning point for him. If Ruth resists the police request, it

could be argued that she will be colluding with Doug's behaviour by protecting him and potentially normalising it. Her reluctance could also be the result of her own fear that Doug may divert his aggression towards her, projecting blame on her for his actions, instead of taking responsibility. Doug may feel the confidentiality agreement should shield him, irrespective of his violent behaviour, which is not the case.

I understand the need to maintain a therapeutic relationship and that this engages clients and nurtures change.

However, the initial boundaries of confidentiality can be referred to here: safeguarding is the priority.

### Strictly confidential?

### Jonathan Harris UKCP (Reg)

Psychotherapist, Combe Martin, Devon  
We can praise Doug for coming to therapy and sticking with it for 18 months. Sadly, however, it hasn't stopped him hitting his wife, although the phrase 'violent argument' might not mean physical violence. Has Ruth been afraid of 'talking back', like Doug's wife, so not addressed his violence?

Ruth told Doug her notes are 'strictly confidential', which is seriously misleading and leads me to wonder about her competence. She considers her primary duty of care is towards her client, but seems unaware that, legally, public interest overrides individual client confidentiality. The rights of the unborn child and his partner rightly trump Doug's right to confidentiality. By not explaining to Doug, from the beginning, that his wife's safety is more important than his confidentiality, Ruth has actually provided a space, not of safety, but of the very secrecy in which abuse flourishes. She can put this right now by going into this in great detail with Doug.

**'By not explaining to Doug, from the beginning, that his wife's safety is more important than his confidentiality, Ruth has provided a space, not of safety, but of the very secrecy in which abuse flourishes'**

Regarding the police request for her case notes, Ruth should phone her professional indemnity insurer's legal helpline. They will

advise her whether she must accede to the request, as normally only court orders must by law be honoured. Ruth needs to know the law relating to cases of abuse. This is even more vital where the client is both the abuser and abused (historically, in Doug's case).

The request is the legal manifestation that private violence needs public exposure. This is an opportunity for Doug to deal with the rage he carries from his abusive birth family. Now is the time for Ruth to use the therapeutic alliance to help him to break his cycle of violence. She could engage seriously with him to help him to find ways to control his violence and explore a future with his pregnant wife. ■

## March's dilemma:

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

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

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

A few months ago, a client who has been seeing Elsa about a bullying line manager

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

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

Please email your responses (300 words maximum) to John Daniel at [dilemmas@thinkpublishing.co.uk](mailto:dilemmas@thinkpublishing.co.uk) by 3rd January 2018. The editor reserves the right to cut and edit contributions. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but they will not be answered personally.

# My ideal supervisor

In this month's Talking Point, we asked readers to tell us what qualities they look for in their supervisor, and why



## **Karin Brauner**

**Bilingual integrative counsellor in private practice and part-time care worker with children with disabilities**

My ideal supervisor is someone who can offer the qualities of holding and supporting me along with challenging and telling me what is what: someone who allows me to talk about my mistakes, to rant and 'go off on one'; someone who is compassionate, caring and empathic, and gives me a chance to explain what I mean if I haven't done so clearly. It's very important that I don't feel I have to censor myself in supervision - that I can say whatever comes into my head about my clients or what is going on in the room, and that the supervisor will listen and explore that with me, and not judge me. My current supervisor is very good at modelling self-care and self-awareness, which I think is important. She is also good at checking that I am OK with what she has said, and if something hasn't been right for me, she cares and she wants to fix it. She's willing to accept it if I feel she has got it wrong. She also listens if I need to vent about my personal stuff, and share something of herself in that too. Looking at what I don't want in a supervisor, I don't want them to use the space to process their own stuff - the place and time for that is in their own therapy. And I need my supervisor to meet me where I am - I've had supervisors who have delivered a double message, pushing me to go beyond my skills and competence, yet also undermining me.

## **Mo Perkins**

**Family relationship coach, therapist, supervisor and trainer**

It's really important to me that my supervisor has already achieved everything I am trying to achieve. They need to be several steps ahead of me, based on the principle that you can only take your client as far as you have gone yourself. You can't pull people up if you're on the same level. So, for example, they would have to be running a thriving counselling/coaching business, and be creative and forward-thinking. Obviously, they also need to have heaps of knowledge and skill in working with families, using a fusion of coaching and therapy. They need to be able to challenge, support and develop me in all the areas in which I practise. I currently have a separate business coach - I find it helpful to have those two perspectives - but, ideally, I'd like all of that wrapped up in one person.

