Therapy Today

For counselling and psychotherapy professionals

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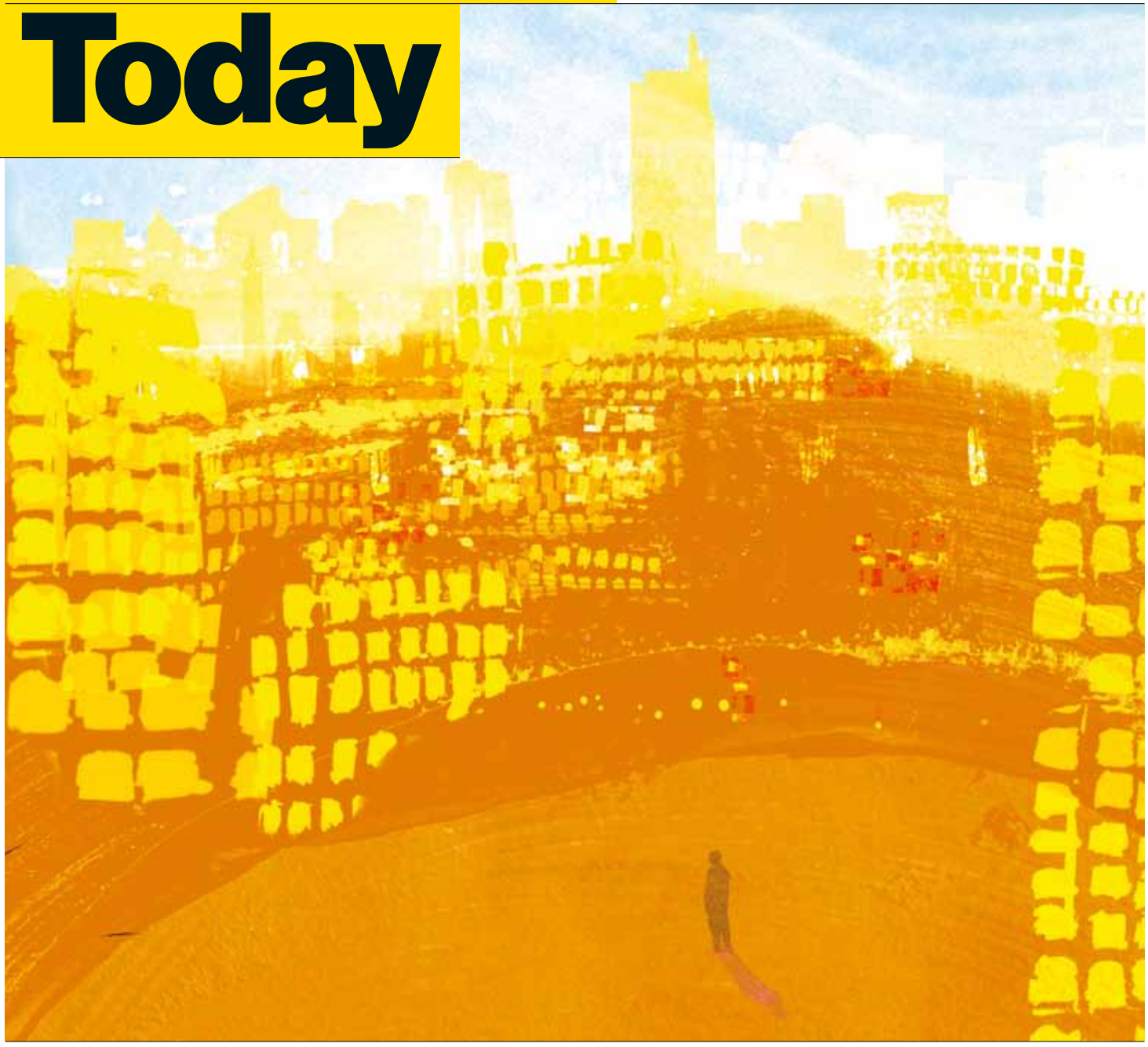

Counselling in China

Me and my big bag of worries – an 11 year old's tale

Happiness, health and old age

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

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- BACP Children and Young People
- BACP Coaching
- BACP Healthcare
- BACP Private Practice
- BACP Workplace.

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Contents

Sarah Browne
Editor

I've been hearing for a number of years about China's growing need for counselling as it transitions to an economic superpower, so I'm pleased to be able to publish Gareth Davey and Xiang Zhao's article, which gives a good introduction to the status of counselling in China today. It is fascinating to reflect on how unsuitable some Western models of counselling are for Chinese people. The Chinese are brought up to identify with the group rather than as individuals. Also, they see the practice of openly expressing thoughts or feelings about family members to outsiders as dishonouring to their family; to remain outwardly passive and restrained is seen as positive. The values of person-centred counselling, for example, can therefore be difficult for Chinese clients; focusing on independence, autonomy and self-direction may conflict with obeying parents and dependence on family. Some clients may be unable to make decisions without consulting their parents. The client in our case study tells us she would prefer her therapist to tell her what to do. As the article says, Chinese clients often have a preference for CBT but even this needs to be adapted to cultural needs.

Pete Connor has spent the last 25 years counselling people with HIV. As he says, 25 years ago a positive HIV diagnosis was a traumatic and catastrophic event. Many of us lost friends and colleagues to AIDS in the late 80s and early 90s and, before reading Pete's article, I hadn't fully realised that HIV is now a chronic but treatable condition. People with HIV can now live out a more or less natural lifespan. But, as Pete describes, newly diagnosed clients may present in great distress, believing they have just received a death sentence. People facing a life-time of powerful drugs with unpleasant side-effects may understandably struggle to look on the bright side. The role of the counsellor is no less vital than it was 25 years ago.

Features

Cover illustration by Simon Pemberton

Regulars

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Visit TherapyToday.net to read articles written exclusively for our website. This month: Colin Feltham in conversation with Pete Connor; Simon Pemberton discusses his illustrations; our 'From the archive' article explores writing about experience and reading other people's diaries; the new episode of 'The Wednesday group'; and the latest news, updated weekly.

Study backs school-based counselling

School-based counselling can significantly improve children's mental health and emotional wellbeing, a new study shows.

The study was led by Katie McArthur at the University of Strathclyde, with funding from BACP and NHS Greater Glasgow and Clyde, and is the first randomised controlled trial (RCT) to show clear benefits for school-based counselling, as it is typically practised in the UK.

In total, 33 young people aged 13–16 were randomly assigned either to receive up to nine sessions of school-based counselling over the course of a school term, or to a waiting list. The counselling was based on humanistic and person-centred principles. Both groups were assessed at six and 12 weeks using the Young Person's CORE (YP-CORE) and a range of other mental health and wellbeing measures.

At 12 weeks the young people who had attended counselling showed significantly lower levels of psychological distress than did those on the waiting list. They also had significantly higher levels of self-esteem and fewer psychological difficulties and were closer to achieving their goals.

The study has been published in *Psychotherapy Research*. Katie McArthur led the project as part of her PhD. She has previously described the challenges and opportunities presented by RCT research in *Therapy Today* (July 2011). Katie said, 'The fact that the young people who had counselling improved more than those on the waiting list is powerful evidence that the counselling itself made the difference. The amount of change was large and compares well with the effects of other school-based interventions, such as those based on CBT.'

Mick Cooper, co-researcher and Professor of Counselling at the University of Strathclyde, said the study findings demonstrated the value of providing mental health and wellbeing support to young people in secondary schools. 'These findings are encouraging and add considerably to the growing weight of evidence to support the argument that young people can benefit when they can access a school-based counsellor.'

www.tandfonline.com/loi/tpsr20

More employees come to work when they should be off sick

Employees are taking fewer days off sick but more are coming into work when they are unwell, the 2012 Chartered Institute of Personnel and Development (CIPD)/ Simplyhealth annual *Absence Management* survey shows.

According to the survey, average absence has fallen from 7.7 to 6.8 days per employee per year, but almost a third of employers report an increase in the number of people coming into work ill. 'Presenteeism' was higher in organisations where redundancies were expected in the next six months.

Stress was the most common cause of long-term absence for the second year running. Stress-related absence was up, with two-fifths of employers (40 per cent) reporting a rise over the past year and only one in 10 reporting a decrease.

Reported mental health problems among employees had also increased: 44 per cent of employers reported an increase in employees with mental health problems in 2012, compared with 39 per cent in 2011 and 21 per cent in 2009.

www.cipd.co.uk

Report says more parenting programmes are needed

Parenting interventions can make a big difference to children's lives and futures but they must be more widely available, delivered properly and targeted at the children who need them most, the Centre for Mental Health (CMH) says in a new report.

Five per cent of children under age 11 have a severe behavioural problem and 15 per cent have moderate behavioural problems. Behavioural problems in childhood are linked with higher risk of suicide, poor health, unemployment and crime in adult life.

The report, *A Chance to Change*, is based on a review of published research, detailed studies in four areas in England and a survey of parenting leads. It says that parenting programmes are effective and cost-effective, but often they are not implemented properly and in many areas there aren't enough places, so many parents can't get help.

The CMH is to produce a range of practical tools to improve the delivery of evidence-based programmes.

www.centreformentalhealth.org.uk

Miliband's therapy pledge

Labour Party leader Ed Miliband has pledged to make access to talking treatments a legal right under the NHS Constitution.

In a speech to the Royal College of Psychiatrists in October, Miliband said: 'Talking therapies can help people and can save money, so they must be an NHS priority.' The NHS Constitution includes the right to medical treatment.

Ed Miliband has recently disclosed that he sought the help of a bereavement counsellor following the death of his father.

Miliband said a Labour government would bring an 'end to the artificial divide between physical and mental health services and ensure that they are properly integrated'. He also called for action to tackle stigma and discrimination and criticised media commentators such as Jeremy Clarkson and Janet Street-Porter who, he said, 'abuse the privilege of their celebrity to insult, demean and belittle others'. Both have made public derogatory comments about people with mental illness.

BACP Director of Research, Policy and Professional Practice Nancy Rowland said effors to improve the integration of physical and mental healthcare through training 'would support both the psychological and physical needs of patients, particularly those with long-term conditions'.

Weight loss patients should have counselling

A report from the National Confidential Enquiry into Patient Outcome and Death has criticised standards of bariatric weight loss surgery. *Too Lean a Service?* reviewed 357 cases in the NHS and private sector. In only a third was the care of patients considered 'good', a third did not get adequate follow-up after surgery and only 29 per cent had psychological counselling beforehand. *www.ncepod.org.uk*

Correction and clarification

In October's *Therapy Today* News pages (p6) we ran a news item about a study in the *British Journal of Guidance and Counselling* (volume 40, issue 5) reporting 'Secondary school students' views of inhibiting factors in seeking counselling'. The news report erroneously stated that the study findings showed that young people 'prefer to talk to friends and family about their problems, rather than a school counsellor'. We fully accept that this was an inaccurate and potentially damaging misreporting of what the study actually showed, which was that, of those pupils who indicated they would not see a school counsellor if they had a problem, and who also provided a reason as to why they would not see a school counsellor, the most frequent reason provided, by 36.6 per cent of participants, was that they would talk to other people.

The paper can be accessed at www.tandfonline.com/doi/full/10.1080/03069885.2012.719603

Abortion consultation cancelled

Health Minister Anna Soubry has called off a Government consultation on abortion counselling.

The consultation was promised by the Government after a proposal by Conservative MP Nadine Dorries to require abortion counselling to be provided separately from abortions was defeated in the House of Commons in September 2011 by 368 votes to 118.

But Anna Soubry has now announced that the Government no longer plans to conduct a separate consultation on the issue, although it will look at the recommendations from an inquiry into unplanned pregnancies currently being conducted by a cross-party group of MPs.

Soubry told MPs: 'It is of primary importance that, when a woman is seeking a termination, there is no delay in her achieving that. That is why it is so important that, if a woman is going to have a termination, she does it as quickly and as soon as possible.'

Shadow public health minister Diane Abbott, who resigned from the cross-party group in January this year, welcomed the cancellation of the consultation as a 'victory for women'. But Nadine Dorries said the decision was 'bizarre' and accused Soubry of trying 'to impose her personal belief on her role'.

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Growing old happily

New research shows a clear link between happiness and better physical and mental health in old age *Catherine Jackson reports*

Older people who are happier live longer, with less disability, and stay physically well longer into old age.

These findings come from the latest round of data collected for the English Longitudinal Study of Ageing (ELSA), now in its ninth follow-up year. Based at University College London, ELSA was launched in 2002 to collect information from a large population sample on ageing and health, wealth and quality of life. The first cohort of 12,099 people aged 50+ was interviewed in 2002/03; the latest, of 10,275 (including over 9,000 of the original 'core' participants), was interviewed in 2010/11.

The data, published last month in ELSA's fifth biennial report, tell us that, in general, older people with better psychological wellbeing are protected from physical disability and coronary heart disease and remain fitter and more active into later life. They also show that older people who enjoy their lives and have a sense of fulfillment, autonomy and control are more likely to live longer – the risk of dying is three times greater among people who are least happy.

ELSA identifies social engagement as a crucial factor in 'successful ageing'. Older people who are socially disengaged are at higher risk of loneliness, unhappiness and poorer physical health and cognitive functioning. Those who take part in clubs and classes, have strong family and friendship networks and participate in their communities are generally happier and healthier.

A number of further factors also appear to determine successful ageing: wealthier older people tend to enjoy better psychological wellbeing and greater enjoyment in life, as do those who are married. Older people who are physically active and still in paid employment or who do voluntary work have better psychological health. And transport is identified as particularly important: the free bus pass is, literally, a passport to a happier, healthier older age.

One in six ELSA participants were identified as severely socially disengaged. The Campaign to End Loneliness estimates one million-plus older people are lonely and socially isolated. This suggests a significant and growing social and healthcare issue.

Steve Boddington, who heads the psychology and psychological therapy services for older people at South London and Maudsley NHS Foundation Trust, says the ELSA data confirm what is well known: 'It appears to be a web in which one factor influences another, creating a virtuous cycle of wellbeing that affects not just the emotions but also physiology, meaningful social activity and ultimately life span,' he says.

But older people are not a homogeneous group: each older person brings a lifetime of experience, good and bad, that will influence how they deal with the challenges of ageing, he points out. Talking therapies are, he argues, an important component in addressing these interlinked issues and older people aren't getting the equality of access that recent legislation and Government policies have promised.

In the first wave of Improving Access to Psychological Therapies (IAPT) sites, just four per cent of referrals were aged 65 and older. 'Proportionately, by IAPT's own targets, this should have been nearer 12 per cent. But older people actually make up 21 per cent of the UK's adult population,' Steve points out. 'IAPT says older people have access to its services as there is no upper age limit, but actually it does discriminate against people who can't make it to their clinics, because very few services provide a home-based treatment option. It also sends out bundles of questionnaires, which will put off a lot of older people. Policies like these mean the service ends up being covertly discriminatory.'

Steve hopes the extra resources currently being channelled into training IAPT counsellors to work with older people will help improve the service's reach and equip practitioners with the specialist skills that he believes they need to work successfully with this age group. 'There is so much more to be done to improve access at primary care level.'

Poor recognition of common mental disorders in later life (depression in older people is notoriously under-diagnosed) and unfounded beliefs about older people not wanting talking therapies also create barriers to their accessing counselling, Steve argues. He dismisses arguments that talking therapies are less effective with older people: 'If they're offered in an age-sensitive way there is increasingly convincing evidence to the contrary.' He also points to emerging evidence that older people who do engage with therapy are more likely to complete treatment than are younger age groups.

Another barrier is older people's self-selection: 'Older people tend to say they are not important; that someone else needs help more than them. To me that points to an internalisation of society's de-valuing of old people.'

Age UK is one of the few sources of specialist counselling for older people. Some, but by no means all, Age UK branches provide a low-cost service. Helen Cooke offers counselling to people aged 50+ at Age UK in the Isle of Wight. She is an accredited counsellor but works voluntarily, and the service was initially free. She now has to charge £20 a session, to cover supervision and other costs. It is, she believes, a deterrent, and not what she would have chosen.

She says that, for some older people, counselling will be an alien concept: 'Older people are often of the generation where the stiff upper lip is highly valued so to start getting in touch with their feelings at this point in their lives is challenging. I spend quite some time at the beginning of the process checking out with clients what their understanding is and spelling out what counselling isn't. I find that works best. A lot of clients see counselling as befriending and I need to make it clear that it isn't a fireside chat and that I have expectations that they will enter into it and that it is hard work.' Most continue with the counselling when they understand what it is, she says.

Mike Fox has worked with older people for over 25 years and has been a counsellor for 10 years. He is co-author with Lesley Wilson of *Counselling Older People with Alcohol Problems*. 'You are working with far more life experience and a greater range of life transitions – not just their current transitions but issues in the past that haven't been resolved. But the potential for change from marshalling all the resources gained through life is enormous,' he belives. 'I have found a conversational style and narrative approach works well. It allows people to tell the stories of their lives so you gradually gain a picture and can relate that to the issues that they are bringing. It feels more like a natural experience to them.'

But he says the current economic and cultural climate in the NHS and social care services is hostile to improving access to counselling for older people. 'It is terribly difficult to get funding. Services that have been collaborative are turned into competitors, which is so unhelpful, and the requirements for funding can threaten the integrity and effectiveness of what you want to do. But I don't think generic services always offer older people what they need and how they need to be approached and what needs to happen to maintain engagement.'

Pat Simmonds has a different view: 'To say to someone of the older generations that they need counselling might be helpful for some but I think it still carries a stigma. Counselling has a place, but it's quite a small part.' She set up her Sharing and Caring group in Worcestershire some 15 years ago, when she was Chief Officer at what was then Age Concern Wyre Forest (now Age UK). When she retired, she continued to run two monthly social groups, renamed Reaching Out, as a volunteer. She says they are a lifeline to older people at risk of social isolation.

'Maybe people in their 70s perhaps can give out a little bit but those in their mid-80s and older, I don't think they find that so easy. They might be happy speaking to their faith leader or minister, but I think there is still this thing that "we don't tell our troubles to strangers". My helpers will notice if someone isn't happy and we make sure to talk to them. If they're poorly and can't come, we send our love and hope to see them next time. It is better if you can do it by showing you care and getting them to come to social groups like Reaching Out and join in.' ■

The ELSA study findings can be accessed at www.ifs.org.uk/ELSA

Hear them and believe them

Christiane Sanderson

The recent allegations against Jimmy Savile have galvanised the media, the BBC, institutions and the Government to ask how such a predatory paedophile could 'hide in plain sight' for over four decades. Those who work with survivors of childhood sexual abuse (CSA) will know only too well that society prefers to turn a blind eye to the unpalatable reality of the sexual abuse of children.

Survivor charities such as One in Four have been inundated with calls in recent weeks from CSA survivors who have been too ashamed and afraid to speak out about their abuse, for fear of not being believed. Many of the survivors who have contacted us are desperate to talk to someone who is familiar with and understands CSA and who will listen to them and help them. But, like many other charities, One in Four has had its funding drastically eroded in the past two years; we get nothing from statutory sources and are now reliant on grant funding and client donations. We are only able to offer long-term counselling to some 80 clients a week and are having to place callers on a lengthening waiting list. With a reliable source of funds, we could be offering counselling to more than double that number.

This is very distressing for survivors who have found the courage to break their silence and, despite repeated betrayals of trust, are willing to trust again.

As the scale of abuse by Savile emerges, there is a danger that the voice and needs of survivors of CSA will be lost amid the clamour for costly and lengthy inquiries. The Jimmy Savile Charitable Trust is considering applications for funding to support survivors of CSA, but there is no guarantee that funds will be allocated and released and the process could take a long time.

I am concerned that any funds will be conditional and will not necessarily provide the longer-term counselling that many survivors of CSA require. All too often, survivors of CSA are offered short-term counselling by generic counsellors who have little or no experience or specific training. The dehumanisation, betrayal of trust and distortion of reality that are axiomatic in CSA are best repaired in the presence of a witness who will give a voice to the abused and facilitate the restoration of trust in self and others.[1] This is difficult to fully achieve in short-term counselling.

We have seen an increase in enquiries from survivors who, despite having had short-term counselling, have found that their trauma symptoms have been re-triggered by the Savile allegations. Many of these survivors feel they would benefit from further counselling and yet are unable to find appropriate counsellors. Re-traumatisation is also being reported by clients currently receiving counselling who are experiencing an intensification of trauma symptoms such as flashbacks, intrusive memories and nightmares.

