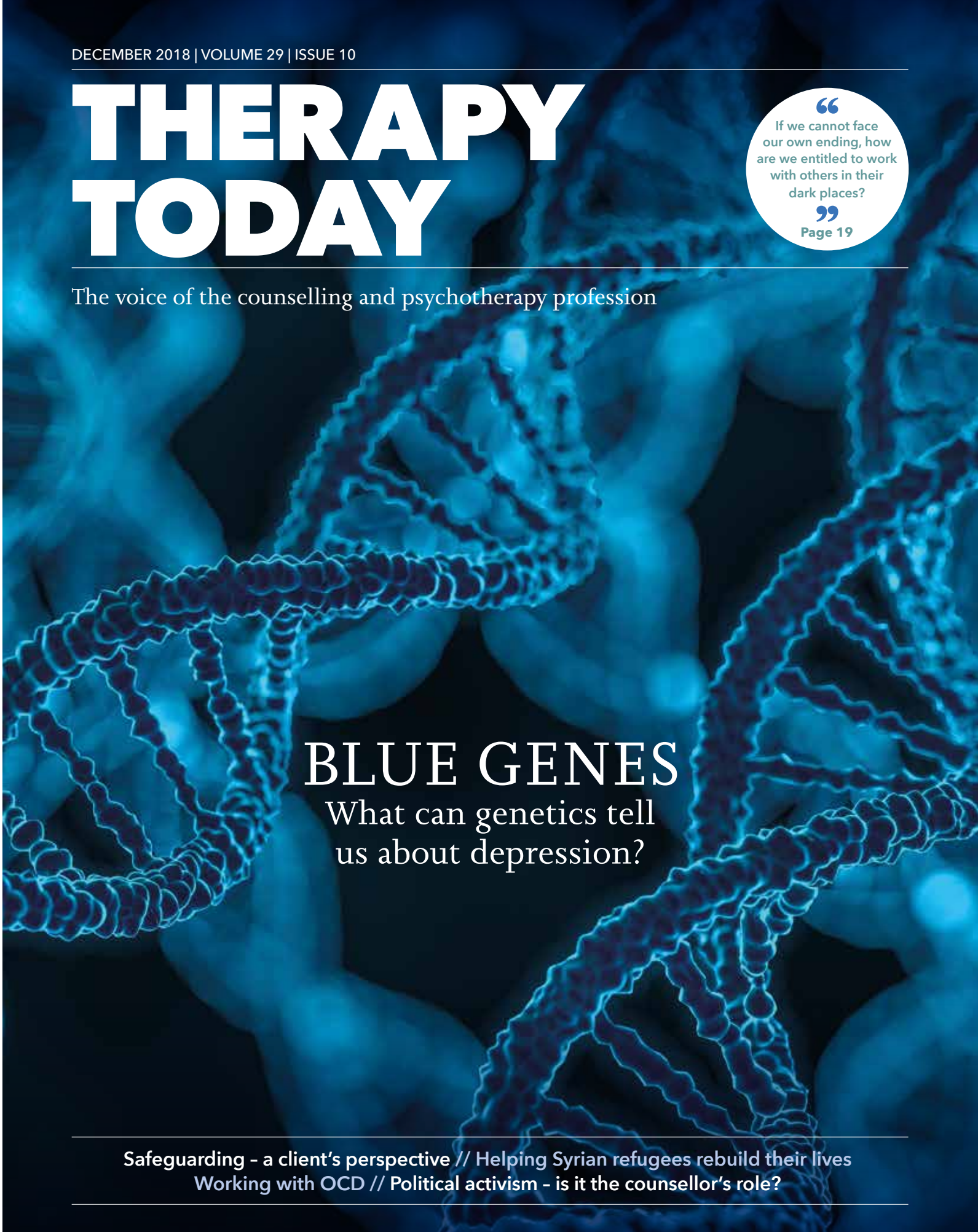
DECEMBER 2018 | VOLUME 29 | ISSUE 10

THERAPY TODAY

The voice of the counselling and psychotherapy profession

> If we cannot face our own ending, how are we entitled to work with others in their dark places?
>
> Page 19



BLUE GENES

What can genetics tell us about depression?

Safeguarding – a client's perspective // Helping Syrian refugees rebuild their lives
Working with OCD // Political activism – is it the counsellor's role?

Imagine a world where a quick swab of your mouth could indicate which medication you are prescribed for depression.

A world where you could even tell from a saliva test which type of talking therapy might work best for a client's particular anxiety condition, depression or personality disorder. A brave new world indeed, and it's not such an unlikely scenario, as this month's news feature on genomics research reports.

Of course, the promise of any major medical breakthrough is very exciting, but advances in the identification of genes associated with specific mental health diagnoses throw up a bunch of significant ethical concerns – not least, the shadow of eugenics. Some question whether this focus on genomics in the diagnosis and treatment of mental health problems is at the expense of the therapist's traditional holistic understanding of how life experiences, stress and systemic social factors affect our mental health.

You'll find the debate on these emerging dilemmas on pages 8-11.

Rachel Shattock Dawson
Consultant Editor

CHARLIE BEST

Editor's note

December is traditionally a time when we turn our thoughts to others less fortunate than ourselves. This month's feature on the Syrian refugees (pages 20-23) welcomed into the UK through the UNHCR's global resettlement programme is a salutary reminder that this war is about to enter its eighth year, still with no resolution in sight. The title, 'We are here but we are still in the war', encapsulates their unimaginable situation – alive, safe, housed and fed, but with their hearts and minds with families, friends and their communities still in Syria, at daily risk of death in the ruins of their homeland. Therapists can certainly offer techniques for managing the effects of the traumas these refugees have been through, but, more importantly perhaps, they also offer a space where they can share the acute, unreachable ache of the loss of sense of self, community, meaning and home they have left behind.

Alongside, the festive holiday, with its long, dark evenings, is also traditionally a time for storytelling. In her feature on pages 30-33, Lucy Cavendish explores what counsellors and therapists can learn from fiction. Susie Orbach believes that the author and the psychotherapist have much in common in that both are concerned with mining the depths of human experience. This is surely no less true of the traditional storytellers whose words were retold by the Grimm Brothers and whose telling vignettes of archetypal human behaviours have found their way into our annual pantomimes. Why not take yourself out to the theatre and do some off-piste mining yourselves? Have a good holiday. *Therapy Today* will be back in February.

Catherine Jackson
Editor

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

MemCom WINNER MEMBERSHIP EXCELLENCE AWARDS 2017

COVER IMAGE: SHUTTERSTOCK

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Therapy Today is published on behalf of the British Association for Counselling and Psychotherapy by Think, Capital House, 25 Chapel Street, London NW1 5DH
t: 020 3771 7200 w: www.thinkpublishing.co.uk

Printed by: Wyndeham Southernprint, Units 15-21, Factory Road, Upton Industrial Estate, Poole BH16 5SN

ISSN: 1748-7846

Subscriptions
Annual UK subscription £76; overseas subscription £95 (for 10 issues). Single issues £8.50 (UK) or £13.50 (overseas). All BACP members receive a hard copy free of charge as part of their membership.
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'Novelists, like depth psychologists, reach places very few can. We both work with words in the ear, in the mouth, with phrasing, with hesitation, with beauty and with the aesthetic arc of what is endeavouring to be expressed'

Susie Orbach (page 31)

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Here and now

The big issues

Regulars

Your association

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In the news

Our monthly digest of news, updates and events

GP waits 'too long'

People are having to wait too long to see their GP when they have a mental health problem, making their situation worse, says Mind.

Mind and independent research charity Picker surveyed 8,000 people seeking help from their GP for mental health problems. One in three said they had to wait six days or more for an appointment, 44% said the wait was longer than expected, and a third said their mental health deteriorated in the meantime.

The survey comes as NHS Digital reports that depression has overtaken obesity as the second most common reason for people to consult their GP, second only to hypertension.

Mind Chief Executive Paul Farmer said: 'Most people accessing support for their mental health will only be seen by their GP, so we need to ensure that GPs have the right support and training and that services have sufficient funding to provide high-quality, timely and appropriate care.' **bit.ly/2DfvjmF**

Job security concerns

Worries about job security and the rising cost of living are affecting the mental health of many people in work, a Business in the Community (BitC) survey has found.

The survey of more than 4,000 people found that a quarter of employees are struggling to make ends meet, less than half are satisfied with their current financial situation, and two-thirds say their mental health and wellbeing is affected by worries about personal job security (66%), the state of the economy (65%) and the cost of living (77%). Sixty per cent say they have lost sleep and are suffering from stress, lack of concentration and fatigue due to financial worries. Younger people are most at risk: 90% of those in their 20s say their mental health is affected by worries about the cost of living.

Just 17% of workers said that their employer supported staff with financial difficulties. BitC says employers should be doing more to help their staff, including making loans and providing access to counselling, debt advice and other support services. **bit.ly/2AC5eLR**

Put children first

More than 120 organisations, charities and teaching unions have joined forces to call on the Government to do more to safeguard children's wellbeing.

The coalition, which includes BACP, has written an open letter to Prime Minister Theresa May and Chancellor Philip Hammond highlighting the barriers blocking children and young people's life chances today. They say fewer than one-third of children and young people with a diagnosable mental health problem will get access to NHS-funded treatment this year; record numbers of children are being taken into care every day; only three in 100 families of disabled children think the health and care services available to their children are adequate; the number of children with special educational needs who are awaiting provision has more than doubled since 2010; and up to three million children are at risk of going hungry during school holidays.

The coalition is asking parents, guardians, families and other members of the public to show their support by signing a public petition to the Government and using the hashtag #ChildrenAtTheHeart on social media. bit.ly/2PxxrbM

31%
rise in suicide risk among 75- to 84-year-olds

Budget bounty 'not enough'

The £2 billion increase in NHS funding for mental health announced in the November budget will not be enough to achieve the Government's goal of parity of esteem with physical health, BACP has said.

The Institute for Public Policy Research estimates that spending on mental health needs to double to achieve genuine parity.

The Chancellor has earmarked an extra £250 million a year over the next five years for boosting mental health crisis services, including 24/7 helpline support; children and young people's crisis teams in every part of the country; comprehensive mental health support in every major A&E department; more mental health specialist ambulances; and more community services such as crisis cafés. The funding increase will also pay for the new school-based mental health teams in England.

Martin Bell, BACP Deputy Head of Policy and Public Affairs, said: 'This investment in crisis care should be welcomed, but there also needs to be additional investment for increased access to psychological therapies so that people can get help earlier, reducing the chances of people needing help in an emergency.' **bit.ly/2OiVnyp**

Loneliness strategy

GPs will be able to prescribe community activities to patients experiencing health problems due to loneliness.

The measure is part of a loneliness strategy launched by Prime Minister Theresa May and will come into effect by 2023. Funding will be provided so that GPs can refer patients to social activities such as cookery classes, walking clubs and art groups. Loneliness is known to be associated with a higher risk of both mental and physical ill health.

As part of the strategy, the Royal Mail is to pilot a new scheme in Liverpool, New Malden and Whitby whereby postal workers will check up on lonely people during their usual delivery round and help link them with support from their families and communities. £1.8 million has also been provided for new community cafés, art spaces and gardens.

Laura Alcock-Ferguson, Executive Director of the Campaign to End Loneliness, said: 'The Government strategy will also only succeed if many of us in all walks of life make an effort every day to make all of our connections more meaningful.'
(See the BACP round-up on page 49 for BACP comment)

Halfway towards parity

MPs have called for action to fill the gap between IAPT and secondary mental health services that leave many people without access to talking therapies.

In a halfway report on progress towards achieving the goals of the Government-backed Five Year Forward View for Mental Health, the All-Party Parliamentary Group on Mental Health has called for more choice of NICE-backed psychological therapies to be available. People need 'the therapy that will be most effective, not just the therapy that is available', the report, *On the Road to Parity*, says. It also says too many people with complex mental health needs are deemed too unwell for IAPT but not ill enough for referral to secondary care, and criticises the lack of therapy provision for older people.

BACP has welcomed the report but has challenged its recommendation that more psychology graduates should be recruited to provide talking therapies. BACP Head of Policy and Communications Suky Kaur said: 'This ignores our members who could, with some top-up training in IAPT, provide a rapid expansion of the psychological therapies workforce as well as meet the need to expand the choice of psychological therapies.' bit.ly/2CRVT4Q

Older people at suicide risk

GPs and mental health services should be more alert to suicide risk among older people, researchers at Manchester University say.

The researchers used data from the UK Clinical Practice Research Datalink to analyse rates of self-harm and suicide among people aged 65 and older. Overall suicide risk was 4.1 per 10,000 person-years, but increased by 31% among 75- to 84-year-olds and by 76% among people aged 85 years and older. People over 65 who self-harm are 145 times more likely to go on to take their own life than those who have not self-harmed, the data showed.

The study also found that only 12% of older patients who self-harmed had been referred to a mental health service for aftercare and 11% were prescribed tricyclic antidepressants, which can be toxic when taken in overdose. Both are contrary to NICE recommended practice.

Lead researcher Dr Cathy Morgan said: 'This study emphasises the need for early intervention, careful alternative prescribing and better support for older people who may see their GP following an episode of self-harm or for other health problems.' **bit.ly/2P2dIdo**

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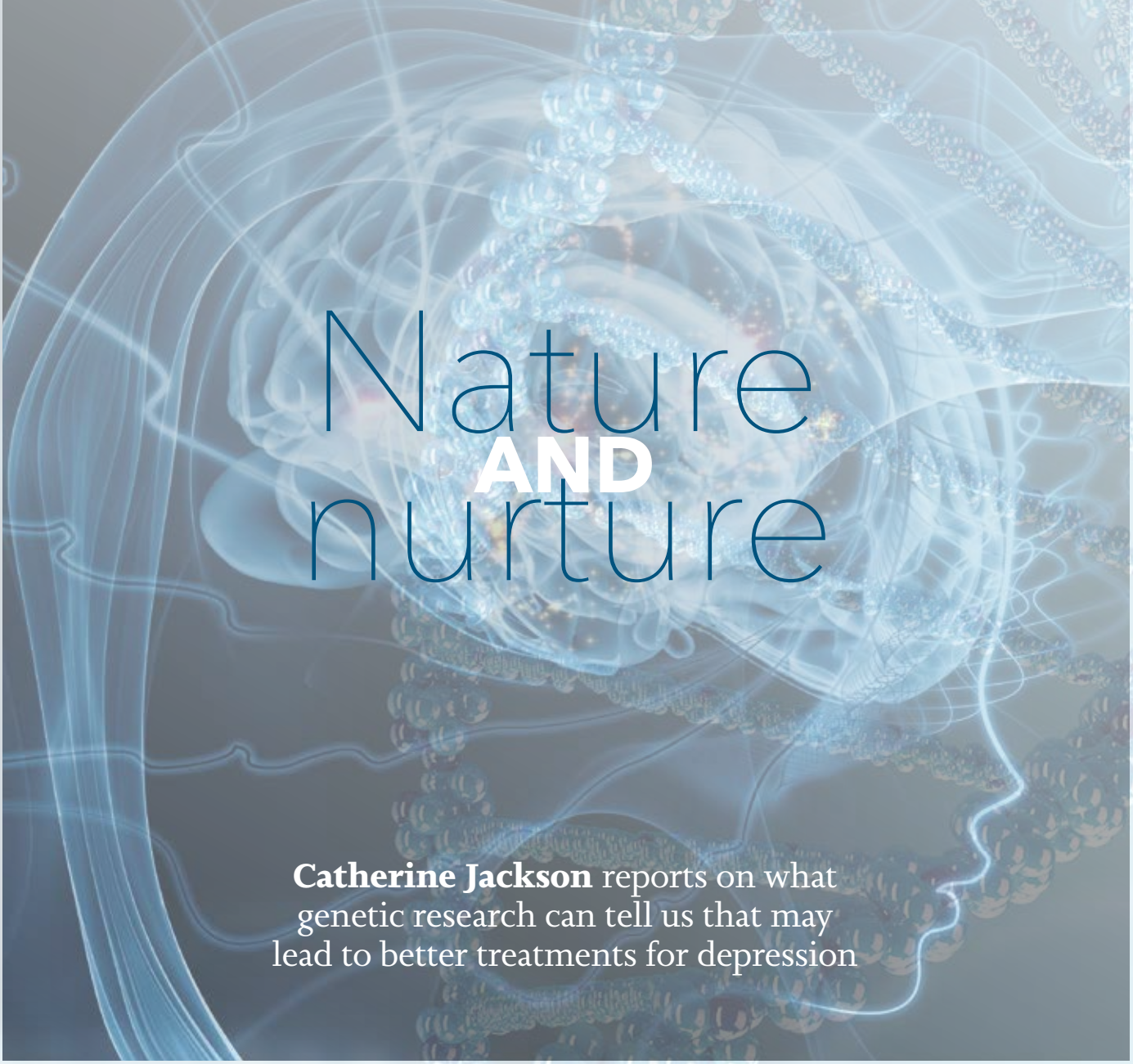

Nature AND nurture

Catherine Jackson reports on what genetic research can tell us that may lead to better treatments for depression

Research into the genetic causes of mental health problems received a significant boost earlier this year with the publication of a huge international study identifying a number of genes associated with depression.[1]

The study, by the Psychiatric Genomics Consortium (PGC), involved some 200 researchers from across the world, including four UK university-based genetics-research centres. It amassed data on 480,000 people from seven different datasets and from these was able to identify 44 genetic variants that are risk factors for depression.

Genomic research has grabbed public attention with its promises that it can identify 'faulty' genes responsible for heritable illnesses that can then be targeted and eradicated – the ultimate preventative medicine. While this has been possible with some clearly heritable disorders, such as Huntington's disease, researchers have so far failed to reliably identify a 'schizophrenia' or 'bipolar' gene, for example, that proves that either of these conditions are inherited in that same clear-cut way. This is not least because neither are clearly identifiable as discrete disorders. This new study confirms this complexity in the genetics of mental health conditions: 'Major depression is not a discrete entity at any level of analysis,' it concludes.

Indeed, it adds to the complexity by presenting evidence that depression shares biological processes with experiences regarded as symptoms of 'schizophrenia', and very probably other mental health conditions, knocking dead the already contested veracity of the diagnostic categories devised and used by psychiatrists, and detailed in DSM-5 and ICD-11. Depression 'is a complex malady with both genetic and environmental determinants', it concludes.

Benefits of genomics

Psychiatric geneticist Gerome Breen, Reader of Neuropsychiatric & Translational Genetics at King's College

London, heads up the NIHR Maudsley Biomedical Research centre, part of the National Institute for Health Research (NIHR) BioResource, a major UK biobank. He was involved in the PGC study and is anxious not to overstate what genomic research is discovering, while excited by what the latest study is telling us.