## **John Bassett**

**Psychodynamic psychotherapist in private practice**

The best way to describe what I look for in a supervisor is to talk about the one I've got. I walk in the room and we're working straight away. But she also provides space for me to reflect and think. I want that space to think about what is going on in the room between me and her, and between me and the client, as well as to be challenged. Our sessions are very full; it's very subtle how she works

but I come out feeling somehow rinsed, and knocked about a bit. I appreciate her ability to put her finger on the unconscious processes going on between me and the client, and pinpoint my unconscious defences and where I may be colluding with the client to avoid certain issues. She's also often slightly ahead of the curve - she can spot things in a client's presentation that I haven't seen





*'It's really important to me that my supervisor has already achieved everything I am trying to achieve. They need to be several steps ahead of me... on the principle that you can only take your client as far as you have gone yourself'*

SHUTTERSTOCK

### Darren Magee

Integrative counsellor and supervisor in private practice

**I've been seeing my current supervisor for several years. That continuity and familiarity is important because it means she doesn't just know my working methods and practice, but she knows me, in a wider sense, so is aware of other factors that may be influencing my work at that moment. So, if I'm talking about a client I'm having difficulties with, she can bring the conversation back to what it is bringing up in me that I haven't thought of, and she can help me tap into other skill sets and other strengths that I can draw on, as well as my counselling skills. She is also very versatile - she has been able to adapt to my needs when I've been in other roles - in management positions, for example. She can draw on a vast range of models of supervision. She was recommended to me by a colleague who said, with a bit of a glint in his eye, that she could be quite 'motherly'. I realised when we met that he didn't mean apple-pie motherly, more Mary Poppins - apple-pie with a hint of steel.**

coming, before it's even manifested in the session. I work a lot with metaphor and symbolism, which she encourages, but also keeps in check; I like that light and shade. I have a colleague who has two supervisors, one Freudian and one Kleinian, and she takes the same clients to both; she says it helps her find where she is between them. I think there is definitely some value in that.

### Caz Binstead

Counsellor and mindfulness-based cognitive therapist in private practice, and supervisor on a clinical training programme

**A really important quality for me in a supervisor is someone who embodies openness and curiosity within a contained, trusting space. It is paramount to me that I feel safe enough to fully explore my client work, the intersubjective relationship, and myself when relevant. This means good boundaries, strong grounding in experience, a non-judgmental attitude and a lightness of touch. I don't want someone who tells me what to do, but they need to have the confidence and knowledge of me as a person and a therapist to support and also challenge and inspire me. I find these characteristics in my two supervisors, who both, individually, bring important 'extras' that I find useful. One of my supervisors knows the BACP ethical guidelines like the back of her hand, and helps me bring them to bear on my practice. The other is a chartered psychologist as well as a psychotherapist, and he challenges me intellectually.**

### Nicola Logan

Person-centred, integrative counsellor and supervisor, working in private practice and in an NHS occupational health service

**My ideal supervisor needs to know where I'm coming from: they need to be trained in, or have a good understanding of, person-centred practice. When I was training, the tutors used the metaphor of a harbour - they held us so we could take risks and learn in a safe place. Supervision continues to provide me with that harbour, that place of calm and reflection where I can talk things through and work out my strategies before going back out into the stormy waters. I have to feel a rapport with my supervisor. Genuineness and honesty are very important, and a readiness to challenge me. I also want them to be able to walk the walk and talk the talk - to speak from experience. I've had several supervisors; they've all been very different. To me, it's like following a line of lanterns down a path. As a supervisor myself, I believe that when you become aware that you are no longer meeting the needs of your supervisee, you have to have that conversation, and light them on their way.**



‘Therapeutic work in Cambodia, a post-genocide nation, is very demanding, and vicarious trauma certainly takes its toll’

# HOW DO YOU TAKE CARE OF YOURSELF?

**Lynne Barnett** immerses herself in photography to relieve stress and refresh her focus

**Figen Murray’s article on self-care** (May, 2017) made me smile. I bring similar knitted teddy bears to Cambodia, where I currently live and work as a volunteer. They are made by a team of wonderful knitters from churches in the UK, who have found new meaning, purpose and value in life through reaching out in this way to the children here in Cambodia. They call it their ‘knitting ministry’.