> 'This need can be seen in the increase in enquiries from survivors whose trauma symptoms have been re-triggered by the Savile allegations'

If the large scale sexual abuse of children, as seen in the Savile case and in Rochdale, is to be prevented, professionals need to seize this opportunity to enhance their awareness of the deception and manipulation involved in CSA, and ensure that they have a better understanding of how paedophiles groom not only their victims but also other adults in the child's life, to reduce the risk of detection.[2]

Mental health professionals need training in the complex dynamics inherent in CSA, such as the deliberate distortion of reality, traumatic bonding and how shame, traumatic loneliness and isolation can serve to silence the victim. We also need to understand how paedophiles use their status, power and authority over children to make them complicit in their abuse, and how – as in the religous sexual abuse in Ireland – they are able to dupe a whole nation and its criminal justice system.[3]

The only way to protect children in the future and provide the best possible service to survivors is to make sure that they are listened to and believed. Victims and survivors need to know that they will no longer be silenced or betrayed. We as professionals must speak out to ensure that all survivors are given access to counselling and are fully supported in their healing. ■

Christiane Sanderson is a lecturer in psychology and counselling, trustee at the charity One in Four and author of The Warrior Within: a One in Four handbook to aid recovery from childhood sexual abuse and sexual violence (*One in Four; 2010*). *Visit www.oneinfour.org.uk*

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2. Sanderson C. The seduction of children: empowering parents and teachers to protect children from child sexual abuse. London: Jessica Kingsley Publishers; 2004.
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Why I love research

Barry McInnes

I didn't get off to a good start with numbers. I have two memories of maths, more accurately described as traumatic flashbacks.

Double maths – two hours of torture and increasingly desperate and eventually vain attempts to avoid ritual embarrassment. Ambivalence didn't come into it – this was true loathing.

Cut to home, cut to homework. My father is standing over me, trying to explain some finer point of basic algebra. Numbers swim before my eyes, my brain fogs. He doesn't say it, but I feel it – stupid. He's an engineer, dammit. Overall, it's a very unpromising trajectory.

Now, stay with me, because here mysterious things begin to happen.

First, I pass my maths O level with flying colours. It's hard to say who is more surprised, me or my father. Second, some months after leaving school, I am offered a job as a trainee accountant. I have a real job, with numbers in it. I accept this career opportunity with gratitude and optimism.

Time passes. I have made the seamless transition from accountant to counsellor and therapy service manager, and I am invited to sit on BACP's Research Committee. Some time later, I make a presentation on therapy service outcome evaluation to the Society for Psychotherapy Research. Later yet, and my work involves travelling the length and breadth of the UK training practitioners and service managers to implement and use routine evaluation. Terms like 'statistically significant change' and 'meta-analysis' trip effortlessly off my tongue. And then fast forward to now, where one of my roles is Visiting Lecturer delivering a research module on a social science degree.

> 'Along the journey I learnt that academic research and the realities of everyday practice bear little relationship to each other'

How did this happen? How did a virtual maths refusenik transform into a passionate advocate of research and evaluation in psychological therapy? How did someone who, frankly, struggled with long division, morph into a Visiting Lecturer?

I strongly suspect that at some point, shortly after my 15th birthday, I was kidnapped by aliens and subjected to lengthy and mind-altering experiments!

OK, I've had my fun – here's the alternative narrative.

In 1994 I was appointed as Head of Service for the Royal College of Nursing (RCN) Counselling Service. As well as providing a brief counselling service for RCN members, part of our remit was to encourage the provision of high quality staff counselling by NHS employers. The rationale was simple – the RCN's 340,000 members were mostly employed in the NHS. Because their employers were not taking responsibility for the wellbeing of their own staff, we were picking up the pieces.

It became clear at an early stage that an argument for the establishment of comprehensive staff counselling based on appealing to employers' better natures was going to be a short one. We needed evidence that counselling was an effective intervention that could reasonably be justified in cost terms. The BACP Research Committee was an early port of call in my search for an evidence base. To my astonishment, I found myself co-opted onto the committee; I brought one thing the committee lacked at the time, which was a solid practitioner-based and service-based perspective.

I didn't find my evidence base just then, but subsequent work by the committee led to the development of Professor John McLeod's groundbreaking review of the evidence for workplace counselling interventions.[1] It was the forerunner for the range of systematic reviews of other sectors commissioned by BACP. It still sits on my bookshelf and I feel proud to have played a part in its birth.

Along the journey I learnt that academic research and the realities of everyday practice bear little relationship to each other. The fact that research shows an intervention to be effective does not mean that a service offering that intervention will be effective. This requires service level evaluation, and you can only credibly argue for this when you practise what you preach.

Let's face it – research can be deadly dull. Dry at best, irrelevant at worst. Yet it needn't be that way. In subsequent columns my challenge is to breathe a little life into its sad corpse if I can, to perhaps make it just a little more relevant, a little more lively. There may even be a story or two along the way. ■

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

Reference

1. BACP. Counselling in the workplace: the facts. A systematic review of the research evidence. Lutterworth: BACP; 2001.

Sorting out my bag of worries

Billy Hague (aged 11)

I only got big when I were about eight. Then I really put it on.

There was a lot going on at home that were hard to handle. I've got an older brother, Charlie. He's been diagnosed with Asperger syndrome. Charlie wouldn't leave his bedroom for about six months and then he were in a hospital for four months. Mum and dad were working and, with Charlie, they had to care more about him than me. I were getting bigger and bigger and my friends didn't want to speak to me – except one; he's always stayed my friend. It were hard with schoolwork too, because I've got dyslexia.

I came to Shine when I was 10, in 2010. It was my mum's idea, I think. I used to come two evenings a week and on Saturdays for basketball and other sports and swimming. We also learned about portion sizes and how to take care of yourself and how much exercise you need. The time I lost most weight was when I went away for a week on a residential programme. We did a lot of outdoor activities. It was the first time I were away from home without my family. It was good being with kids my age who were my weight. At school people were always faster than me in games but at residential we were more equal.

Kath said it might help me to come to counselling. I were doing a lot of exercise but I weren't losing weight. I was OK with counselling. I'd had it before, with my brother; we had family therapy. I thought it were a good idea to get some stuff out that I couldn't speak to my friends or my family about.

I saw Kath six or seven times. In the first session she gave me a questionnaire to fill out. It were a chart with red, green and amber colours to show where you were for things like risk and functioning and wellbeing. I was all on red but after a few sessions it was going to amber and then green.

Kath told me this story about the bag of worries. There was this little girl and she had this bag that she put all her worries into and the bag got bigger and bigger and then her grandmother said to her, why don't we open the bag and see what's in it. Because it were too big for her hardly to carry. And the grandmother said, that isn't your worry, that's your mum's worry; that's your dad's worry; that's your teacher's worry. So we did that with my worries and we came out with about eight worries and we wrote them in the middle of a spidergram. We talked about the big worries first and then when I were sorting them, the others got better too.

My worries were my brother first, then my mum and dad, my friends and then my weight and some others. Charlie's very in my face and if he can't get what he wants he gets very physical and starts pushing me and hitting me and I'd just go into the cupboards and fridge and get something to eat and watch videos or play a game.

We talked how he were hurting me and how I needed more privacy, and about my mum and dad working so much because they run their own business and that it felt like they cared more about Charlie and the business than they did about me and how we weren't spending any time together doing anything nice as a family. My mum and dad thought everything were alright because on the outside I looked like I was OK. That's because I'm not one of those kids who goes out with friends and smokes and gets into drink. I were just spending more and more time on the computer and playing games on my mobile.

> 'I thought it were a good idea to get some stuff out that I couldn't speak to my friends or my family about'

It were good to get it all out. Kath said I were worrying about everybody else and not about what I were doing. I didn't know that was happening until Kath said that. I didn't think I should care about myself. I thought I should care about other people and that is such a realisation.

She didn't tell me what to do; she said I needed to say what changes I thought I needed to make. Like I weren't sleeping and she said to me, what can you do, and in the end I said I had to give my mum my mobile to stop me going on it at night.

We talked about confidence and not feeling you are alone. And at the end of the session we'd make a list and I'd say what could go back to my mum and dad and what did I want to keep to just us. And then we met with my mum and dad and I said what I wanted to change.

I've lost a load of weight and this year I've started ice hockey. I really love ice hockey. I'm asthmatic but when I'm skating I don't get wheezy. I go three times a week. One night it's hockey skating and another it's figure skating. With figure skating, I'm faster than everyone, except one girl; she can skate faster backwards than me. ■

About Shine

Shine Health Academy is a community-based voluntary organisation in Sheffield that aims to help obese young people aged 10–17 years lose weight and increase in confidence and self-esteem. Kath Sharman is its founder and director. Visit www.shinehealthacademy.org.uk

I am feeling powerless

Rachel Freeth

Jean is angry. She sits opposite me, bolt upright on the edge of her chair, and stares intensely into my eyes. As she talks, she begins to raise her voice. By the time she is telling me that no one has ever done anything to help her or her family, she is shouting loudly.

Although I don't experience her as angry with me specifically, I feel tense nevertheless ; I really wish she would stop shouting.

Most mental health professionals are used to dealing with angry patients. Many of us will also have had numerous experiences of being shouted at over the course of our professional lives. This is more likely in some settings – for example, in mental health inpatient units. Sometimes anger is obviously linked to the nature of the person's inner disturbance – for example, paranoid ideas or extreme mood states. For others, environmental factors have a more obvious direct role. Being on the receiving end of coercion and control will precipitate and perpetuate anger in many people – and there is a good deal of both practised in mental health care settings.

I find meeting anger in others doesn't get any easier with time and experience, and sometimes it is hard not to take it personally. Even when anger is directed at me and seems personal, I try not to respond defensively. And, as all good therapists know, if we can hear, acknowledge and take seriously the anger in the other person, it often dissipates. This doesn't always happen, of course. In highly emotionally charged hospital environments, faced with an angry patient, it is not uncommon for staff to reach for the medicine trolley.

> 'What really disturbs me about Jean's story is that she feels let down by professional helpers – past and present. I am conscious I am one such helper'

Jean is continuing to shout and she is now jabbing her finger in the air. I consider asking her to stop shouting, especially as she is almost certainly disturbing other meetings in neighbouring rooms. Having not met her before, though, I don't know how she is likely to respond – with more anger perhaps? I am on the verge of taking this risk when, almost as suddenly as she started shouting, she stops, seemingly exhausted and willing to relinquish control over her interaction with me.

Long after she has gone I reflect on why I felt so uncomfortable in the presence of her anger. There seemed more to it than the sheer intensity of her emotion. I analyse the interplay of factors related to her story, my own story and the context of our encounter. It is complex. It usually is.

What really disturbs me about Jean's story is that she feels let down by professional helpers – past and present. I am conscious I am one such helper: I belong to a profession and work for an organisation with which she is angry and in which she has no confidence.

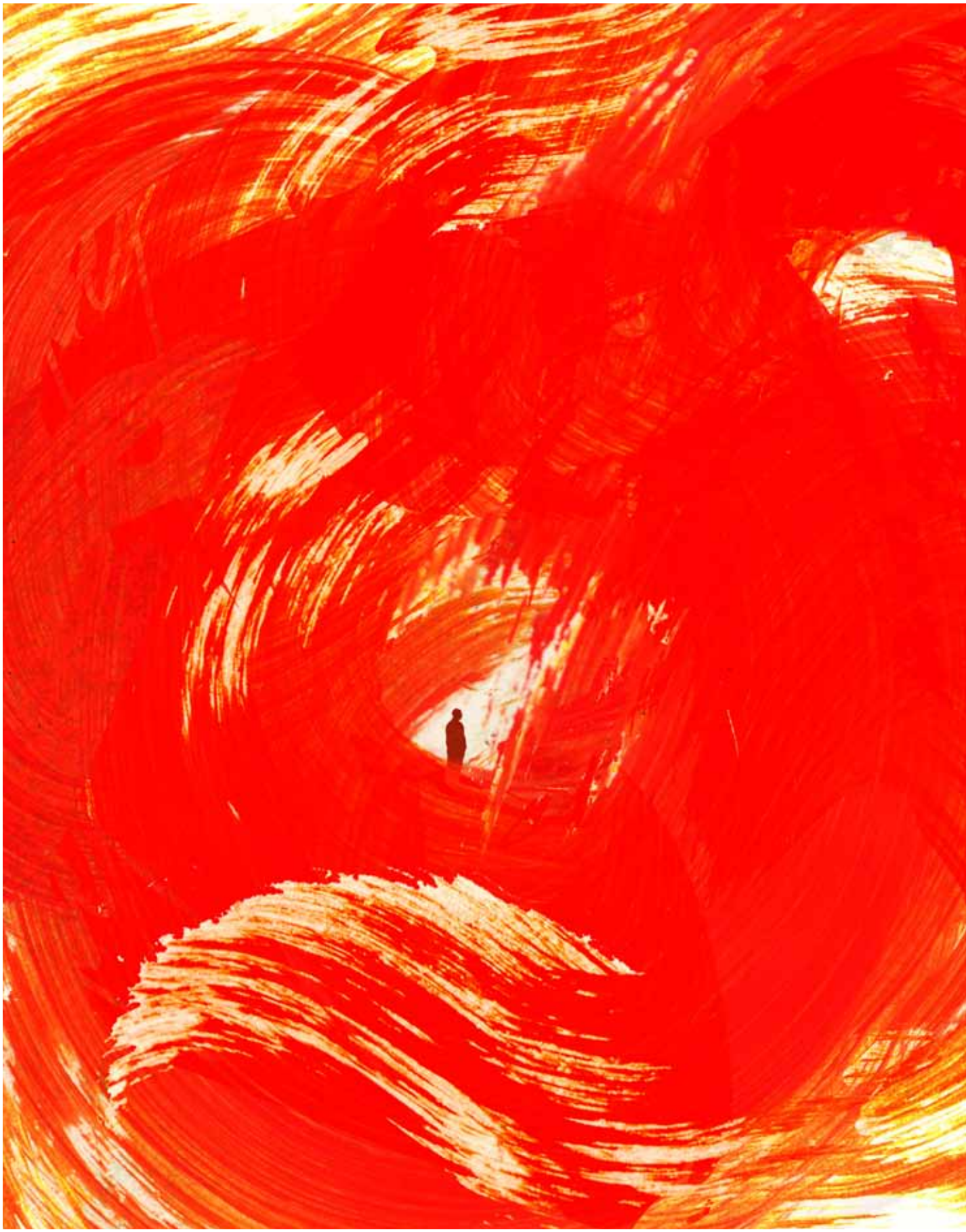
The truth is, I find her anger understandable. I am the fourth consecutive psychiatrist she has seen, due to staff resignations and service reorganisations. The room where I see outpatients is cold, bare and smells. It communicates little care and attention for those who come to see me in states of fear, anxiety or despair. Furthermore, Jean has been diagnosed with a mental illness in a way that pays little attention to the very real social problems and circumstances with which she has struggled over many years.

What then is my task? Can I do more than just have a conversation about medication? Should I try to provide some sort of reparative experience? What might this involve and is this even possible, given the severe constraints on my time and the limitations of my role? Should I refer her to the team of psychologists with which I work? Jean does not strike me as the sort of person who wants to reflect on her thoughts, emotions and behaviours. For her, the problems and solutions are 'out there'. To a large extent I think she is right.

What I do know is that, when presented with this not uncommon scenario, I feel powerless. Yet Jean has come to see me to 'make her better'. Perhaps this, then, is my major source of discomfort.

I know I need to watch how my own feelings of powerlessness play themselves out. I am aware too, that in the current climate, I need to be increasingly vigilant of this. ■

Details have been changed to protect identities.



Counselling in China

As China transitions to a modern nation, the status of counselling in the country is also changing. *Gareth Davey and Xiang Zhao* report on the growing demand for talking treatments

Illustration by Simon Pemberton

The Chinese are experiencing rapid and profound social change as their country transitions to a modern nation. The fourth largest country in the world, with 1.4 billion people, China is now an emerging economic superpower with impressive economic development, rising living standards and breathtaking achievements in global affairs.[1] Quality of life has improved in recent decades and many Chinese now have lifestyles that were beyond reach only a couple of decades ago. However, many people are also finding it difficult to adjust to the fast pace of change and new ways of living. Typical stressors include clashes between traditional and modern values, the increasing cost of living, high property prices and competition in society and in the job market. In addition, myriad social problems hide behind the economic data that glamourise China's success: corruption, crime, drugs, inequality, social exclusion and other social ills put pressure on citizens. As a consequence, the incidence of emotional and behavioural problems is increasing and China now has one of the highest rates of mental illness in the world.[2] Anxiety, depression, alcohol and drug dependence, divorce, and relationship problems have become prevalent in recent years, and suicide rates are high.[2]

With the changing economy, Chinese employees face new challenges in the workplace. Western business and management practices have gained popularity and have brought with them Western working life problems. In recent years, the job market has become very competitive and China's unemployment rate has risen, in contrast to the past when the State assigned jobs to everyone. An increasing number of Chinese employees report work-related stress, burnout and an impossibility of maintaining work–life balance, which adversely affects their motivation, productivity and satisfaction at work, as well as life outside work. Rural migrants in Chinese cities face further difficulties as they take on the jobs that locals refuse, with long hours and low pay.

Young people in China also face immense pressure. A major problem is exam stress. It is customary for Chinese parents to have high expectations of their child's academic achievement. Confucianism (traditional Chinese philosophy) emphasises educational

achievement and success. Millions of high school students sit the annual Chinese national college entrance exam and compete for a very limited number of university places. Chinese youth spend all their time studying, and the pressure has been linked to anxiety and stress, depression, fear of failure and even suicide.[3] Other troubles typically reported by Chinese adolescents include loneliness, relationship problems and internet and video game addiction.[4]

For all these reasons, demand for counselling in China is increasing. Public awareness of counselling has also contributed to its rising status as there is now much more public discourse about personal problems and therapies in books, magazines and the broadcast media. The Government recognises the important role of counselling and has launched several initiatives. However, China is a developing society; the Government's priority has been to meet its people's basic needs; pursuit of economic development takes precedence over other issues.

Another challenge is stigma associated with seeking help for personal problems that might bring shame to Chinese clients and their families. The Chinese are more likely to seek advice about life's problems and stresses from family, friends or social workers; counsellors and other caring professionals are seen as a last resort. Therefore, although much has been done in recent years in China to improve the social standing of counselling, further initiatives and strategies are urgently needed.

Availability and counselling

Although therapy in China dates back to ancient times, the Western concept of counselling was introduced only recently, in the 1980s. Since then its status has developed rapidly and counselling centres and services are now available in almost every Chinese city and also in a wide range of settings, such as mental health clinics, hospitals, private practice, companies, high schools, universities and in the armed forces and prisons.[4] However, the availability of counselling is limited mainly to urban areas: there is a marked rural–urban divide in China, as well as other regional disparities.

China has no counselling association or professional body equivalent of BACP. The profession is currently represented by mental health and psychology organisations. The Chinese Association for Mental Health was re-established in 1985 as a national body for mental health professionals and has several committees with responsibility for overseeing counselling matters. There is also a counselling branch of the Chinese Psychological Society (Clinical and Counselling Psychology). These organisations have undoubtedly done a great service to the development of counselling in China. However, the profession does not yet enjoy a stand-alone identity, independent of psychologists, and the credibility and work group identity of counsellors is comparatively low.

China's stance as an authoritarian state is one reason for the rarity of professional bodies across a range of professions. Most associations are government-owned; the Government tends not to support non-governmental organisations (NGOs) and exerts tight control over their legal status and rights. The censorship of NGOs by the Government also undercuts their effectiveness and pushes them to the periphery of decision-making.

Counsellor training and registration

Counsellor training and registration in China are still at an early stage of development. A small number of colleges and universities offer counselling courses, but they are typically tagged onto psychology and allied programmes. Not surprisingly, the supply of counsellors falls short of demand. Career pathways in counselling are not clearly defined and counsellors tend to earn low salaries. Many counsellors in China do not have the job title of 'counsellor' and perform multiple roles in addition to counselling. For example, school counsellors also teach and have responsibility for the whole-person education of their students, including educational and career guidance, moral education, personal development and guidance on interpersonal issues. This lack of professional identity has led to a public misunderstanding of counselling. Even so, counsellor training is increasing in popularity and trainee counsellors are excited by the opportunities and potential of this emerging field.

The Ministry of Human Resources and Social Security established a national counsellor registration (licensure) system in 2002, which includes a counselling qualifications framework and a licensing board. There are three grades of licence: assistant counsellor (grade 3) requires successful completion of a government-approved course and a national examination covering topics such as counselling skills, developmental

'Counselling models in the UK emphasise autonomy, individualism and self-actualisation. Chinese culture emphasises collectivism, pragmatism and interpersonal relationships'

and social psychology, mental health and personality disorders and psychological assessment; counsellor (grade 2) requires completion of advanced counselling courses and a national examination, as well as three years' experience at grade 3 or its equivalent (eg postgraduate training); senior counsellor (grade 1) requires three years' experience at grade 2 or its equivalent.

The national examination is held bi-annually (May and November) and consists of theory and practical tests, although grade 3 applicants only take the theory test. The pass mark is approximately 60 per cent and successful candidates are awarded a nationally recognised certificate that confers their status as a licensed counsellor. Counsellors can also train through other routes: for example, there is an independent examination system for psychotherapists, which is administered by the Ministry of Health.

Licensure is now regarded as the gold standard for employment as a counsellor. Counselling centres and associations are also regulated by the Government, which separates counselling services as either commercial (fee-based counselling services, which are regulated by the Administration of Industry and Commerce), or non-commercial (free counselling in schools and prisons, which are regulated by the Ministry of Civil Affairs). However, the counselling licensure system has limitations. Only college and university graduates in psychology, education, medicine and other subjects authorised by the Government are eligible to apply; aspiring counsellors with degrees in other subjects, or without degrees, cannot pursue counselling as a career. The national examination has also been criticised for insufficient testing of counselling competence as it emphasises theoretical knowledge rather than practice skills. The availability of supervision and internships is limited in China, and ongoing supervision is not currently a requirement of licensure. In any case, many counsellors in China do not yet have formal qualifications.