'It's important to state that only a minority of risk for depression is explained by genetic factors,' he says. 'What we find from previous large-scale studies is that there are associations with genetic variation. Having identified these variations, we can now look at the function of these genes, to understand what the underlying biology might be.'

Currently, genomic research on depression and anxiety has targeted the genes implicated in the regulation of serotonin in the brain. Breen says the PGC study opens up completely new avenues for research. 'If we can understand a bit more about the causes, hopefully we can identify alternative biological mechanisms that can be targeted by drugs. The serotonin route has generated a class of drugs that work for some patients and not others. That's just one mechanism. If you look across medicine, you'll find treatments try to tackle the disorder in a lot of different ways – to target different mechanisms – but for depression, serotonin is just the one that is being targeted, and if you don't respond to more than two antidepressants your depression is seen as unresponsive to treatment. But these drugs are very similar to one another. We need to know more about other potential mechanisms.'

And, he says, there is another route that may be more immediately useful: 'Antidepressant response as phenotype is twice as heritable as depression itself. We think there may be genetic predictors as to whether someone is likely to do well on current antidepressants or on other forms of treatment, including psychological therapy.'

This is the focus of the GLAD study, based at King's College London. GLAD (Genetic Links to Anxiety and Depression) is breaking new ground by exploring not just the genetic links with depression but also the social and environmental risk factors, and aiming thence to improve its treatment. Thalia Eley co-leads GLAD with Breen. Professor of Developmental Behavioural Genetics and a psychologist by background, Eley's particular interest is in therapygenetics – what genetic research can tell us about the most effective ways to treat mental health conditions. She is currently engaged in work that will, she hopes, enable doctors to finesse their prescribing so that patients diagnosed with depression get the most effective treatment for them, whether it is medication or talking therapy, and get it straight away, rather than go through what can be a lengthy process of trial and error.

'Therapygenetics is using genetics to predict treatment response,' says Eley. 'We hope to come up with a risk index that allows someone, when they first go to their GP with anxiety and depression, to provide simple demographic and clinical information and a saliva sample that will help the GP identify what treatment options would work best for them, whether that is medication or talking therapy.'

'Currently we don't really know much about what treatments people do best on, other than people generally do better on the kind of therapy they prefer.'

She points to the current waiting lists for talking therapy and the challenge in ensuring people get the therapy that works best for them: 'The NHS can't afford to provide everyone with one-to-one therapy, and there's a lot of alternative delivery models on offer, such as group therapy, psychoeducation workshops, online programmes, bibliotherapy and apps. My hope is that this work will give people some research-based evidence about which particular mode of treatment offers the greater likelihood of them getting better so they can get it straight away.'

> 'Ultimately, we hope to be able to come up with a risk index that allows someone... to provide simple demographic and clinical information and a saliva sample that will help the GP identify what treatment options would work best for them'

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Response to treatment

Eley has been involved in recent research looking at the links between genetic variations and how people respond to different types of psychological therapy. The therapies are all CBT-based and include one-to-one, groupwork, online therapy and guided self-help. 'Early findings have been somewhat mixed,' she admits, 'but several studies have provided promising evidence that individuals respond differently to different psychological interventions and that genetic differences are capable of predicting those different susceptibilities to psychotherapy.'

She is encouraged by the findings of a 2016 international study based on the 'differential susceptibility hypothesis' – that genetic variants are implicated in how we respond to both negative and positive environments.[2] So, for example, people with a particular genetic variant have been shown to be more sensitive to adversity than others with a different genetic variant, but have also responded better to positive factors such as social support and positive life events. The study departed from the 'single faulty gene' approach and used information from thousands of genetic variants to form a polygenic score to test children's response to positive and negative parenting in a sample of some 1,400 children aged 12. It then used the same scoring to compare overall treatment response in 1,000 children and young people aged 5–18 with a diagnosis of anxiety disorder who were given individual CBT, group CBT or parent-led CBT. The children and young people with the highest environmental sensitivity scores responded best to individual ▶

CBT and next best to group therapy, while those with the lowest sensitivity to their environment had similar outcomes, regardless of the intensity of the therapy.

The findings need replicating with a larger sample but are promising, Eley says. 'What we are finding is that your genes put you in a certain place on the spectrum of emotional vulnerability to stress, but that, if you are taught psychological techniques, it can increase your resilience and reduce your vulnerability and so move you along the spectrum. You don't simply inherit a set of genes and grow up depressed. In terms of someone's genetic profile, you can't change their genes, but changing their environment can make a difference to how they manage life's stressors.'

The mental health research charity MQ is supporting the GLAD project. Director of Research Sophie Dix says: 'We know that counselling works for some people, but not everyone, and we also know that IAPT offers a fairly prescriptive process in terms of what it can give. It's a great system but, at the end of the day, you only get a certain amount of sessions, pretty much whatever your symptoms and history. We don't know enough about talking therapies and how they work and for whom they work.'

Dix points to recent research in which 80% of GPs admitted that treating mental health problems is a process of trial and error. 'They say they just try one approach after the other, based on what is available in their area and their own experience. Genomic research takes us one step further by bringing a scientific approach to understanding what causes mental illness. Of course, there is no single illness called depression and there are myriad factors involved, including life experience and trauma, but there are undoubtedly biological factors too. Given that for many people drugs are the first line of treatment, genetic research offers a way of working out what will and won't work for them, so they can avoid that treatment odyssey.'

Ethical concerns

On the surface, both the search for genetic causation and genetic therapy indeed seem to offer benefits to people with depression, and society in general, given the huge human and economic costs. And yet, a quick google search produces a worrying number of websites, mostly based in the US, offering genetic testing for a long list of mental health conditions and even selling DIY home-testing kits for autism, ADHD, depression, schizophrenia and bipolar disorder. Another search produces newspaper and journal articles asserting definitively that mental illness is genetic, and research papers making conflicting claims for their discoveries. When we are talking about potentially life-long, disabling conditions that already carry a huge social stigma, this work cannot be taken at face value.

> 'People don't necessarily find it helpful to have a biogenetic explanation – it lends itself to fatalism, which works against the therapeutic alliance and hope. It also raises false expectations that we can intervene at a genetic level'

Camillia Kong is a Senior Researcher specialising in psychiatric genomics at the University of Oxford. A moral and political philosopher by background, she has been investigating the ethical issues raised by genetic research in mental health and is deeply concerned by her conclusions.[3]

'It is quite a reductive explanation of mental disorder and intellectual disability,' she says. 'My concern is that, if our sight line is entirely focused at a genetic level, that diverts our attention from the person as a holistic being who is impacted by relationships, life history, structural inequalities and environment and social issues. If you argue that there are genetic reasons behind why we develop certain illnesses and behaviours, it means our practical recommendations don't address the other pressures and systemic issues.'

Kong's other concern is the stigma still associated with mental health conditions, particularly schizophrenia and bipolar disorder diagnoses, and the assumption that they are life-long and incurable. 'People don't necessarily find it helpful to have a biogenetic explanation – it lends itself to fatalism, which works against the therapeutic alliance and hope,' she says. 'It also raises false expectations that we can intervene at a genetic level and that somehow the problem can be removed that way. I think researchers over-promise – they have to, to attract funding – but even if academic institutions pay for the research, and the results are more measured, public expectations are still very high and the more nuanced findings are ignored.'

Always, there is the shadow of eugenics hanging over the work, she says. 'We have to be careful about how this research is interpreted in relation to people who are seen as deviant or different from the rest of society. The eradication of behaviour phenotypes that we find undesirable opens what Troy Duster calls the "backdoor to eugenics".[4] I understand the strong scientific impulse – if the science can do it, we are supposed to do it. But there is a sense in which we are resigning ourselves to these developments and trying to fit around them. We are not on an inevitable march towards enlightenment; we have agency and choice about how we understand and use genomic technology in mental health. It's not that we shouldn't do it, but we need to be very critically aware of the reasons why we are doing it,' Kong warns.

In the US, psychiatrist Colin Ross specialises in psychological treatments for trauma. He is deeply sceptical about the benefits of genetic research in relation to mental health and the huge sums of money being poured into it. An unquestioned assumption that mental health problems are hereditary has entered medical discourse, he says. He recently tracked back the supporting evidence for a statement in an editorial in a recent issue of the highly respected *American Journal of Psychiatry*, stating that anorexia nervosa is a 'biologically based, heritable syndrome'. When he finally reached the end of the thread and scrutinised the referenced research, he

found no such conclusion.[5] 'The data in fact provide evidence that anorexia is at most a tiny bit genetic and is almost entirely environmental in its causation,' he says. 'Scientists used to talk about looking for the gene for schizophrenia and had to give up. Now they're looking for the genes for depression. If there are several thousand risk genes contributing 1–2% of the risk in an astronomical number of combinations, you are never going to be able to recruit a large enough group of people to demonstrate which genes are operating.'

Moreover, the promise of drugs that are individually tailored to every individual's genetic make-up is equally unaffordable, Ross argues, given the research costs of developing just one drug. 'Psychiatry, academia and the pharmaceutical industry have huge vested interests in mental illness being a genetic brain disease, rather than an understandable reaction to adversity, because that is going to need medication,' he says. 'Everybody is in this hypnotised trance, buying into it, whereas nobody would buy it if the research was about psychosocial factors. We are seeing studies finding that one gene might make a one or two per cent contribution to this or that mental disorder, but if your research were to find one psychosocial variable that contributed that much, everyone would laugh in your face.'

Epidemic of distress

Consultant clinical psychologist and trainer Lucy Johnstone saw the effects of stigma first-hand when she worked in the Welsh Valleys, not far from Cardiff University, where the MRC Centre for Neuropsychiatric Genetics and Genomics is based. 'Clients would tell me they were going down to Cardiff to give blood to this research project in the hope that they would be able to help someone else not suffer as they were. They probably hadn't been able to afford to go Cardiff for years,' she says. She recalls one client, who had made great progress in a group for survivors of sexual abuse, who attempted suicide after attending what was advertised as a bipolar support group and being told she had a life-long brain disorder.

> 'What is the point of pouring money into exploring biological causes of human suffering? Essentially what we should be offering people is the opportunity to be heard and to make sense of their life'

Johnstone is co-author of the *Power Threat Meaning Framework* – a psychosocial alternative to diagnosis that understands mental distress and emotional suffering as a response to what has happened in people's lives, relationships and social environments.[6] 'At one level, genetic research is a catastrophic waste of money, and at another these are devastating messages that can keep people stuck in a narrative that is tremendously damaging,' she believes. 'If we buy the idea that depression is a medical illness, it's understandable that one of the areas for research is genetics, but the answer to what makes people miserable, desperate, anxious, hopeless and despairing is lots of things that are extremely unlikely to have genetic causes, like loss, abuse, poverty, adversity, social isolation and social inequality. In the face of all that, you have to wonder, what is the point of pouring money into exploring biological causes of human suffering? Essentially what we should be offering people is the opportunity to be heard and to make sense of their life.

'We are in the middle of an epidemic of distress, in which deprived communities are the epicentres, where people have very good reasons to be depressed. You can flood these areas with antidepressants but, not surprisingly, the rates of depression are not decreasing. There are lots of political reasons for not joining the dots,' she says.

The jury is still out. Richard Bentall, Professor of Clinical Psychology at the University of Sheffield, has been at the forefront of research demonstrating the role of social and environmental factors in severe mental disorders and challenging the biological model, and might usefully offer the last word here.

Back in 2016, he called for balance:[7] 'The problem is not genetic research: it's naive genetic research,' he blogged. 'We need to restore balance to the nature vs nurture debate.' He called on UK medical research funders to support studies that explored not just the genetics of mental illness but also the social and environmental factors, and that could lead to a 'truly bio-psycho-social understanding of mental health'.

With GLAD, we may be seeing the fruits of an important sea change. ■

GLAD is currently seeking volunteers to provide data to the National Institute of Health Research (NIHR) Mental Health BioResource to support studies exploring risk factors for depression and/or anxiety. Visit **https://gladstudy.org.uk** for more information.

Catherine Jackson is Editor of *Therapy Today*

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The month

Our monthly round-up of film, theatre, the media and events

Radio

Gender recognition

The Government's consultation on the Gender Recognition Act has prompted polar extremes of reaction from both sides of an argument about potentially conflicting human rights. *Women's Hour* plunges into the heart of the debate with this hour-long discussion, involving

trans people, legal experts, politicians and feminists. The programme explores the current proposals for reform, why they are needed, and the fears of feminists that giving the right to gender self-definition to trans women will take away women's hard-won rights to safe spaces. Listen again to this even-handed discussion on BBC Radio 4. **bbc.in/2EKmbrP**

Video

Haters gonna hate

Splendidly, in preparation for the festive family season, The School of Life has come up with a video encouraging us to be less polite with our loved ones. It sings redemptive praises of the fruitfulness that can unfold in a heated discussion. It reminds us what might have happened in their childhood when a client is intensely outwardly polite but inwardly convinced that no one can truly love the real them. Its message is that it's good to hate in order that we can love. Watch *The Danger of Being Too Polite in Love* on YouTube. bit.ly/2CFTh9g

Television

Students on the edge

Another tick for the BBC, this documentary was filmed over a term by students struggling with their mental health at university. We meet Lauren, in her final year, who lives with OCD and is thinking of applying for an extension as she wobbles on the edge of self-harm and suicidal feelings. Amy, a first-year student, is battling with deadlines and a diagnosis of emotionally unstable personality disorder. This is a frank look at the struggles of young people in education and an education itself for student counsellors and all those working with young people. Catch it on BBC iPlayer. bbc.in/2q8LTvX

Art

Freud meets Dali

Dali, a big fan of Sigmund Freud, finally got to meet his hero in 1938. This exhibition celebrates that coming together of two influential figures of the 20th century. What did Freud make of Dali and his recently completed painting 'The Metamorphosis of Narcissus'? Explore your own conscious and unconscious reactions to the painting and learn more about what Freud really thought of surrealism. This is also a chance to gen up on the myth of Narcissus and narcissism in psychoanalytic thinking. *Freud, Dali and the Metamorphosis of Narcissus* runs at the Freud Museum in London until 24 February 2019. bit.ly/2ybMTnr

The month media pages are compiled by **Nadine Moore**

Know of an event that would interest *Therapy Today* readers?
Email media@thinkpublishing.co.uk

Film

Lizzie Borden took an axe...

Lizzie Borden's trial in 1893 for the murder of her father and stepmother in a brutal axe attack was a public sensation. Director Craig Macneill delves into the backstory behind this emblematic tale with electric empathy and feminist punch. Like Freud's hysterics, unmarried, 32-year-old Lizzie (Chloë Sevigny) experiences fainting spells and is considered unfit to make her own decisions. We watch as her autonomy is slowly whittled away by her strict and domineering family, until the arrival of a new maid, Bridget (Kristen Stewart), revives her sense of independence and potency. A feminist fable of repression and desire, *Lizzie* is in cinemas from 14 December.

Theatre

UNRAVEL THE RAINBOW

Chloe lives in a world that is completely grey, but at night her dreams are full of colour. Her elders try to hush up her descriptions of lush green forests and yellow sands. This fable of the fight for self-expression, and what you know in your heart is true against the evil designs of the Grey Queen, is bound to delight.

Join Chloe in her courageous journey to unleash all the seven colours of the rainbow in a seasonal treat for four- to seven-year-olds that adults will enjoy too.

Chloe and the Colour Catcher plays until 6 January 2019 at Bristol Old Vic. **bit.ly/2q8v2sY**

Television

LEARNING TO GRIEVE

After a year of struggling to cope with depression following his sister's death, musician and presenter George Shelley presents a series of frank discussions with loved ones and others who have been bereaved, in a bid to help better understanding of the grieving process. Shelley describes grief as 'glitter' – no matter how hard you try to tidy it up, little fragments remain. With bereavement linked to suicide risk and mental-health problems among young people, this is an important arena to learn more about. Catch it again on BBC iPlayer. **bbc.in/2JgwLol**

Television

Keeping it real

Catch-up

Here's another BBC drama to give you an excuse to bed down in front of the TV this winter. *In My Skin* is a coming-of-age story that at first feels like a comedy akin to *The Inbetweeners* but soon hits you with a painful uppercut. We follow 16-year-old Bethan through the obstacles of teenage life while she hides from her peers the fact that she's her mum's carer, to the detriment of her mental health. Catch it again on BBC iPlayer. **bbc.in/2CJoycu**

The month

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

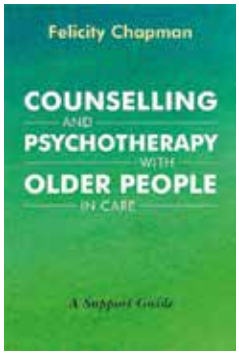
Reviews

Counselling and Psychotherapy with Older People in Care: a support guide

Felicity Chapman (Jessica Kingsley Publishers, £27.99)

In her introduction, Felicity Chapman expresses the hope that 'by the end of this book you can see… why you might become totally addicted to working with this wonderful group of people' (p21). She provides a comprehensive guide to working in this complex, specialist field that takes a deeply respectful, collaborative and empowering approach towards 'a population of adults who confess… that they feel cut off from society, ignored, thrown away' (p34).

The incidence of psychological distress in older people in care is 52%, but the current generation is particularly uncomfortable about seeking help for psychological issues. Chapman addresses psychological, physical, systemic and socio-political barriers to engagement, presents an integrated model for intervention and describes evidence-based approaches. These include narrative and mindfulness-based therapies, illustrated with case examples from clients experiencing the most commonly encountered issues: grief, loss, change, readiness to die, pain, childhood trauma and unresolved PTSD. Chapman stresses the importance of competence in engaging therapeutically with these issues and provides searching questions after each chapter, encouraging reflection on our own motivations and attitudes towards engaging in this challenging but rewarding work with older people in care.



Sarah Baker MBACP, counsellor in private practice, Dorset

How Shostakovich Changed my Mind

Stephen Johnson (Notting Hill Editions, £14.99)

Russian composer Shostakovich captured the emotional zeitgeist in arguably the most dramatic and perplexing music of the 20th century.

This book explores two interdependent themes: the therapeutic effects of music and the profound effect of Shostakovich's music in particular on the author. Shostakovich is said to have saved his own life by withdrawing his complex fourth symphony, in which he experimented in a way that Soviet authorities would have found incomprehensible and unacceptable.

In his mid-teens, Johnson immersed himself in the fourth symphony, finding method in its apparent madness. He describes how the music helped him in his struggle with depressive illness and bipolar disorder. The other theme of the book is music's extraordinary ability to help us access feelings on the edge of awareness. The author draws parallels between Shostakovich's genius for capturing a nation's emotional mood and the power of effective therapy.