Therapeutic work in Cambodia, a post-genocide nation, is very demanding, and vicarious trauma certainly takes its toll. Part of my role is teaching self-awareness and self-care, but tending to my own needs is often the first thing I overlook when faced with the absolute poverty and enormous need around me. To me, the historical and current trauma in Cambodia is on a par with a metastatic growth or nuclear fallout.

Recently, one of my Cambodian trainees challenged me on this double standard in

self-care. This wise young woman pointed out that, as an educated person, I should know better. She said that having such compassion was wonderful, but not if it caused burnout. She paraphrased my own words. I was indeed confusing my learners. The catalyst for change was her parting comment: ‘Anyway, sister, you cannot die until you finish teaching me. So please self-care!’

So, mindful of her warning, I have since actively improved my self-care strategies. A ‘camera day’, as I call them, helps me lose myself in nature and creativity. I thoroughly enjoy photography and use the photographs to complement my creative reflective writing - another love of mine. As my eye fixes on a subject through the lens, my stress just drifts away and I refocus on beauty. There is such a thrill in capturing those precious scenes and interactions, and in so doing, I refresh my focus on life. ■



## About Lynne

Lynne Barnett is a counsellor and Director of the Centre for Health Counselling at the University of Puthisastra, Phnom Penh, Cambodia. She has lived in Cambodia for three and a half years, and has been volunteering there on short-term visits since 2005.



**How do you take care of yourself?** Email [therapytoday@thinkpublishing.co.uk](mailto:therapytoday@thinkpublishing.co.uk)

# From the Chair

‘We will continue to robustly question both the methodologies used by NICE to derive its recommendations and the recommendations themselves. We are not prepared to accept that counselling is a second-rate therapy for depression’

**B**ack in July, I raised the potential threat to counselling from the current revision of the NICE guideline on depression in adults. BACP was one of a number of mental health organisations that feared a repeat of what happened in 2009, when we had to fight to stop counselling being dropped as a recommended intervention for depression in the NHS. In September, I was able to give the good news that counselling was back in the consultation draft. The final revised guideline will be released in the New Year. But that doesn't mean we can now put it all behind us.

Counselling may be in the current draft guideline (and this may still change before January), but it remains a second-tier intervention for depression. CBT is still the primary, preferred option, and counselling is recommended only for mild-to-moderate depression.

BACP questions this, based on a number of concerns about the NICE guideline process. I want to focus here on the methodology from which the guideline was derived.

First, we question the statistical model used by NICE to inform its recommendations. Technically, it is known as a network meta-analysis of randomised control trials (RCTs). Professor Pim Cuijpers, considered the world expert on RCTs on treatment of adult depression, has recently argued that there can be no confidence in the findings of any RCTs of treatments for adult depression to date, nor in any meta-analytic study derived from them, because they are either too small, or they are influenced by bias, or both.<sup>1</sup> Yet the draft guideline nonetheless makes confident assertions about 'best' treatments for adult depression.

Second, the guideline recommendations exclude evidence from large practice data sets - including IAPT's own data. This

is perverse, because the NICE guideline aims to improve NHS treatment for adults with depression, and the IAPT data, which is massive and based on actual NHS patients, evidences how adults with depression experience NHS treatment. Why NICE should ignore these data is hard to understand. Notably, the data also show that, in IAPT, counselling is just as effective as CBT.

Third, network meta-analysis is a newer, highly complex form of meta-analysis - the best methods to do this are still being debated and developed. With respect to the depression guideline, the NICE network meta-analysis relies on important assumptions that BACP believes may be flawed, casting doubt on the trustworthiness of the findings. Given that different conclusions about 'counselling' were drawn by three other recent, major meta-analytic studies, the grounds for the NICE recommendations for counselling seem shaky.<sup>1,2,3</sup>

We will continue to robustly question both the methodologies used by NICE to derive its recommendations and the recommendations themselves. We are not prepared to accept that counselling is a second-rate therapy for depression.