Counselling theories and practice

Counselling theories and practice in China borrow extensively from Western methods and the books and course syllabi are similar to those in the UK. The most common approaches adopted by Chinese counsellors include behaviourism, cognitive behavioural therapy (CBT) and psychoanalysis. However, Western-based methods are not always appropriate for Chinese clients, and they must be used with care.[5] This is because the counselling models with which we are familiar in the UK are grounded in Western culture and values and, therefore, generally emphasise autonomy, individualism and self-actualisation through achieving personal desires and goals. In contrast, Chinese culture emphasises collectivism, pragmatism and interpersonal relationships. Chinese people regard their problems as indicators of poor social relations and so tend to deal with them through consideration of others. Chinese counsellors, therefore, focus on restoration of harmony and relationships in the client's social milieu.

Chinese clients regard counsellors as experts and authority figures and expect advice and solutions in the same way that people in the UK consult medical doctors for diagnosis and prescriptions. They tend to have less tolerance for ambiguity and prefer directive and goal-oriented counselling, so approaches such as CBT seem to be more effective.

Cultural differences in expression and social construction of emotions also need to be considered when counselling Chinese people. People in the UK and other Western cultures tend to show their emotions; Chinese culture favours emotional moderation and restraint and the promotion of social harmony over individualism and personal expression. Chinese clients initially downplay emotional expression in counselling sessions, and are less likely to admit to experiencing anxiety, depression and psychological problems. Chinese clients may also somatise their emotional and mental health problems by describing physical, medical symptoms. Physical symptoms are more socially acceptable ways of expressing mental troubles, and Chinese philosophy does not differentiate between body and mind.

Western counselling approaches have been modified to fit the Chinese culture. For example, CBT is typically modified for Chinese clients by shifting some emphasis from the client as the primary agent to the social factors that influence their decisions. Gentler interventions are preferred to individualistic counselling techniques such as assertiveness training, direct discussion of sensitive issues and extreme emotional expression.

Examples of modified counselling approaches in China include cognitive insight therapy, which is a form of psychodynamic therapy developed by Youbin Zhong and based on Chinese culture and beliefs;[6] Taoist cognitive therapy, which integrates cognitive

'Chinese clients regard counsellors as experts and authority figures and expect advice and solutions... They tend to have less tolerance for ambiguity and prefer directive and goal-oriented counselling'

The student's tale

Qianqian is an 18-year-old high school student in Kunming city, south west China. She was born and raised in the city and self-identifies as Han Chinese, non-religious and middle class. Qianqian lives in a school dormitory on weekdays and returns home at weekends. She has no siblings because of China's one-child policy, which restricts married couples in urban areas to only one child.

Qianqian has self-referred to counselling because she feels under pressure from the national college entrance exam, which she will sit next summer. Despite Qianqian's good academic performance in school, she has been struggling with the prospect of taking the exam and is worried she will get poor marks and disappoint her family.

Although school exams are a concern for young people everywhere, Chinese students face particularly intense pressure, for various cultural and social reasons. China's national college entrance exam is very competitive: more than nine million students sat the exam in 2012, and a large proportion (about 40 per cent) were unable to secure university places. The demand for higher education has rocketed following China's economic reforms in the 1970s, and universities have been unable to keep up with demand. The exam is regarded as a key determinant of life chances in China's very competitive society and job market. Therefore, Qianqian and her classmates, like other students across China, begin intensive preparation as soon as they start high school.

Qianqian describes her predominant mood as 'anxiety', which she relates to her feelings about her exam. During the previous month she has experienced physical symptoms such as dizziness, loss of appetite and nervous habits, which she finds embarrassing and frightening but, when she recently consulted a doctor, they could find no medical or physical basis for her symptoms. While Qianqian's situation is difficult, she does not appear to be in crisis, and does not express thoughts of self-harm or suicidal feelings.

Although Qianqian describes having a good relationship with her parents, they hold high expectations of her achievement in the exam. Chinese tradition emphasises a high standard of educational success; failure is regarded as family shame. Although Qianqian's teachers have been supportive, they continually emphasise the exam's importance and the need to study. School teachers in China are also under pressure as their reputation and job security hinge on the number of their students who succeed in the exam.[3]

Regarding social relationships, Qianqian has not had difficulty making and keeping friends, and she considers herself to have a strong social network. However, she has felt socially isolated from her peers during the past year or so because of everyone's devotion to exam preparation. She has also encountered disapproval from her parents whenever she attempts to have any kind of social life, as they are concerned she will be distracted from her studies.

Counselling plan

Several years ago, Qianqian's school set up a counselling centre, which provides free individual and group counselling to help students address academic, emotional and interpersonal concerns. The most common concerns reported to the centre include academic issues, such as study skills and time management; adjustment to school life; personal issues, such as homesickness,

'Chinese students face particularly intense pressure... the college entrance exam is seen as a key determinant of life chances in China's competitive society'

relationship problems and room mate problems, and mental health issues, such as anxiety and stress. The centre has three staff, including two licensed counsellors, although they also have administrative and teaching duties.

Qianqian was reluctant at first to seek counselling because of the stigma associated with seeking help for personal problems. However, the increase in her anxiety in recent months has prompted her to seek help from the counselling centre.

Following an initial assessment of her situation – her thoughts and feelings, coping strategies, past history, goals in seeking counselling etc – the school counsellor develops a treatment plan consisting of individual therapy sessions once a week for 12 weeks. The primary focus is on stress management and general problem-solving skills to help Qianqian identify and understand her stress and anxiety triggers and change how she deals with them by using coping and relaxation techniques. This will be supplemented with CBT and also activities to help Qianqian improve communication with her parents and friends and achieve a better study–life balance.

Qianqian's counsellor will use a modified form of CBT to enhance its compatibility with Chinese culture. For example, Qianqian is reluctant to directly express emotions, as Chinese culture favours emotional restraint, and she prefers to communicate her problems indirectly and through non-verbal expression. Therefore the counsellor initially refrains from direct discussion of deep-rooted emotions and instead uses microskills to enhance communication and a working alliance. The counsellor will also fully consider Qianqian's social situation and its role in her anxiety, as Chinese people tend to address anxiety and life's pressures through consideration of social relations.

Other issues will need to be considered in the counselling approach. Qianqian has said that she would like the therapist to tell her what to do, which is typical of Chinese clients, who prefer directive counselling and regard counsellors as experts and masters whose status and values the clients endorse through deference.

This is a fictionalised case study created from typical client presentations.

therapy principles and Taoism (a Chinese philosophical and religious tradition), and Shudao therapy, developed by Longguang Lu, which is directive and confrontational and challenges thoughts and interpretations, and is based on theories of energy flow and blockage of energy meridians.

Chinese counsellors have also developed indigenous therapies. Well-known examples include enlighten (*kai dao quan wei*), qigong boosting (*qi gong yin dao*), recreational therapy (*xiao chou yi yue*) and distracting therapy (*yi qing bian qi*).

Although integrative and indigenous approaches have obvious advantages, Chinese and Western counsellors question their efficacy. For example, some approaches have developed quickly, without alignment between theory and practice, and contain incompatibilities between Western and Chinese cultural assumptions. The strengths and weaknesses of these approaches have not been evaluated sufficiently, and further research is needed to identify the theories and styles best suited to Chinese clients.

The future

Counselling in China has come a long way in a short time and has strong potential to flourish in the years ahead. However, it is still at an early stage of development and faces a number of challenges. Interaction with counsellors in other countries is likely to lead to an enhanced mutual understanding of counselling. Counsellors in China are very interested in sharing their experiences and learning about current counselling approaches in other countries and they welcome collaboration and dialogue with their counterparts in the UK. As the world's most populous country, with a unique culture and a fast-developing economy and social system, China is also in a unique position to contribute to the development of counselling in the UK. An appreciation of counselling and culture is particularly important for UK-based counsellors who serve culturally diverse communities and wish to extend their understanding beyond the Western perspective. ■

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Xiang Zhao is a licensed counsellor (grade 3) in China. A school counsellor based at the Yunnan Experimental School in Kunming, Xiang is very interested in dialogue with UK counsellors. Email xiangzhao@ymail.com

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'Myriad social problems hide behind the economic data that glamourise China's success... China now has one of the highest rates of mental illness in the world'

Life after death

Pete Connor describes some of the remarkable changes he has witnessed during the past 25 years while counselling people living with HIV

Illustration by Simon Pemberton

Chris recently tested HIV-positive at our one-hour Fastest Clinic and is signed off work with anxiety and depression. At 22, he seems very young and I'm moved by his youth and slightly irritated by his casual manner.

'What's been going through your mind since you were diagnosed, Chris?'

'I don't know really. It's no big deal... there are treatments. I just didn't think it would happen to me. I never went with older guys... I took a few risks but who doesn't?'

'Thinking you were safer with younger guys, you didn't always have safer sex.'

'Well, you're having a good time, take a few pills, you don't want a downer on things... It's no big deal.'

'You don't feel being HIV is a big problem now there are treatments and yet you're having difficulties sleeping and feel anxious?'

'It's like nothing and everything has changed... does that make sense?'

I notice a shift in me from irritation to sadness as I sense how lost this young man feels, with very few existing coping strategies for the potential impact of HIV.

'You know that things will change but aren't sure how. Maybe meeting some other positive gay men might help? We can put you in touch.'

'Yes, sure, it would be good to meet a few poz guys now.'

Twenty-five years ago a positive HIV diagnosis was a traumatic and catastrophic event. No effective treatments existed and, while some survived longer-term, most people's prospects were bleak; illness, disability, disfigurement, end-of-life issues, bereavement and grief dominated counselling sessions. Dramatic advances in HAART (highly active anti-retroviral therapy) medications or combination therapies, whilst not offering a cure, now mean that most people with HIV have the possibility of a normal life expectancy. Learning to live with a chronic rather than a severely life-limiting condition is usually the challenge now.[1]

Counselling can be a place to explore with the individual the potential impact of HIV on future plans, hopes and aspirations and to identify, strengthen and apply existing coping strategies, as well as develop new ones. Common issues include disclosure decisions, potential impact on work, safer sex and relationships, treatments and lifestyle/self-care. All can be explored in a hopeful and forward-looking way that is so different from my memories of the start of the epidemic. Although late diagnosis, severe medication side effects and drug-resistant viral strains can mean that people still die of HIV-related disease, this is rare.[2]

Many newly diagnosed people may not need counselling as they may gain more from one-to-one or group peer support, community support/buddying or complementary therapies. Counselling may be more useful later on if the impact of HIV becomes more acute. However some people – those with few existing coping mechanisms who are showing signs of growing distress – are likely to benefit from counselling soon after diagnosis.

Social and psychological impact

Tatenda avoids my gaze, tears falling as she talks about stopping her medications. She occasionally attends our BME service users group but dreads meeting someone she knows from back home in Zimbabwe. Tatenda worries about her lack of official leave to remain in the UK and about doing casual work to earn money.

'How do you feel about the medications?'

'I know I should be grateful for the opportunity to be well but I don't deserve them.'

'You don't deserve them?'

'Who am I to live when better people than me have died?'

'Part of you appreciates the chance to remain well and part feels guilty that...'

'Yes, and you do not know life without the pills.'

My thoughts drift to when there were no 'pills'; when my partner died, his body ravaged by Kaposi's Sarcoma (KS), the classic AIDS-defining cancer, his bone marrow damaged by rudimentary early treatments. I remember my friends Katie and Clare, who died in the years soon after David, and the others lost in the 1980s and early 1990s. I resist sharing these memories and refocus.

'Life without these drugs was and is terrible and yet part of you chooses that life?'

'I want to live, to have a husband and babies, but who would choose me with this disease?'

'You want these things but feel that HIV stops you.'

'Of course!'

'You know women with HIV through our women's group who have partners and children?'

'I do not deserve them.'

After Tatenda's session I think of Dean, who used his medications so erratically that his virus became treatment-resistant and eventually attacked his central nervous system, leaving him paralysed in a wheelchair. I feel desperate for Tatenda to avoid the same problems and discuss this in supervision.

Cytomegalovirus (CMV)-related blindness, KS sores covering emaciated bodies, neurological damage and AIDS-related dementia are mostly a distant memory now. However, treatment failure can mean their re-emergence

‘Counselling can be a place to explore with the individual the potential impact of HIV and to identify, strengthen and apply existing coping strategies as well as develop new ones’

and counselling can be a time to discuss the social and psychological implications of starting and managing lifetime medications. Medication management is much simpler now practically, but taking the drugs may be difficult psychologically, due to feelings of grief and guilt and continuing HIV-related stigma. Despite greater awareness and understanding, HIV-related prejudice, discrimination and shame continue, and this is at least partially determined culturally. Harassment and unfair treatment persist. Counselling offers a space to explore the emotional impact. Controlling medications can sometimes be the only way for those feeling disenfranchised and powerless to exert some control.

Interpersonal issues

Tom has been coming to counselling for three months since he and his partner, John, were diagnosed. They had an open relationship and Tom blames John for HIV entering their relationship, believing that John had unsafe sex. Tom recently disclosed that a neighbour’s friend had sexually abused him in childhood.

‘I never knew if I was gay because he made me or because I was anyway. Maybe he was doing me a favour.’ Tom laughs grimly.

‘How do you feel when you say that, Tom?’

‘I know it was wrong, that it wasn’t my fault. I know inside that I’m not gay because of the abuse; we’ve talked about all that but... I get confused sometimes.’

‘Your head says one thing but your feelings sometimes say something else?’

‘It’s since the HIV. It was all locked away but I feel dirty again, like people can see the badness, the sex and disease. It’s like John’s abused me as well and being gay has caused it all. I thought I was proud to be gay but now I’m not sure. Maybe they were right.’ There are tears in his eyes.

I think of my own gayness, my own battles with internalised oppression and abuse, and feel an identification with Tom, while trying not to confuse our processes.

‘Being gay has been a positive thing for you but now you’re feeling the negative messages too. Would you say some more about what being gay means for you, Tom?’

A positive HIV-diagnosis can trigger the re-emergence of old traumas, including abuse of various kinds, as well as a return to partially negotiated life stages and transitions. Self-esteem and/or identity problems may need to be addressed; HIV-related stigma can re-evoke painful feelings connected to gender, sexuality and body image. Relationship issues may also be explored in counselling, including when and how to disclose status, being in a sero-discordant relationship where only one person is infected, sex and safer sex, and if/when to have children, especially now that protocols are so effective in preventing HIV transmission to the baby. HIV may put more stresses on relationships through the impact of medications, the initial route of infection, ill health and social problems and, as people live longer, the challenges posed by longer-term relationships.[3]

Growing old with HIV

Yvonne, 65, stares at her body, hating the ways it has changed through being on combination therapies since her diagnosis 13 years ago. Trousers hide her thin, veiny legs and shrunken bottom and she is self-conscious about her sunken face, stripped of fat. Following a post-divorce relationship, Yvonne endured several years of unexplained medical problems before finally being diagnosed; her GP did not consider her to be at risk of HIV.

‘What do I have to look forward to now? My children have their own families and never ask how I am nowadays. I live off a tiny pension, have to take horrible drugs that make me look like a freak and feel...’ Her tears start to fall.

‘You feel...?’

‘Like I’m a toxic old bag. Life has nothing left for me. I exist to keep the virus alive. Why struggle on, like a zombie?’

‘You feel that you’re just existing, the living dead.’

‘Yes, and now the bloody tablets aren’t working and I have to change them again. I feel so tired and don’t know what I’m doing anymore. I hate it!’

‘I know that we’re arranging some acupuncture for you, Yvonne, and the doctors are trying to find you a better combination, with fewer side effects. Maybe here we can explore what might give your life a sense of purpose, although I realise that’s very difficult.’

Living long-term with HIV can be exhausting, with some experiencing difficult side effects from the medications, such as lipodystrophy (redistribution of body fat), peripheral neuropathy (nerve damage) and all-pervasive fatigue. Changing drug combinations can be helpful but can also provoke anxiety; the pros of effectiveness have to be balanced against the cons of side effects. The challenges of ageing may also lead to existential questioning of meaning and purpose; physical, social and financial issues all impact on aspirations and goals. The tasks of living with HIV have changed from coping with endings and death to managing continuing life and the future; from dealing with sudden, debilitating disease at a young age to coping with growing older with a chronic condition requiring life-long medications; from live-for-the-

‘A positive HIV-diagnosis can trigger the re-emergence of old traumas, including abuse of various kinds, as well as a return to partially negotiated life stages and transitions’

moment financial management issues to struggling long-term on part-time wages, lower benefits and a small pension.[4]

Then and now

‘I’m not going to die, am I?’ His face is covered in sweat, his body painful with KS sores and now perhaps he has pneumonia; Geoff is terrified.

‘The ambulance is here, Geoff, you’ll soon be on the ward.’ I’m evading his question, shaking. It’s 1987; I’m 24, he’s my third client and he’s just collapsed.

Later, in the hospital, after sitting in silence by his bed: ‘I’ll come back tomorrow, Geoff.’ Hands touch goodbye.

‘Bye, Pete.’

I telephone the next day. ‘Geoff passed away during the night, sorry,’ says the ward sister. ‘We’re trying to contact relatives; can you help?’

‘They don’t want anything to do with him,’ I explain, struggling to breathe. ‘He was only 22.’

Many memories have surfaced during the writing of this article – painful and depressing memories and joyous and inspiring ones. I realise how unprepared I was initially and how vital in-depth training, personal therapy, challenging supervision and learning from experience have been.[5] Having moved from an essentially person-centred perspective to greater integration, I now use a psychosynthesis framework to incorporate the transpersonal. Psychosynthesis offers me a practical and pragmatic approach but each counsellor will find her/his own way of working with the issues presented by clients. HIV counselling involves working with all life issues, but additional training and expertise in areas including sex and sexuality, internalised homophobia, racism, cross-cultural work and addictions, as well as the medical aspects of HIV and the skills of multi-disciplinary working, are clearly advantageous.

The challenges presented by HIV have changed radically over the past 25–30 years and service providers have adapted accordingly. In 1987, by far the majority of clients with HIV in Bristol were white gay men. Now, at Terrence Higgins Trust West, roughly 40 per cent of the service user group are women and 30 per cent are African or African-Caribbean, and significant numbers are aged over 55. Joint work with agencies such as Refugee Action and Age UK and internet-based information, advocacy, advice and peer support services, such as myHIV.com, also reflect these changing demographics.

Certain developments have been painful for some: a sense of disempowerment as charities adopt a more corporate approach and place greater emphasis on outcome measures and evidence-based work. Activism, radicalism and the sense of community tended to dissipate but not completely disappear as agencies became increasingly reliant on state funding.

Counselling remains a core service of many HIV organisations; its focus may have changed but its importance remains. People with long-term physical conditions are more at risk of mental health problems,[6] which makes ongoing access to counselling crucial. Many people with HIV are now able to enjoy healthy, happy lives, relatively free of HIV-related problems, but others still experience physical, emotional and social problems related to the virus, and counselling remains a key resource. As funding becomes tighter and medical treatments improve, my hope is that the social care of people with HIV does not drop lower down the list of priorities.

This article is necessarily personal, in that it reflects my own history and perspectives; the picture it paints is incomplete, rooted as it is in a country with good health care services and comparatively high standards of living. It is dedicated to Geoff and those he represents. ■

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The clients quoted in the vignettes in this article are fictional composites based on many different cases.

Therapy Today.net

Visit www.therapytoday.net to read Colin Feltham ‘In conversation’ with Pete Connor.

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Write, read, share, reflect

Groupwork can be a powerful catalyst for change. *Jeannie Wright* describes the challenges and rewards of therapeutic writing groups

Illustration by Simon Pemberton

Groups have an immense potential energy for therapeutic change. Yet, paradoxically, given how many years of my life I have spent in groups, I don't like them. I avoid them; that's why I write – one reason, anyway. For me, groups are exhausting; I need several hours to recover from them, whether as participant or as facilitator. On the other hand, I know that the relationships, the diversity and experience of the members of a confidential group, can be a powerful resource for therapeutic change.

'Given that there can be no "self" without "other" and no "individual" without "group"... trying to understand more about the "self" is fundamentally a group exercise. At the same time, we often fear groups.'[1]

We're in a large, sunny room. Outside, the horse chestnuts are just beginning to flower. Traffic rumbles two roads away. The tables have been pushed to the side and low, red, relatively comfortable chairs are in a circle. Twenty-five people sit waiting to start. Our purpose is to explore 'Reflective and creative writing: journal writing and therapy' in a three-hour structured workshop.

This is an experiential group and, I hope, that's what participants are expecting. It is a new group for me to work with; some people already know each other well. I introduce myself very briefly and ask everybody to say their name and one thing nobody else in the group will know about them. It is an icebreaker that often raises a laugh, with examples like, 'You might not know that I don't like cucumber – yuck!'

I'm very aware as I look around the 'landscape' of the group that we are all unique in the way in which we'll experience the next few hours.