Omar Sattaur, counsellor at the University of Manchester

Introduction to Countertransference in Therapeutic Practice: a myriad of mirrors

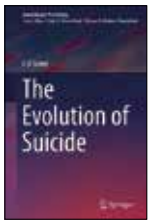
Paola Valerio (ed) (Routledge, £24.99)

This book opens with a thought-provoking foreword by Andrew Samuels, followed by an introduction and review of contemporary thinking about countertransference and the notion of the wounded healer. It poses questions such as 'Whose "stuff" is it?' and 'Do we always need to know?'

What I found most valuable were the detailed examples illustrating a broad range of experiences in therapeutic practice, supervision, teaching, groups, organisations and schools. There are also chapters on dream interpretation and reflexive research. What is revealed is a far cry from the idea of the therapist as a blank screen; this is the therapist as a 'real' person. Some chapters include the client's perspective on the therapy.

This collection has relevance to everyone working therapeutically. There is even a chapter called 'CBT versus Countertransference'!

Deborah Petrich MBACP (Accred), UKCP Reg, integrative psychotherapist in private practice



The Evolution of Suicide

CA Soper (Springer, £99.99)

This book started life as a PhD thesis, which is apparent in its style, format, amount of references – and its price. You'll want to find it in a library. But if you can get hold of it, it's a fascinating read. Soper posits the idea that suicide is an evolutionary puzzle and likely to be a maladaptive by-product of an adaptive trait. As she quotes: 'Once you equip a creature with the capacity to think, it is bound to think of other things than you originally intended' (p71). This introduces the 'brain' element of the 'pain and brain' model of suicide. The 'pain' element refers to emotional pain that is part of being human. Soper points out that suicide is hard to do and suggests this is in part due to our survival instinct. The low suicide rates (1.4% of all deaths) may be explained by the evolution of anti-suicide mechanisms, including psychodynamic defences and mental disorders. Furthermore, she proposes that the stigma and taboo around suicide serves a protective function. Psychotherapy, she argues, can restore a favourable paradigm of self-in-the-world and reduce suicide. Contrary to what the title might suggest, this is an upbeat exploration of suicide with a positive message.

Jeanine Connor MBACP, child and adolescent psychotherapist

What book contributed to making you the person you are?
Email a few sentences to reviews@thinkpublishing.co.uk

First lines

'In literate societies we all have a relationship with writing, from self-defining "writers" at one end of a spectrum, through to those who hate the very thought of putting "pen to paper" at the other… many have compared the digital revolution to the invention of the printing press, in terms of its ongoing and unforeseeable implications. Personally, I am delighted that (often) younger people are creating whole new modes and genres of expression.'

Psychodynamics of Writing
Martin Weegman (Routledge, £25.99)

Previews

Understanding and Treating Sex and Pornography Addiction: a comprehensive guide for people who struggle with sex addiction and those who want to help them (2nd ed)

Paula Hall (Routledge, £19.99)

This updated edition, written for client and counsellor, includes pornography addiction, chemsex, internet offending and female sex addiction. It examines the latest research and outlines Hall's integrative CHOICE recovery model – a sex-positive approach incorporating CBT and psychodynamic theories.

Case Conceptualization and Treatment Planning: integrating theory with clinical practice (4th ed)

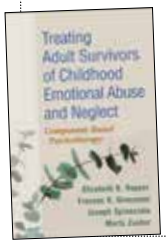
Pearl S Berman (Sage, £59.00)

This updated edition includes new material on trauma-informed care, development across the lifespan and evidence-based practice. Each chapter includes case studies and client interviews, with detailed steps for developing practice and treatment plans, and concludes with questions designed to engage the reader in critical thinking about the complexity of human experiences.

Treating Adult Survivors of Childhood Emotional Abuse and Neglect

Elizabeth K Hopper, Frances K Grossman, Joseph Sinazzola and Marla Zucker (Guilford Press, $35.00)

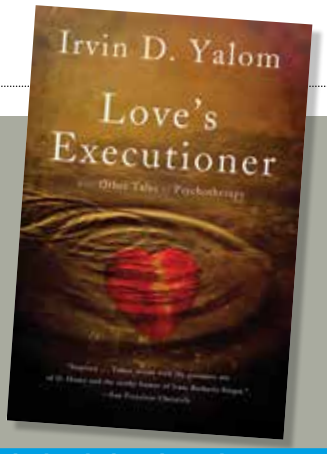
This book provides an evidence-based framework for component-based psychotherapy (CBP). The model addresses four primary treatment components (relationship, regulation, dissociative, narrative) that can be tailored to each client's needs. Extended case studies bring to life the client and therapists' own experiences of the application of the model.



Learning Along the Way: further reflections on psychoanalysis and psychotherapy

Patrick Casement (Routledge, £29.99)

In this pair to his first book, *On Learning from the Patient*, Casement traces the development and application of psychoanalytic technique. He cautions against preconceptions that steer the analytic process along familiar lines and argues that greater openness to being led by the process emerging between analyst and patient can frequently lead to unexpected and fresh insights.



The book that shaped my practice

Love's Executioner and Other Tales of Psychotherapy

Irvin D Yalom (Penguin, £7.99)

This book of case studies has an enduring influence on my practice. In one, Yalom concedes that he dislikes working with patients who are in love. He is convinced that his 70-year-old patient's love for a young man is unrequited – although he is later proved wrong. However, wanting to disillusion her, he becomes 'Love's Executioner' – hence the book's famous title. Yalom considers that existential issues of death, freedom and meaning are often behind his clients' presenting issues.

I admire his willingness to diverge from the strictures of his psychoanalytic training and the honest appraisal of his prejudices. He acknowledges that his bias can lead to poor practice, which in turn becomes a learning experience. Yalom's influence has enabled me to acknowledge that my own shortcomings do not necessarily mean failure and that I do not have to adhere to the orthodoxies of received wisdom.

Val Simanowitz, counsellor, supervisor ex-trainer

Letters

Send your letters to the Editor at therapytoday@thinkpublishing.co.uk

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

Confronting racism

I would like to congratulate you on the fantastic October issue on 'Black matters' - in particular, the news feature, 'Why we need to talk about race'. As a white woman in a mixed family, a number of the issues raised are ones very close to my heart, and in my experience they are not explored in any depth in counselling training. The assumption that just offering the core conditions without any further self-exploration of race (and other) intersectionality falls greatly below the bar of providing a 'good enough' base for the client. If we are to shy away from going to our own difficult places and our own prejudices and assumptions regarding race, then we have absolutely no place in the counselling room. I applaud this article for including so many diverse voices who have direct experience of race issues in the counselling room and for not shying away from directly challenging those of us who have not had this lived experience.

Thank you BACP for covering this topic with eyes wide open. May it instigate a change in teaching institutions and individual counsellors alike. One can hope.

Naomi Nyamudoka MBACP

Complex racial identities

The enslaved West African was stripped of their culture, their name, their language and their religion - that is, their identity. This loss was only half the process; they were also compelled to appear to accept a new lesser, unequal identity enforced by extreme violence and a legal status that equated them with property. They were then offered the illusion of assimilation. This represents a very profound intergenerational trauma, held at the communal as well as individual levels within our common society, that demands attention.

Erica Mapule McInnis ('Understanding African beingness and becoming', October 2018) tackles these issues directly. Erica's project is about encouraging black therapists to address black needs and develop a strong, black identity. Reading her article reminds me of the struggle identified by Carl Rogers of rejecting an external locus of evaluation in favour of our own journey towards self-growth, and of identifying and rejecting drivers and slogans externally imposed as outlined in Transactional Analysis, rebuilding on its own terms a new cultural narrative to replace the lost identity and confronting the identity imposed from without. It actually goes to the heart of the matter.

But I believe Pan-Afrikanists are in danger of ignoring the other side of their own heritage. Most Afro-American and many Afro-Caribbean people have ancestors who were white, Native American, Chinese or other. Complex identities are the reality of this multicultural world and cannot be resolved by choosing one part or another of a simple binary opposition.

There is a tendency towards homogenisation. Why use Jamaican patois? Not all Blacks are Jamaican; not all Jamaicans speak patois. It also obscures the Francophone and Hispanic Caribbean. The movement needs to move away from a glorification of an ancient Kemetic past, so distant that it can become whatever we want and whose relationship to historical West Africa is far from clear. It is the living and evolving traditions of Ashanti, Dahomey, Oyo, Benin, Kalabar, Kongo and others that are ancestral.

> **"We have co-created a group with friends, also white psychotherapists, who meet to discuss these issues. We also talk... with friends and colleagues of colour. We are all complicit and we can therefore all be part of the solution"**

Is it our role to encourage people to move from the therapist's definition of a non-struggler to the therapist's definition of the authentic struggler, or is it our role to encourage people to find their own solutions, which may be different from our own?

We are all living in the same streets of the same society and the conceptual net that defines (traps) one section of our society as black also defines (traps) me into someone else's concepts of white. If we all research honestly our roots and heritage, what we will discover is complexity, and if we work with our own complexity, we can develop our own identity.

David Jones MBACP, MPhil

The full version of this letter can be read on the *Therapy Today* pages at **www.bacp.co.uk**

Addressing whiteness

We were heartened to read the articles in the October issue addressing race and the ways in which it affects not only trainees and practitioners but also our clients. As Robin DiAngelo explains, racism isn't an event, it's a system.[1] In other words, our society is set up structurally to benefit white people.

Like Bea Millar and Suzanne Keys, we agree that white therapists need to reflect on our whiteness and our relative privilege. We agree with Dr Yvon Guest, who explains that there is no internal solution to racism: we are where we are because of colonisation and structural oppression. We have co-created a group with friends, also white psychotherapists, who meet to discuss these issues. We also talk about these issues with friends and colleagues of colour. We are all complicit and we can therefore all be part of the solution; there is no high horse here; rather, there is active and empathic engagement. We would like to read more material written from outside the white frame of reference in *Therapy Today*. A regular column and a raft of contributors of colour talking about all manner

Don't let this be a flash in the pan

I sit here at my desk reading the October 2018 'Black matters' edition of *Therapy Today* and am filled with mixed emotions of joy and sadness. The joy being that *Therapy Today* has taken the long-overdue but nevertheless advantageous step in recognising the depth of existing and emerging talent within the black counselling world. Equally to recognise the vast vacuum that still exists within the counselling forums up and down the UK when it comes to understanding the devastating impact of race and racism.

When *Therapy Today* still has to mention, in the 21st century, the first black president of BACP, I feel it's a shame on our profession and society as a whole.

I'm thankful to have got through my journey with fortitude, resilience and determination as one of only a few (some silent, some not) black members in my varied counselling groups in the 1990s who dared not to be marginalised. It was at times a brutal experience. However, as time has healed my wounds, I have felt more capable and robust for the experience. The process taught me a lot about group dynamics and how systems consciously and unconsciously include and exclude, especially if you are the only visibly different member of that group.

I hope this wonderful issue is not a flash in the pan for the BACP and I look forward to more intellectually diverse publications that increase the awareness of the professional black presence in the field. This in turn enables the white other to be a bit more sensitive and considerate of their colleagues and clients whose generational experience of oppression and micro-aggression continues to be a daily occurrence.

In times of Brexit and the rise of the far-right across Europe and beyond, the need to keep the consciousness of race, diversity and cultural awareness at the forefront of our thinking is never more necessary than now.

Cassius Campbell MBACP, BAATN

of issues, not just race, would add richness to your publication. We look forward to reading, talking and processing more with fellow colleagues about these issues.

Jane Czyzselska MBACP
Psychotherapist
Alena Dierickx MBACP
Counsellor
www.shoreditchtherapy.com

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1. DiAngelo R. White fragility: why it's so hard for white people to talk about racism. Boston MA: Beacon Press; 2018.

The full version of this letter can be read on the *Therapy Today* pages at **www.bacp.co.uk**

Intersectional approach

We would like to congratulate BACP on the most recent issue of *Therapy Today* that covered the theme of 'Black matters'. We appreciated this validation of keeping discussion around race alive and so we commend Catherine Jackson and David Weaver as key leaders in BACP supporting this consciousness. We thought contributions from all authors were very relevant - though would like to mention the contemporary perspectives that Natalie Bailey, Erica Mapule McInnis, Helen George and Isha Mackenzie-Mavinga presented that help readers consider race and culture with deeper perspectives, including the importance of taking an intersectional, social-justice approach when it comes to questions of race and psychotherapy.

We believe this is a time when race relations are under pressure. This is likely to continue in Britain and Europe and so we hope to see more of this expressed explicitly by organisations like BACP as we move forward.

The Black, African & Asian Therapy Network

> "It may also be true that, as we get older, we have learned to be less judgemental and more sensitive and tactful"

Keep looking forward

I was intrigued and amused to read Martin Adams' views on temporality and retirement (Letters, October 2018). The letter appears to have made some assumptions, which I feel compelled to address.

I did not qualify as a psychodynamic psychotherapist until the ripe old age of 70, nearly four years ago. Prior to that, I had a very happy and successful career in various branches of the 'caring' professions - as well as at the business end of fashion for some time.

Like many older people - and I don't deny my great age - I realise that our 'faculties diminish' as we get older, but I am sure Martin would concede that we are individuals and that illness or mental incapacity is, unfortunately, not confined to 'older people', although he does not specify what age that might be. On the plus side, we are likely to have gained the richness of experience - we are probably more confident and may have raised a family. As for 'enriching our lives' with interests, commitments and passions, that never ends and certainly does not wait for retirement.

What can we offer to our clients? I can of course only speak for myself, but I have clients between the ages of 24 and my age and older. Some have been with me for over two years. Perhaps word has not got around that 'the therapist is not to be approached'. It may also be true that, as we get older, we have learned to be less judgemental and more sensitive and tactful. Are our lives 'reduced and constrained?' ▶

For more letters and the uncut versions of these, go to the TT pages of the BACP website: **www.bacp.co.uk**

> **“The idea that a master’s degree is the only way forward… seems to go against the grain”**

My six grandchildren certainly keep me pretty busy. And as for Jean-Paul Sartre believing we ‘stop being truly human’, surely this sentiment deserves debate? It’s certainly controversial.

I guess I am of the opinion that, as Jung said (also a long time ago): ‘… life behaves as if it were going on, and so I think it is better for an old person to live on, to look forward to the next day, as if he had to spend centuries, and then he lives properly… when he is living and looking forward to the great adventure that is ahead, then he lives, and that is about what the unconscious is intending to do.’[1]

Norma Yam UKCP BACP

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Clinical endings

I was interested to see Martin Adam’s letter (Letters, October 2018) about the retirement question in the *Therapy Today* ‘Analyse Me’ feature. Martin pointed out how few interviewees seemed to have thought about this important question, the inadequacy of some of the responses and the consequences of not taking account of temporality.

I have found very useful Anne Power’s excellent book on retirement in counselling and psychotherapy, *Forced Endings in Psychotherapy and Psychoanalysis*.[1] The ‘forced endings’ she deals with include other ruptures to the work, such as relocation, pregnancy, sudden incapacity and death. The discomfort Martin alludes to enters the picture viscerally because practitioners, especially those in private practice, must face the fact of their own demise and plan for it as part of a responsible and ethical stance on work. What gets in the way are the sense of omnipotence, phantasies of immortality and loss of identity if no longer working, and Martin is right that we cannot assume we will know when to stop. Anne Power’s research found a good number continuing into their 70s, 80s and beyond, exacerbating the risk of ‘dying in harness’ (some with no clinical will in place). This can lead to collusion between client and therapist regarding the latter’s decline, the former effectively adopting a carer role. And it’s not only individual practitioners; the same questions, though perhaps less acutely, will also affect organisations.

Surely the important issue of how we plan for our own endings should be incorporated into therapy trainings and CPD as central to putting the client first. If we cannot face our own ending, how are we entitled to work with others in their dark places?

Roslyn Byfield MBACP (Accred)
Psychodynamic counsellor in private practice

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1. Powers A. Forced endings in psychotherapy and psychoanalysis: attachment and loss in retirement. Hove: Routledge; 2015.

Robotic peas in a privileged pod

I was very interested to read Norman Claringbull’s letter on ‘Beating the bots’ (Letters, October 2018), and especially the last part stating that all therapists should have a master’s degree. I am one of the ‘new breed’ he describes, but alas I am only undertaking my level 5 diploma in psychotherapy. In my somewhat limited knowledge of the profession, I was under the impression that counselling was for all trainees and clients alike. It surely should be in touch not just with the client but with society as a whole and be able to work with all.

I am from a working-class background and I have found taking this course with a family and a job to be hard going financially and emotionally. This is my fourth year of training and I am truly proud of where I and my colleagues have got to today, and also all the hard work we have yet to undertake to be able to complete the course.

I am also struggling with the idea that one of the problems he rightly points out about robot counselling is that they are all the same; this will ensure the client gets the same response - a pre-written algorithm, as it were. Norman Claringbull suggests that all therapists should have the same qualifications; this will inevitably alienate a large group of potential therapists, but may also ensure that all therapists are the same, when I am of the belief that we should be individual and let ourselves come through. We are told to be authentic. I have been in different professional roles before undertaking training in this profession and now I am encouraged to truly be myself.

The idea that a master’s degree is the only way forward and only for the people who can afford to pay the right price seems to go against the grain. I believe, as I take my very new and tentative steps on the path to be a qualified counsellor, that our uniqueness and individuality should come from all walks of life, with cultural and ethnic diversity, and that this will ensure we are ‘future proof’.

Joanna Robertson
Student counsellor

Around we go…

It was with a feeling of *déja vu* that I read the news report in October’s *Therapy Today* that NHS England has issued guidance for GPs encouraging them to offer room for counsellors in their surgeries. Having spent a large part of my career fighting to retain counsellors in GP surgeries following the introduction of IAPT, I am pleased to see that the benefits have finally been recognised.

The timing of this news is prescient as this issue of *Therapy Today* will be my last; I have just retired. Perhaps the old adage ‘what goes around, comes around’ has relevance.

Joan Foster MBACP (Snr Accred)

'WE ARE HERE...

...BUT

Jude Boyles works with resettled Syrian refugees seeking to rebuild their lives in the UK

The Syrian conflict is now entering its eighth year. The war feels ever present and I follow it daily in the news, knowing that my clients are connected to it at all times. The toll on the Syrian people is huge. Since the start of the conflict, 6.3 million Syrians have been displaced internally; thousands have made dangerous sea journeys in search of safety; nearly three million children under five have grown up knowing nothing but conflict, and 4.9 million Syrians, most of them women and children, have sought refuge in neighbouring countries.[1]

A year ago, I joined the Refugee Council in South Yorkshire to develop a psychological therapy service for Syrian refugees experiencing mental health distress who have been resettled in the UK via the Vulnerable Persons Resettlement Scheme (VPRS). The distress can be linked to the conflict and their flight, difficulties in resettling in the UK or earlier experiences, such as child marriage, violence or torture. Referrals of children, families or adults are usually made directly by project workers based at the Refugee Council, by refugees themselves or by other agencies working with refugees.