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CHARLIE BEST



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## BACP board and officers

**Chair** Andrew Reeves **President** David Weaver **Interim Deputy Chair** Caryl Sibbett  
**Governors** Natalie Bailey, Eddie Carden, Sophie-Grace Chappell, Myira Khan, Andrew Kinder, Vanessa Stirum, Mhairi Thurston  
**Chief Executive** Hadyn Williams **Deputy Chief Executives** Cris Holmes, Nancy Rowland

# BACP round-up

Our monthly digest of BACP news, updates and events

## New member logos



You can now download your new-look logos and certificates from the members' area of our website, to promote your work to the public. Your new logo incorporates the same information as your current one, but has been updated to reflect our new look. If you have an entry on our Find a Therapist directory, your logo there has also been updated.

When you've downloaded your new logo, you'll be able to start using it on your own website and stationery. Don't worry if you have

stationery printed with your old logo on, or you're not able to update everything straight away. We're hoping to have completed the changeover to our new look by the end of 2017, so if you could aim for the same deadline, that would be really helpful.

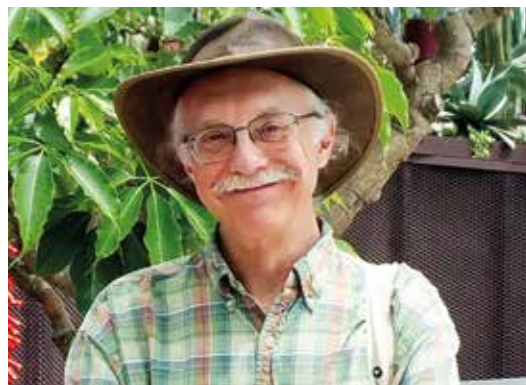
Going forward, we'll be contacting you more by email. To help us keep in touch with you about your membership, please make sure you have your most up-to-date email address saved in the members' area.

## Our response to NICE guidance

We've recently responded to the draft NICE guidance on depression in adults, which was published for consultation in July. We raised many concerns with the proposed guideline, including NICE's privileging of RCT evidence, failure to include large, standardised, routine datasets, and assumptions of the cost-effectiveness of the recommended interventions.

You can read our full response on our website, at [www.bacp.co.uk/policy/campaigns](http://www.bacp.co.uk/policy/campaigns)

Thank you to all members who shared with us your views on what the proposed changes mean for you and your clients.



## Plan your CPD for 2018

Why not start planning your 2018 CPD schedule by registering your interest for some of our conferences and events?

Highlights for 2018 include our children and young people conference, 'Working with Children in their World: a practitioner's response', on Saturday 24 February in London.

On Thursday 8 March, in Manchester, we're holding an event called 'Working Effectively with Trauma in Healthcare Settings'.

We're looking for members to present at these events, so if you'd like to deliver a session, email [katy.hobday@bacp.co.uk](mailto:katy.hobday@bacp.co.uk)

Our 24th Annual Research Conference is on 11-12 May in London, titled 'Counselling Changes Lives: research that impacts practice'. We're delighted that Professor Robert Elliott (University of Strathclyde) is to present the Friday keynote address on 'Evidence and Politics in the Humanistic-Experiential Psychotherapies: a love-hate story', and Professor Dr Pim Cuijpers (Vrije Universiteit Amsterdam) will be our keynote speaker on Saturday, with a paper on 'Four Decades of Research on Counselling for Depression: directions for the future'. A key topic of discussion will be how research from routine practice can provide new insights into the therapeutic process.

**If you'd like to attend any of these events, email [katy.hobday@bacp.co.uk](mailto:katy.hobday@bacp.co.uk) or call us on 01455 883300.**



## Self-care guidance

To mark World Mental Health Day on Tuesday 10 October, we asked members to tell us how you take care of yourself. The theme this year, set by the World Federation for Mental Health, was 'mental health in the workplace'.

We thought you would like to know some of the things members told us. Heather Coppel, a student member from Wrexham, said: 'I try to walk daily, at least 20 minutes, and hike up mountains on a weekend, also doing something creative.' For registered MBACP Sara Matthews, the recipe for self-care is: 'Know my early warning signs that there are unmet needs or feelings. Work four days a week only. Hoover (weird but true). Time alone. Cats.' Jo Allen, student member from Derby, said: 'Pacing myself and planning my day and working week carefully. Trying to get outside, even just for 10 minutes a day.'