'You and I can have an experience of the same landscape, but each of us will generate that experience according to our own individual perspective.'[2]

On the other hand, I notice some gender and racial groupings as I glance round and take in the visible differences. A majority in the circle are women over 30 and there are two with grey hair. There's one African Caribbean man and another man who is much younger than the average age of the group. He looks to be in his early 20s.

When I run writing groups there is always a point at which I ask people to start writing. I've usually given some notice in the advertising for the group, and some participants are self-selecting: you wouldn't sign up if you weren't interested in this kind of reflective self-writing. On the white board is a very rough outline of the session, with the start and end times and a break in between time slots marked: 'Write!' Instructions will be given, inviting people to write.

I write what I can't or choose not to say. It is also essential that I feel in charge of this writing – the active and autonomous agent – rather than following someone else's instructions. I started writing my thoughts and

‘Liberating and emotional’

Monique describes her experience of the reflective writing group

It is so long ago, writing... I feel that this might really not be for me, words; how can this day be of importance? I am going to go with the flow and see what the day will bring. It feels a very safe place to be. We are all aware of confidentiality.

We start by writing for six minutes. We are asked not to worry about grammar or spelling and just empty our heads. No need to think about it, let it flow as it comes. Surprisingly, I find myself writing easily and am delighted about that.

We sit in the group and debrief. How did I find it? It was liberating and I stopped and thought about things I had forgotten. I used to write poems as a young person. They meant a lot at the time. I somehow was reminded of this today during those six minutes. I hadn’t given that side of me a thought for many, many years and now here it popped up. It was intriguing.

We then proceeded to write a letter to ourselves. This time it was longer: 15 minutes. We were told to forget the ‘inner critic’ sitting on our shoulder, to push the critic off our shoulder and be kind to ourselves. After we finished we had the opportunity to read parts of the letter to ourselves and then in pairs. This was a choice; all is ‘for our eyes only’. No pressure to share at all.

I decided to share and during the time of reading out aloud I discovered that it was very emotional. The sharing part was of immense value; looking into the eyes of the person listening to me was an important part of this experience. I saw compassion in her eyes.

Had I expected this level of emotion? No, I really hadn’t and it struck me how therapeutic this whole experience had felt. Simply to stop, reflect and write. And somehow reaching the core of my being, the parts I had forgotten about.

The last exercise was around 30 minutes long and we were asked to write about the changes and decisions we have made in our lives that have defined us but... what would have happened if we had taken different decisions?

Again, it was an amazing experience, freeing and giving me so much insight. It made me realise how often I made decisions and sometimes took chances in my life. Rewriting the future with a different path was very clarifying as it helped me to reflect on my past by looking at a possible different future. And I wrote my first poem after so many years, delighted that a part of me was freed.

feelings at an early age in diaries and old exercise books and have maintained the habit. In the 1970s, when I first trained as a counsellor, we were asked to write our autobiographies – a forerunner of the now common practice of requiring trainee counsellors and psychotherapists to keep a reflective journal. Who reads that raw material, those personal and developing professional disclosures, is a crucial choice, a boundary not always made clear in educational and health settings where journal writing is required. Making explicit what writing might be suggested for sharing and what is ‘for your eyes only’ is an important part of facilitating writing groups. Setting and holding boundaries in a confidential setting is also clearly crucial. The writing group must be a safe enough space to explore personal experience. Small subgroups of three to five participants are ideal for the reading out of self-chosen sentences or sections of writing. The anticipation of disclosing the written words can be hard to contain for some, who will ask: ‘Can I go first and get it over with?’ Keeping time boundaries and ensuring that everyone is clear about who is responsible for timing in the subgroups needs careful attention.

Reds, greens and ambers

In facilitating writing groups, I’ve noticed there are three subgroups that form almost immediately. I shall call them the greens, the ambers and the reds.

The greens are ‘the naturals’. ‘I love writing,’ they say, ‘always have. I’ve kept diaries since I was about five.

‘It is essential that I feel in charge of this writing – the active and autonomous agent – rather than following someone else’s instructions’

Now I don't know what I think until I've written it down.'

The greens nearly always can't wait to start writing in the group. They sit on the edge of their seats and create a buzz from the outset. They don't engage with the chatting some group members do before starting to write; they take themselves off to a corner or sit on the floor or out in a corridor. They are the men and women who have kept reflective diaries and journals since they were very young, certainly from when they were teenagers. Writing for them is a form of individual, expressive therapy, usually requiring solitude, so there is novelty for them in being in a writing group. The group, at its best, makes solitary writing more social, more collective.

Then there are the ambers: the 'I can't write' group. 'The thing is,' they say, looking anxious, 'I'm not sure what to write about.'

The ambers are another group of people who may have some experience of expressing thoughts, feelings and ideas in writing from an early age but with a twist. They lack confidence, probably because at school they were told by some English teacher with a red pen that they 'can't write'. They can often be won round, but it requires care. They usually arrive fearful of public humiliation. Immediately they notice the large posters stuck on the walls:

- 'This writing is for your eyes only, until and if you decide you want to share it'
- 'Nobody will be judging your writing'
- 'How you write, what you write on, or in which language, is up to you'
- 'Spelling and grammar don't matter.'

The ambers soon find that all those school rules can be forgotten. They can gradually be convinced that they are the experts on their own experience and that they can't get this kind of writing wrong.

The energy in the room changes when I ask people to start writing. These days people bring laptops, iPads and other keyboard writing preferences. I often provide some coloured paper and pens.

The third group, the reds, just don't like writing, and often don't bring any writing materials; they barely bring themselves. They don't want to see their thoughts and feelings on paper or on a screen, and resent being asked to keep a personal learning journal, if it is a requirement of a course. They can also create a challenge for the facilitator by talking, not just before but during the writing sessions, interrupting and distracting others. Silence is important to the group process:

'Like a mindfulness meditation, a Quaker meeting full of silent waiting and wondering, a star-filled, clear night sky, the writing gifted me transcendence from the ordinary. It let me hear what had been inaudible.'[3]

Morag Cunningham's words highlight how the writing is essentially solitary, and that this silence in the group facilitates the 'transcendence from the ordinary'.

Managing the reds is tricky and can call for a more prescriptive style than my usual 'we are all adults and here by choice' approach. If I sense their presence is becoming too disruptive, I might have to point them in the direction of the door, or at least recommend they write rather than talk because they are distracting others in the group. In my experience, this has rarely been necessary, perhaps because there is usually sufficient motivation to get on and write, or draw – to reflect in some way on paper. Another option is to talk to them separately, in a corridor or in another room, about what's happening for them.

Why writing groups?

Reflective writing groups can be compared to other groups using creative approaches. They are useful to those who are struggling to know where to start, how to write and what to include, as well as for those who find writing a natural way into self-exploration. Research into the therapeutic outcomes of writing groups is limited.

There is a relatively large body of research into the therapeutic experience of facilitated writing, but it is mostly related to the individual, rather than to people writing in groups. The published literature and research into expressive writing in a clinical setting, ranging from randomised controlled trials to case studies, is expanding. Social psychologist James Pennebaker provides a regularly updated bibliography of research into the 'writing paradigm' on his website.[4] Pennebaker and his associates in the US tend to take a CBT perspective, and the medical model is reflected in their research assumptions.

The experience of a writing group is like entering a sanctuary, a writing space, protected from the outer pressures of the world. Like other expressive arts linked to therapy, such as music therapy, art therapy and dance and movement therapy, creative writing is powerful. Harnessing the experience of facilitated, confidential group process allows individual exploration in writing in an atmosphere that supports and strengthens. ■

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'The experience of a writing group is like entering a sanctuary, a writing space, protected from the pressures of the world'

Dilemmas
Client encounters in a dual role

This month's dilemma

Deidre works as a therapist in a local voluntary counselling service, where she also has a managerial role and is expected to attend outreach and networking meetings.

However, at a recent event she notices that a client of hers is also present. Deidre leaves the event and tells her manager, who is not very pleased that she left the meeting. The manager is now considering appointing only non-practitioners as managers of the counsellors and counselling service.

What ethical issues are involved and what should Deidre and/or her manager do in this situation?

Justine Oldfield
BACP senior accredited counsellor

What a position for Deidre to find herself in. She sounds to be a well-trained and experienced counsellor, keen to try to help the clients she sees in this voluntary service. Neither Deidre nor her manager appears to have discussed the potential problems that might arise from her dual role, leaving Deidre standing with a foot in each camp – that of counsellor and that of a manager for the service.

During her training Deidre is likely to have attended at least one lecture on how to deal with encounters with clients outside the consulting room. The lecturer will have stressed that it is possible that this will put a client in an invidious position and may jeopardise his/her emotional safety if s/he is forced to acknowledge her counsellor when she is with others. The issues here are the values that make a good counsellor – respecting human rights and dignity as well as protecting the safety of clients.

It does not sound as if Deidre's manager understands why Deidre felt she had to leave the meeting. It doesn't seem that she has had counsellor training herself. Now she is intending to appoint only non-practitioners as managers. Here are two knee-jerk reactions from two people who both obviously care about the clients using the service and their wellbeing, but are taking two quite different ways of trying to act in those clients' best interests. Deidre will be concerned that non-practitioner managers will struggle to understand the ethics that underpin the safe working of counsellors with clients, and that this could undermine how counsellors in the service are able to work in the future.

> 'Possibly the worst approach is the one that Deidre took. She fled when she saw a client. This can hardly be said to be transparent'

Deidre and her manager need to talk this out. If her manager understands why Deidre made the decision to leave the meeting, it should be possible to make a new agreement to recognise her right to leave a meeting if a client happens also to be there. It might be possible for the manager to ask for a list of attendees in advance, so that she and Deidre could look at this together first.

Of course there is the possibility that Deidre's manager decides that she wants her counsellors to work to the requirements stated in their contracts, leaving Deidre with the agonising choice of either to work ethically at the service and so give up her managerial role, if that is acceptable to her manager, or to tell her manager that, ethically, she isn't able to remain in meetings that a client attends, for any reason. This may well lead to Deidre falling on her sword, of course, but counsellors are adept at helping clients to navigate these issues and Deidre could choose to help herself.

Heather Dale
BACP senior accredited counsellor

The central issue for Deidre is whether or not the two roles that she currently holds in the same service, of counsellor and manager, are compatible. If she continues with her dual role, it seems inevitable that she will also continue to meet clients at events.

This is a common enough occurrence in many small towns and cities around the UK, where the likelihood of unplanned encounters with clients outside the therapy hour is ever-present and needs to be thought through and addressed with clients in advance. Generally the key here is clear contracting, which allows the client to choose how they want to respond: whether to say hello or ignore the counsellor if they do meet inadvertently.

Deidre's situation is slightly different. She will have some idea of the sorts of situations in which she may meet clients or former clients. She now also knows that these may be formal situations; indeed she may even be asked to sit on the same panel or board meetings as some of her clients. Deidre will have a different professional persona in these situations and it may be hard for a client used to seeing her in one role (as a counsellor) to adapt to seeing her in another. It can be hard to feel that you are sharing your individual counsellor with other people or to see someone, who up until now has given you her full attention, engaging with others.

In itself this is not necessarily a problem: the BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy* states that dual relationships may have 'a powerful beneficial or detrimental impact that may not always be easily foreseeable'. However Deidre and her manager need to agree under which

circumstances such an encounter may be beneficial, and under which it may be detrimental. There is also the issue of who decides (Deidre, her manager, or the client), and what yardstick is used. Ultimately, clients need to be made aware of the likelihood, and be content with what is in place.

Possibly the worst approach is the one that Deidre took. She fled when she saw a client. This can hardly be said to be transparent, and Deidre will need to talk this through with the client next time they meet and discuss what happened, and what the client would like to happen should the situation reoccur.

In addition, Deidre and her manager need to have a conversation about how they both see the service developing. For example, they need to discuss whether it would be more appropriate to appoint a manager who is counsellor-trained but who does not counsel within the organisation. Deidre could choose to extend her managerial role or to remain in a counsellor-only role.

Whatever the decision, it is important that it is made in a fair and transparent way that protects the interests of the clients of the service first.

Bod Cantwell
Network developer

Deidre has been put in a position where she felt she had to make a choice between her organisation's responsibilities and her responsibilities to her client. At the time she decided not to stay in the meeting. I wonder what worst-case scenario caused her to turn around and leave the meeting?

Understandably, her manager feels disappointed and to ensure this does not happen again wishes to enforce a new rule to prevent a counsellor taking on this dual role. However this does not need to happen; rather, it needs to be reflected on and processes introduced to avoid it happening again.

What was Deidre worried about? Was she concerned about how her client would feel seeing her? Was she also concerned about how uncomfortable she would feel not knowing how to act around her client?

This is why contracting is so important, although it is sometimes overlooked as a formality. What if next time Deidre were to ensure that she covered this eventuality in the contract? If she gave her client the choice of what they would like to happen if they were to meet outside the counselling environment in, for example, a meeting? Would the client want to be acknowledged? In what way? What if they were introduced?

Deidre could offer this solution to her manager stating that all new (and existing) clients will have this addressed in their contract, so there is a prior agreement about how such a meeting outside the counselling room will be handled by both parties. This will ensure that Deidre is able to attend meetings and the counsellors will not feel they have to make a choice between ethical and professional obligations.

> 'This is why contracting is so important... there is a prior agreement about how such a meeting will be handled'

Jane Kahan
Counsellor and supervisor

The central issue for Deidre is whether or not the two roles that she currently holds in the same service, of counsellor and manager, are compatible. If she continues with her dual role, it appears inevitable that she will also continue to meet clients at events.

There is no reason why Deidre should not maintain both roles, provided she is willing to be honest with her clients about the possibility of meeting outside the therapeutic hour. The BACP *Ethical Framework* does not forbid dual roles, but cautions care about entering into them. I think Deidre would need to be upfront with her clients about the possibility of meeting in other circumstances. Provided it is written into the client contract, I do not see why there should be a problem. After all, we often meet our supervisors, or even trainees in therapy, at BACP events or training events. Provided the clients know in advance, so that they can chose whether to work with Deidre or someone else, I do not anticipate this would present a problem.

On the other hand I think there may be good reasons to separate out the functions of manager and counsellor. They are different roles requiring different skills and there is no reason to think that a good counsellor will necessarily make a good manager, or vice versa. Deidre and her manager need to sit down and work through these issues between them so that everyone in the organisation knows where they stand.

Next month's dilemma

Sally is a counsellor in a small voluntary organisation. Last week she met a new client, Kevin. He has come to counselling because his relationship has just broken up and he is very unhappy about it.

Kevin tells Sally that 25 years ago, when he was teaching, he instigated several relationships with 14-year-old pupils. He says he is now deeply ashamed and would never do anything like that again, but at the time many other teachers were doing much the same thing and he just got 'caught up' in it.

What should Sally do?

Please email your responses (500 words maximum) by 28 November to Heather Dale at hjdale@gmail.com. Outline how you would manage the dilemma and make your thinking as transparent as possible. Readers are also welcome to send in their dilemmas for consideration for publication, but these will not be answered personally.

I am not a victim

Child psychotherapist *Lydia Tischler* talks to *John Daniel* about surviving the Nazi work camps and training with Anna Freud *Photographs by Jacky Chapman*

I was born in 1929 in Ostrava, Czechoslovakia. I grew up under the cloud of Nazism. I was the younger of two sisters. When Hitler occupied Czechoslovakia in 1939, my father managed to escape to England via Poland and Sweden. My mother, sister and I were to follow but got only to Krakow when the Germans invaded Poland.

We returned to Czechoslovakia in the spring of 1940 and I spent the next 18 months in a Jewish orphanage in Prague. My sister was in a youth hostel, as my mother was unable to support us. The home was very enlightened; the director, Miss Weingarten, trained with Anna Freud in Vienna, as I later discovered. Even so, I was very unhappy and angry there. Later on I understood that my mother had no other option. I was just coming up to 11. I trace back my interest in the dynamics of institutions and their effect on children's relationships to adults to my stay there.

When I went home by train to Ostrava in December 1941, I was put in a compartment by myself because I had a yellow star and so I had to be segregated. A German officer demanded that the conductor throw me out because he wanted a compartment to himself and his floozies. The conductor was probably a Communist and took great relish in telling him he couldn't. When the conductor tried to arrange my coat collar to hide the star, I said, 'I'm not hiding it.' I thought, 'If I have to wear it, I'll wear it: I'll never deny being Jewish.'

In September 1942 Ostrava's Jewish population was transported to Theresienstadt, a transit camp for transports east to Auschwitz. In spite of the many physical privations, there was a thriving cultural life. It was there that I first encountered classical music and opera. I worked in the market garden, growing vegetables for the Germans.

In Theresienstadt rumours were rife about the existence of gas chambers in Auschwitz. Postcards sometimes arrived from there and they became a means of sending coded messages. When the existence of the gas chambers was confirmed, such was the need for denial that people didn't believe it.

My mother and sister were called up for transport in October 1944 and I volunteered to join them because I didn't want to be left behind. The conditions and the degradation at Auschwitz were beyond comprehension and yet I remember thinking, 'You can cut off my hair and take my clothes but you can't touch my inner core.' We were warned by seasoned inmates that children aged under 16 were sent to the gas chambers. As I wasn't yet 16, I gave a false date of birth. On our arrival Dr Mengele – the Angel of Death – sized me up and said, '*Stark wie ein Pferd*' – strong as a horse. Compared to Auschwitz, Theresienstadt was a holiday camp.

I was in Auschwitz for three days before being sent to a work camp in Germany to dig trenches. To keep us fit, we were given an extra bowl of soup. I became an expert with the pneumatic drill. Six months later we were transferred back to Theresienstadt in open cattle trucks. The Russians liberated us from there in May 1945. I still feel in my throat the rawness of the vodka given to me by a Russian soldier.

I didn't see my mother again. For years I had the fantasy she might still be alive. Had I believed it, I would have looked for her. After the war and before going to England I looked after some orphans and it was there I decided to work with

'I have made use of my experiences. The Nazis didn't make me a victim. That's what makes you able to go on living'

children. Later I came to realise this was my way of trying to mother myself.

After liberation I went to live with my father in London. I came as part of a children's transport sponsored by a Jewish refugee organisation. He was a broken man. I found a school by following some girls in school uniform and asking if I could be admitted. I had no idea it wasn't free.

After leaving school, I worked as an assistant nurse in a children's home. The director of the home was in analysis with Anna Freud and she introduced us to the psychoanalytic theory of child development. This inspired me to train with Anna Freud.

Five times weekly analysis was part of the training. My Hungarian analyst and I began in English but when I described how in the camp we used to kill bugs on the wall with our clogs I used the German word *Wanze*, and I said it with so much affect that my analyst suggested we continue in German, so that my early memories were more affect-laden.

The training was very rigorous. Part of it was writing 'weeklies' summarising the themes of the week's therapy. I was remiss and didn't always write my weeklies and I got hauled before Miss Freud once – a very sobering experience.

I graduated in 1958 and worked in various child guidance clinics. In 1962 I applied for the post of child psychotherapist at the Cassel Hospital. Tom Main, its medical director, had set up a unit for mothers with puerperal psychosis and their babies. It was the first of its kind with a psychoanalytic orientation in the country and was based on his philosophy that to admit a mother without her child was admitting her without her symptom. Earlier I had seen the film *Play and Personality* made at the hospital that showed the effect of the mother's illness on their children. The opening shot showed a mother walking into the hospital holding a child's hand. That is what inspired me to apply for the post. Salo Tischler, who later became my husband, was appointed as child psychiatrist at the same time.

During my 23 years there I was involved in developing a child psychotherapy department offering inpatient and outpatient treatment. From a mother and baby unit, it grew into a family unit where whole families were admitted for treatment. I took early retirement at 55. There had been too many changes and I was a bit burned out. I then got involved with the British Association of Psychotherapists. Later, I was invited to set up the first child therapy training in the Czech Republic. That is my proudest achievement. They think of me as their Miss Freud.

It's important to remember the Holocaust but I don't feel the need to talk about it. I returned to Theresienstadt for the first time 10 years ago. We went to the house where I lived and I could still see the bug marks on the walls. I went to Krakow last year and saw two tours advertised: one to the salt mines and the other to Auschwitz. I can see that people want to know what happened there but to make it a tourist attraction, that offends me.

I can forgive what people did to me but how can I forgive them for murdering my mother? It would mean forgiving Hitler. How can you? But I don't think, 'Poor me, what a life I had.' I have made use of my experiences. The Nazis didn't make me a victim. That's what makes you able to go on living. ■

How I became a therapist
Elspeth Schwenk

Elspeth Schwenk relishes the blend of academic rigour and therapeutic creativity offered by counselling – and the room to grow

What made you decide to become a therapist?
A mentor suggested I might find my natural niche in counselling and he was right. When I moved to the US I enrolled on an MSc in counselling psychology, discovered systems theory, and the rest is history.

What were your hopes when you became a therapist?
This is such a generative profession; our training creates an amazing toolbox. I sensed it would be a demanding career and I liked the blend of academic rigour and therapeutic creativity. Perhaps my best hope was for a career home, with room to grow.

Have these hopes changed and if so, in what ways?
What has emerged is a concern for practitioners. Recognising the benefit of support, mentoring and supervision during my journey, I hope to offer others similar support.