Therapy is unfamiliar to most Syrians. To make our service more accessible, we describe therapy as a place to build up resilience after the war and to cope with the stresses of resettlement. It is new to me to be working within a refugee agency, rather than in a clinical team or service. Many of my colleagues are refugees themselves and all have a wealth of both personal and professional experience that they share. Because the therapy service is located directly within the resettlement team, refugees are able to access us quickly and easily. It also means I can trust that all the essential practical resettlement tasks and processes will be delivered by the Refugee Council's project workers, which frees up our small team to focus on the therapeutic work.

UNHCR resettlement scheme

The VPRS is the UK's contribution to the UNHCR's global resettlement programme for Syrian refugees. Many of Syria's refugees are living in urban settings and camps in neighbouring countries – mostly in Jordan, Lebanon and Turkey.[2] The UNHCR's resettlement programme provides for the most vulnerable to be resettled on the grounds that they have urgent humanitarian or security needs and are not able to return home or integrate safely in the country they have fled to. Those deemed vulnerable include survivors of torture, women at risk, disabled refugees and those with serious medical conditions. I use the term Syrian refugees here to include Kurdish refugees from Syria.

Syrian refugees resettled in South Yorkshire, where I am based, are offered

SHAHID KHAN, NICOLAS ECONOMOU, YMPHOTOS, CHRISTIAAN TRIEBERT/SHUTTERSTOCK

WE ARE STILL IN THE **WAR**'

one-to-one support by Refugee Council project workers in the first year to help them settle into social housing, apply for welfare benefits, register with GPs and get any urgent medical needs treated. The adults are helped to register for language classes and to register their children in local schools; they are guided through our public systems and services and helped to orient themselves in this strange land. The project workers' aim is to gradually taper off the support as people gain confidence. They offer as much help as necessary and as little as possible, to ensure they are empowering the families they work with.

In my role within the VPRS, I manage a small team of sessional and volunteer adult therapists and two part-time child and family therapists. I carry a caseload of adults. Our approach is informed by Judith Herman's model for working with people who have experienced atrocity,[3] and so our first priority is building a therapeutic alliance and establishing safety.

We first conduct a holistic assessment to gather an understanding of the range of difficulties that might be causing distress and explore with clients what might be helpful to them within the 12 sessions of therapy we offer. Our aim is to offer a short-term therapy service, although long-term therapy provision is badly needed across the region.

'The depth of the relationship we have formed has meant that ending therapy can trigger a renewed sense of loneliness'

The themes presented are wide ranging: the atrocities they have witnessed and experienced during the conflict, traumatic loss or disappearances of family members, torture and violence through to historic abuse, including child marriage. Some refugees have endured many years of poverty and oppression in the neighbouring countries where they first fled, and many struggle to resettle in the UK, away from their families and communities, often in a hostile environment.

Many of my clients are traumatised and have felt frightened and overwhelmed by psychological and physical responses to their experiences that they do not understand. In these cases, early therapeutic work will involve some psychoeducation about trauma and its effects and teaching them ways to manage the symptoms, such as grounding and breathing techniques. For many clients, their distress relates to the death of or separation from family members as well as the impact of living through a war. These refugees have found it helpful to talk with me about their losses and for them to be witnessed – what Papadopoulos calls 'the delicate balance between therapeutic intervention and therapeutic witnessing'.[4]

With some clients, our focus is on the present and how to build a life in the UK when you are feeling lost and/or dependant on systems that you experience as humiliating. Clients describe how they are afraid that they will never be able to live a meaningful life here in the UK, to be able to fully contribute and feel settled. They can find it reassuring and affirming to have these feelings normalised and to be reminded of what they are doing well.

The feedback from our clients over the last year has been that 12 sessions are almost always helpful and meaningful. Despite this, I have ended work with clients feeling sharply aware that there is a need for further long-term therapy to address their trauma from histories of abuse and/or torture, as well as what they witnessed and experienced during the war. The depth of the relationship we have formed has meant that ending therapy can trigger a renewed sense of loneliness. As van der Kolk writes: 'Social support is not the same as merely being in the presence of others. The critical issue here is reciprocity: being truly heard and seen by the people around us, feeling that we are held in someone else's mind and heart.'[5] ▶

Working with refugees

I have learnt so much about Syrian culture from this work and find myself recognising snatches of Arabic now. I work with the same group of four interpreters, who are a crucial part of the team. Because we work together daily and so closely, they have come to capture my way of communicating and understand the way the team works. We meet regularly for a supervision group to explore practice and to provide support, as the issues and themes brought by our clients often echo their own.

Working with an interpreting team who are based within the refugee agency has thrown up challenges too, as it has been almost impossible to ensure that they have no other contact with our clients. It is generally considered best to use interpreters in therapy who have not interpreted for the client in other settings, in order to preserve therapy as a unique and separate space.[6] The interpreting team often meets clients at drop-ins and sometimes have even been at the airport when the family first arrives in the UK, as part of the Refugee Council team. The fact the interpreter is familiar has helped on some occasions, but mostly we aim to pair up with an interpreter who is less familiar or not known.

We are confronted by the Syrian conflict daily. My clients watch news reports on their phones constantly and receive a steady trickle of images and film footage from friends and families back in Syria, Jordan or Lebanon. Their families in Syria remain at risk and they follow every outbreak of the conflict.

I have understood and respected the need for clients to keep their phones on in sessions when they are expecting news of family members trying to flee an area being hit. I have even looked at footage from the conflict in sessions. 'Look, this is my street now, my home and that's my business... this was it before. Look at our house... our shop.' It is deeply saddening to witness and connect with what people have lost and what they have/are living through. As a client said recently: 'I'm here, but we are still in the war.'

It's crucial for me to know as much as I can about the war, the conditions and treatment of people when they flee to neighbouring countries, as well as about Syrian culture and the importance of family, land and faith.

Many left their homes thinking they would return in a month or so, and few expected the conflict to last. The years in Jordan, Turkey, Iraq and Lebanon were mostly hard. Families were discriminated against and were living in precarious circumstances, often with limited access to medical care and education. Since the outbreak of war, UNHCR estimates that 739,000 registered Syrian refugee school-age children and adolescents have not been able to attend school. Prior to the war, 94% of Syrian children were enrolled in primary and lower secondary schools.[1]

Dignity and social justice

Kholoud Mansour, a Syrian with a background in humanitarian analysis, research and writing, has written eloquently about the importance of dignity in Syrian culture. He quotes a doctor he interviewed for his research: 'We feel like lab rats. International organisations come to us with countless needs assessment and questionnaires; they leave, and we never receive assistance from them.'[7]

When clients talk of those years as a refugee, they express outrage and anger at the attitudes they encounter and the affront to their dignity. I have gone on to read more about dignity and its significance for Syrians. Mansour writes: 'From the very onset of the popular uprising in Syria, dignity has played a role at both the individual and collective level. One of the earliest and most prominent slogans during the Syrian uprising and the subsequent conflict was "the Syrian people will not be humiliated".'[7] He describes the centrality of dignity in Syrian narratives and explores the impact on Syrians of the humiliation they have felt when dealing with resettlement agencies.

'What she wanted was to talk... a place where she could say the things that she wanted to say where no one else could hear'

Bemak argues that it is the role of the therapist to be aware and actively engage with social injustice: 'Inherent in this more active stance is the assumption that social justice is an integral part of psychotherapy. To neglect issues that present themselves regularly to refugees that are inequitable, unfair, discriminatory, or a violation of their human rights is unconscionable.'[8]

Some of our clients have had some form of psychological intervention after they fled Syria and before they came to the UK. One of my clients described with amusement being taught a breathing exercise as she and the therapist listened to planes circling overhead. My approach is rarely technique driven or symptom focused, but I included these techniques in my description of what I could offer as I was anxious to find a way to be helpful in just 12 sessions. At our assessment, she told me in no uncertain terms that she wasn't interested in being taught techniques; what she wanted was to talk. She wanted a place where she could say the things that she wanted to say where no one else could hear. She didn't want to burden her family with her suffering.

Working with families

Many of the people I am working with are in their 50s and older, and many have chronic

health problems or are disabled. This has meant I see them in their own homes, as their mobility is limited.

Learning English becomes harder as we grow older and many parents describe being left behind by their children. My clients have usually led full and relatively good lives in Syria and have lost everything they took years to build. They have had to leave behind land and businesses that have been in their family for generations. I witness daily the ache for home and the life that was before. I will always remember the words of an older Kurdish client, who told me: 'I will never be who I am here, because who I am was there and part of that life.' She had been the centre of her small village; that life was gone and her future would never be the one she had hoped for and expected.

Yet, only a week later, as we approached our final session, another client told me that he now realised he still had the same qualities and was still the same man; he was just in a different place. He now believed he could forge a life here, despite his losses.

Most of the refugees I have worked with have come to the UK with their immediate family, although, sadly, older children may have been left behind. As could be expected, roles and family dynamics are changed by resettlement. But while displacement can be the trigger for disruption of family life and traditional gender relations, for some families these disruptions were already occurring.[9] Sometimes the family system is affected by displacement and families are in crisis; at other times, a traumatised individual causes confusion and concern as their family struggles to understand what has caused such a change in the person they knew.

Sometimes male family members have felt threatened that their partners are confiding in me; some are curious about what we talk about. Flexibility and a willingness to meet with families/partners and explain what I do and why are crucial. Families are keen to support struggling members and sometimes the family can build on and re-enforce the work I am doing if they become involved. I have found so far that, even when one partner has concerns about therapy, this changes over time and the privacy of our work is respected.

Key to this is my respect for the families I work with and my genuine curiosity about the differences in how we might think and understand the world around us.

'My work is full of sadness and distress, but there is also often laughter at the frustrating aspects of resettlement and their impacts'

Some therapy takes place in other venues. I see clients at a community centre in a small town and at a GP practice, as well as at our Sheffield base. Offering therapy from a nurse practitioner's clinical room might feel familiar to many NHS therapists, but offering therapy when seated on a huge white leather sofa in a snooker hall was a first for me. I find it is possible to create a unique and private space wherever you are. I have also learnt to accept the gift of specially made food when I visit clients in their own homes – the trick is to eat little and fast, in order to progress the session without losing too much of the therapy time.

Receiving visitors with food is at the heart of most cultures and it is certainly very important for the Syrians I am working with. I have grown to love the sweet treats and the ritual of the strong Syrian coffee that starts or finishes a session.

My work is full of sadness and distress, but there is also often laughter at the frustrating aspects of resettlement and their impact on clients' lives.

Many clients have angrily described the ridiculous hoops they have to jump through to access their rights, or laugh after they have attended an assessment for therapy with a statutory service and been sent home after one session with leaflets in English on panic attacks or managing stress. Their amusement and outrage at the UK's failures and incoherent, clunky systems is infectious and I am reminded of another quote from Kholoud Mansour:[7] 'Dignity is how much you reject humiliation and how strongly you react to it.' ■

QUETIONS123 / SHUTTERSTOCK

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Fiona Kennedy describes the corrosive effects of obsessive compulsive disorder on people's lives and how to work with it

What if I...?

Paulo is a successful, charming businessman, working in the fashion industry. He has a powerful ability to visualise, which he uses in his work. Paulo is dyslexic and felt a failure at school; he disappointed his teachers and parents by failing to follow in his brother's academic footsteps. He became the joker, always up to mischief, but inside he was highly anxious.

His father died when he was seven and Paulo was brought up with a terrifying, physically abusive stepfather. At puberty, he worried about getting erections by accident in public. In adulthood, at work, he would excessively check his output for errors. When he married and started a family, he began to panic about harm coming to the children. He avoided travelling long distances and going on holiday through fear that he would have an asthma attack and cause an accident. His sleep was disturbed by 'what if' thoughts, which he dealt with by making complex plans to prevent harm coming to himself or those he loved.

Then a colleague was arrested for grooming a 13-year-old. Paulo was appalled. He thought, 'I was his friend - perhaps I'm a paedophile too.' Checking back over past relationships, he remembered being in a relationship with a 15-year-old when he was 16, confirming his belief. He became withdrawn, sleepless and depressed, and began avoiding going out in case he saw a child, and tried not to watch any media with any sexual content.

What is OCD?

Obsessions are defined in DSM-5 and ICD-10, the diagnostic manuals for mental ill health, as recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress. The person reacts against the thoughts and tries to ignore, suppress or 'neutralise' them with other thoughts or actions. The thoughts frequently involve being responsible for harm to others and an urge to do something to prevent that harm. They may also involve fear of harm to the self, such as being contaminated by germs and contaminating others. Many obsessional thoughts begin with 'What if?'. Sexual themes are common - for example, someone might obsessively fantasise about their friend's husband when with their own partner. Religious themes are also common. My Catholic grandmother believed that if we recited the '30 Days Prayer' each day without

fail for 30 days, we'd achieve our life's desires. As a girl, I spent endless evenings plodding through it, with Nana in the other bed doing the same. Neither of us ever managed to complete the 30 days. Little did I realise at the time, but this was a classic example of obsessive compulsive disorder (OCD).

Intrusive thoughts and images are often negative, but positive thoughts can be distressing too. 'Pride comes before a fall', for example, expresses the notion that, if you are too pleased with yourself or your own performance, or take something for granted, things will go badly wrong.

Obsessions are always accompanied by compulsions. In the past it was thought that there was a subtype of people who did not experience compulsions (so-called 'pure' obsessional thinkers). However, once covert rituals (eg thinking a 'good' thought) and reassurance-seeking were recognised as compulsions, studies found that 100% of people with obsessions have compulsions.[1,2] Compulsions are repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession or according to rigid rules. The actions are aimed at reducing distress or preventing some dreaded event or situation, but are either not connected in a realistic way with the event or are clearly excessive. Examples include cleaning, hand washing, checking (plugs, doors, locks or one's appearance). They may involve rituals such as arranging things, doing things in a certain order or counting, touching, rubbing or tapping, blinking or even staring. One client, who had intrusive thoughts about cutting his beloved father's throat, felt the compulsion to 'neutralise' these thoughts by loudly shouting 'F*** off!' People with Asperger's and autism are particularly prone to OCD, possibly because they live with high baseline anxiety.

> 'People with lifetime OCD report spending as many as six hours a day on obsessions and four-and-a-half hours a day on compulsions'

People with lifetime OCD report spending as many as six hours a day on obsessions and four-and-a-half hours a day on compulsions. This severely affects home life, social functioning, academic achievement, employment and use of health care. Between 30-60% of people with OCD are unemployed, and 99% have another disorder – most frequently, mood disorders, especially severe depression, and anxiety disorders, especially social phobia, specific phobia and panic.[3]

OCD is rare – only two to three per cent of us will experience it, but 13-28% of us experience some OCD symptoms. For one in four men with OCD, it starts before the age of 10. For women, onset tends to be in the teens or early adulthood and there is an increased risk of developing OCD after giving birth. Tics, depression and substance use in childhood and early adolescence are risk indicators for OCD, as is having a close relative with OCD.[3]

What works with OCD?

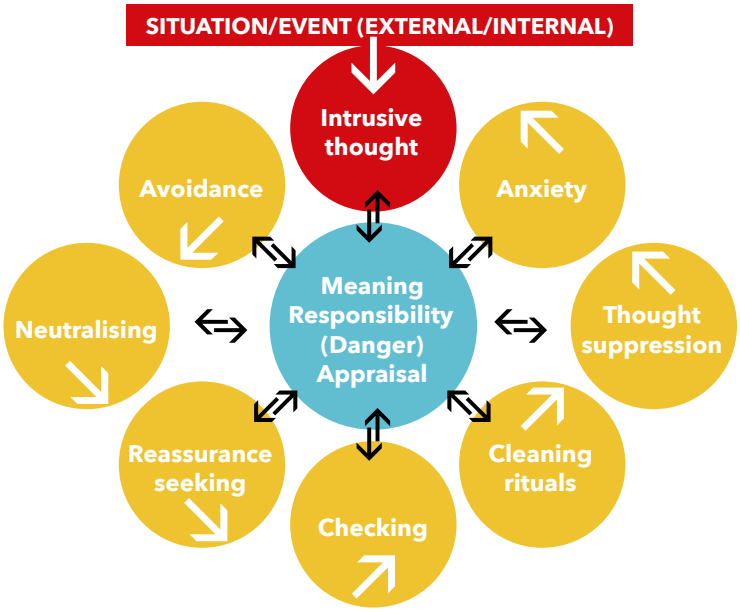
NICE recommends cognitive behavioural therapy (CBT) for OCD. It also recommends SSRI antidepressants, in combination with CBT when OCD and depression are present together.[4] There is a growing evidence base for acceptance and commitment therapy (ACT) for OCD.[5] These therapies change the way the client relates to their thoughts and feelings. CBT produces new perspectives, changing the meaning a person gives to their thoughts. ACT focuses on 'defusion' and mindfulness practices, such as noticing one's thoughts without engaging with them, as well as clarifying values, as outlined below.

In assessment, as well as the clinical interview, asking the client to keep a diary of thoughts/images/urges, the meaning ascribed to them and the compulsions they perform can give a good baseline, as well as providing material to target. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS)[6,7] identifies target symptoms and level of insight. The Obsessive Beliefs Questionnaire (OBQ-44)[8] helps identify beliefs driving the cycle.

The most commonly used formulation of OCD from a CBT perspective is Salkovskis' 'Vicious Flower' (see left).[9]

Applying this to Paulo, he appraised as true his thoughts about being a paedophile simply because he had them. Having the thoughts meant he was a bad person and might harm a child, and that he was responsible for preventing this happening. He sought reassurance and checked his memories for any signs of paedophile behaviour (compulsions). The harder he tried to remember, the more confused he got, ▶

FIGURE 1: SALKOVSKIS' 'VICIOUS FLOWER'[9]



until he felt he could not trust his memory and might have forgotten important incidents. He tried not to think about being a paedophile, and failed, making him feel out of control. He also used avoidance (making sure he was never alone with children).

Understanding obsessions

Intrusive thoughts are often negative and obviously upsetting for the client but they can also be neutral or even positive. It is the catastrophic appraisal of the thought that can lead to fear, guilt, disgust and shame. OCD involves 'overthinking': fruitless attempts to solve the problem. Anxiety levels rise, thinking becomes more black and white and extreme, and clarity is lost. Occasional 'success' keeps the process going. Thought suppression results in more negative appraisals of the thought, and also a feeling of failure to control thoughts.

Avoidance of situations, conversations or other input that might trigger obsessional thoughts can lead to constriction of the person's life and reduction of joy and pleasure and pave the way for depression. As well as the risk factors mentioned above, negative feelings about the self (self-schemas or core beliefs) create vulnerability to developing OCD. An exaggerated sense of responsibility may be learned in childhood by being held responsible by others, such as teachers or parents. A core belief such as 'I am a bad person' may create an underlying assumption that 'I am responsible', which in turn leads to negative automatic obsessional thoughts such as 'It's my fault'.