We're putting together some guidance for members on self-care. This resource is now ready for review and we're looking for members who would like to join a focus group to give us feedback on how it might be improved. If you'd like to be involved, email [susan.dale@bacp.co.uk](mailto:susan.dale@bacp.co.uk). We expect to publish the guidance towards the end of the year - we'll let you know when it's available.

### Nancy Rowland leaves BACP

Nancy Rowland, Deputy Chief Executive Officer for the past two years and before that Director of Research, Policy and Professional Practice, is leaving BACP. She has been with the association since she was appointed Head of Research in 2003.

Announcing her decision, Hadyn Williams, BACP Chief Executive Officer, said: 'After more than two years of transformation at BACP at the senior leadership level, and after 13 years' service in research, policy and professional practice, Nancy has decided it is now time to leave BACP. While this will be a massive loss to the organisation, Nancy has promised to remain connected to us and will continue to promote BACP and everything it stands for with her usual vigour and passion. I know you will want to join me in wishing Nancy success and happiness for the future.'

Cristian Holmes has been appointed to a new, combined role of Deputy Chief Executive and Chief Operating Officer.

## Older people and mental health

We recently carried out a survey looking at whether older people seek help from health professionals for anxiety or depression, and what response they receive when they do so.

Worryingly, more than half those aged over 55 who had sought help from a healthcare professional with symptoms of depression and nearly two-thirds of those with symptoms of anxiety weren't referred for counselling or any other talking therapy. Yet the survey also showed that 68% of this age

group would be open to counselling or psychotherapy if it was recommended.

Our President, David Weaver, said: 'Older people with common mental health conditions are more likely to be on drug therapies and less likely to be receiving psychological treatment, compared with other age groups. This isn't fair, and we want to see increased access to psychological therapies for our ageing population.'

**Read more about the survey on our website at [www.bacp.co.uk](http://www.bacp.co.uk)**



# BACP round-up

## Royal reception

BACP members were among the 350 guests who attended a reception at Buckingham Palace on World Mental Health Day, 10 October, to recognise and celebrate their work and that of their colleagues and professions in the mental health sector.

We're delighted to report that BACP members John Cowley, Myira Khan, Debra Gordon, Martin Hogg, Professors Sue Wheeler and John McLeod, Carmel Mullan-Hartley and Kate Anthony were among those representing the counselling professions at the reception, which was hosted by the Duke and Duchess of Cambridge and Prince Harry, in their roles as founders of the national Heads Together campaign, to thank people in the sector for the support they provide

to so many going through difficult times in their lives.

The Duke of Cambridge said: 'You have all been invited to the palace to recognise that, in the UK, we now accept that the health of our minds is as essential as the health of our bodies. We know that none of the recent work we have supported through our Heads Together campaign would have been possible without the people in this very room.'

Prince Harry said: 'All of you helped change the language around this issue, shifting away from fear and shame, to a more open and optimistic sense about what we can achieve when we simply start talking. All of you showed what is possible when we get our Heads Together.'

## Older people lead

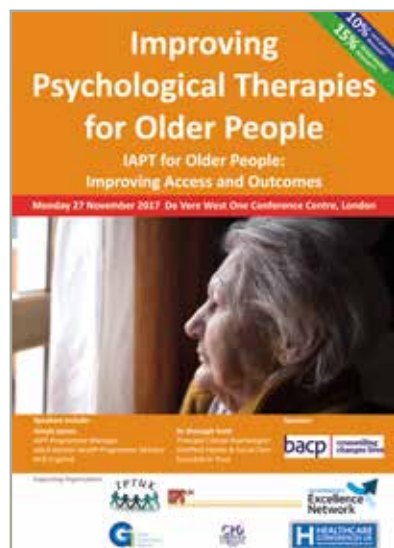
Jeremy Bacon, our new Lead for Older People, joins us this month.

Jeremy will be taking work forward on this important strand of our strategy to improve access to talking therapies for older people.

Jeremy comes to BACP with a strong background in mental health, advocacy and working with older people. His previous job was Project Manager for the British Lung Foundation's Breathe Easy national network of support groups for people with lung conditions.

Jeremy will be taking forward work on the important strand of our strategy to improve access to talking therapies for older people.

He said: 'Leading the BACP's Older People Strategy is a task that I take on with relish. With over three million older people in the UK living with a mental health problem, it's vital that the value of counselling and psychotherapy is understood and communicated to a wide range of audiences.'