What do you think makes a good therapist?
Connectivity and humanity. Curiosity and warmth. Being able to stay with the ambiguous, coupled with 'not knowing'. A willingness to be transparent in the therapeutic relationship. Perhaps the main ingredient is an ability to be totally real, to be open and honest emotionally and have sufficient confidence to work creatively.

What is the best advice you have received, and why?
Apart from the initial signposting, it was probably a professor in Boston who continually challenged me to relax and have confidence in my work. And the Earl of Montrose, who said: 'He either fears his fate too much, or else his deserts are small. Who will not put it to the touch, to win or to lose all.' It's an 'all or nothing'

statement that has challenged and guided me for years.

What values do you hold dear?
A combination of integrity and authenticity is important. John Powell, a Jesuit priest, wrote about being 'Fully Human, Fully Alive'. To me this means engaging with my world and those around me. I'm a dreamer at heart but I have learned that I have to live in the here and now to make those dreams happen.

What do you enjoy about being a therapist?
First, it is such a privilege. I relish the independence it affords me, but also enjoy the connectivity of working with such an awesome range of therapists and clients. Every day is different and there is always a new challenge around the corner bringing new opportunities.

What do you find most challenging?
Sometimes it is letting go and moving on, but with every goodbye comes a new beginning. Sometimes the career path has been a little obscure, but I think I'm well suited to creating my own journey and I really value the freedom to push the envelope and explore new ways of working.

'I'm well suited to creating my own journey and I really value the freedom to push the envelope and explore new ways of working'

Which books have you read that inspired you?
The Chronicles of Narnia by CS Lewis. *The Wind in the Willows* by Kenneth Grahame. Moving to something a little more philosophical, *The First Circle* by Alexander Solzhenitsyn, which I first read when I was 17; it opened my eyes to the world beyond my sleepy shores. Last, *How to Think Like Leonardo Da Vinci* by Gelb, encouraging transformational thinking.

Has becoming a therapist changed you?
The combination of training in three continents, coupled with personal therapy and continuous supervision and working with a range of clients has certainly contributed to my personal and professional development. I should also highlight the influence of my family, and my husband Gil in particular, who has been my companion on this journey for 33 years.

Has your view of the role of therapy in a changing society altered since qualifying?
Having qualified in the US, where counsellors anticipate a career, I was disappointed to discover a sparse landscape in the UK. I found my niche, but it has often felt like uncharted ground. However, the profession is finding its voice and place within society; the best is yet to come. ■

Dr Elspeth Schwenk is a counsellor and psychotherapist, supervisor and trainer in Wiltshire. A member of the BACP Workplace Executive and BACP Board, she has been Acting Deputy Chair of the BACP Board of Governors for the past year.

Questionnaire
Terri Apter

Psychologist and writer, *Terri Apter* describes the values and influences that shape her life and work *Photograph by Manni Mason*

When did you become interested in psychological therapies?
My father was a psychoanalyst, so I had little choice whether or not to find psychology interesting. His analytic schema (in so far as I understood it) seemed limited, reductive and somewhat arrogant, so I became fascinated by more flexible therapies.

What gives your life purpose?
I don't have one big purpose, but lots of things energise each day. Sometimes it's just a matter of getting routine stuff done. Most important to me is offering a good emotional legacy to my children.

What is your earliest memory?
Loving my sister, and her telling me I was a nuisance! I must have been about three years old.

What are you passionate about?
Words – I am amazed at what language can do. Music – who are we that we can create such sounds and be moved over and over again? Regenerativity, in Erikson's phrase – giving and not taking from future generations. My privacy – this is strange given the nature of my writing, but I dread how personal exposure can distort things.

Do you always tell the truth?
No, but I'm a very bad liar and never get away with it!

What has been the lowest point in your life?
This is a chilling question. I don't think it has come yet. The lowest point would be me being responsible for harming someone else, or a child or grandchild being hurt.

How do you relax?
I relax by working or reading or walking or listening to music. When I want to drain my mind I watch television.

What keeps you awake at night?
Worry – usually about my friends or family, or the next day's presentation. Guilt over something I've said or done.

What makes you angry?
There is the anger that comes and goes when I'm tired or hungry or have too much to do. Then there is an anger so deep I almost don't dare feel it, and that's generally about unfairness and cruelty.

Which person has been the greatest influence on you professionally?
Carol Gilligan. She has an inspiring charm and intelligence. The person whose work has influenced me most over the past five years is Peter Fonagy.

How do you keep yourself grounded?
Ah – I would not describe myself as grounded.

What are you reading for pleasure right now?
Marlowe's *Edward the Second* and *Parade's End* by Ford Maddox Ford.

Do you fear dying?
No. I don't have trouble with the prospect of dying, but I do fear the process.

What would you have written on your tombstone?
I cannot imagine having a tombstone.

What do you feel guilty about?
All sorts of things. I don't always distinguish between feeling bad that something has happened and feeling guilty about it.

What makes you laugh?
Warm laughter – friends, family and my cats. Intrigued laughter – complex language and unexpected connections. Angry laughter – some politicians.

Where will your next holiday be and why?
My ideal holiday is chilling out at home, but my family has different ideas, so my next holiday will be somewhere one of them wants to go.

If you could change anything about society what would it be?
Any *one* thing? Well, I'd like to see a society that has a more sane approach to individual value (as opposed to celebrity). On more practical terms, I'd like legislators to be aware of the law of unintended consequences.

What is your idea of perfect happiness?
I have no concept of perfect happiness because life changes and you lose as well as gain in the process. Transient happiness ranges from simple physical comfort to enjoying others' company.

Do you believe in God?
'No' is both a truthful and misleading answer.

What's your most treasured possession?
I take great enjoyment in the look and feel of many things but I do not treasure any possession.

What do you consider your greatest achievement?
I have no idea. I see only fragments of achievement, and it would be for others to construct something from them, or discard them. ■

Terri Apter is a writer, psychologist and Senior Tutor at Newnham College, Cambridge. Her most recent book is Difficult Mothers: understanding and overcoming their power.

Letters

Human qualities count too

I just wanted to write to thank the readers of *Therapy Today* for their fantastic response to my article 'Bad science and good mental health' in September's issue. Well over 50 people chose to respond personally to my NHS email address, many of them providing stories and insights of their own. These responses have only added further weight to my conclusion that the 'evidence-based' culture of NICE guidelines and IAPT to which today's counsellors are expected to conform is much less about science than about current political fashion and control.

I am delighted that my article resonated with so many counselling practitioners and that nobody contacted me with an opposing view. Some might argue that this is a self-selected sample of like-minded people but, given the size of the response, it could more reasonably be concluded that this is a statistically representative sample of counsellors across the UK. This in itself could qualify as a genuinely democratic and scientific measure of opinion and experience among a wide range of counselling practitioners.

I thought it would be useful to give the general flavour of the responses that I received, without identifying anybody or revealing anything confidential. Many people were curious about what had happened to the 2007 paper on psychological principles that I and others produced for the Secretary of State for Health. Although not formally published by the Department of Health, this paper has subsequently been widely quoted and has gained much respect. It has even been adopted as an underpinning philosophical framework for the policy implementation guidance (March 2012) for psychological therapies in Wales and also for the strategy for psychological therapies in the South Staffordshire NHS Foundation Trust. Many of those who received a copy of this paper told me that they had found these principles useful for informing their own future practice. In case anyone else would like a copy of this paper, I attach my email address again at the end of this letter.

Many people also resonated with my conclusion that Maslow's hierarchy needs to be turned upside down and gave examples from their own practice of why a meaningful life with physical disabilities or problems is more liveable than a spiritually empty life in a working body.

Others chimed with my own observation that the failure to use even basic attachment theory to inform mental health practice renders UK services blind to critical relationship issues. Some people gave me stories of their own emotional development, making it clear that their own problems fitted much better with the mindful and personalised scientific framework that I was outlining than the mindless medical materialism being imposed on us all nationally. The irony is that, even when medicine does appear to work in alleviating mental health problems, it is in no small measure due to the unmeasured psychological qualities of the medical practitioner/client relationship. Our evidence-based culture, however, does not require the human qualities of psychiatric practitioners to be measured, only their drugs. If the relationships formed between psychiatric practitioners and patients were also measured, then we would perhaps have a more genuinely evidence-based way of discriminating between ineffective and helpful practices within psychiatry.

So where do we go from here? One step is perhaps to make a united call for the NICE guidelines to incorporate psychological standards of care for all practitioners, and most particularly standards of empathy, attachment and relationship. This was my original aim in working with the Secretary of State for Health in the Labour Government back in 2007. Maybe BACP can start a petition.

Martin Seager
Consultant clinical psychologist/adult psychotherapist. Email martin.seager@swyt.nhs.uk

Rally for counselling

In many letters and articles in *Therapy Today* over the last year or so, BACP members have expressed serious concerns about the predicaments in which counselling and psychotherapy now find themselves. We are facing an ever-more challenging set of professional and socio-economic circumstances, within which our field is attempting to grapple with a new regulatory proposal, the influence of NICE guidelines, the demands to be 'evidence-based' and to provide *certain kinds* of evidence, the decimation

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of counselling/psychotherapy and other mental health services in and beyond the NHS, the narrow approaches of the IAPT service and the dominance of some forms of therapy at the expense of access to other, long-standing and effective therapeutic traditions that are so valued by clients.

We believe these matters require urgent attention and so announce a rally and conference on 'The future of counselling & psychotherapy', on Sunday 2 December in London. We will look at the issues with the latest cutting-edge thinking and consider radical alternatives for the future of our professions. Speakers come from all sections of the counselling and psychotherapy worlds, from major organisations to private practice counsellors establishing low-cost alternatives to NHS provision. We hope to see some of you there.

Full details can be found at www.allianceforcandp.org/page7a.html

Jennifer Maidman
MBACP
Arthur Musgrave
MBACP (Snr Accred)
Andy Rogers
MBACP
Andrew Samuels
Former Chair, UKCP
For the Alliance for Counselling & Psychotherapy

Embracing the world

As a practitioner involved in integrating meditative practice and therapy, I appreciate the greater space recently given in the pages of *Therapy Today* to the healing properties of disciplines such as mindfulness and yoga, and to their latent applications in our work as therapists. In 'Yoga for the mind' (*Therapy Today*, October 2012), Jane Ryan makes several interesting comments. She states: 'Yoga can positively affect self-regulation and decrease hyper-arousal'. She also quotes yoga teacher Mira Metha, for whom yoga is 'the control of the mind with the goal of spiritual peace... founded on ethical conduct and calm-inducing mental habits'. She relates the notion of control to the neuro-biological notion of affect regulation. But the two notions are only superficially linked. There is in fact a wide distinction between control and affect regulation.

Control, arguably the goal of yoga and of disciplines linked with Hinduism and Indian Buddhism (the latter a major influence on mindfulness-based cognitive therapy) aims at restraining the entire sphere of emotions and feelings, which many religious traditions disparagingly refer to as 'the passions'. Control is needed through the cultivation – as Ryan writes – of 'meditative states, the culmination of yoga... the fruit of practice arising from stilling the senses and concentrating the mind'. The all-too-human dimension of the passions is problematic, intense and challenging. It is also very rewarding and, as it happens, what makes us humans.

Control is different from 'affect regulation' as well as 'self-regulation', although the two terms are often used interchangeably in some mindfulness and yoga literature.

For Schore, 'affect regulation is not just the reduction of affective intensity, the dampening of negative emotion, but it also involves an amplification of positive emotion, condition necessary for more complex self-organisation'.[1]

Similarly, 'attachment is not just the re-establishment of security after a dysregulating experience and a stressful negative state, it is also the interactive amplification of positive affects, as in play states'.[1]

The above point is crucial: affect regulation is learned within primary and significant relationships in the life of the infant and the adult, rather than via proficiency in the use of techniques, spiritual or otherwise. Harmonious connections with a primary caregiver not only engender a feeling of safety but also 'a positively charged curiosity that fuels the burgeoning self's exploration of novel socio-emotional and physical environments'.[1] The aim of self-regulation is not to curb intensity *per se* but to develop resilience and widen the range of one's response to life's variegated and often unpredictable occurrences.

Mindfulness approaches and applications of yoga to therapy are currently fashioned as 'a form of mental training' aimed at reducing vulnerability to 'reactive modes of mind that might otherwise heighten stress and emotional distress or that may... perpetuate psychopathology'.[2] As such, they certainly contribute to alleviating distress, providing the sufferer with a certain amount of freedom from compulsive or dangerous behaviours. At the same time, it might be worth asking whether this stance may also bring about a regrettable loss of intensity. Massumi[3] defines intensity as the *inassimilable*, ie what the self fails to assimilate. The self cannot by definition assimilate experience in its entirety, no matter how hard it tries, for the latter is always greater. Even if the self did manage that, it would only be left with a structure, at the most a symbolic hold over experience. Therefore affirming the primacy of the affects and the importance of affect regulation over the need to control them incorporates intensity and keeps our very humanness alive. It also avoids creating a potentially draining psychological conflict. The yoga and mindfulness practitioner certainly gains *control* over his/her passions but, arguably, loses intensity (wrongly and summarily perceived as detrimental to wellbeing).

I am not dismissing meditative practice or yoga *per se* but only questioning a one-sided interpretation of their practice. There are several ways of approaching meditation and learning from the vast reservoir of Eastern wisdom. We can either shun the blood, sweat and tears of the world or embrace them. We can look down at our rich and often troublesome feelings, emotions and passions and try to suppress, overcome and go beyond them: we will surely gain greater control but we will lose something precious in the process. Or we can befriend them and consider them with awe and respect. Many will be familiar with the image of the lotus flower growing out of the mud. We humans are made of *humus*, or soil; a meditative practice cannot afford to forget this element.

Moreover, a detrimental effect engendered by a

reductive understanding of meditation and yoga is a polarisation of one's psychological life, as my clinical work continues to teach me. The typical meditator and yoga practitioner is often caught up in the oscillation between indulgence and purification – between, as one client put it, 'having a fun, lively and crazy time and bouts of cleansing rituals where I do lots of healthy eating and yoga or meditation retreats'. Often the paradox in similar cases is that, in spite of the client's identification with the latter (ie the slightly enforced positive striving), it's the former (ie the 'fun time') that feels beguilingly more real.

Manu Bazzano

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Yoga's true science

The article 'Yoga as therapy' in the October issue of *Therapy Today* stimulates me to attempt an explanation of why and how the science and philosophy of yoga have a vital role to play both in the development of counselling and in the development of individual and world consciousness as a whole.

To understand yoga is to truly understand the transpersonal psycho-spiritual realm. The philosophy of yoga is *Advaita Vedanta*, from ancient Sanskrit (language of the Gods), and, put simply, translates as non-duality – duality representing the individual's sense of being a separate mind-body entity wherein the egoic sense of separation resists our spiritual-intuitive sense of being part of a cosmic whole. This is something that therapists from Carl Jung to Carl Rogers have intuitively understood and explored over many decades. In yoga this struggle between the smaller *self* and the infinite *Self* is discussed at length; typical manifestations of this struggle are low self-esteem, depression and anxiety.

The introduction to yoga for most Westerners skips the lengthy preparatory stages and begins typically with the physical practice (*asana*), breathing (*pranayama*) and sometimes meditation (*dhyana*), and hence these practices are very often misunderstood and misinterpreted, leading to misguided investigations, as suggested in the approaches outlined in the article. The physical practices do not stand alone but are parts of an integrated whole and when taught in isolation can lead to all kinds of problems.

Unfortunately the Cartesian approach to understanding humans-Being, whether through yoga, invasive surgery or the use of prescription drugs, lies at the root of the problem and anyone who seeks to use yoga as 'a way of treating psychological problems' or to 'isolate factors that give rise to brain changes and to see how specific yoga practice may achieve this' is demonstrating a worrying inexperience of yoga.

This essentially empirical scientific approach is akin to systematically removing parts of a rat's brain to isolate the part that houses memory. It is perhaps worth noting that, when all but the sensory motor parts of a rat's brain are surgically removed, the rat still remembers how to negotiate a maze and find food – supporting the view of many yogic sages that our memory is not actually located in the physical body but in the causal body.

The whole essence of yoga is that it is 'wholistic', one-ness, non-duality! The very word *yoga* means unification of the individual's sense of self with universal consciousness, cosmic love, creation, self-realisation, where there is no longer a sense of a separate Being.

The ancient yogis dedicated their entire lives to their practice in the aim of reaching self-realisation; the process is not one that can be dismembered for the convenience of quick-fix, 21st century, sticking plaster solution-orientated scientists with their microscopes.

To understand the importance of the science and philosophy of yoga for counselling one first has to understand, through personal experience, the spiritual context in which the physical mind-body entity exists; the quantum *field* now recognised by quantum science.

Practices that are described by the empirically scientific approach as 'controlled breathing' are, to the yogi, *pranayamas*, and *pranayama* is the movement of *prana*, and *prana* is the life-force, energy, pure consciousness. It is not breathing exercises (it has even been claimed that some celebrated yogis have demonstrated that, once *prana* movement is mastered within the body, breathing becomes unnecessary to sustain life). To take any yogic practice out of context and examine it under the microscope as a purely physical manifestation is to completely misunderstand the very essence of yoga.

So how does yoga influence and explain our experience of human-Beingness?

Existence is the manifestation of intelligent energy. Any doubters at this point should study quantum physics because, rather like an empirically orientated doubting-Thomas, a psycho-spiritual explanation will not suffice and the experiential route will take too long.

Yoga identifies five bodies (*koshas*) that comprise the human-Being. These bodies, or sheaths, are the physical (flesh and bones), the energy body (*prana*), mental (personal mind), discrimination (Buddhi), and bliss (sublime). The interconnectedness of our five bodies is the process of life that has, since the Freudian era, often been called the unconscious or subconscious mind by those unfamiliar with yoga, who perhaps acknowledge something exists beyond the physical realm and beyond cognitive processes but lack any science that explains the phenomena.

Anyone familiar with energy practices such as Tai Chi, Chi Gong, martial arts, Chinese medicine or acupuncture will already be aware that energy not only flows within the human body but can be purposefully channelled to bring about change. In yoga this energy, *prana*, is channelled through

72,000 *nadis*, similar to the acupuncture meridians, and distributed via energy centres, known by many as *chakras*.

Each *chakra* relates to specific areas of the physical body and will reflect the health, or dis-ease, in that part of the body. A full understanding of the *chakras* will naturally shed much light on the emotional/mental health and history of a client; reciprocally, the health history of a client will shed light on their specific psychological experiences.

Investigating 'how specific breathing practices can alleviate symptoms of post-traumatic stress disorder', for example, is like watching a 3-D movie without the special glasses – you miss the point. Yoga would see PTSD, for example, as a form of frozen energy, the flow of which was interrupted at the point of the original trauma, and the location of this psychic knot (*granthis*) will relate to the nature of the actual trauma. For example, sexual abuse would manifest in physical dis-ease in the pelvic region and be centred around the two lower *chakras* (*mooladhara* and *swadhisthana*). The so-called stretching (*asanas*), breathing (*pranayamas*) and meditation (*dhayana*) are practices that release psychic knots (*granthis*) and allow the energy to regain a healthy state, resulting in an immediate improvement in both physical and mental health. Surgeons around the world have reported such changes as unexplained spontaneous healing.

Yoga, as a holistic practice, treats underlying energy traumas and consequentially brings about the manifestation of improved physical and mental health. Yoga is not a physical practice that happens to affect our well-being.

Turiya Gough
MBACP (Accred)

What price survival?

I was interested to read the articles and letters in the September and October issues of *Therapy Today* about the changing provision of counselling services. As a new and proud owner of a BACP member's card who is thinking about starting the path to accreditation, I find that I am in uncharted seas as far as destination 'paid job' is concerned.

Many of the independent charitable organisations providing counselling, where I might have expected to continue placement or even find paid counselling work while working towards accreditation, have over the past two or so years lost their local authority funding and have been forced to close. Of the charitable nationwide services providing counselling – for example, Mind, Relate, Cruse Bereavement Care and Rethink – at least one of these is closing premises and reducing counselling provision. This means that there are far fewer opportunities within the safety of an organisation for newly-qualified counsellors to gain experience.

And, of course, since I have completed my basic training and have not yet embarked on a further course of study and so do not currently have BACP student membership, I can no longer access the list of placements on the BACP website.

However, (to continue the metaphor) there appears in the broiling sea a landmass that is pushing itself up from the depths and it is called IAPT. While I welcome the idea of a structured referral and assessment process for clients, and centralised service provision, I am left wondering about its nature. Just last month one of my local healthcare trusts, in advertising for the entry-level IAPT position of psychological wellbeing practitioner, specified that this was suitable for people wanting to retrain, eg social workers, teachers, healthcare professionals, but not it seems people with a counselling qualification who are not one of the above. Since these positions give access to excellent training at King's, I wonder what the future looks like for practitioners outside the IAPT system. So I phoned them up and said, 'Look, I have a degree in integrative counselling, what can I do for you?' And guess what? They said, 'Oh, ring back when you are accredited.'