Understanding compulsions

It is generally accepted that the purpose of performing compulsive behaviours is to reduce distress. The distressing thought creates anxiety and the person does something to decrease the anxiety, if only for a short time ('negative reinforcement'). Positive reinforcement can be present - for example, when a person gets pleasure from a sense of control. These 'short-term gains' keep the behaviour going. But compulsions cause long-term pain, such as shame, embarrassment, fatigue and missing out on life.

Recent work[10-12] has shown how repeating actions leads to changes in the way information is processed. Just glancing at a clock, we know the time. But if we stare at it for several minutes, we will be less sure. The more repetitions, the less certain we become of exactly what we've done and whether we've done it properly. As our certainty decreases, the need to repeat increases.[13] We also switch from perceptual to conceptual processing, thinking excessively as we repeat. 'Parsing' happens with repetition - we break down actions into smaller and smaller parts. For example, instead of just washing my hands, I must wash the palms, then the backs, then the thumbs, fingers, under the nails, between the fingers etc. Now it becomes hard to remember whether I have done all of it or not, which means I have to start the sequence again, to feel sure.

Christine Purdon and her team at the University of Waterloo, Canada, recently studied the detail of what people are up to when they are carrying out compulsions.[14] Participants were people who washed their hands excessively. She discovered that people stopped their compulsions voluntarily about 53% of the time. The rest were stopped involuntarily because the person was interrupted or had to go out or go to work etc. Paul Salkovskis has coined the term 'stop rules' to describe the conditions that allow people to stop voluntarily.[15] Like him, Purdon found that there had to be a 'felt sense' of satisfaction - a sense that the washing had prevented harm. Without this, the person was not able to stop. There were no objective criteria such as the number of times or length of time that the actions were repeated.

The fact that a compulsion is a subjective feeling makes it tricky to limit the behaviour in any objective way. If we ask the client to limit the number of repetitions, for example, they will not get the 'felt sense' signalling 'stop'. Without the felt sense, the client's confidence in their memory goes down. Purdon also found that compulsive behaviour needs a trigger - it does not just randomly occur. So, for example, touching something that might be contaminated is often a trigger for washing.

'The more repetitions, the less certain we become of exactly what we've done and whether we've done it properly'

Treating obsessions and compulsions

Values work

The treatment of OCD historically has involved exposure (eg touching a toilet seat) and response prevention (eg not washing the hands afterwards). Though successful 70% of the time for willing clients, there is an almost 50% refusal and drop-out rate. We need a very strong reason to willingly experience the horrible feelings that exposure work brings. If I asked you to walk over some hot coals, you would say no. If I asked you to walk over hot coals to save a loved one's life, you probably would.

Values work helps the client get clear on what kind of person they want to be and what kind of life they want to lead, ideally. So, values are the reason for reducing compulsions. Paulo, for example, wants to be a fun and loving father; he wants to go swimming with his son, but his paedophile obsessions get in the way. The 'two pieces of paper' exercise from ACT involves writing your values on one piece of paper and appraisals of your obsessional thoughts on another. The values paper might say 'Be a fun dad', 'Be a supportive and available partner'. The thoughts paper might say 'This thought about being a paedophile means I might be one', 'I need to protect all children from my terrible urges'. The client holds the pieces of paper, one in each hand. When we hold the thoughts paper closer to our face we can see only thoughts. When we hold the values paper near to our face, we see our long-term life goals. The thoughts are still there but farther away from us; they are not our focus. The ability to focus on our values can be learned with practice. This can help us tolerate discomfort on our journey towards a life we value.

Working with obsessions

We have two options when working with obsessional thoughts and feelings: working with the appraisal of the thoughts and working with the thought processes.

It's important to validate the client's distress and normalise their experience. Psychoeducation is useful - for example, sharing facts. Purdon and Clark,[16] found that as many as 22% of men and 11% of

women had had thoughts about choking a family member. Learning that no one has complete control over their thoughts and that it is impossible to avoid mistakes are also important. The 'junk email' metaphor is useful too: if you received an offer to put £10,000,000 into your bank account, you would probably delete it. But instead of deleting thoughts, we appraise or interpret them as signals of threat that indicate that something needs to be done now.

The problem in OCD is not fear of something terrible happening to you or a loved one; it is the belief that the thoughts are indications that harm will occur, that immediate action is required, no matter how minute the probability of harm, and that it is morally imperative to perform the compulsion and achieve certainty. The therapist aims to help the client see these thoughts as naughty puppies in the backyard of their mind – out of control and in need of training. We want to put the person back in charge, not by getting rid of the puppies but by stopping them taking over the whole of our life.

We can use Socratic questioning to curiously explore appraisals of the thoughts: 'How did you learn that this thought means X will happen?'; 'What would someone who disagreed say?'; 'You seem to be assuming that if you think X you need to do Y...' We can use Theory A vs Theory B. Theory A says: 'This thought says I could be HIV positive. I need to be absolutely certain I'm not. It would be irresponsible not to get repeatedly tested.' Theory B says: 'This is just a thought. I can accept the tiny risk I might be HIV positive just as I accept the risks of driving.' We can set up behavioural experiments to test out Theory A and Theory B. 'Helicoptering' is a great technique – we can teach clients to stop, mentally hover above the situation, look down at what's happening, check out their values and decide from there how to proceed.

With intrusive thinking processes, we can show clients how overthinking increases anxiety and doubt and befuddles us, even though it produces occasional relief. We can teach alternatives to engaging with the content of the thoughts. Mindfulness skills can, with practice, allow us to leave horrible thoughts and feelings floating on the surface of our awareness. We can 'drop an anchor' onto our breath, or onto an activity that pursues our values. 'Defusion' skills from ACT, such as singing intrusive thoughts in the shower to a popular tune, can help you gain perspective and become aware that they are just thoughts. Teaching clients to tolerate uncertainty and challenge the idea that perfection is always required are other important strategies.

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Training in working with OCD is available from SDS Seminars Ltd **www.skillsdevelopment.co.uk**

and from GreenWood Mentors Ltd **www.greenwoodmentors.com**

Working with compulsions

Staying focused on values increases willingness to tolerate the horrible feelings that will come along if we resist the urge to carry out a compulsion. Perhaps you yourself have a mild compulsion, such as needing to turn the toilet roll so the paper hangs away from the wall? If you choose to resist the urge, the feeling of anxiety or disgust or distress will increase, and then decrease. Most clients are not aware that the decreasing bit will happen; they believe the feelings will just get worse. The metaphor of urge-surfing is useful: if we mindfully sit with an urge, say to scratch our nose, the urge will increase and then, within a minute or so, decrease. It's like being a surfer balancing on the surfboard until the wave subsides and comes gracefully to the beach.

Setting 'finishing criteria' for compulsions, such as 'I will stop washing my hands after two minutes', is a common intervention. But then the client does not have the 'felt sense', which is the usual signal to stop. Mindfulness practice allows clients to experience anxiety and self-doubt and learn they can be tolerated.

Behavioural experiments involve clients making predictions about what will happen if the compulsion is not carried out. Paulo might say: 'If I don't take my asthma inhaler in the car, I will have a panic attack, be unable to breathe and crash the car.' He could make alternative predictions: 'If I don't take my asthma inhaler but use my paced breathing skills and stay focused on my realistic thoughts, I will be fine,' or 'I may have a panic attack but I can still drive my car safely while that is happening.' After working on new skills and insights, Paulo could test out the predictions and see which ones best fit what happens when he drives the car.

Working with avoidance/escape

Avoiding triggers of intrusive thoughts and images, avoiding talking or thinking about the content of thoughts and attempting to neutralise behaviours all serve to strengthen OCD through negative reinforcement. 'Widening the window of tolerance' means expanding the client's range of exposure to challenging or triggering activities and situations. This can be done by practising mindful acceptance of urges to avoid, reducing advance planning and reducing reassurance-seeking. Graded exposure to feared situations allows the client to practise new coping skills.

Working with core beliefs/schemas

Core beliefs or schemas are beliefs about ourselves learned in childhood. Typical examples include: 'I am not good enough/a failure'; 'I am a bad person'; 'I am unlovable'; 'The world is a dangerous place'; 'Other people are unavailable.' These lead to underlying assumptions, such as 'I must prevent harm coming to others'; 'I must get everything right'; 'I could be responsible for bad things happening.' The downward arrow technique can help access core beliefs: 'What does it mean that you have these intrusive thoughts?' The client who is afraid she might drop the baby might say 'It means I can't be trusted'. 'And what does that mean?' 'It means I am a bad person'.

Once the core beliefs are clear, we can use the CBT thought-reviewing techniques ▶

RECOVERY COURSE

N The problems were **Named** – 'I am having thoughts/an image about being a paedophile and needing to check to make sure I'm not' – and acceptance shown.

A **Awareness** was built with validation of the client's thoughts, feelings (shame and self-disgust) and behaviours around the problem. We used formulations describing thought processes and compulsions in detail.

V Paulo was helped to clarify his **Values** about being a good father and having fun with his kids.

I We **Identified** the function of the problem – Paulo was trying to reduce his anxiety by seeking reassurance from his wife, by avoiding children, by checking back through his memory for times he may have behaved like a paedophile. All of these gave short-term gain and long-term pain. Paulo planned to use mindfulness skills and urge-surfing to resist these behaviours and tolerate the discomfort.

G Paulo set some **Goals** in line with his values: he wanted to go swimming with his son. He began with 'baby steps' towards this goal, such as driving his son to the pool and watching him have a lesson.

A Paulo was helped to **Accept** himself and counteract his core beliefs that he was not good enough. He made an image of 'little Paulo' and began to show compassion to this 'inner child'.

T Paulo was helped to **Tackle trauma** in his past by understanding the effects of being bullied at school and his violent stepdad on his belief in himself. He was taught to make powerful and competent images of himself handling these bullies.

E Paulo was helped to become aware of his **Emotions** and reduce their intensity. He used graded **Exposure** to gradually stay in situations that triggered his paedophile fears.

S Paulo was taught new **Skills**, including mindfulness, self-soothing, paced breathing and urge-surfing to help him move away from his obsession and towards his valued life.

described earlier. Compassion focused therapy (CFT) and schema therapy offer ways of inducing self-compassion, such as the two-chair technique. The client becomes their 'inner bully' in one chair and speaks to their 'self' in the other chair. It's often shocking how brutal the words and tone they use can be. The client then occupies the opposite chair and argues against the bully, ideally accessing some emotional response, but certainly daring to stand up to the bully and defend him or herself.

With Paulo, I used CBT+, an approach integrating CBT, ACT, CFT and DBT (dialectical behaviour therapy) that I have developed with my colleague David Pearson.[17] We take the client through a process for which the acronym is NAVIGATES, as illustrated in the box above.

Obsessional thoughts and the compulsions that go with them are very common; it is the distress they cause that we should treat. There are techniques that can provide the client with alternative ways of dealing with their distressing thoughts, feelings and urges. Values are important - they represent the reason why someone might be willing to tolerate increased discomfort in the short term in return for greater richness of and satisfaction with their life. Counsellors can be very helpful for people with OCD, provided they are familiar with what works and have some specialist training. ■

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‘It was like seeing a photo of the Earth taken from space – I realised my own insignificance, and it was surprisingly comforting’

Eyes flicking from side to side, I conjured up a recent image from my nightmares: ‘There’s a prison cell in Syria, eight or nine people crowded in the dark. There isn’t enough air, they are suffocating.’ Tears rolled down my cheeks, I refocused on the face in front of me. ‘I don’t think this is working.’

My therapist, Ruth, agreed. She had been attempting to use eye movement desensitisation and reprocessing [EMDR] with me for a number of months. I’d been reluctant from the start. I couldn’t bring myself to focus for long on the violent images that so troubled me - memories from my decade of writing about the most horrific abuses.

Promoted to the role of editor at a large human-rights charity in my early 20s, my daily work consisted of sifting through survivor testimonies, deciding what was fit for public consumption, and tidying up researchers’ work into neat, publishable reports. Sometimes the survivors’ stories were accompanied by photos and video evidence, much of it considered too gory to be released to the outside world.

Following the Arab Spring in 2011, I was drafted in to cover emerging violations in the Middle East. Torture, rape, bombings, unspeakable cruelties of every kind. Over several years, as the conflicts spread, images of suffering crowded my days and crept into my nightmares. I stopped sleeping, became withdrawn and anxious. After a diagnosis of PTSD, I sought help from a private trauma therapist. It took several attempts to find the right person, someone willing to tackle the problem head on.

At first, I wasn’t sure that Ruth was the right therapist for me either. She was convinced of the merits of EMDR, whereas I wanted tools to allow me to continue working on human-rights issues without being constantly re-traumatised. I wanted to stop feeling the burden of responsibility for those people whose lives had been destroyed, people I felt I could help if only I worked harder. ‘You leave your own human rights at the door when you come to work here,’ a researcher on Central Africa once told me. ‘Out there, people are suffering worse than we can even imagine. What right do we have to complain?’ I felt this keenly - the guilt at letting down the victims, the survivors, their families.

And so, Ruth worked hard to come up with new solutions, new ways to help me let go. ‘Draw a circle on a piece of paper,’ she said. ‘It’s a pie chart. We are going to assign responsibility for those prisoners in Syria.’

I started to divide up the circle, giving slices of the pie to governments, the international community, warring factions in a far-off conflict. When my chart was complete, Ruth said: ‘And what percentage is your responsibility?’

It was so simple; I saw it at once. It was not my fault that these people had suffered; I had very little influence over the outcome. It simply wasn’t within my power. It was like seeing a photo of the Earth taken from space - I realised my own insignificance, and it was surprisingly comforting.

Back at work, I did request changes to my workload. I felt able to refuse subject matter that I knew would be particularly upsetting. Everybody has their limits, their individual triggers. But for the rest, I now see that my 9-5 work is enough. Yes, by documenting these crimes, compiling the evidence, I can play a small role in a huge system that might one day change things for the better. But I bear no responsibility for those lives lost or ruined. My contribution is small but significant in its own way, and it is the most that I as an individual can do. And that’s all you can ask of anybody. ■

About the author

Saphia Fleury is a writer and editor specialising in international human rights law. She has commissioned, co-written and edited numerous books and reports on human-rights issues and holds a degree in human-rights law and practice from the University of London and in linguistics and literature from the University of Hull.

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Are you sitting comfortably?

Lucy Cavendish believes fiction can help counsellors better understand and work with the human condition

Non-fiction books about therapy are, of course, essential to counsellors and therapists. In addition to the theorists, books written by experienced therapists describing what they've learned from their work are incredibly important in our career-long learning. Patrick Casement's *On Learning From the Patient* was my bible when I was doing my Level 4 integrative advanced diploma. But I also believe we can learn a lot from fiction. It's not just that we can have a deep emotional reaction to these books; I believe the stories within them help us understand the human condition.

I was once so engrossed in Elena Ferranti's Neapolitan quartet that I actually missed my flight. The other passengers filed past me in the departure lounge but I sat on, enchanted by the writer's deeply intuitive understanding of the relationship between two young girls who grow into adults and fall in and out of love and their successes and failures. When I finished the last novel, I cried. There is a gaping void in my life where I wish that book could be again, promising many more hours of reading to be endlessly enjoyed.

In this, I find I am not alone. I talked to a random range of counsellors and therapists whose work interested me to find out if and how they use fiction in their work and practice. Psychotherapist and writer Susie Orbach believes novelists are not unlike therapists. She told me: 'Novelists, like depth psychologists, reach places very few can. We both work with words in the ear, in the mouth, with phrasing, with hesitation, with beauty and with the aesthetic arc of what is endeavouring to be expressed.'

She is, she said, 'intrigued and affected by books that deepen my understanding of what it means to be human. For me, Philip Roth's writing is like psychoanalytic practice. It takes our ordinary or known assumptions and turns them inside out and makes of them such complexity and humanity, even when he is evoking the cruellest of thoughts and actions.'

Rewriting our narratives

Says psychotherapist and writer Philippa Perry: 'A part of every successful therapy is about rewriting the narratives that define us, making new meanings and imagining different endings.' She finds that it is the client's own 'fiction' - the story of their lives that they tell themselves - that is used in order to respond to the world in an emotional, physical and cognitive way.

I remember very clearly reading Thomas Hardy's *Tess of the D'Urbervilles* when I was a young woman. My anger and outrage at her treatment by the men around her and the male-dominated society in general felt almost overwhelming at the time. But I also connected strongly with her sense of burning, debilitating shame and of not feeling 'good enough'. However, burning through the novel is the abiding love that she holds and cherishes and yearns for, and this is what shone through for me.

When it comes to clients, Tess's story does not seem too far removed from present-day problems. On a more general level, we are in the midst of the #MeToo movement, which can, in some ways, be understood as a reaction to exactly that kind of situation. Time has not lessened women's sense of hurt and betrayal - the only way out for Tess was an act fuelled by anger. Yet this sense of violence and volcanic anger at having been 'wronged' and 'thwarted' also comes into the therapy room.

Perry points out: 'Our way of being in the world comes from stories that we read. Our minds are formed by narratives. Stories may unconsciously influence us to act in one way or another, but they also enable us to think about ourselves in an objective way. The use of storytelling helps us to gain some distance from ourselves and gives us perspective. The great thing about a story is that it is flexible. We can change a story from one that does not help us to one that does.'

Therefore, in terms of stories around shame/anger/vengeance, clients do not need to end up imprisoned (like Tess) by their own actions and emotions. This is how I use fiction in my practice. I can feel the client's pain, shame, sorrow and anger, just as I felt that of Tess when I read Hardy's book. But, together, we can write a different ending, or suggest/offer/come up with something far more hopeful and reparative.

'The way we talk to and about ourselves and the way in which we edit our own stories can and does change our emotional life,' says Perry. 'I relish books written in the 1920s, 30s and 40s, because I suppose they tell me about my parents' world and help me understand them better, which in turn helps me understand myself better.'

Universal stories

'From the beginning of time, mankind has been fascinated by stories, not just as entertainment but as a way to make sense of the world,' says couples therapist and author Andrew G Marshall. 'What is most extraordinary is that the oldest surviving manuscript - found by the explorer Henry Layard in 1839 under a mound of sand in the Mesopotamian desert - would be instantly recognised today. *The Epic of Gilgamesh* is about a society threatened by a great evil that is saved by Gilgamesh, who overcomes extraordinary odds and kills the monster. Gilgamesh has saved the world and can return home triumphant. Although this story was found in the remains of one of the earliest cities built by mankind, biblical Nineveh, we are still watching it today at our local multiplex - for example, as the latest James Bond movie.'