Jeremy will be presenting on 'Psychological therapies for older people': public perception, barriers to access and the evidence' at a major conference on improving psychological therapies for older people, on 27 November in London. [bit.ly/2zrMOWP](http://bit.ly/2zrMOWP)



## Gender, sexual and relationship diversity

We have just published a new resource on 'Gender, Sexual and Relationship Diversity' (GSDR), the first in a new stream of publications on Good Practice across the Counselling Professions.

The resource is written by Dr Meg-John Barker, Senior Lecturer in Psychology at the Open University, therapist and activist-academic specialising in sex, gender and relationships and author of many academic books and papers on these topics.

The resource explores current cultural attitudes and understandings of GSDR, offers in-depth explanations of gender, sex, sexuality and diverse relationships, and summarises key principles and good practice for culturally competent counselling work in this field.

**The resource is available for members to download free at [www.bacp.co.uk](http://www.bacp.co.uk)**

## Training curriculum for counselling young people

We are pleased to announce that BACP's Counselling Young People (11-18 Years) Training Curriculum is now available to download. This curriculum is an evidence-informed curriculum framework for working with young people aged 11-18 years. The curriculum is underpinned by BACP's Competences for Humanistic Counselling with Young People (11-18 years) and is intended for training providers who want to deliver training courses for counselling young people in a variety of contexts. The curriculum is designed to be flexible to meet the diverse needs of different training providers and potential students.

The curriculum is divided into three stages:

**Stage 1: Introduction to Counselling Young People** is for post-qualified counsellors who wish to work towards a qualification in counselling young people, and also for current counselling students on adult-focused, accredited training courses who wish to undertake some of their placement hours with young people.

**Stage 2: Formal Award in Counselling Young People** is for post-qualified counsellors who



have successfully completed the Introduction to Counselling Young People (Stage 1), or for those who can evidence, via a formalised APL procedure, that they have acquired equivalent knowledge and understanding through previous CPD and/or prior experience of counselling young people.

**Stage 3: Additional Subject Areas** covers optional subject areas for higher level and top-up awards. These subject areas can also be delivered as CPD training workshops for qualified young people's counsellors.

The curriculum and competences can be downloaded from the BACP website. If you have any questions or feedback about the curriculum, please contact Caroline Jesper, Professional Standards Development Facilitator, at [caroline.jesper@bacp.co.uk](mailto:caroline.jesper@bacp.co.uk)

## PROFESSIONAL CONDUCT NOTICES

### Findings, decision and sanction

Theresa Jacobs

Reference No: 552348  
Somerset BA1

The complaint against the above individual member/registrant was heard under BACP's Professional Conduct Procedure and the Professional Conduct Panel considered the alleged breaches of the BACP Ethical Framework for the Counselling Professions.

The Panel made a number of findings and was unanimous in its decision that these findings amount to serious professional misconduct, given the behaviour of Ms Jacobs and the gravity of the findings.

The Panel found some evidence of mitigation and would have imposed a sanction had Ms Jacobs still been in membership.

**Full details can be found at [www.bacp.co.uk/prof\\_conduct/notices/hearings.php](http://www.bacp.co.uk/prof_conduct/notices/hearings.php)**

## Competences for working with young people

During the development of our Counselling Young People (11-18 years) Training Curriculum, we reviewed the Basic Young People Competences. The outcome is a more relevant and coherent set of competences for counsellors starting to work with this age group.

From May 2019, accredited courses that allow students to take up practice placements working with children and young people will need to refer to the elements in Stage 1 of the Counselling Young People (11-18 years) Training Curriculum.

We hope this 18-month transition period will give accredited courses time to make any necessary adjustments before the Basic Young People Competences are removed from our website.

As with the Basic Young People Competences, the elements in Stage 1 of the young people training curriculum can be delivered and assessed in three ways: as a separate module/unit to the accredited course, as a distinct award, or in collaboration with a CYP placement provider.