My current ambivalence about accreditation is probably partly fuelled by what happened with my last client whom I was seeing in an unpaid placement. A few sessions into the counselling, something presented itself that was not in the initial assessment and, in order to maintain ethical practice, I felt the need to see a personal supervisor during the work, for which I paid several hundred pounds. So I am paying out a significant sum of money in order to provide a professional service for which I have spent some years training.

Whatever our personal feelings around money, we are, whether we like it or not, living in a society where goods and services are costed, invoiced and have to be paid for; where basic living requirements have to be purchased. Whether the finance is visible or hidden, the counselling room and the counsellor's time is always paid for.

I earn my money by working for the NHS in a non-clinical capacity. It is interesting that primary care is now funded under the 'payment by results' Government initiative, which is currently being rolled out to the mental health services. In primary care, physical illness can be quantified (largely) and therefore, for the most part, it has a predictable prognosis: we know that a doctor's time costs this much and to heal the patient will cost this much; therefore the care provider is allocated funds of this amount for this number of patients. There is much current debate on how this can possibly be applied to treatment of mental illness when depression, for example, varies so much in presentation and treatment, but applied it will be from next year.

The current favoured NICE treatment for depression is CBT, and GPs can now refer to IAPT if they want to/their budgets allow. There is clinical evidence that CBT works, but I notice that providing an average six weeks of CBT sits quite happily within the payment by results framework and makes it much easier for GP cost centres to purchase their counselling services, and is quantifiable in terms of treatment and cost. A patient comes in, is assessed, is treated, is assessed again

and, hopefully, shows an improvement. I use the words patient and illness here deliberately, since there is an expectation that the practitioner will indeed put right, will heal whatever is the identified disease (rather than dis-ease).

I can't help wondering what IAPT would have looked like if it had been decided to provide it through social services rather than the NHS. However, in following this thought I am very quickly back in the area of funding again: our welfare services have been slowly withdrawn over the past 10 or so years or more, and in the current climate it is often the service user who is asked to purchase essential services independently, from private providers, if they can afford it, the expectation being that otherwise there is an insurance policy in place to cover such costs. I wonder how many vulnerable people fall through the net.

It seems to me that there is an ethical issue here, for where in all of the above is the client? I wonder how a client's needs and wants will be recognised and provided for under a medical framework of treatment. Whatever theoretical model of counselling one adheres to, it is generally recognised that depression (to continue with this example) is best understood and treated holistically for long-term results. This includes somatic symptoms, behaviour, thought processes, interpersonal relationships and social and environmental situation, in terms of the *individual*. Will this framework allow for the individual to take the process as far as they need in as much time as they need?

So how do I see my role as counsellor? Is it as a fellow traveller rather than a healer? My own favoured approach owes a debt to Petruska Clarkson's model of adapting the therapeutic relationship and approach to the client. If a client reaches out to me across their darkness, I would like to think that, if I were to respond, then I would be able to stay with them as long as was needed and not have to leave them falling.

I wait to see what will come out of all of this, and what this new counselling world will look like. I wonder about the referrals process, assessment, training, service provision, delivery, supervision, registration and, of course, funding.

However, I like to remain optimistic. After all, when the landscape is changing, then the opportunity is presented to define it.

Anna Pinsent

We work for our wage

I was captivated by Kevin Ryan's letter about payment for counselling (*Therapy Today*, September 2012). It spoke volumes to me.

As counsellors we all need to consider our feelings, attitude and thoughts around this thorny subject, so here goes.

Money placed in our hand or money just appearing in our account, whether gold, paper or numbers in a computer, what a mess we are all in right now. The emotion surrounding money is a fascinating study and one much researched.

As a counsellor, I consider myself a professional. I am qualified and I have been in the industry since 1966, apart from 20 years when I had salary as a nurse and a midwife, earning money, yes money, from the National Health Service, God bless it.

In 1974 when I worked at a local specialist plastic surgery hospital, I received my remuneration in cash in a little brown envelope. Reward for caring, reward for professionally washing a fellow human being, reward for cleaning wounds, for giving food and giving comfort and, yes, for using my counselling skills. As time passed I received a pay slip and numbers appeared on a strip of paper and then in my bank statement; I was psychologically removed from my earnings.

Between 1966 and 1973, as a counsellor, I was part of a pilot scheme to pay counsellors (yes, actually pay us) and that was in the days when BACP was based in an outbuilding at Herbert Gray College. The rest is history and counselling is now mainstream. Educated, trained, supervised and 'theraped', counsellors are now part of society. We deserve our remuneration; we are paid professionals, as are vets, podiatrists, physiotherapists and dieticians, and it doesn't matter whether we are paid electronically, cash in hand or with beans – we work for our wages.

Pam Adams

Touching the depths

I was moved and reassured to read Rachel Freeth's reflection in 'In practice' (*Therapy Today*, October 2012). With her, I deeply 'dislike processes that attempt to objectify what is ultimately subjective' and would concur that such 'evaluations' may be examples of 'shallow simplification', choking 'holistic individualised care'. The clients I accompany and the trainee counsellors with whom I work powerfully remind me that the essence of the therapeutic journey is fundamentally held within the unvoiced and the unexplained.

Through my work within a Macmillan Cancer Centre, I am drawn frequently to the 'edge of the abyss' with my clients. Week by week I am challenged to listen as the most moving moments of pain, hope and struggle weave through sometimes chaotic processes, exemplifying the inherent fluidity of our humanity.

I strongly believe that these processes, reactions and responses absolutely defy description and that our yearning to define might be prompted more through fear than through vibrant, courageous, and compassionate 'being'.

If we are not to risk diminishing our clients' stories, maybe we need to learn to listen differently. Perhaps it is our professional definition of 'health' that we need to revise; maybe too our personal understanding of the nature of pain. For perhaps, ultimately, it is only when we truly touch the depths of such that we may become less inclined to measure and assess and more drawn to plunge, with open hands and open hearts, into the mystery of it all.

Ruth Bridges
MBACP counsellor and trainer

The real thing?

Annie Tunnicliffe (Letters, *Therapy Today*, October 2012), comparing counsellors with prostitutes, states that 'in counselling the love is not faked'.

She does, I think, make a huge generalised assumption about both prostitutes and counsellors.

William Johnston

A carer's view of anti-psychotics

Alison Faulkner (Talking point, *Therapy Today*, October 2012) raises the vital issue of the rights of people diagnosed with schizophrenia to refuse anti-psychotic medication. However, as the sister and 'nearest relative' of a man diagnosed with 'severe and enduring' schizophrenia for 33 years, I feel there is a voice missing – that of people who live close to people with this illness.

My brother was in and out of hospitals for 25 years (which included several attempts at 'talking therapy') until he was placed under a Home Office section six years ago, and since then he has been under lock and key. I believe this was avoidable: each time he went into hospital my brother was stabilised with anti-psychotic medication, during which time his body stopped trembling, he was able to go the shops, socialise and relax, be creative and take an interest in life.

Each time he was sent out to live independently he refused all psychiatric support, stopped taking his medication on the grounds that it was his human right to do so, and became terrified, threatening, paranoid and painfully tense, unable to eat or sleep. Inevitably this ended up with him being arrested and the cycle would start again. Each time he became more ill and depressed.

Now he is like a prisoner, which breaks my heart. He can't come to us for birthdays and Christmas, is no longer creative and is calmer but not at all well on enforced medication. If he had been made to take this anti-psychotic medication steadily his life would not be so restricted, and other people, including me and my young daughter, would not have been so terrorised by his illness.

Name withheld

Spirituality and Chopin

I was struck by the way that Andrew Powell (Questionnaire, *Therapy Today*, October 2012) expresses his spirituality and the way he answered the standard set of questions. I particularly liked his comment, 'I have awareness of God,' rather than *belief in God*.

Raised in a fundamentalist Christian household, my own faith has undergone many transformations over the years, and I would say that my personal spiritual pathway is definitely a work in progress. Having been strongly encouraged to share my faith when young, I now feel much more wary of imposing something on others that they may not be ready for.

As it happens, I am also a pianist, and as a child, Chopin was my favourite composer!

Finally, I also find his closing remark resonating with me too – 'We are known by the fruits of our labours.'

That's enough for me, too.

Jennie Cummings-Knight
MA, MBACP, MIFL, PGCE
Counsellor and trainer

Crisis at Christmas

Crisis at Christmas opens centres across London over the Christmas period that offer homeless people companionship, hot meals and warmth and essential health and other services.

We are looking for volunteers with a qualification in therapeutic work – therapists, social workers, counsellors and trainee counsellors, for example – to help provide the befriending service this year.

Volunteer befrienders work with our more withdrawn guests, helping them to access the services on offer and providing support in cases involving mental health.

Shifts run from 9am–6pm, from 23 -29 December.

You can find further details on the Crisis website at www.crisis.org.uk/volunteering or call 0300 636 1000.

Your support will be much appreciated.

Lizzie Green
Services coordinator, Crisis at Christmas; www.crisis.org.uk

Because it works

The thinking heart: three levels of psychoanalytic therapy with disturbed children
Anne Alvarez
Routledge 2012, £22.99, 214pp
ISBN 978-0415554879
Reviewed by Jeanine Connor

'I love psychoanalysis, not least because it works.' So reads the opening line of the introduction to this brilliant book. Hear, hear! I first read *Live Company*[1] as a trainee, and remember being intimidated, baffled and ultimately educated by Alvarez's writing. This book challenged and enlightened me in much the same way. It is not for the faint hearted, and readers without a pretty solid psychodynamic base may struggle with its concepts.

In essence, the book guides the reader through levels of interpretation with disturbed states of mind. Drawing on previous psychoanalytic theories and techniques, Alvarez advocates subtle changes in grammar and syntax, depending on the patient's state of mind. The 'three levels' of interpretation (and of the title) are the explanatory level, which involves 'why-because' interpretations with neurotic, normal or mild borderline states of mind; the descriptive level, involving interpretations that attribute and elaborate meaning (for example, with borderline or developmentally delayed states of mind), and the vitalising level, involving interpretations that attract attention and assign meaning to patients who are unable to listen or feel, and find it difficult to be interested in anything at all (such as those with autistic, psychotic or perverse states of mind).

Alvarez revisits and elaborates previous psychoanalytic literature – her own and that of others. The 16 pages of bibliography might suggest that this is all she does but the flesh of the book is its rich case studies, which hang on the theoretical bones and bring the whole book alive.

I like it that Alvarez, with her 50+ years of experience, isn't afraid to revisit her clinical work or previous hypotheses and consider what she could have done differently, or better even. I recognised aspects of my own patients in many of the cases presented, and felt encouraged to revisit, reconsider and ultimately reframe my thinking about them too.

Alvarez is a great teacher; her knowledge is immeasurable, her writing is brave and her reflections are humble. She claims that her thoughts are 'only considerations, because the complexity of the human mind... ensures that there can be no manual' (p86). I believe that the work of Anne Alvarez is the closest we can get to such a manual.

Jeanine Connor is a specialist child/adolescent psychodynamic psychotherapist and writer

REFERENCE:
1. Alvarez A. Live company: psychoanalytic psychotherapy with autistic, borderline, deprived and abused children. London/New York: Routledge; 1992.

Eating disorder self-help

8 keys to recovery from an eating disorder
Carolyn Costin and Gwen Schubert Grabb
WW Norton & Company
2012, £14.99, 278pp
ISBN 978-0393706956
Reviewed by Meg Harper

Do not be put off by the rather dull title, cover and weighty format. It is unfortunate that this very practical self-help book, intended for people with an eating disorder, looks like a government research project. It is, in fact, remarkably readable (if a little difficult to find your way around). Granted, many self-help books veer tastelessly towards garish covers and glib titles, but I can't see a Waterstone's buyer thinking this book would have mass appeal, and that is a great shame.

While its basic approach will be familiar to many practitioners working with eating disorders, *8 Keys* has plenty of additional tips and strategies that were new to me. The section on finding meaning and purpose has much that would be transferable to other clients struggling with issues of hopelessness and low self-worth. Moreover, although designed as a self-help book, it contains much that a counsellor would find useful and it could form the basis for a programme that client and counsellor tackled together. Each section suggests ideas for writing assignments to further explore and consolidate the work.

I question, however, the value of including so much personal testimony; I found myself skimming these sections. Personal testimony can be very encouraging, but the amount here made it a very solid book, which might deter some people. Without the personal testimony, it would be half the size and far more manageable. If its primary audience is the person with an eating disorder, a shorter book and a more upbeat cover would be more encouraging.

It's also relevant to note that the authors are based in the USA so, inevitably, some of the content will be irrelevant to the UK client.

For example, there was an assumption that it would be straightforward to find a 12-step group, should the client feel s/he needs one.

Another flaw is that this book is poorly designed. There are sections within sections where the sub-headings are not clearly distinguished. The idea of the 'four-fold way' discussed in the final chapter is excellent but it was remarkably difficult to work out which of the many different ideas explained were the four key principles.

Meg Harper is a counsellor, writer and creative practitioner

Building on Bowlby

Attachment therapy with adolescents and adults: theory and practice post-Bowlby (revised edition)
Dorothy Heard, Brian Lake and Una McCluskey
Karnac 2012, £21.99, 252pp
ISBN 978-1780490427
Reviewed by Trudi Dargan

Presented in three substantial parts, this complex and content-rich book explains a new attachment paradigm that builds on Bowlby's original ground-breaking work on early infant attachment to offer a more extensional model for working with adolescents and adults.

Part one introduces the concept of 'survival with wellbeing' and the instinctive restorative process whereby a self sustains its wellbeing. The authors advance the notion that a person's capacity to explore, share interests and relate creatively, equally and affectionately with peers and partners is stymied when wellbeing is threatened and care needs remain unmet, thereby cementing a survival mode of being. The exploratory psychotherapy practised by the authors and explained here is built on these concepts and emphasises the importance of sustained empathy in fostering creativity and exploration.

Separate chapters in this section explain five of the instinctive restorative systems in this seven-system model: the defensive self, the care-seeking self, the care-giving self, the exploratory interest-sharing self and the sexual self. The authors explain how sharing joint interests and goals draws individuals together, increasing their sense of vitality and competency and restoring wellbeing. I found the chapter on the sexual self and the explanation of the three functions of sexuality particularly interesting and illuminating.

A chapter illustrating the restorative process in diagrammatic form brings much needed clarity to the theory. Part one closes with an explanation of the two final systems – the internal and external supportive/unsupportive systems – which are activated when an individual is alone and under threat. The authors' ideas on self-support are very pertinent and well worth consideration.

Part two demonstrates the theory in practice, using 'live' case studies drawn from clinical practice. An informative chapter on effective and ineffective care-giving and patterns of interaction resonated with me and the two chapters on exploratory group psychotherapy provided valuable insight into its application.

Although wordy in parts this book makes a robust contribution to our understanding of the concept of survival with wellbeing. I can recommend it in particular to practitioners working with adults.

Trudi Dargan is a multi-disciplinary counsellor in private practice

Students' choice

Thinking of becoming a counsellor?
Jonathan Ingrams
Karnac 2012, £14.99, 162pp
ISBN 978-1780490168
Reviewed by Marc Brammer

This book provides what it says on the tin. Written for those contemplating training as a counsellor, it is a plain-speaking introduction to psychotherapy and counselling and the main modalities, and aims to help the potential trainee decide if they are a) suited to the work and b) what approach would best suit their particular skills and aptitudes.

The introduction gets straight down to business with a short explanation about what counselling is, and (soberingly) whether there is a need for it in the current economic climate (the reader will be relieved to know the answer is yes), as well as a warning of the financial and emotional costs of training that the student counsellor can expect.

The book's nine chapters provide a necessarily brief but clear account of the development of counselling/psychotherapy: Freud, Jung, Klein, Rogers, Kelly and personality types, Berne and transactional analysis, Ellis and rational emotive behaviour therapy, and more. Ingrams pulls together material, often amusing, from a range of sources that are (note to would-be researchers) scrupulously referenced at the end of each chapter for those wishing to follow them up. His aim is to show the reader where these pioneer practitioners came from, to chart their journeys into the profession, and pick out what influenced their theories and the models they devised. This, in turn, will help the fledgling counsellor undertake their own journey and guide the choice of modality they wish to pursue.

And, having brought them to the point of decision, the conclusion offers straight-talking advice to the would-be student: 'Accept yourself for who you are' and 'Don't take yourself too seriously' are good messages to carry into training.

The book ends with a reading list of classic, wonderful texts that (in my view) every trainee counsellor needs to read.

My only criticisms are that the author's phrasing can be a little jarring and some sections are, despite his good intentions, overly wordy and would benefit from diagrams to illustrate and break up the text. This was particularly so in the

sections on transactional analysis and rational emotive behaviour therapy.

Overall, however, I would recommend the book as a useful introduction to those completely new to counselling and one that will help them decide if it really is for them (and they are for it).

Marc Brammer is a counsellor in a further education college and a freelance journalist

The lost father

The birth father's tale
Andrew Ward
BAAF 2012, £9.95, 206pp
ISBN 978-1907585418
Reviewed by Omar Sattaur

Andrew Ward was still a teenager when he accidentally learned that he was a 'father'. The inverted commas around the word 'father' are intended to suggest ambiguity, which lies at the core of this very personal account of Ward's search for his son, more than 30 years after the machinery of adoption removed him from Ward's life. This is a life seen through the lens of loss and is one of very few published accounts of adoption from the birth father's perspective.

Ward's story is one of anger, guilt and shame, and their impact on his intimate relationships, choice of career, psychological wellbeing and perhaps even his physical health. Above all, the book tells of Ward's confusion about who he is in relation to his birth son: has he even the right to call himself a father?

Ward's experience of the adoption process in the late 1960s is shocking. Adulthood in the 1960s began at 21, and Ward and his girlfriend were treated like misbehaving teenagers. He describes how they were kept apart and out of the loop while a faceless authority made all the decisions about their son's future. Never once did that authority consider their wishes.

Ward writes of the years of fantasising about his son, where and what he might be doing, what he looks like, and *is* like, as a boy and man. Could/should he have done more to stop the adoption process and assert his wishes? He describes the depression he would fall into every year around the time of his son's birthday.

Aspects of the book are frustrating. We don't know why it took Ward so long to consult his own father about some of these issues (his father was adopted). Why did he choose to search official records and files rather than contact his son's mother (he had the address of her parents, so this wasn't an impossibility)? The poor communication between the various parties involved, the unvoiced pact to never mention the adoption, Ward's unassertiveness, uncertainty and vacillation between trust in and anger towards authority pervades the book. Frustratingly, for me, these conflicts are not analysed. And perhaps this, in itself, speaks eloquently about the impact of the adoption process on Ward's life.

That experience left a gaping hole that he has spent a lifetime trying to fill. Work with a birth father will inevitably entail engaging very deeply with issues of loss and identity. Counsellors will find useful the graphic description of the many ways in which the loss of his child can affect the birth father's personal and professional relationships, life goals and sense of fulfillment.

Omar Sattaur is a BACP accredited counsellor and EMDR practitioner

The science of knowing

Clinical intuition in psychotherapy: the neurobiology of embodied response
Terry Marks-Tarlow
WW Norton & Co 2012, £24.99, 278pp
ISBN 978-0393707038
Reviewed by Nick Totton

This book seeks to address some of the key questions and debates in psychotherapy and counselling today. What is the role of the body in 'talking therapies'? How much can and should we manualise our work? What is the relative importance of reason and intuition? What parts do imagination and metaphor play? But to me this is a flawed attempt at what could be a really significant publication.

As Terry Marks-Tarlow explains, intuition is an inherent quality of our embodied experience. This should come as no surprise: both folk wisdom and body psychotherapy appreciate the centrality of 'gut feelings', 'heart wisdom', knowing something 'in one's bones'. However it is always comforting to have scientific backing, and Marks-Tarlow shows well how neuroscience has established the crucial role of implicit (preconscious) knowledge in human relationship and how this works in a practical way in the therapy room. She is not, of course, advocating that we drop reason and theory; rather, that their appropriate place is testing and processing what she calls 'flashes, hunches, and gut feelings', which are the meat of therapeutic work.

I have two problems with this book. First, the content is strongly dominated by left brain/right brain theory: that each brain hemisphere specialises in one form of information processing – the left brain (managing the right side of the body) being straight-line and logical, and the right brain (left side) gestalt-based and intuitive. There is considerable evidence for something like this. However the two sides are joined, and cooperate closely. More importantly, the scientific language gives only an illusion of explanatory force: how does saying 'left brain' add anything to the idea or experience of rationality? What does saying 'right brain' add to our understanding of intuition?

My other problem is that the book is extraordinarily badly written and edited. 'Raising people's cackles' is just one of many slips to get through. Worryingly for a psychoanalyst, Marks-Tarlow also thinks the famous saying 'Sometimes a cigar is just a cigar' is an attack on Freud, when Freud himself said it. For me, this slapdash writing seriously mars a potentially important book.

Nick Totton is a supervisor, body psychotherapist and trainer

Pearls and polemic

Strengths-based supervision in clinical practice
Jeffrey K Edwards
Sage 2012, £38.99, 243pp
ISBN 978-1412987202
Reviewed by Penny Henderson

This book could be required reading for supervision training if only it were half its size. The key messages about strengths-based supervision are sound but the polemic may leave UK readers cold.