He points out two important insights: 'First, every culture, throughout all time, has told the same stories. These plots offer an extraordinary insight into what it means to be human and the problems that come with that territory. And second, as soon as we are old enough to focus on pictures and understand words, we are told stories by our parents. We are introduced to the ▶

'The great thing about a story is that it is flexible. We can change a story from one that does not help us to one that does'

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world around us through stories and remain mesmerised by them for the rest of our lives. Every new experience – whether good or bad – will be fitted into a much bigger story: our autobiography. When we meet someone new, we become a character in their ongoing life story and, whether we like it or not, how we are perceived will be coloured by the story they are constructing about their own life. This is why understanding the stories that we tell ourselves and others is a direct route to our unconscious.'

Fairy tales hold particular therapeutic riches. *Jack and the Beanstalk* can potentially help with a client who has come out the other side of a damaging relationship or an addiction problem. The giant, according to Marshall, is in some way their own behaviour. As Bruno Bettelheim, the Austrian-born American psychologist known for his work with emotionally disturbed children, points out in *The Uses of Enchantment* that these stories help children (and adults) figure out and experience difficult and sometimes frightening situations and emotions. Stepmothers loom large and are generally to be feared. Children get poisoned, put in ovens, forced to work as kitchen skivvies and cast out of (or imprisoned in) castles. Yet their stories are ones of survival. Their message is that unbearable things can happen to you, but you can overcome them. 'Although novels and stories continue to shape us and form us all our lives, the ones we read or hear first will have the most impact when we are at our most plastic,' Philippa Perry says.

Author and scholar Christopher Booker claims there are seven basic plots in fiction:[1] overcoming the monster; rags to riches; the quest; voyage and return; comedy; tragedy, and rebirth. These plots feature continually in the counselling room. By reading fiction we can experience the human condition deeply in our imagination and also deep within our psyche, and then draw upon it to further our understanding of who we are, what makes us tick and what prevents us from ticking.

For me, JM Barrie's *Peter Pan and Wendy* is a work of great psychological significance. Mrs Darling, despite many suitors, chooses Mr Darling because she realises that, although he is a decent and good man, he will never have the psychological insight to delve deeply into her very being. Thus, she holds a box inside her, and in that box is her essence of

'By reading fiction we can experience the human condition deeply in our imagination and also deep within our psyche'

self that Mr Darling will never reach. Then what about Peter Pan himself, the little boy who doesn't want to grow up, who has to sew on his shadow? He can't accept adult things and so never wants to grow up and has to be forced to accept his Jungian shadow side. I use this quite a lot in my therapy work, either sharing the plot if it seems useful or keeping a knowing inside me, inside my 'therapy' box of tricks. It keeps me mindful of what my client is and isn't showing. I think about what the client decides is OK to reveal to me, or maybe I am Mr Darling for them sometimes, unable to see them truly, in all their vulnerability.

Making sense of life

'Stories are us,' says author, broadcaster and BACP fellow Phillip Hodson. 'We need to feel the world makes sense despite all obstacles, that our inner life mimics our biology with a beginning, middle and end. One definition of insanity is that your life story never "adds up". This obviously happens when you find yourself involved in a narrative of someone else's making whose "logic" escapes you.'

If we are our stories, then the retelling of them as fiction – or reading about a character who seems to inhabit our world in a way that we believe we do – can be very revelatory. We use our stories to inform our own lives. Sometimes that's fine. Other times we become so enmeshed in our own life story that it seems impossible to change the outcome or ending. Yet we can 'quest' – we can go from psychotherapeutic rags to riches; we can overcome the monster.

Author and agony aunt Virginia Ironside finds herself drawn to fiction about addicts: 'My mother was an addict and I've lived around addicts all my life. I've always been fascinated by their mentality and what drives them to lapse again and again.' She says that, when talking about addiction or answering letters concerning addictions, she uses works of fiction to help her understand an addict's feelings and emotions. 'Addicts experience rare periods of relief from their feelings of disconnectedness and isolation. On a personal level, a single line from a story – "Not one of them ever told me life was worth living", from *Julia and the Bazooka* by Anna Kavan – gives me great comfort. I think it's how people can feel and yet, for many of us, this is a difficult concept. Not everyone thinks life is worth it, and that's when the despair sinks in.'

This one sentence might make all therapists pause. Maybe we sometimes assume that everyone thinks life is worth living on some level: that everyone wants to shift or change or rewrite their story or at the very least edit it and maybe dare to hope/think about a different ending. Maybe we think that is what has drawn our clients to therapy. But fiction can inform us differently – a client may come for help and then, like Anna Kavan, who was addicted to heroin for most of her life, head out and carry on in the same way. Sometimes it's enough to be heard and understood in our addictions – witnessed in some way.

For Ross Hyslop, counsellor and founder of the counselling consultancy Synaptein, novels such as Frank Baum's *The Wonderful Wizard of Oz* raise thought-provoking ideas. 'Clients generally enter into the therapeutic relationship because they feel powerless in a certain aspect of their life, like Dorothy losing Toto. As a therapist, my goal is to explore the client's world before their defence mechanisms rearrange their internal reality. Gaining entrance into their world is the first obstacle to encounter. After breaching the mental wall, we enter a world without fixed reference points or stable terrain – Oz.' Hyslop uses the Dorothy metaphor explicitly with clients: 'It's a powerful tool to ask clients to think about Dorothy. She had the power to return herself home all along; she just didn't know it. Clients stuck in a debilitating internal narrative seek to discover their power to reconstruct and return home.'

How we tell our story and how useful, or not, our stories are, can lead to significant breakthroughs in the therapy room. *Anna Karenina* can, according to therapist

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Andrew Wallas, the self-styled 'Modern Day Wizard', be very useful when working with clients with narcissistic traits. 'It informs my clinical practice every day of my working life. There are two related but separate themes that are psychological traps for all narcissists. First is the preoccupation with image, particularly self-image. The second is that the entire novel is an account of the time and energy taken to feed and support this image. The greatest tragedy for all narcissists is that they do not love themselves. They are enslaved to an image and always know that this is not who they are. We often look outside ourselves for happiness and, of course, this search ends in failure, because it is totally impossible to find happiness rooted in anyone or anything outside of ourselves. Yet we spend our lives in this futile search.'

Wallas says he finds it helpful to remind clients that the dilemma we all face on a regular basis is whether we want to take responsibility for our own lives or whether we will blame others. '*Anna Karenina* helps me to remember that the only path to happiness is "radical responsibility" where we refuse to blame outer circumstances for our predicaments,' he explains.

Clients can get 'stuck' in their own story – for example, 'I'm a child of an alcoholic'. They can get very attached to the story and use it as a defence/excuse for their behaviour and avoidance. With couples, I often find one of them inhabits the 'wronged' position. What really shifts things on is when I invite the couple to look at their story. Sometimes it's based on *Babes in the Wood*: 'We are here together against the hostile world.' Then one 'babe' strays, dips a toe in the water of the world outside. Yet, despite the terrible pain, this may well be an opportunity for the couple to grow up, leave their glade and venture out into a more real and adult world. Being babes in the wood is no longer helping the couple; it is stunting their growth.

The real work often comes when a client trusts the therapist enough to detach from their story and look at it through a different lens. For counsellor and writer Foluke Taylor, reading Toni Morrison connected her with her feelings and thoughts about being a black woman and a therapist. 'In her books, Morrison depicts all kinds of non-recognition and unseeing, along with the intersections of gender, class and race that inform them. Her characters sometimes wish to focus less on their enslavement than their desire to be loved. She often focuses on the crushing objecthood of blackness.' Drawing on Morrison's work to enhance her understanding of human psyche in the therapy room has helped Taylor conceptualise the complexities of working with race: 'When we see racism solely as hate, the discourses that emerge lack nuance and fail to bring us closer to working effectively with race in the consulting room. Notions of the cross-cultural – focused on finding out about an other – frustrate me because they risk underestimating and reducing what is required to see and navigate, within therapeutic relationships, the everyday distances and failures of recognition with which we live. Fiction is an invitation to keep on looking.'

I have come to realise that, in my practice as a counsellor, I draw frequently on fiction to inform my understanding of the human mind and emotions. The stories that come into my therapy room can seem almost more fantastical than fiction, yet they are real and the clients have a deep desire to make sense of them. For the thing about novels is that they can tunnel through the top soil and then burrow deep into the earth, through the strata of our psyche until they find the molten lava beneath. ■

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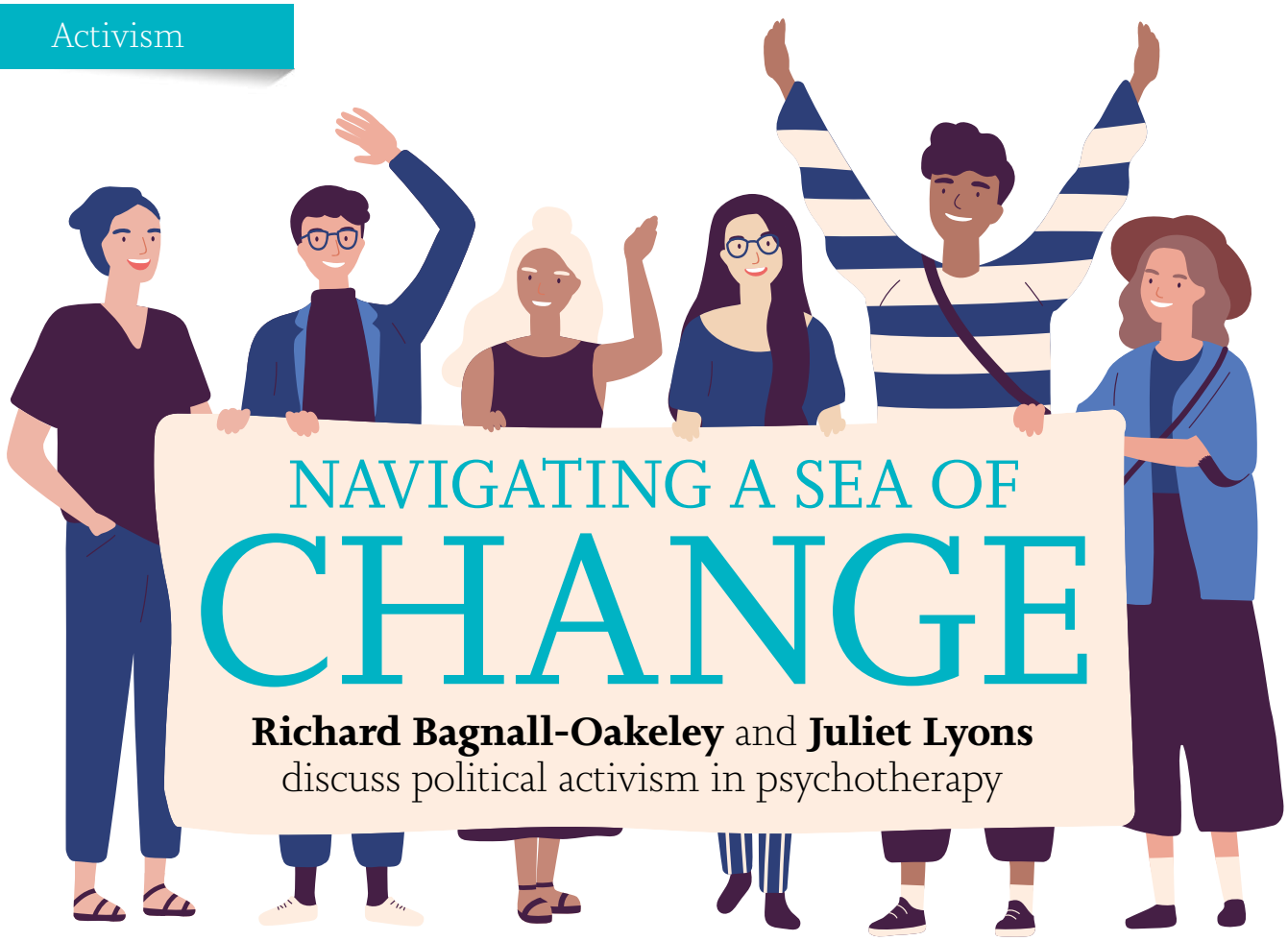
Lucy Cavendish
About the author

Lucy Cavendish is an integrative counsellor and writer in private practice in London, Oxford and Henley-on-Thames. She works with individuals, couples and teenagers and also runs teen workshops for parents. She is a member of the OTS group for therapists www.ots-oxfordtherapycentre.co.uk



NAVIGATING A SEA OF CHANGE

Richard Bagnall-Oakeley and **Juliet Lyons** discuss political activism in psychotherapy

The last two years have seen a resurgence of activism and political engagement among psychotherapists, counsellors and psychologists. It has grown from the ground up, provoked by political and economic pressures that are affecting therapists and their clients alike - cuts in access to therapy services, the increasing impact of austerity policies on already vulnerable groups, and a narrowing of access to jobs and courses for trainee therapists with limited means of support.

This article is in the form of a discussion between us about the major sea change we see occurring and the place for political activism within the profession. We start with our histories of political activism, to put what we say in context.

Juliet: I've always been interested in human rights and organisational aspects of how we care for each other. But now, when we are facing the level of crisis in our profession that we are seeing, both for clients and for professionals, it is impossible to ignore the outside world. Elizabeth Cotton's extensive research in *The Future of Therapy*[1] shows us what is happening. She predicts that the UK could be within a decade of genuine therapeutic professions dying out and the advent of 'a mental health service made up of tick boxes and compulsory wellness with psychoanalysis relegated to a heritage industry'.

It is widely acknowledged that there is a crisis in mental health services, yet the Government is not looking at the wider picture of how we care for each other in our society, and not consulting with professionals that work in these services. Instead, ideology, rather than in-depth engagement, is driving mental health policy. We strive with our clients to understand, to build bridges and to enable healing and change. If we are constantly badgered into being more money efficient, we will lose the basic security and trust in what we do that enables therapeutic practice to flourish. I love this profession, imperfect and frustrating as it is. I believe the core principles - that we can help each other, that we can work deeply and relationally - are worth preserving. So my fight for the profession has come out of a love for it.

Richard: For me, personal change and social change have always been interlinked processes. Our brains and psyches grow and develop through relationships, and I would argue that the current social epidemics of anxiety, depression and distress, particularly among young people, reflect the distortion and breakdown of social relationships in a toxic political environment. In my work as a school counsellor, I see every day how my child clients and their families are affected by social and economic policies eroding welfare support, increasing housing insecurity and exacerbating social division and exclusion. Psychologists for Social Change have highlighted the direct

> 'I love this profession, imperfect and frustrating as it is'

psychological harm caused by neoliberal 'austerity' policies that increase experiences of 'humiliation and shame, fear and distrust, instability and insecurity, isolation and loneliness, being trapped and powerless'.[2]

I need to regulate my anger, grief and sense of paralysing helplessness if I am to remain useful to my clients as their therapist, but it feels essential not to repress, split off or deny these damaging experiences affecting my clients. We need to find a way not only to think and speak as therapists about social issues, but to intervene in the wider social and political discourses.

Solidarity and support

Juliet: Essentially, I see therapists and counsellors coming together to support each other and our clients by reasserting core ethical values of relationship-based therapies during very difficult times. Many counsellors, psychotherapists and psychoanalysts have been politically active and involved in the political arena for many years. But we are also seeing a younger generation of psychotherapists and counsellors who want to talk, know about the changes occurring and protect our profession. They recognise the urgency – well-established, respected courses are closing and it is becoming harder and harder for people to afford to learn the skills needed to join our profession. Many training courses have a large experiential component, while weighty fees and working voluntarily to build up clinical hours means that diversity in the profession is compromised. We are in real danger of relationship-based therapies becoming the exception. We need a sea change to turn the tide.

Richard: For me, it's more about a network of little streams with the potential to join and swell into a wider, stronger flow. While we need to insist that our work as therapists is properly valued, there is also an opportunity here for therapists to develop a stronger sense of solidarity with struggles outside the profession. That is how the Psychotherapy and Counselling Union (PCU) emerged – from many years of conversations between therapists feeling the need to hold a position that faces both 'inwards and outwards', along with a recognition that the 'inner' worlds of client and therapist cannot be viewed in separation from their 'outer' social and political contexts. We recognise that advocacy for therapists as a profession is inseparable from engagement with the social and political conditions of our work. Therapy is fundamentally an ethical, relational project that embeds therapists in our society, and inherently challenges instrumental, objectifying models of the person. That is why the PCU's slogan is 'standing up for therapists and therapy'.

As individual therapists working with socially deprived clients, it is easy to become resigned to a position of helplessness in relation to the social systems affecting their lives. However, there is potential for us to make our voices heard, as a group, as advocates for our clients on the basis of our ethical stance towards the world. In some ways this might mean that, as well as therapeutic support, we try to cultivate a sense of solidarity between therapists and clients.

Juliet: One of the phrases that has struck me as important in these discussions is 'in solidarity'. I feel a little frightened of it, imagining perhaps something too solid, like pieces of metal being soldered to a heavy, weighty form, never to be detached. And I wonder, what is its relationship to empathy? Empathy, while expressing that you understand and feel a deep connection to someone else's feelings, can also provide the distance to be able to allow enough thinking space to make thoughtful connections that the other hasn't seen or thought of. But solidarity is something else. It is empathy, but it also surrenders to the acute vulnerability that another is feeling. A client's story highlighted this to me. She was from South America. She'd experienced a teenage break-up and was refusing to eat, as a result of her pain. Her father, a socialist activist, responded by saying: 'Today, I will not eat too.' I expected a parent to comfort: 'Come on, eat, it will be OK.' A therapist's response might have been, 'You want to show me how sad and empty you feel and how brave you are in not looking for comfort in food.' I was surprised and delighted by her father's response and the deep connection and commitment he was expressing in this action. He wanted her to know that today her pain was his pain and he stood by her; that her vulnerability was his vulnerability and he could sit with her in that place.

Richard: I'm stirred and also unsettled by this story. Positioning ourselves 'in solidarity' with others, if it is not to be merely rhetoric, is challenging for therapists. It implies over-riding the differences between us and taking an explicit position of support for – indeed identification with – an oppressed subject in a power struggle in opposition to their oppressor. As therapists, our habitual exploratory stance, acknowledging contradictions and ambiguities rather than absolutes, can be very useful when applied to the processes of political organising, but sometimes our wish to remain in a detached, reflective 'observing I' position can be defensive. It remains important to hold on to critical reflective capacities so as not to be swept away by group passions – we all see the shadow side of group identities in the current upsurge of populist racism and social ▶

ORGANISATIONS EXPLORING POLITICAL ASPECTS OF THERAPY, MENTAL HEALTH AND SOCIAL POLICY

- **Alliance for Counselling & Psychotherapy** https://allianceblogs.wordpress.com
- **Black, African & Asian Therapy Network** www.baatn.org.uk
- **Climate Psychology Alliance** www.climatepsychologyalliance.org
- **Counsellors Together UK** http://ukcounsellors.co.uk
- **The Future of Therapy** https://thefutureoftherapy.org
- **Mental Health Resistance Network** http://mentalhealthresistance.org
- **Pink Therapy** www.pinktherapy.com
- **Psychologists for Social Change (*formerly Psychologists Against Austerity*)** www.psychchange.org
- **Psychotherapists and Counsellors for Social Responsibility** www.pcsr.org.uk
- **The Psychotherapy and Counselling Union** https://Psychotherapyandcounsellingunion.co.uk
- **Radical Education Forum** http://radicaleducationforum.tumblr.com
- **Support Not Separation** http://legalactionforwomen.net/category/support-not-separation

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polarisation. However, there's a life and energy in collectively affirming each other, in claiming identities as part of a group, which is a crucial part of being fully human.