All of the requirements in our previous statement on CYP practice placements remain the same. You can find out more on our website at [www.bacp.co.uk/accreditation](http://www.bacp.co.uk/accreditation)

# BACP round-up

## BACP accreditation

Newly accredited members, services and courses

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

### Counsellor/ psychotherapist

Joanne Allmand  
Zoe Aston  
Clodagh Boyd  
Sharon Cassidy  
James Chapman  
Caroline Chessher  
Jane Chilvers  
Timothy Dalton  
Katharine Edwards  
Christine Graham  
Melanie Hallows  
Connie Harvey  
Frances Jebb  
Yvonne Jepson  
Lesley Kipps  
Karen Klosinski  
Sean Lowden

Joanne Marks  
Jo Moloney  
Sabrina Mudie  
Emma Mullaly  
Lorna Nash  
Maxine O'Brien  
Dominic Quinn  
Sarah Saatzer  
Cecilie Sasu  
Colin Scott  
Ivana Sharp  
Elaine Sherrington  
Johanna Sikkell  
Billi Silverstein  
Nicola Springle  
Polly Wong

**Senior accredited  
counsellor/  
psychotherapist**  
Ian Tromp  
Jennifer Smallwood

**Senior accredited  
supervisor of  
individuals**  
Johanna Kosterink

**IACP/BACP  
recognition of  
accreditation  
counsellor/  
psychotherapist**  
Collette Mayers  
Caroline Togher

**Accreditation  
reinstated**  
William Hanmer-Lloyd  
Helen Gerolaki

**Members not  
renewing  
accreditation  
Counsellor/  
psychotherapist**

Maeve Allison  
Jocelyn Ashton  
Nathalie Bearryman  
Susan Bentley  
Caroline Brown  
Linda Cox  
Glynwen Lewis  
Pauline Low  
Sandra McDerment  
Francesca Mettam  
Alys Mikolajczyk  
Nick Papé

Barbara Penn  
Louise Power  
Julie-Ann Scott  
Kate Sloan  
Mary Sutton  
Gillian Thomas  
Williamina Winwood

**New and renewed  
accredited services**

We would like to congratulate the following organisational members on achieving and/or renewing their BACP accredited status:  
**Services**  
Mind in Tower Hamlets & Newham (MiTHN)  
Savana Inc Ltd

All of the details listed are correct at time of going to print. Please be aware that BACP may have more than one member with the same name. To check whether someone is a registered accredited member, please visit the BACP Register at [www.bacpregister.org.uk/check\\_register](http://www.bacpregister.org.uk/check_register) For a full list of current accredited services and courses please visit the relevant BACP accreditation directories at [www.bacp.co.uk/](http://www.bacp.co.uk/)

## EVENTS CALENDAR

27 November

**Professional development day**  
Societal rape: myths and traumatic reactions  
With Sally French  
**Norwich**

22 January

**Coaching specific client groups**, identifying your niche and marketing your offer effectively  
**London**

14 February

**Professional development day**  
Integrating artwork into your counselling practice  
With Pauline Andrew  
**Norwich**

24 February

**CYP Conference**  
Working with children in their world  
**London**

8 March

Working effectively with trauma in healthcare settings  
**Manchester**

12 March

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

24 March

**Professional development day**  
Supervision: relationship, authority and ethics  
With Steve Page  
**Southampton**

17 April

Working with critical incidents: prepared, not scared – are you ready to respond?  
**Edinburgh**



# Analyse me

## Graham Music speaks for himself

**Why did you become a therapist/counsellor?** For the right and wrong reasons. I honed my initial skills in the cauldron of family life, where vigilance and predicting moods were assets.

Later, when some of my omnipotence subsided, I needed my own therapy, and, grateful if still omnipotent, I risked venturing into this field. I have remained constantly fascinated and smitten ever since.

**Where do you work?**

I do some private work, mainly with adults, at home, in a quiet basement consulting room. The bulk of my work has been in NHS settings, for years at the Tavistock and Portman NHS Trust, with maltreated children and young people, many of whom are also perpetrators.

**How do you work?**

Probably psychodynamic, but I hate silos and believe passionately that there is no best way of being a therapist. For example, I integrate humanistic as well as mindfulness and other approaches, alongside psychoanalytic ones, and am especially influenced by the relational school and neurobiology.

**What's your special interest?**

I have a passion for child development, neurobiology and linking new findings to clinical practice. Currently, my interests centre on the body, addictive states and capacities such as self-regulation and interoception.