In the opening pages, Edwards quotes research showing that services managers want people of 'good quality, substance, integrity and who hold a positive attitude' (pxi). This book is about how to support the development of those values through supervision.

Edwards is an enthusiastic advocate for the supervisor to attend to the development of the supervisee, encouraging agency and motivation through appreciation of the strengths of the individual. His non-hierarchical approach seeks to recognise, appreciate and capitalise on the knowledge, integrity and ingenuity of supervisees. He uses some lovely metaphors, such as the 'trim tab' – the small part of the rudder that changes the ship's direction.

The content of the chapters on the strengths-based approach are scholarly, conversational and pragmatic. Edwards provides excellent overviews of post-modern, social constructionist, solution-focused, positive psychology and narrative theories. He gives very good examples. He writes about others' work in a refreshingly respectful way. From the post-modern tradition, and US experience, his discussions on cross-cultural and multi-cultural themes are excellent. He summarises key US texts on supervision from other approaches, explores what he calls the 'executive skills' of the supervisor, explicates his approach, and looks at the larger picture around management and leadership. His epilogue, a personal statement of the impact of encouragement in his own young life and his difficulties with writing, is endearing.

Edwards also writes for practitioners as much as academics, so counsellors and students will also find the content very helpful.

Set against these positives, the UK reader may find off-putting Edwards' repetitious polemic about the managed care medical model, the pharmaceutical industry's preference for a deficit model, and the negative impact of therapy politics. Edwards is setting out his stall, but he does go on.

Penny Henderson is a supervisor and co-director of Cambridge Supervision Training

Big book of CBT

The CBT handbook
Windy Dryden and Rhena Branch (eds)
Sage 2012, £29.99, 498pp
ISBN 978-1849205528
Reviewed by Elaine Davies

This is an essential resource both for students of cognitive behavioural therapy (CBT) and qualified cognitive behavioural therapists.

The editors are well known and highly respected in the field of and have brought together 23 other contributors with equally impressive lineages.

The 500 densely written pages are definitely required to cover the breadth of subject matter; each chapter is a short essay in itself, with diagrams, illustrations and still further reading.

The book is organised in five parts that (logically) cover theory, practice, common challenges, specific populations, settings and core professional issues. Student CBT practitioners will find the first three sections invaluable. More seasoned practitioners might dip into parts four and five to explore the use of CBT in different settings and with different client groups, from children to private practice to self-care and reflective practice.

For practitioners working in other modalities, the book is a well-referenced and substantial introduction.

The handbook is better than similar publications that attempt to provide this comprehensive resource. It is clearly written and jargon-free; the contributors demonstrate considerable knowledge and experience in their respective specialist fields. It was also very refreshing to find chapters on ethics and supervision, which are often left out of books of this kind.

I really enjoyed the book, gained new knowledge of benefit to my own practice, and would recommend it as a first point of reference for practitioners on CBT theory and its many applications.

Elaine Davies is a manager/ senior cognitive behavioural therapist in an IAPT service

From the Chair

So much to talk about

We can't take our eye off the other important issues on the agenda, says *Amanda Hawkins*

Time and process always astound me. You feel like you are getting nowhere and then, all of a sudden, you arrive. Six years ago, when I joined the Board, we were talking about statutory regulation; we carried on doing so for the next few years. Then, one day in May 2010, it all changed and we started to talk about voluntary assured registration.

Laurie Clarke and I went to our first interview with the Professional Standards Authority (PSA) last month, where we were quizzed about a range of topics relating to our formal application to become a holder of the counselling and psychotherapy register. I have complete confidence that BACP is more than ready to move on to this more mature professional standing. It is our time. We expect a final decision in the next few months.

Also over the next few months, we will be sending out information on pathways onto the register. Another very helpful resource is the BACP Register website at www.bacpregister.org.uk

As our strategic thinking starts to fall away from matters to do with registration, there has been time and space to focus on other issues. I want in particular to signal two: online therapy and criminal justice. Both are of significant importance to BACP.

In October we held the first meeting of the BACP online expert reference group. We sat around the table with a range of professionals who currently work in the online therapeutic arena. It's an important area; increasingly children and young people want to access therapy in this way – at least as a first step. The group brought their experience, expertise and questions to the table, and together we started to think about some of the really important issues. What is online therapy? What would a core training look like? Should online therapy be included in counselling and psychotherapy core training? What are the ethical considerations when working with clients who aren't even in the same country as the counsellor, let alone the same room? Does online therapy even need always to involve a 'live' counsellor or therapist?

This is an exciting development in our field that a number of therapists have been pioneering for some years. We should have given it more attention earlier; our focus has been on other issues. We need to give it due attention now and start to debate these and other questions as they emerge.

Criminal justice is a complicated field. For many years the reform agenda has advocated 'care not custody' for offenders. As a profession, counsellors and psychotherapists interface with many aspects of the criminal justice system, but I am not sure how we do this strategically and from what evidence base. I don't see any change in the wave of people who are affected by criminal justice: more people are sent to prison, and the courts are as busy as ever dealing both with victims and perpetrators of crime (some of whom, of course, are victims as well). There seems to me to be little focus on the impact of their current experience or, indeed, past experiences. Is it time we thought about how we can help, not in our individual practice but as a cohesive profession?

'What are the ethical considerations when working with clients who aren't even in the same country as the counsellor, let alone the same room?'

While not wishing to make you feel uncomfortable, it's important that we face the facts on the mental health of prisoners. According to the latest Prison Reform Trust prison factfile,[1] 10 per cent of men and 30 per cent of women in prison have had a previous admission to a psychiatric hospital. The figures for young offenders are no less startling: 35 per cent of girls and 13 per cent of boys aged 13–15 in youth custody have depression; 17 per cent of girls and seven per cent of boys have self-harmed; 16 per cent of girls and seven per cent of boys have post-traumatic stress disorder.

There is no question that a large proportion of young people and adults in prison have significant mental health and emotional problems. What is the contribution of counselling to their care and to preventing re-offending? What does our society want and need from counselling services in prisons? How can we better support victims of crime? I think we need to have this conversation, to shine a light into some of these dusty corners. We have therefore planned a strategic thinktank to help BACP and the profession debate and decide how we can be more effective and helpful in this area. ■

Reference

1. Prison Reform Trust. Bromley briefings prison factfile. London: the Prison Reform Trust; June 2012.

Something for all

In the latest article about BACP's divisional journals, *Eleanor Patrick* introduces the BACP Children & Young People journal

The BACP Children & Young People division

Becoming a member of BACP Children & Young People links you with a large, diverse and experienced group of practitioners, committed to furthering ethical and effective counselling and psychotherapy with children and young people. For further information, contact julie.camfield@bacp.co.uk

Could you describe yourself and your professional background?

When my children left home I trained to be a counsellor and then specialised in working with children and teenagers, making sure I completed all the necessary training and accreditation to work in schools. I now also have a small, rural, private practice. My first profession was freelance writing, editing and proofreading. These two professions co-exist quite happily now, and often mesh nicely in the field of child mental health. When I have a moment, I read, write fiction, do arty stuff for relaxation and make music. Oh, and I maintain a relevant blog.

Who is the journal for?

We have a large, eclectic membership working in a wide variety of places with all kinds of young people. Some are starting out, others are much more experienced. There's going to be something relevant in the journal for anyone to think about, whether they counsel or make use of counselling skills in this arena.

What is in the journal?

I aim for the content to be useful to all our readers, whatever the stage of their career. For this reason, quarter by quarter, we cover theory, practice, research, and all the significant issues that come up in counselling young people.

I no longer cover news because there are daily and weekly email bulletins now that cover our area of mental health. Apart from that, we range across many models, from play therapy to dialectical behaviour therapy. I use both member and non-member contributors who are experts in their field or who write from their particular experience, and also child practitioners from across the world who I feel have something to say about our work.

The current issue features wilderness therapy, executive functioning, the problem of choice and consent, working with clients who have severe learning difficulties, faith issues in bereavement and loss, personality difficulties in adolescence, and an interview with a provider of IAPT for young people. Plus regular columns.

As editor, what have been your priorities?

It's important to me to include this wide variety of content so that our members will find something of value to them in each issue. The work we do in our therapy rooms is grounded in so much more than the latest fad. I also bear in mind that buying books can cost a huge amount if members want to read the latest ideas, so my editorial policy is to provide material that ameliorates this in some way. Feedback suggests that people often read the journal in one sitting, and value it. We must be doing something right!

> 'It's important to me to include this wide variety of content so that our members will find something of value to them in each issue'

Are you looking for readers to contribute?

I always commission exactly for each issue but over the last few years I have gradually been offered more pieces from members, and commission these too. I believe we have a huge resource among our 4,500 members (including organisational ones) so I am delighted to now be using this effectively. I'm not sure why it happened less before, but our membership has risen exponentially, so maybe we have reached a critical mass of expertise in our midst. That's good for everyone.

What has given you greatest satisfaction in this role?

Knowing and communicating with so many lovely people around the world who value young people as much as I do. I'm hugely grateful to my network, both as editor and practitioner.

Could you sum up in three words what you hope the journal provides for readers?

A satisfying fix! ■

To contact Eleanor, please email empatrick@aol.com. Her blog is at www.childtherapyandmentalhealthblog.co.uk

BACP Children & Young People *is published four times a year. It is free to members of the BACP Children & Young People division and available on subscription to non-members. Contact Julie Camfield (see left) for details.*

In-house student counselling works

More than four out of five students who have received counselling through their university or college say it helped them complete their course, new research supported by BACP shows

Almost as many (79 per cent) say it helped them do better in their academic studies.

The study was conducted by Patti Wallace, BACP Lead Advisor, University and College Counselling, using data gathered through members of the Association for University and College Counselling (AUCC) division.

Quantitative data were provided by 5,537 students at 65 universities and further education (FE) colleges across the UK who completed a course of counselling during the 2011–12 academic year. Data on a sub-set of 1,263 students from 53 universities and colleges were included in the qualitative analysis.

In the quantitative survey, 54 per cent of students said that counselling was either an important factor or the most significant factor in helping them stay on at university to complete their course and another 27 per cent said it was one of many factors. More than half the students (50.6 per cent) said counselling was either an important or the most significant factor in helping them do better in their academic work, and 28.4 per cent said it was one of a number of factors. In total, 82 per cent of students said counselling had improved their overall experience of being at university or college, and 78 per cent said it helped them develop skills that would be useful in obtaining employment.

Students said counselling provided 'a safe space' and helped them understand and cope with their problems better, which in turn helped them feel more confident, optimistic and hopeful for the future.

In the qualitative data analysis, just 16.8 per cent of the 1,263 students reported any unhelpful aspects. These were largely characteristics of the service and included insufficient numbers of sessions, waiting time to begin counselling too long (on average 15–20 days), insufficient early and late appointments, length of each session too short (although all were the standard 50–60 minutes), and location of waiting area too public. A few students identified unhelpful aspects of the counselling approach: specifically, not enough direction from counsellor, not enough focus on solutions or active coping strategies, not enough emotional containment at the end of sessions, and too much 'just listening'.

The models of counselling and the number of counselling sessions completed varied across students and institution. 'This shows the positive impact is therefore associated with counselling provision in general, not a particular model or number of sessions. The findings support current practice in FE and HE counselling in which a range of counselling approaches and lengths of contract are employed,' Patti said.

Subsequently Patti has collaborated with CORE IMS to create a research tool based on her research questions. The tool, known as CIAO (Counselling Impact on Academic Outcomes), is available to all CORE Net subscribers. Patti and Jo Pybis from the BACP Research department have designed an excel spreadsheet so that AUCC members without access to CORE Net can also collect and analyse outcome data for their own service. This is being sent to all AUCC members this month via the AUCC mail bases and will soon be available via the AUCC website.

The study is reported in full in the November 2012 AUCC *journal. A briefing paper is available from Patti Wallace at patti.wallace@bacp.co.uk*

BACP launches new NHS commissioning guide

BACP has published a new guide to help members negotiate the new NHS commissioning structures

The guide, *Interpreting and Engaging with Local Change*, is the first in a series that will be produced over the next year. It explains to members how the NHS is now structured and how and where they can intervene at local level to ensure that high quality counselling services are commissioned to meet need.

The guide explains the key changes introduced by the Health and Social Care Act 2012, the lines of accountability and the roles of the new national governance bodies – the NHS Commissioning Board, Public Health England, Monitor (the financial regulatory body), the standards watchdogs the Care Quality Commission and Healthwatch England, and NICE. It explains how local clinical commissioning groups (CCGs) are structured and operate, and the opportunities for counsellors and psychotherapists to bid for contracts through the 'Any Qualified Provider' (AQP) system. It also explains the role of Health and Wellbeing Boards, which will ensure services work together to identify and meet local need.

A key section sets out the points where counsellors and psychotherapists can themselves contribute to the commissioning process, using the opportunities provided by key policy drivers such as the government agendas for personalisation, prevention, wellbeing and equality.

'Our aim is to help practitioners understand these major changes in the NHS and enable them to develop their own strategic engagement plans,' said Nichola Watson, NHS Commissioning Project Officer, BACP.

The guidance is available free at www.bacp.co.uk/commissioning

Workplaces are measuring up

Workplace counsellors and services would welcome guidance on how to use measures more effectively to monitor and demonstrate effectiveness, a survey commissioned by BACP Workplace division reveals

The study, *Measuring Up? measuring effectiveness and impact in workplace counselling and EAP settings*, was conducted by BACP Workplace executive member Barry McInnes to explore how the workplace counselling and Employee Assistance Programme (EAP) sector is responding to the challenge of measuring the quality and effectiveness of its services.

A total of 155 people returned information: 132 practitioners and 23 individuals working in non-clinical or service-based roles, including five in EAPs and 10 in internal workplace counselling services, mainly in the NHS, higher and further education and the private sector.

The respondents were typically female (76 per cent), aged 56–65 (46 per cent) and used an integrative approach. The majority were members of BACP (88 per cent) and BACP Workplace division (60 per cent).

Three quarters (75 per cent) of the individual practitioners used measures, but only 65 per cent of the service respondents said they were used in their organisation. EAP practitioners were more likely than internal practitioners to use them (86.4 per cent compared with 68.8 per cent). The overwhelming majority used CORE (64 per cent). Other measures mentioned include GAD-7 (26 per cent), PHQ-9 (21 per cent) and EAP case closure reports (27 per cent).

Individual practitioners were broadly enthusiastic about the use of measures: 73 per cent were either generally, largely or highly positive; 11 per cent were sceptical and just one per cent were largely or highly negative. The most commonly reported uses were to identify clients at risk (76 per cent of respondents), to determine the client's level of distress or need at assessment (71 per cent), and to validate the client's sense of progress (69 per cent). Only 20 per cent of individual practitioners said that using measures had little or no impact on their practice. Just six per cent felt that measures were unhelpful and intrusive to the therapeutic process.

The overwhelming majority of services (87 per cent) were also positive about the use of measures. Internally based services were slightly more positive than EAPs. The two outcomes most commonly evaluated by services were psychological health/wellbeing, cited by 93 per cent, and levels of stress (80 per cent).

For individual practitioners, the most common obstacle to using measures was time (cited by 49 per cent), followed by the costs of data collection and analysis (35 per cent). Some 17 per cent said they lacked expertise in how to make best use of measures in their work with clients, and 21 per cent said they didn't know how to interpret or analyse the data they collected. Just 19 per cent said that their own attitude or ideological standpoint was a barrier.

The main obstacles to using measures reported by services were also time to administer them (71 per cent), but 43 per cent reported attitude or ideology as a barrier. Internal service practitioners highlighted more obstacles or challenges than their EAP counterparts.

Respondents cited a range of needs for further guidance on the use of measures, including what to measure, which measures to use for what purpose, and how to manage evaluation data.

Barry McInnes said the survey uncovered wide variations in practice among practitioners and services and a clear need for guidance on how to make better use of measures. 'Areas such as client satisfaction are routinely measured, but the monitoring of other key areas that demonstrate service quality, such as unplanned ending rates and risk, appear not to be routine.' Rick Hughes, BACP Lead Advisor, Workplace, said the survey findings underline the importance of measures in the sector. 'We need to measure the impact and value of what we do so we can demonstrate its human value and cost-effectiveness to organisations.'

The survey findings will be used to inform BACP guidance for practitioners and workplace counselling services in developing their measurement practice and expertise. The full report will be published on the BACP Workplace website and reported in BACP's journals.

Keeping workers well

BACP says the Government should do more to encourage employers to provide dedicated counselling services in their workplaces

In a statement to mark National Stress Awareness Day on 7 November, BACP highlighted findings from its recent research showing that more than half of employees (53 per cent) feel stressed by their jobs and most would like their employer to provide a confidential workplace counselling service.

Rick Hughes, BACP Lead Advisor: Workplace, said: 'Counselling is a cost-effective way of providing timely support for employees, so that problems can be managed before they trigger illness and subsequent absence.'

According to the latest Absence Management survey, produced annually by the Chartered Institute of Personnel and Development (CIPD), stress is (at 30 per cent) the most common cause of long-term employee absence. Yet almost a third of respondents said their organisations are not doing anything to reduce it.

'We hope to see the Government encouraging employers to implement dedicated counselling services in their workplaces, and in doing so make a valuable investment to ensure that staff are kept in work, off benefits and able to make the most of their time at work and at home,' Rick Hughes said.

The CIPD survey can be accessed at www.cipd.co.uk

‘Ask Yalom’ event sold out

Places for the BACP ‘Ask Yalom’ event in London on 4 February 2013 are already sold out, the BACP Events team reports

Irvin Yalom will speak to the event by video link from California. he will be interviewed by his son Victor, who is also a psychotherapist, and will answer questions from the audience.

A BACP one-day summit will follow on 5 February, also at the QEII Conference Centre in Westminster. The summit will discuss counselling and psychotherapy in the 21st century and will address topics including the development of the profession into new arenas; the profession’s potential to influence at the highest political levels; the dilemmas facing the profession in balancing its core values with working in a competitive, commercial context, and the impact of innovations in service provision.

For more details, please visit www.bacp.co.uk/events/conferences.php

World Mental Health Day

The Government must make more funds available for research into the efficacy of talking therapies in the treatment of mental illnesses, BACP has said

In a statement issued to mark World Mental Health Day on 10 October, BACP highlighted the key potential role of counselling and psychotherapy in helping people with depression.

Depression is the most common mental illness. In the UK, up to 12 per cent of the population experience depression in any year, and some nine per cent have mixed anxiety and depression.

‘Research indicates that counselling and psychotherapy are effective interventions for a range of psychological problems, particularly depression. We urge the Government to recognise the importance of counselling and psychotherapy within the NHS by making more funds available to support research into the efficacy of talking therapies,’ BACP Chief Executive Laurie Clarke said.

Making Connections comes to Oxford in the new year

The next BACP Making Connections event takes place on 30 January 2013 in Oxford

Making Connections events provide an opportunity for BACP members to meet BACP officers and network with others in their region.

Speakers at the Oxford event include Sir Richard Bowlby, son of John Bowlby and a former scientific photographer in medical research. He now gives lectures to healthcare professionals to promote understanding of his father’s work on attachment theory.

Also speaking will be psychotherapist, developmental consultant, writer and broadcaster Andrea Perry, who will talk on the use of creative techniques to work with loss and bereavement, and Maxine Aston, who specialises in counselling individuals, couples and families affected by Asperger syndrome.

Making Connections will be coming to Wales on 19 March. Details of venue and speakers are still to be confirmed.

To register and for more details, visit www.bacp.co.uk/makingconnections or call 01455 883300.

South Wales spirituality group

A new Counselling with Spirit group has been established in South Wales by members of the Association for Pastoral & Spiritual Care & Counselling (APSCC)

The well-attended inaugural meeting of the group took place at the end of September, thanks to the hard work of APSCC member Melody Cranbourne Rosser.

ASPCC Counselling with Spirit groups provide regional forums and networking opportunities for therapists interested in all aspects of spirituality in counselling.

APSCC is able to support any member wanting to set up a group in their own area. The division will organise publicity if local members are able to take on the practical arrangements.

Please contact Lynette Harborne, Chair of APSCC, at lynette@innpact.co.uk. For details about the South Wales group, email Melody Cranbourne Rosser at mcranbourne@hotmail.com

New *Counselling at Work* editor

Nicola Banning has been appointed editor of the BACP Workplace journal *Counselling at Work*

Nicola replaces Rick Hughes, who has stepped down after many years in the post. Nicola has specialised in workplace counselling, working with individuals, teams and organisations to promote wellbeing in the workplace. She is a regular contributor to *Counselling at Work* and *Therapy Today* and is a former BBC producer.

Nicola said: ‘I am delighted to be the new editor. I have inherited from Rick Hughes a journal that is highly regarded by people in the workplace counselling field. The journal has played a key role in my development from trainee to practitioner and also as a writer. It is a rich resource for engaging with many of the issues that we, our clients and our organisations are currently facing.’

Nicola can be contacted at counsellingatwork.editorial@bacp.co.uk

Counselling in schools debate

Counselling in schools received a ringing endorsement during a debate in the House of Lords on NHS mental health services

The debate was called by Lord Alderdice on 8 October. Ahead of the debate, BACP's Policy Unit contacted peers who had registered to speak, to raise with them BACP's concerns about current counselling and psychotherapy provision.