I'm excited that we are beginning to see a growth in alliances between service user groups, such as the Mental Health Resistance Network, and those in the helping professions, including therapists.

Risks and dilemmas

Juliet: Therapy groups are also starting to talk to each other. We are beginning to talk across organisations. Online forums are playing a role, where we can inform each other, discuss and learn. And we can be proactive as well as reactive. But I do think there are also difficulties and risks in becoming political. There are immediate risks such as burn out, frustration, fears of too much unity or too much separation. But more widely, traditionally our profession has been careful about what we reveal to clients. And, no doubt, we may be accused of not properly processing and acting out on the anger and frustrations of our profession. How can we ensure we do not undermine our professional positions if we have an open bias?

Richard: I think we are always political. Being 'apolitical' involves tacitly upholding the status quo. Issues of social power, privilege and inequality have always been present in our consulting rooms, and a few therapists have been open to exploring them. However, what has become more apparent is that, if we continue to see ourselves as in some way detached from social and political forces, therapy risks losing its viability as a profession, both ethically and as a way of making a living. Therefore, there is a need for therapists to become politically active as a group, to support each other and our clients.

It's true that, in the therapy session, we seek to cultivate an open, curious, accepting position towards our clients and their experiences, to help develop reflective capacities and possibilities. However, we are always situated in a social and political context: sometimes 'neutrality' can involve defensive avoidance of ethical choices.

These are intensely polarised and emotionally charged times. We can't avoid taking a position, but moral certainty easily becomes rigid and denies the humanity of the 'other side'. Whether on a demonstration or an online forum, I need to maintain an inner creative tension and hold an ethical position that leaves room for empathy with the other, self-doubt and the 'not knowing' that is a core value of relational therapies.

Juliet: Politics and psychotherapy are often at odds. Where neoliberal economic policy looks at outcomes and results, psychotherapies look toward process and integration. Current Government involvement in therapies is driven by statistics. In some ways, it is understandable that policies are developed from research. But this is fundamentally in conflict with most therapies, which allow space for uncertainty, the soul, the unknown and, again, the shadow. Statistics throw a glaringly bright light. We all know that how we read what we see is subjective, and it is the shadow as much as the illuminated that the psychotherapist takes into consideration - what is not seen, what we are not able to 'see', what it is hard to admit to, what the unconscious and collective unconscious holds. Therapists and counsellors are not being listened to by our politicians. This was painfully evident to me from the recent Health and Education Committees' joint enquiry into mental health in schools, where, in the two sessions, not one school counsellor was present. There is a fantastic cohort of services for children in schools that is being deeply undermined by cuts to school funding and almost ignored in the recent Government Green Paper on Transforming Children and Young People's Mental Health Provision.

Richard: Perhaps we need to make the success of school-based counselling central to our arguments for a decentralised, non-manualised, flexible, relationship-based approach. Those of us working as school counsellors come from a plurality of backgrounds and are a living rebuke to a medical-dominated 'one- size-fits-all' approach to mental health. But to do this we are going to have to network, organise and be far more assertive than we are used to being.

Juliet: I would like to see psychiatry, psychologists, psychoanalysts, therapists, counsellors and those in the caring professions coming together in meaningful ways and in more active roles. We all know that relationships are complex and we need to look towards the bigger picture as well as the detail.

Richard: I think we need to continue building the nascent networks across modalities, across professions, and between professionals and their client groups, to develop new, richer discourses about what a healthy society could be like. As Elizabeth Cotton says: 'We all have to become citizens in mental health, not just clinicians if we are to survive.'[1] ■

Richard Bagnall-Oakeley & Juliet Lyons
About the authors

Richard Bagnall-Oakeley is an integrative psychotherapist and supervisor who works mainly with children and young people. Following a long history of involvement in various grass-roots campaigns for social change and social justice, he was one of the founder members of the Psychotherapy and Counselling Union, which he now chairs. He lives and works in Tottenham, North London.

Juliet Lyons is an integrative child psychotherapist and secretary of the Psychotherapy and Counselling Union. She works in private practice in west and south-west London and has been a school counsellor for 12 years. She previously worked for Sure Start, in a nursery setting and with adults with severe learning disabilities.

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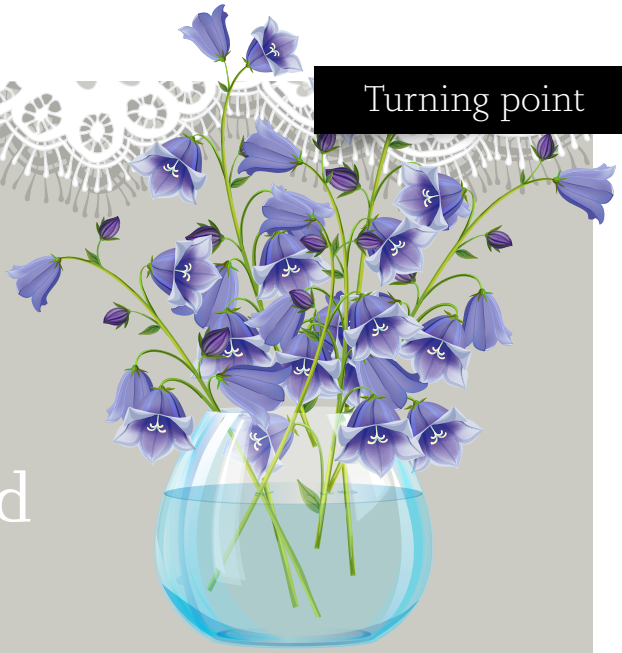
‘I was practising an embryonic form of vicarious introspection, a relational term that had not then been invented’



Like many private practitioners I always ensure there are fresh flowers in the consulting room. Having retired from NHS work to a little cottage in the country I can pop into my garden at any time for fresh supplies. Consciously, I am merely providing a pleasant environment, but I often wryly recognise later that the display, however humble or grand, has been unconsciously or half-consciously designed to reassure, calm or stimulate the particular person I would be seeing that day.

In my late 20s (I am 75 now), I undertook my first five-times-a-week traditional analysis – couch, blank-screen analyst, free associations and dreams required of me, interpretations handed down to me – in short, the works! What I remember most is the crackling of the stiff, hygienic paper on which I laid my head, no doubt casually torn from a roll similar to the ones you see on your GP’s examination couch. I vowed that, should I ever abandon my NHS job and set up in private work, I’d invest in gorgeous cushions, silk drapes or cuddly blankets to make people feel more welcome. Did the Institute of Psychoanalysis fear an outbreak of lice, or what?

Many years later, still in the NHS but burdened with a mortgage, I set up a small after-hours practice in my spare room. In a charity shop, I found a set of very old but unused linen antimacassars with a wonderful variety of edgings: interlocking loops, diamonds, scallops, fringes, tiny beads, coloured threads among the white, some with tassles, and some without.

It is only now, when I look back, that I see how this hoard not only represented revenge on the Institute but also a dawning awareness of the central importance of a shared, non-clinical relationship between treater and treated – a notion foreign at that time to the therapeutic elite. So, Eloise, a theatre director, got the coloured threads. John, a Quaker, got the plain white with squares along the bottom. The lady who lived on a barge got the purple and gold beads, and the scholar of Victorian history got the fringes. I had no awareness that I was matching up patients to antimacassars as I fetched them from the laundered pile in my drawer and laid them on the couch for each one’s session. I only realised the fit much later and put it down to coincidence.

Yet already I was practising an embryonic form of vicarious introspection, a relational term that had not then been invented. It means the therapist has such accurate empathy she can be inside her patient and look inside herself as if she were that patient, while maintaining her own separateness and sanity. Not an easy feat. In the patient’s skin, she can explore herself and identify unmet needs while, as her own therapist self, she tries to meet some of them – such as which antimacassar would be preferable to the non-reassuring, clinical paper of the Institute.

The meeting of such apparently simple needs through vicarious introspection paves the way to the unearthing of other major needs resulting from the patient’s earlier traumas. The therapy couple are communicating intimately, not just trading information and explication. The therapist does not choose the antimacassar she would like if she had the patient’s problem, thinking herself empathic. Rather, she intuits, by getting inside her patient, which is the right one to meet the subjective, not objectively observed, need of her patient.

Flowers now – antimacassars then: the same phenomenon, but now I can more readily appreciate consciously what I am up to when, without thinking, I discard the heavy ruby rose for the trembling sweet peas. ■

About Wyn

Wyn Bramley is semi-retired and runs a small private practice in rural Oxfordshire. Her last post was director of the University of Oxford master’s programme in psychodynamic studies, which she set up in 1996. Her latest book is *The Mature Psychotherapist: Beyond Training and Ideology* (Free Association Books, 2017). She has a particular interest in and experience of couple therapy, as well as being a group analyst.
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Setting digital boundaries

How do you deal with the bings and buzzes from mobile phones in the counselling room?

Sarah Worley-James MBACP (Senior Accred)
Counsellor and student counselling service co-ordinator

I take a pragmatic view as mobile phones, and in particular smartphones, are part of everyday life for most of my university-student clients. Some turn their device off at the start of the session; others rush to do so if it rings or vibrates. Yes, it can cause a distraction, in the same way as a loud voice in the corridor may do. I encourage clients to remain focused on the session if a call or message arrives – although sometimes the content of the message or the regularity of the buzzing has led the work into a productive area. Having a real-time, tangible and meaningful example to work with in brief therapy can prove beneficial. Smartphones have wide applications: clients write notes on them to bring to the session and use mental health apps to record changes in mood and monitor progress. These can be discussed in sessions and support the autonomy of the client to continue the therapeutic work beyond the counselling room.

Hilda Burke MBACP
Psychotherapist and couples counsellor in private practice

One of clients' most commonly expressed benefits of coming to therapy is having time and space to think and reflect. I believe a key factor in creating this space is that phones are off. For 50 minutes there are just two people (or three for couples work) present and available to one another, without interruption, which is a rare occurrence now that we're used to bleeping, buzzing noises trespassing on our interactions with others. It wouldn't bother me if a client were to lay their phone on the table, so long as it was switched off. If they were to hold it in their hand (switched off), I might explore that with them – what it means to them to hold it and why they need to do that. It's an issue I became fascinated with when I was writing my book on managing phone addiction, *The Phone Addiction Workbook* (Ulysses Publishing, out June 2019). More broadly, I do feel the over-use of our smartphones can be detrimental to our emotional wellbeing, and many of my clients are acutely aware of the negative impact their phones can have on their interactions with partners, children and friends. But, like the Dalai Lama has said: 'Whether technology's effect is good or bad depends on the user. It's important that we shouldn't be slaves to technology; it should help us.'

Guthrie Handley MBACP (Accred)
Counsellor in private practice

At the start of every session I always make a point of checking in front of my client that my phone is on silent. I usually make a comment about the importance of not being disturbed and place the phone out of sight. Invariably, my client does the same. If a client tells me they're waiting for an urgent call, that's fine; I'm happy if they leave their phone on but out of sight. So far, I've never had a session disturbed by a phone call. Sometimes clients will use their phone to share photos and drawings with me or to read out things they want to talk about, and I find that really useful – the immediacy of it. I think it can be a new and positive way of connecting in a session. Once the client has shared whatever it is, I encourage them to put the phone aside and focus on our work together, face to face, with no phone staring up at the two of us.

SHUTTERSTOCK

Ian Black MBACP
Individual and couples counsellor
I deal with each case on its own merit – what's best for the therapy. If a client is anxious for news of an operation or imminent bereavement but willing to go ahead with the session, I'll take an 'OK, let's see how it goes' approach, with the phone left on. Football scores can wait, however. When it comes to couple work, often couples are apart all day, working and parenting, and evenings are spent on smartphones/tablets, catching up on social media or working. Although the partners may be in the same room, they are in different worlds and certainly not talking in any meaningful way. Smartphones off in the therapy room shows that they can talk for an hour without distraction, using the time to communicate their feelings and be understood by their partner, leading to better empathy and understanding. This can be replicated at home by having a phones-down period every evening, to help rebuild what has been lost in the relationship.

Jane Darougar MBACP
College counsellor and BACP UC Sixth-Form Colleges representative
I work with 16- to 18-year-olds and their devices can be such an integral part of their identity and how they view and connect with the world that to exclude them from the therapeutic space would potentially exclude a significant part of who they are. Allowing them into the room offers a portal to their experiences. My clients sometimes share excerpts of what they are looking at and the music they are listening. This can give me a real insight into their thoughts and feelings. How a client reacts to intrusive messaging can be revealing in issues of coercive control in intimate relationships. If their partner is constantly texting, it can give us a chance to explore their response and the demands being made on them. For others, the interruption of a 'bing' from a phone helps them tolerate the intensity of the therapeutic space. Yes, it can be irritating and break the flow, but without it some clients would not be in the room at all. Sometimes, I notice they'll get their phone out and check even if it hasn't buzzed, almost to give them a moment away from the feelings. With shorter-term clients (4-6 weeks), I wouldn't address it. In long-term therapy, we will work towards being together with no interruptions and look at how they allow themselves to access this space, how being at other people's beck-and-call impinges on their needs, and at the root of their anxiety, about not instantly acknowledging someone's message.

Lawrence Railton MBACP (Accred)
Counsellor working with young people and adults
Working with young people, I find the phone is often in the room and offers therapeutic opportunities. For many 11- to 18-year-olds, a phone is a key aspect of their identity, connecting them to friends and allowing them to develop a sense of self. Most have an awareness that using their phone in sessions is impolite. However, some automatically read a message or respond to an alert, and this demonstrates, I think, how normal it is to share their attention. Younger people seem able to be in the room and out in the world at the same time (via their device). Showing interest in their phone, its use and what apps and games they favour can be a great way of developing a therapeutic alliance. I may suggest apps that I think have a therapeutic value. Sometimes, a client wants to provide evidence of how someone else is communicating with them by showing me a message. If I banned phones outright in the therapy room, I'd miss a big part of my clients' lives. If I tell them to put their phone away, I become just another adult who doesn't get it. The way a client relates to their phone gives insight into their world.

RESEARCH MATTERS

Making sense of research findings requires perspective and access to the counter-arguments, writes **John McLeod**

There are numerous research studies that seem to offer stimulating and insightful findings that might help us improve our therapy practice. But how do we know if the findings are to be believed and trusted? How do we gain that all-important critical perspective on what we are reading?

Informal supervision

One example of potentially useful but controversial research is a study that looked into what differentiates more effective therapists from those that are less effective. This study found that, compared with colleagues who are less successful, therapists who record better outcomes with clients devote more time to improving their skills and knowledge outside direct client contact hours.[1] Among the learning activities these therapists used was informal supervision - talking about cases with peers. Subsequent research then used survey methods, case examples and qualitative interviews to explore the use of informal supervision by therapy trainees on doctoral programmes in clinical and counselling psychology in the US.[2,3] These studies found that informal supervision is common and highly valued. Participants described talking at least weekly to a colleague or significant other about aspects of their work with clients that were concerning them. While research informants acknowledged that formal supervision was essential, informal supervisory contact was experienced as helpful in different ways - the trainee could be more open about expressing uncertainty and personal emotional impact and the discussion was more playful and creative. Informants described themselves as being aware of the ethical issues associated with their use of peer supervision and had implemented strategies for ensuring that client confidentiality was safeguarded.

How effective are antidepressants?

The effectiveness of antidepressant medication is a very different issue but also highly relevant to counselling and psychotherapy practice. Around 10% of the adult population of the UK take antidepressants, so it is inevitable that a significant proportion of therapists' clients will also be using medication. Many of these clients may be worried about the implications of this choice.[4] A recent comprehensive meta-analysis in the *Lancet* reviewed the results of 522 double-blind randomised trial studies that compared the immediate impact (at eight weeks) on major depression of a range of antidepressant medications and placebo.[5] This review was groundbreaking in including unpublished as well as published studies and using a type of analysis that made it possible to compare the efficacy of the different drugs. It was conducted to the highest current standards of transparency and quality control for this kind of review process, with all of the data available on a website. On the basis of analysis of data from more than 116,000 patients, the review concluded that medication is significantly more effective than placebo, and that some brands of antidepressant are more effective than others. These findings were widely reported across the print and TV media as indicating that GPs and patients could be confident that antidepressants are helpful and that many more people could potentially be helped than are currently receiving this kind of intervention for their depression.[6]

'To make a difference, alternative perspectives also need to be out in the open and in spaces where they can be viewed alongside each other'

However, there are alternative interpretations of the findings of this antidepressant review. A brief summary on the NHS website highlights some of the limitations of the study.[7] The website Mad in America[8] carried readable, detailed and closely referenced critical commentaries from a leading science journalist[9] and two doctors who are also researchers.[10,11] Among the many issues raised in these commentaries are the absence of an analysis of the risk of antidepressants, the relatively minor additional benefit arising from taking an active drug compared with a placebo, withdrawal symptoms[12,13] and the difficulties in conducting double-blind studies in this area - many patients can work out that they have been given an antidepressant because of the side-effects. A further important factor is that many patients continue to take antidepressants for several years - the review does not cover the potential risks of this type of real-life pattern of medication usage.

Translating research into practice

Both these areas of research exemplify some of the challenges associated with using research to inform practice. Studies of informal supervision have identified an aspect of therapist behaviour that has previously been somewhat secretive and under-reported. It makes sense that it would be helpful to be able to access as wide a set of views as possible around one's work with clients, so it seems possible that informal supervision may make a positive contribution to therapist effectiveness. Should training programmes offer guidance to their students on how they can ethically and effectively make best use of this source of learning and support? We are not at that stage yet; more research needs to be carried out.

SHUTTERSTOCK

Are the experiences of doctoral trainees on full-time programmes in the US similar to those of trainees in other countries? What does informal supervision look like in the context of the working lives of qualified practitioners? Are there ways in which informal supervision might be unhelpful? What about client informed consent – can all the ethical risks be dealt with?

The research into informal supervision is an example of a scenario that is typical in therapy research. Survey, case-based and qualitative methods are skilfully deployed by members of one research team in one university to map out the parameters of a phenomenon that has considerable practical relevance. However, in order to achieve sufficient density of knowledge to be able to have confidence in how to apply these ideas in ways that will genuinely enhance practice, more work needs to be done to develop a more richly described, contextualised understanding. All too often, this further work does not happen – the landscape of therapy research incorporates many potentially important roads less travelled.