**What do you do for self-care?**

I practise mindfulness daily, do yoga, running, the odd gym session; I share food and talk with friends and family; I read and think; I've been in a blokes' book club for 16+ years; I watch films and plays, walk, have an addiction to charity shops... the list goes on.

**Why do you think therapy works?**

Therapy can only work if a client is reached emotionally and feels contained, met, and, dare I say it, cared for, as well as understood. A bit of experience in the therapist helps, I think, and an odd mixture of humility and confidence, but we have to remain alive, curious and able to hold on to hope while never shirking difficulty. Easy!

**What client presentation do you most dread walking through your door?**

Either of the polar opposites of very flat, dampened down people, or people often labelled as borderline personality disordered. But dread also signals learning points and challenge, which are always the beauty of this work.

**What gives your life meaning?**

Loving and being loved, friendship, and feeling enough inner security to explore, be curious and be stimulated by new ideas.

**What is your favourite piece of music, and why?**

It depends on my mood. As Kit Bollas explained, music can be a transformational object, helping us find self-states we need to access. So, when fired up, it might be The Clash;

when doleful, Leonard Cohen; when poetic, Dylan; when maudlin, Sandy Denny; when spiritual, Bach; for dancing, ska and R&B; when romantic, jazz standards like Ella. I no more have a favourite music than I follow one therapeutic modality.

**What's the longest you've seen a client?**

Over 10 years, with a few clients, and they still mostly keep in touch. Often, profound changes have taken place later on, although, of course, with many clients, change is miles quicker.

**And what's the shortest?**

A few months, due to a mismatch I did not recognise sufficiently. In truth, there was probably something about how I felt about them that I was not able to acknowledge but that got transmitted.

**What's the most recent therapy textbook you've read (and can recommend)?**

I enjoyed Patricia Coughlin's *Maximising Effectiveness in Dynamic Psychotherapy* (Routledge, 2016), a model that challenged me. I am now reading a very different sort of book, Deirdre Fay on *Attachment-based Yoga & Meditation for Trauma Recovery* (WW Norton, 2017) - but I always have a Winnicott book nearby.

**When will you retire?**

Hopefully, with my last breath! Retire really means retreating, and there is always a need for that in life, but even if I don't stay in the NHS for many more years, I hope always to retain my interest and passion in psychology and this work.



About Graham

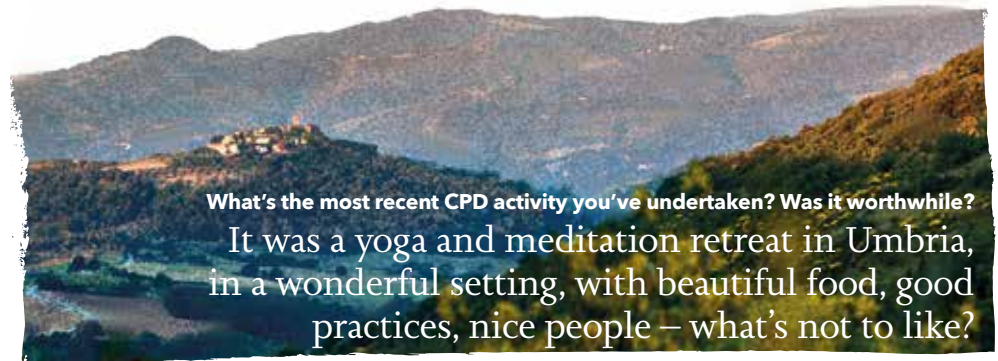
**Now:** a child and adolescent and adult therapist. I also write (*The Good Life* (Routledge, 2014); *Nurturing Natures* (Routledge, 2016)), teach, supervise, am a mindfulness teacher, and try to retain an ordinary life. I am an inveterate pessimist and cynic striving to be an optimist and open-hearted.

**Formerly:** I had an entrepreneurial past - I (mis)spent much of my 20s buying and selling antiques and bric-a-brac on street markets.

**First paid job:** stacking supermarket shelves.



Who would you like to answer the questionnaire? Email your suggestions to the editor at [therapytoday@thinkpublishing.co.uk](mailto:therapytoday@thinkpublishing.co.uk)



**What's the most recent CPD activity you've undertaken? Was it worthwhile?**

It was a yoga and meditation retreat in Umbria, in a wonderful setting, with beautiful food, good practices, nice people – what's not to like?