Issues raised with peers included the evidence used by NICE when developing mental health treatment guidelines. The BACP Policy Unit reiterated BACP's position that NICE should broaden its evidence base and draw on both randomised controlled trial evidence and practice-based evidence, to ensure that the talking therapies recommended in its guidelines offer the full choice of effective modalities.

The Policy Unit briefed peers on the importance of school-based counselling as an early intervention outside primary care. Peers were told that counsellors working in schools offer troubled and distressed children and young people an opportunity to talk about their difficulties and that school-based counselling services in Wales have resulted in improved behaviour, attendance and attainment of pupils in schools and are viewed positively by teaching staff, parents and by children themselves.

These messages were picked up by Liberal Democrat peer Baroness Tyler of Enfield, who referred to the national provision of school-based counselling in Wales and Northern Ireland and called on the Westminster Government to provide similar services in England. Baroness Tyler told fellow peers: 'In my view, current government policy still does not sufficiently reflect the role that counselling and therapy can and do play,' she told fellow peers. 'England lags behind [Wales and Northern Ireland] as the only country without a commitment to school-based counselling services, leaving many young people in England without effective and accessible therapeutic support in schools. With the clear benefits that school-based counselling has demonstrated in improving attendance, behaviour and attainment in schools, surely providing access to school counselling could be one good use of the pupil premium in England?'

Wales launch mental health strategy

The Welsh Government launched its new 10-year strategy for mental health on 22 October

Together for Mental Health sets out the Welsh Government's objectives for mental health services in the coming decade. The strategy is supported by a three-year initial delivery plan and aims to improve the care and treatment of users of mental health services, their carers and their families and also the wellbeing and resilience of the whole population. It reaffirms the Welsh Government's commitment to secondary school-based counselling and continues the Mental Health First Aid programme, which helps people recognise the signs and symptoms of someone with mental health problems.

BACP has welcomed the new strategy as an important step towards addressing the mental health needs of people of all ages and communities in Wales. In particular BACP noted the Welsh Government's commitment to a statutory school-based counselling service for all secondary school aged children.

BACP Chief Executive Laurie Clarke said: 'The Welsh Government has already gone a long way towards recognising the value of counselling and psychotherapy in encouraging wellbeing, particularly in identifying the role that schools can play in tackling mental health problems in children and young people.

'In this latest strategy there is a clear emphasis on the importance of recognising potential problems early on, and taking preventative action. The acknowledgment of the role of counselling in complementing and sometimes as an alternative to medical treatment is also extremely welcome.'

Around the Parliaments

With parliamentarians back at Westminster, BACP's Policy team has spent much of the past month following up contacts made at the various party conferences.

One worrying piece of news that emerged during the conference season was the suggestion that there was to be a reduction in funding for early intervention and that the Early Intervention Grant was to be abolished. Along with other members of the Early Intervention Foundation, which is chaired by Graham Allen MP, BACP wrote to the Prime Minister urging him to 'ensure that the Early Intervention Grant is retained as at present and its funding continues at the current level'.

In parliament, BACP followed up a parliamentary question from Conservative MP Tim Loughton, who raised the subject of mental health services for school-age children and timely access to talking therapies. BACP wrote to Mr Loughton about school-based counselling and the lack of national provision in England.

BACP also responded to the Health Select Committee Inquiry into the National Institute for Health and Clinical Excellence (NICE). BACP's response focused on NICE's guideline development and the evidence base it currently uses to create those guidelines.

For further information about BACP's parliamentary work, please contact Martin Bell, Parliamentary and Public Affairs Advisor, at martin.bell@bacp.co.uk

Completed and active BACP consultations

Completed consultations

Dementia: supporting people to live well with dementia – draft quality standard
Consulting body: NICE

Proposals to extend new mental capacity legislation to the criminal justice system in Northern Ireland and implications for mental health powers
Consulting body: Department of Justice (NI)

Restorative Justice Draft Toolkit
Consulting body: SACRO

Together for Health: a cardiac delivery plan – a delivery plan up to 2016 for the NHS and its partners
Consulting body: Welsh Government

Read BACP responses in full
To view BACP's full response to these and all other consultations, visit the Policy and Public Affairs webpages at www.bacp.co.uk/policy

Active consultations

Fees for registered health and social care services
Consulting body: Care Quality Commission
Nation scope: UK
Deadline for comments: 14 December 2012

New service framework for older people's health and social care services
Consulting body: Department for Health, Social Services and Public Safety, Northern Ireland
Nation scope: Northern Ireland
Deadline for comments: 14 December 2012

CQC strategy for 2013–16
Consulting body: Care Quality Commission
Nation scope: UK
Deadline for comments: 30 November 2012

Service user involvement in education and training programmes approved by the HCPC
Consulting body: Health and Care Professions Council
Nation scope: UK
Deadline for comments: 30 November 2012

Together for health: delivering end of life care
Consulting body: Welsh Government
Nation scope: Wales
Deadline for comments: 30 November 2012

Statutory guidance to Welsh local authorities on the power to promote or improve economic, social and environmental well-being under the Local Government Act 2000
Consulting body: Welsh Government
Nation scope: Wales
Deadline for comments: 20 November 2012

Contribute your views to consultation responses
BACP welcomes contributions from members to its responses to consultations. If you would like to contribute your views to any of the above active consultations, email policy@bacp.co.uk, stating in the subject line the name of the consultation.

Newly accredited counsellors/ psychotherapists
We would like to congratulate the following on achieving their BACP accredited status:
Hilary Barratt
Cherie Battista
Vicky Boyd
Jean Capstick
Susan Cater
Amanda Cockram
Brian Finnie
Sian Fletcher
Norman Foote
Elisabeth Ford
Amanda Foyster
Susan Freedman
Susan Frost
Susan Gallagher
Claire Gladstone
Buick Hamblin
Anne Holland
Caren Horsfield
Jill Hutchinson
Anna Janmaat
Violeta Jawdokimova
Andrew Jenkins
Katherine Jerred
Barbara Lewis
Corinne Logan
Shona Lowe
Amanda Lusty
Daniella Magog
Angela Marston
Anne Martin
Pamela Martin
Karen Mason
Joanne Maxwell
Aine McGlinchey
Karen McWhirter
Sally Muxworthy
Sarah Ogole
Roxana Parra-Sepulveda
Francisca Plummer
Dianne Pole
Janet Prince
Stephania Putzu-Williams
Catarina Rato
Soraya Razban
Sallie Scott
Sally Shand
Christine Simson
Nelly St Leger
Lyndise Tarbuck
Dawn Taylor
Eve Tomlin
Bridget Townsend
Jaquetta Trueman
Werner Valentin
Caroline Webb
Karen Wheeler
Keith Whiteford
Liane Whiteley
Gillian Wier
Collette Wiseman

Newly senior accredited counsellors/ psychotherapists
Rose Falzon
Diana Taylor
Karen Young

Newly senior accredited counsellor/psychotherapist (healthcare)
Hannah Leahy

Newly senior accredited supervisors of individuals
Wendy Morris
Jacqueline Thomas

Newly accredited counselling/psychotherapy services
The Dove Service, Counselling Service;
Surrey Family & Mediation Services, Child Counselling Service;
Birmingham City University Counselling Service

Successful counselling/ psychotherapy service re-accreditation
Carrs Lane Counselling Centre

Members not renewing accreditation
Kym Grosse
Gordon Jinks
Mariam Scudamore

Members whose accreditation has been reinstated
Buick Hamblin
Elisabeth Ford
Sue Grant

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

Researching school-based counselling

BACP Research department is at the cutting edge of new work to gather an evidence base for counselling with children and young people *Jo Pybis reports*

BACP is helping build a robust evidence base for counselling in schools

You may have read in previous issues of *Therapy Today* about BACP Research department's programme of work to increase the evidence base for school-based counselling and counselling children and young people. This is a key priority area for BACP.

BACP Research department adopts a pluralistic approach to research; we feel randomised controlled trials, systematic reviews, practice-based evidence and qualitative methods are all important and appropriate methods for developing the evidence base for counselling and psychotherapy. The programme of work therefore encompasses a number of methodological approaches.

Working with colleagues from Strathclyde University and the Metanoia Institute, we continue to collect evidence using a randomised controlled trial (RCT) approach to determine the effectiveness of school-based counselling. This develops earlier work undertaken by BACP and Strathclyde University, which has culminated in a paper recently published in *Psychotherapy Research* by Katie McArthur (see News), reporting the findings from her pilot RCT that demonstrate the effectiveness of school-based counselling.

BACP Research department is involved in two further pilot RCTs that have been developed using the same protocol. These are 'RELY', which was a collaborative project between Professor Mick Cooper at the University of Strathclyde, Relate and BACP, and 'Align', which is being led by Peter Pearce at the Metanoia Institute. We also continue to seek funding to undertake a full scale RCT of school-based counselling.

We also commission work in this area. Colleagues from the University of Cambridge have undertaken an update of the systematic review on counselling children and young people, which will be published in the coming months and will be free to download from the BACP website. Similarly, via the BACP Seedcorn grant, Aaron Sefi has been awarded BACP funding to research online counselling for children and young people.

In addition, the BACP Research department has been commissioned by Relate to evaluate their online counselling service. This project is currently underway and is expected to be completed next summer.

Alongside all of this, our first practice research network SCoPReNet (the School Counselling Practice Research Network) provides the opportunity for our members to get involved in research and contribute to the evidence base. Work on the network is developing, and in the coming months there will be an opportunity for all members of the network to collect routine outcome measures that can then be aggregated for analysis into one large dataset.

Further to this, the BACP Research department has been involved in editing a special issue of the *British Journal of Guidance and Counselling* on school-based counselling, which is now available. And we continue to work with our policy team to disseminate work in this important area to key stakeholders.

In addition to all of the research projects mentioned above, two very exciting strands of work are being undertaken that are informed by the existing evidence base for school-based counselling and counselling children and young people. Since April 2012 an Expert Reference Group led by Professors Mick Cooper and Tony Roth has been developing a competence framework for counselling children and young people, with particular reference to working in schools. This will be an evidence-informed description of therapeutic practice with children and young people that will provide a basis for training programmes and further research.

It was also recently announced that BACP will be working alongside a consortium, headed by the Royal College of Paediatrics and Child Health, in the creation of a pioneering e-portal that aims to support professionals in identifying and working with children who may be at risk of or be developing mental health problems.

BACP's part in the two-year programme is to deliver e-learning materials that relate to counselling.

We will continue to update you on the progress of all of these strands of work. For further information on any of the above projects, contact the BACP Research team at research@bacp.co.uk

Jo Pybis is Research Facilitator, BACP Research department

Research conference update

Professor Michael J Lambert is to deliver the pre-conference workshop at the 2013 BACP Research Annual Conference

Professor Lambert is Professor of Psychology at Brigham Young University, and is also delivering the keynote presentation on the first day of the conference.

The conference is on 10–11 May 2013, at The Forest of Arden Hotel, Meriden, near Birmingham. The pre-conference workshop takes place in the evening of 9 May. Professor Lambert will highlight the nature and use of clinical support tools (CST) to work with clients when a positive treatment outcome is in doubt.

Professor Lambert will continue the discussion in his keynote presentation on 10 May, 'How to double client outcomes in 18 seconds: using mental health vital signs feedback and problem-solving tools'. The keynote will summarise the results of nine clinical trials in which the same therapists have access to progress feedback and problem-solving tools or practice without feedback.

On the second day keynote speaker Professor Roz Shafran will present 'Psychotherapy for perfectionism: research and clinical practice'. This keynote will present the latest research on the understanding and treatment of perfectionism and go on to provide useful clinical information for counsellors and psychotherapists who come across perfectionism in their practice.

For further information, please visit www.bacp.co.uk/research

BACP Research enquiries

Counselling theory, children and young people and effectiveness of therapy came top of the list of research enquiries to BACP Research department in the first six months of 2012

Between January and June this year, BACP received 114 research-based enquiries on a range of issues of varied complexity. Many enquirers requested details about counselling theory, with information on the person-centred approach being the most sought after. For a brief account of the most common types of therapy go to www.itsgoodtotalk.org.uk/what-is-therapy/types-of-therapy.

Counselling children and young people (CCYP) was also a recurring topic of enquiry. CCYP is a well-supported area at BACP, which has a specialist division, a dedicated practice research network and a number of ongoing research initiatives (see News feature).

Effectiveness of therapy was another important topic. BACP Research department hosts a webpage specifically on this topic at www.bacp.co.uk/research/resources/index.php

Other areas of interest were gender and ethnicity of clients, and the effect of the age of the counsellor on the therapeutic relationship.

BACP Professional Conduct Hearing

Findings, decision and withdrawal of membership
Bridget Bowley
Reference No 560855
Belfast BT36 7QD

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

The Panel made a number of findings and it was unanimous in its decision that those findings amounted to serious professional misconduct on the grounds that Ms Bowley's behaviour seriously contravened the ethical and behavioural standards that should be reasonably expected from a member of the profession.

Mitigation

Ms Bowley accepted her part in the issues described in the findings in a full and frank manner. The Panel also took cognisance of the challenging events in her private life that preceded and continued throughout the events that gave rise to these proceedings.

Ms Bowley told the Panel that she had ceased to work as a counsellor, as her fitness to practise remains impaired, and that she could not see herself returning to the profession in the foreseeable future.

Sanction

Ms Bowley's membership of BACP is withdrawn with immediate effect.

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

BACP Professional Conduct Hearing

Findings, decision and sanction
Linda Saltwell
Reference No 530430
Brighton BN1

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

The Panel made a number of findings and it was unanimous in its decision that those findings amounted to professional malpractice on the grounds of recklessness and the provision of inadequate professional services, which fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill.

Mitigation

Ms Saltwell took the work with this client regularly to supervision and sought additional consultation with a specialist practitioner in the field of mental health. Ms Saltwell had contacted BACP by email to consult on managing an appropriate ending with her client, the complainant. She states that she has since changed her counselling practice and would no longer agree to hold counselling sessions outside the counselling room. Ms Saltwell also stated that she now has a written contract with clients.

Sanction

Within one month from the date of imposition of this sanction, which will run from the expiration of the

Appeal deadline, Ms Saltwell is required to provide a written submission, which evidences her immediate reflection on, learning from and understanding of the issues raised in this complaint. Ms Saltwell is also required to provide a copy of her written contract, which evidences her having satisfactorily addressed the boundary issues identified in this complaint.

Additionally, in no less than six months and no more than 12 months from the date of imposition of this sanction, Ms Saltwell is required to provide a further written submission that evidences the following:

- in-depth written reflection on and analysis of the issues raised and implications for counsellors when counselling clients experiencing enduring mental health problems
- in-depth written reflection on and analysis of the issues raised and implications for counsellors when clients with enduring mental health problems cease to take their medication and her understanding of the importance of maintaining the boundaries between counselling and friendship in those circumstances
- a detailed written account demonstrating Ms Saltwell's understanding in relation to the setting and management of appropriate tasks in counselling, in light of this decision
- a copy of her client contract and a detailed account of her reflections on this contract and any further changes she has made in the light of her learning from the complaint.

These written submissions must be sent to the Deputy Registrar and Deputy Director of BACP Registers by the given deadlines and will be independently considered by a Sanction Panel.

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

BACP Professional Conduct Hearing

Findings, decision and sanction
Mo Kurimbokus
Reference No 590267
London NW7

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

The Panel made a number of findings and it was unanimous in its decision that those findings amounted to professional malpractice on the grounds that Mr Kurimbokus's behaviour was incompetent, negligent, reckless and provided inadequate professional services and fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill.

Mitigation

Mr Kurimbokus indicated that he would review his contract and terms of service and that he would also re-visit his time boundaries with regard to sessions.

Sanction

Within one month from the date of the imposition of this sanction, which will run from the expiration of the appeal deadline, Mr Kurimbokus is required to provide a written submission that evidences his immediate reflections on, learning from and understanding of the issues raised in this complaint.

Within the same time frame, Mr Kurimbokus is also required to provide evidence of his re-written contract and its publication on his website. This should include, as a minimum:

- an indication of the way in which Mr Kurimbokus works
- a link to the BACP's *Ethical Framework* (in case of complaint)
- length of time of sessions and current fees
- whether or not contact outside of sessions is permitted and if so in what circumstances
- the limits of confidentiality
- policy on lateness or non-attendance
- Mr Kurimbokus's policy on note taking, and availability of notes should clients wish to see them.

In not less than three months and not more than six months, Mr Kurimbokus should provide written evidence of a developed understanding of the theory and practice of erotic transference, with a particular understanding of how this may be played out in client work. Mr Kurimbokus is also required to provide evidence that he has an improved and thorough understanding of the need for clear boundaries in his client work, specifically around the timings of sessions and his own responsibility in keeping the time boundaries. He should evidence a positive change in his practice resulting from his knowledge acquired through this process. This work should be signed off by a supervisor who will be familiar with Mr Kurimbokus's practice but who at the time of the Professional Conduct Hearing was outside of his current network.

Following completion of the last written report, Mr Kurimbokus will also be required to attend an interview with the Sanction Panel, demonstrating his positive learning and how his practice has changed and improved.

These written submissions must be sent to the Deputy Registrar and Deputy Director of BACP Registers by the given deadlines, and will be independently considered by a Sanction Panel and at the interview.

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

BACP Professional Conduct Hearing

Findings, decision and sanction
Samantha Earnshaw
Reference No 640875
Essex CM14

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

The Panel made a number of findings and it was unanimous in its decision that those findings amounted to professional malpractice in that Ms Earnshaw acted recklessly and provided inadequate professional services that fell below the standards that would reasonably be expected of a practitioner exercising reasonable care and skill.

Mitigation

Ms Earnshaw emphasised to the complainant and to the Panel her sincere apologies

and remorse for the breach in confidentiality and for her lack of wisdom. She stated that it is her intention to seek further training on confidentiality issues.

Sanction
Within one month from the date of the imposition of this sanction, which will run from the expiration of the Appeal deadline, Ms Earnshaw is required to provide a written submission that evidences her immediate reflection on, learning from and understanding of the issues raised in this complaint.

Ms Earnshaw will be required to appear for interview before a Sanction Panel within 12 months from the date of imposition of the sanction, to give verbal evidence of sufficient learning from and understanding of the issues raised in this complaint.

Prior to appearing at an interview, and within six months from the date of imposition of the sanction, Ms Earnshaw is required to provide evidence of further formal training of no less than 12 hours duration, covering the following issues associated with confidentiality and ethical behaviour in counselling practice:
- trust as fundamental to understanding and resolving ethical issues
- counsellor dishonesty and its impact on the client/counsellor relationship
- appropriate responding and management of client complaints in private practice.

This evidence should be submitted to BACP and should include confirmation of Ms Earnshaw's attendance/satisfactory completion from the training provider.

Upon completion of this training and prior to interview, Ms Earnshaw is required to provide a report evidencing her further in-depth learning and understanding of the issues raised in this case with her supervisor. The report should also evidence that she has sufficiently addressed in supervision her dishonest behaviour and her understanding of her behaviour under stress. This report should be countersigned by her supervisor.

These written submissions must be sent to the Deputy Registrar and Deputy Director of BACP Registers by the given deadlines, and will be independently considered by a Sanction Panel and at the interview.

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

BACP Professional Conduct Hearing

Findings, decision and sanction
Herts & Beds Counselling Foundation (HBCF, currently known as The Counselling Foundation)
Reference No 100634
St Albans AL3 4PA

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

The Panel made a number of findings and it was unanimous in its decision that those findings amounted to professional malpractice in that HBCF's actions fell below the standards expected of a practitioner exercising reasonable care and skill.

Mitigation
The Panel found mitigation of HBCF's actions as follows:
- some concessions as to its failings were made in the course of the hearing
- a limited apology was made to the complainant in respect of the 9 August 2011 email and in respect of some delays in corresponding with her
- changes in some college processes and procedures have been made since this case and HBCF provided evidence of some learning from it.

Sanction
Within three months from the date of imposition of this sanction, HBCF must submit a report setting out clearly their reflection on and learning from this complaint.

Additionally, and as part of that report, HBCF must clearly identify the enhancements to its procedures made as a response to the Panel's findings in this case, including in particular:
- a clear policy for the allocation of Personal and Academic Tutors for students on this course and how that is to be monitored
- the introduction of a new Complaints Policy for students, with clear timelines
- the introduction of a new Appeals Policy for students, with clear timelines.

A clear schedule must be delivered as part of this report to the Sanction Panel, clearly demonstrating the changes from the 2010/11 Course Handbook provisions compared with the provisions for the forthcoming 2012/13 Course Handbook.

These written submissions must be sent to the Deputy Registrar and Deputy Director of BACP Registers by the given deadlines and will be independently considered by a Sanction Panel.

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

Withdrawal of membership

Joel Mahabir
Reference No 505899
London W5 5NE

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

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

Withdrawal of membership

Teresa Webb
Reference No 514620
London N16 9EX

A sanction was imposed on Ms Webb following a Professional Conduct and Appeal Hearing.

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

Sanction compliance

Ronald Rieck
Reference No 556398
Glasgow G31

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

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