The recent antidepressant meta-analysis, and the responses to it, are instructive for research-informed counsellors and psychotherapists in a different way. Informal supervision is a new story; the debate around the effectiveness of antidepressants is an old one. The *Lancet* antidepressant review was itself carried out to address perceived shortcomings of earlier studies and reviews in this area. This is how science works – open dialogue and rebuttal around the meaning of research findings drives knowledge forward.

It is instructive to consider the differences between the current debate over antidepressant effectiveness, and the somewhat similar debate arising from the 2018 NICE guidelines on psychological treatments for depression.[14,15] Anyone interested in following the antidepressant story can access non-technical yet technically robust and coherent counter-arguments to the mainstream position by following up the internet sources listed in the references at the end of this article. By contrast, it is hard for therapists who are uneasy about NICE (or similar research-based policy statements) to move beyond their gut feeling that something is not quite right – the alternative evidence and arguments are not readily available on the internet.

In the absence of open debate, science has a tendency to get stuck. Psychiatrists and others who are interested in antidepressant medication are fully aware of the counter-arguments and critical perspectives to which their research needs to be responsive. It is significant that these oppositional stances often originate in the voices and experiences of service users and practitioners who are outside the mainstream professional community. This happens too, to a much more limited extent, in psychotherapy research.

Few would disagree that making sense of the practical relevance of research findings requires a sense of perspective. The two research areas featured in this column give a glimpse of some of the ways in which perspective is constructed: taking forward the work of others, making space for non-dominant voices, building coherent counter-narratives. To make a difference, alternative perspectives also need to be out in the open and in spaces where they can be viewed alongside each other. ■

John McLeod
About the author

John works at the University of Oslo and the Institute of Integrative Counselling and Psychotherapy, Dublin, and is the author of books and articles on a wide range of topics in counselling and psychotherapy.

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Get in touch

If you have comments or questions about any of these studies, or would like to suggest studies for inclusion in these pages, contact John McLeod at research@thinkpublishing.co.uk

THIS MONTH'S DILEMMA: Can I delete a recording of a client's call without a written request?

Illya works for an employee assistance programme (EAP) as a telephone counsellor. A new referral, Esi, is seeking support because she is being bullied by her line manager. During the call, she becomes agitated and upset about the possibility that what she discloses in the session may get back to her employer and her line manager will hear about it. Illya tries to reassure Esi that calls to the EAP are completely confidential.

Esi refers to the automated message on the EAP telephone answering system saying a record of the call will be kept, and she asks Illya to destroy this record. Illya deletes the written computer record he's made of the call and reassures her that all records have been destroyed.

Following the call, Illya listens to the pre-recorded message and finds it says that calls may be recorded for training purposes and that a record of the caller's conversation will be made but is kept confidential. Illya then remembers being told that all calls are recorded and can only be deleted if the caller sends a written request. He can't contact Esi as he has deleted his computer record with her contact details. He asks his team leader to delete the recording, but the team leader refuses to do so without a written request from the client.

IF YOU WERE ILLYA'S SUPERVISOR, WHAT ISSUES WOULD YOU WANT TO TALK THROUGH HERE? Please note that opinions expressed in these responses are those of the writers alone and not necessarily those of the column editor or of BACP.

Parallel process

Mark Redwood MBACP
Humanistic Gestalt counsellor in private practice

While there is learning here for Illya, it would be all too easy for his supervision to take a managerial turn. For me, this is more about Illya developing a sense of himself extending beyond the client-therapist relationship; he is also part of an organisation and has responsibilities to them too. What I would most want out of supervision is to have the space to explore the shadow side of this organisation, because there is a very clear one.

It seems that Illya is placed in a position of significant individual responsibility (he can delete client records) while being held inside an inflexible, autocratic management system where joint problem-solving and reaching a consensus on how to act are missing. There is also a parallel process between Esi's anxiety about how information about her might be misused and how Illya's own organisation is misusing information. Both organisations have covert information-gathering systems where consent is improperly sought. And Illya might also want to reflect on how his own consent was sought about how his information is recorded and used.

I wonder if this line of approach might also lead Illya to explore his own anxious process in responding to his client: how much was this about his own desire to avoid surveillance? This might lead to an exploration of how he might have stayed more in contact with his client's anxiety.

Countertransference

Philipp Grote MBACP
Integrative counsellor

It sounds like Illya has a naturally caring personality, which is a great asset for any counsellor. It seems he was able to put himself in Esi's situation, feel her concern and experience her agitation and anxiety. Illya may want to explore with his supervisor to what extent he took on this agitation from Esi and how it affected his subsequent thoughts and actions. Was he aware of this countertransference?

He may also value looking at his moral and ethical views on diligence, as outlined in the BACP *Ethical Framework*. As he is a telephone counsellor, the pre-recorded message and the service's confidentiality agreement form part of his contracting with clients. He might explore with his supervisor how being clearer about the service agreement and procedures around confidentiality could have helped him to empower Esi to request her record of the session to be deleted.

However, he cannot advise Esi about this now, and it may be more useful for him to think about the extent and manner in which he has been affected by Esi's agitation. This may provide him with valuable insights into how he might manage his emotional responses with future clients in similar situations and maximise the benefits to his clients that come with his caring and conscientious personality.

> 'There is also a parallel process between Esi's anxiety about how information about her might be misused, and how Illya's own organisation is misusing information'

Refer to ICO guidelines

William Johnston MBACP
Person-centred counsellor in private practice

This, as I understand it, is really not a complicated issue. According to the Information Commissioner's Office (ICO) website, under the heading 'Right to Erasure' (https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/

right-to-erasure/): 'Individuals can make a request for erasure *verbally or in writing*' (my emphasis). There are circumstances under which records can be retained, but this is certainly not one of them. It would appear, therefore, that Illya's team leader is straightforwardly wrong about needing written confirmation – as is the EAP.

I would suggest that Illya draws his team leader's attention to the ICO guidelines. If the team leader still refuses to delete the record, then Illya should report the organisation to the ICO – though he might choose to word things in a slightly more conciliatory manner. The organisation should also correct the message on the telephone answering system, since this is misleading.

I can't see that Illya has done anything to regret or that might need discussion with a supervisor – although he might wish to do so. He might also want to think about how to record a similar request in the future, although, as indicated above, it is really the responsibility of the EAP to have a policy in place.

'Has Esi's anxiety been projected onto Illya? Does he feel he has let Esi down? Working with a highly anxious client can be difficult and it is easy to get caught up in their fears'

Contain the anxiety

Lesley Ludlow BACP (Snr Accred)
Counsellor and supervisor in private practice, Croydon

Effectively, the horse has bolted here, so we are left with the scenario that the recording exists on the system and, without Esi's details to obtain her permission to delete it, it will need to remain there. Having myself worked as a telephone counsellor for an EAP provider, I know there are strict guidelines around maintaining confidentiality and that the recording cannot be released to anyone unless Esi provides permission in writing, so effectively it is secure.

So, the question is, what issues arise from the telephone conversation? Broken promises? Paranoia? Anxiety? Esi is clearly extremely anxious about her manager and fears that she may be bullied further. Her anxiety has built to such a level that she is unable to trust that the EAP provider, and Illya, will not tell her manager about the phone call and, as a result, she wants any evidence destroyed.

As Illya's supervisor, I would be helping him to wonder what has happened between Esi and her manager. It's difficult to know the answers to these questions based on what was probably a very short phone call. I would be exploring what issues Illya is left holding. Has Esi's anxiety been projected onto Illya? Does he feel he has let Esi down?

Working with a highly anxious client can be difficult and it is easy to get caught up in their fears; the paranoia can be contagious. Is Illya left worrying that somehow the details of the phone call will be released, or that he will be told off? I would then explore with Illya if he carries a sense of wanting to do the right thing and worries when he feels he has 'broken the rules'. ■

April's dilemma:

Ariana, a counsellor in training looking for a placement, has been in contact with Hillcrest Therapy, a counselling business in her local area. The service charges full-fee clients £66 per session, paid directly to Hillcrest, which employs qualified counsellors on zero-hour contracts at a sessional rate of £22. A reduced fee of £33 is offered to clients willing to be seen by unpaid volunteer counsellors on placement, which covers Hillcrest's overheads and the cost of in-house supervision, provided by one of the sessional counsellors.

Ariana would prefer a placement in a charity, where clients are charged a lower session fee or no fee, but has been unable to find one. She has concerns about the ethics of a private company profiting from the provision of counselling by unpaid volunteers. She has learned from someone on the same training who did his placement at Hillcrest that they expect him to continue to see clients referred to him while on placement at no pay now that he has qualified and is moving on to a zero-hours contract.

WHAT ADVICE WOULD YOU GIVE ARIANA ABOUT THE ETHICS OF HILLCREST'S BUSINESS MODEL?

Please email your responses (300 words maximum) to John Daniel at **dilemmas@thinkpublishing.co.uk** by 28 January 2019. The editor reserves the right to cut and edit contributions. Readers are welcome to send in suggestions for dilemmas to be considered for publication, but they will not be answered personally.

There's something I didn't say

Sometimes safeguarding means trusting the process

I know what it's like to want to kill my own kids. Not the 'I could kill them' kind of killing when they left a cupboard door open or they swore at me, or when the clean washing I placed outside their door found its way back into the washing basket hours later because it was easier than putting it away. All these things are manageable. A bit of terse sarcasm, some out-and-out shouting or passive-aggressive cooking usually evened things out. They did not merit the planning and execution of a homicidal act.

Loving them - that was the clincher; that was what made overwhelming the desire to remove them from a world of horror.

There was a long time when the very act of not killing myself was achievement enough in a day. I didn't succumb because I loved my children and some poor sod would have to find me, but I did begin to plan. There were months when it was all I could do to get the kids to school, and I didn't always do that. That's when the eldest became a tiny mother to her siblings, and to me. My son's impromptu game of hide-and-seek once angered me so much that I screamed at him until I was hoarse and he was traumatised. They were all only children, not even into double figures. But I was filled with the fear of losing them and fear often masquerades as anger.

I knew something was off kilter. The three of them were the reason I forced myself out of bed at all, and why I didn't touch a drop of the sauce till 4pm - well, 2.30pm if I was desperate. I wasn't exactly an alcoholic, but it ended the torment for an hour or two and then I'd hide under the duvet for the rest of the day - literally hide. Danger filled whole rooms; a sense of dread came out of the TV, up through floorboards, ran out of the taps. It was knitted into the very air.

My children needed me, I knew that, but I was desperate for the horror to end. How would they survive without me? They'd blame themselves - I knew that much. This monstrous world, with its claws in the darkness and its crouching gargoyles behind every piece of furniture, would terrorise my babies. I just could not abandon them to it. But then again, how would they survive with me as a mother? I felt incapable of keeping them safe. So, in time, only one thing came to make sense - I needed to kill them in order to protect them, and I would have to do it myself. No one else would ever murder them so lovingly.

How? My brain was never clear enough to work out the details all the way through. All I knew was that they would have to go together - for comfort. I always imagined that I would be alone, even in death. But the children would be together and safer than they ever were alive - and I didn't know how to do that.

When I hear that some family man has run amok with a shotgun and killed his whole family, I know exactly why he's done it. He loved, but he loved too well. It was too much love and too much pain; he was doing his best, he was doing his job; he was (and it's nearly always a he - I would have been a statistical exception) taking his family to safety the only way he knew how.

My therapist tells me that, 10 years ago, the healthy part of me took me to her door and started me on the long road back to mental wellbeing. I still see her, sometimes once a week, sometimes just once a month, because I am well and balanced and healthy and have been for some time now. I am determined it will stay that way. It's like going to AA - you have to keep going to the meetings to ensure you don't slip up. I have been too ashamed to admit in therapy to my thoughts of killing my children, too scared of admitting them to myself. What I do often tell her, though, is that, if I had known how ill I was and how long it would take me to recover, I'd have been more terrified still, maybe fatally - if you know what I mean.

Understanding and forgiveness

I didn't know I was mentally ill, but I knew things were confusing and scary and that I was often physically unwell, paralysed almost. Now, as I read this, I cannot believe I lived with such poison coursing through me. We have never managed to quite get to the bottom of the cause of all that damage. We have our strong suspicions - a combination of traumatic circumstances - but to me, they don't seem to accurately reflect the depth of the problem.

What I do know is that I never once doubted the process. I worked hard to understand ▶

'My therapist tells me that, 10 years ago, the healthy part of me took me to her door and started me on the long road back to mental wellbeing'

ILLUSTRATION: LUKE BROOKES

myself, to forgive myself, to face things that were difficult to face. I wanted it all to be different; I couldn't live with more of the same and I believed that one day, if I worked hard enough, it would come to an end: all the fuzzy cotton-wool days, the days when I couldn't lift my head; the days when rage was roaring inside; the moments when I discovered that the incessant screaming was coming from me; the weeks of migraines; the times when one foot would just not go in front of another, when even sunny days were bleak and windswept; the never-ending fatigue and the endless, endless tears; the months filled with an unidentified guilt, the breakdowns... one after another after another.

But through it all, there were my children and there was therapy. They were what drew me through one day to the next. I felt that we were a perfect fit, my therapist and I. She says that I grabbed onto our sessions as though they were a lifeline because I knew that I was about to drown and the healthy part of me was fighting like a bear to keep afloat. There were times when I was so afraid that it was all I could do not to beg her to move in with me. I gave myself homework after every session. Her advice was to relax and just be, but I didn't know how. I only knew who I was when I was striving for something and there was no bigger prize than not being 'like this' any more. I picked over every word that passed between us. I pondered every question. I remained healthily sceptical; I never lost sight of my independence. I was constantly asking, is that related to me? Does she really understand me? What do I think?

In those first sessions, I'd file everything away. I was so used to being unsupported that I was utterly unable to think, chew over or respond with someone else present. After the sessions, I'd drag it all away and gnaw at it for a week and return, full of questions and ruminations. We realised early on that, for me, it was important to know why we were doing things; I needed to understand the process. Everything needed a context. I couldn't just blindly trust my therapist.

There were times when I worried about my therapist's ability to cope with the extent of my problems. Not that she ever seemed to waver in her steadfast hold of me. But occasionally I'd see a flicker of concern and I didn't like that at all, because it made me worry that, if I was too much for her, she would 'give me away' and then where would I be? Unsaveable, in free fall. And that made me work even harder.

Therapy gave me the rules for living. I was completely unable to navigate life and relationships without constantly feeling that I'd been dropped off a cliff. My therapist built the scaffolding with me, little by little. I love that she tells me that I put the work in. That there was no way I was going to let it fail. I would say that one of the darkest times in therapy brought about a turnaround that I liken to an ocean liner changing direction. It was huge, cumbersome, it made lots of waves, but at least I was going in the right direction at last.

> 'But through it all, there were my children and there was therapy. They were what drew me through...'

Keys to survival

It happened after I had described to her a night when I was so terrified, my heart was racing so fast, I honestly wanted to jump out of the window to get rid of the energy. But my eight-year-old was in bed with me and she was my priority, so I got out my drumsticks and drummed on my quilt for hours, muffling the sound, until things finally began to calm down. I knew instinctively that concentration and application were the key to survival. This tale provoked a rare moment of obvious concern from my therapist. I was surprised. I had simply accepted it in my life as one of the odd things that happened to me constantly, in one form or another, and over which I had no control. I simply learned to survive them. I had either huge highs or interminable lows, and the highs were accompanied by the racing heart. We talked, I researched and I realised that this was not common and that I might be experiencing bipolar episodes.

I had an assessment and was assured that, although I was on the path, I hadn't arrived at that particular destination. For a while I felt worse, because it meant that things were still up to me; there was no miracle medical intervention, and I was so very tired of fighting constantly with myself. Sometimes, I really wanted my therapist to suggest it was time to go into hospital. I was often a wreck. But I am so glad now that she didn't - that she recognised the fighter in me and that she had faith.

I realised that I understood the mechanics of bipolar swings and that, at last, I really had something to get my teeth into, to limit the climbs and avoid those vertical drops that arrived so very suddenly and didn't leave for months. It was practical; I understood the process and how it related to me. It was something real that I could do *now* to help myself. And I did; I stopped those swings. Therapy helped me to do that. That twice-weekly space for me to be honest and emotional and accepted, no matter what, brought those swings to a halt.

And, because I conquered all of that, that is why I am finally able to admit that I know what it is like to love your children so much that you think the only way to keep them safe is to kill them with your own two hands, because no one else could ever care for them like you. That is why I was finally able to tell my therapist, to face that final fear.

Because I have told her. I went to my session and confessed. I hadn't told her at the time because I didn't want her to have that burden of knowledge, the burden of having to do something with the knowledge. I didn't want to have the kids taken away for something I was thinking about but not doing, and I didn't know her well enough then to know if I could trust her.

Now, I think she would have reassured me that I wouldn't actually do it because the healthy part of me refused to give up. Right from the off (she reminds me), the therapy was all about keeping my children safe. They were constantly in the room; our conversations returned to them again and again. Were they getting what they needed? Where were they when such and such happened? What did they say about this or that? I was their lifeline, but they were also mine. They were three glorious reasons for me to live and none at all to die. My therapist knew that. That is why my children are now fully grown, independent young adults, who are close to their mum and I continue to love them to distraction - but then, I always did. Therapy did that. ■

About the author

The author wishes to remain anonymous. She has shared this article with her therapist.

From the Board

‘If you’ve heard a rumour or read something you don’t agree with, or you are unsure about any aspect of how BACP works for you, please get in touch!’

As the year draws to a close, for many of us this is a time to reflect on our professional and personal lives and how our year has been.

For me, it’s been a really steep learning curve as I’ve settled into my role as a BACP governor, learning about the governance side of BACP as well as the operational side. I, like many other members, was unhappy in that I felt ‘my’ professional organisation wasn’t listening to me, particularly around the issues of the time and cost of accreditation and customer service in general. It felt like there was a wall between ‘them’ (BACP) and ‘us’ (members) – I felt a sense of disconnection and not being heard.

I feel I have hit the ground running and have experienced BACP’s willingness to listen to challenge and look at how to make changes. For example, BACP has agreed that the charge for resubmitting a deferred accreditation application should be dropped. And, at the time of writing, the accreditation team is working on reducing the time it takes to assess applications too. I’ve attended members’ events and conferences and heard many concerns and fed them back. What has been a real eye-opener for me was how willing to listen everyone at BACP has been. My experience has been that the team at BACP House is made up of hugely talented and dedicated people and the Board itself is a group of very passionate therapists and professionals who work really hard on very full agendas at each of the regular meetings throughout the year.

So, I’m left wondering about my sense of disconnection. Does social media play a part in keeping us all at arm’s length? Do some of the misconceptions about BACP gain credence when they go unchallenged?

There are many events planned for 2019, including Making Connections days covering the four nations. We definitely want to hear you! If you’ve heard a rumour or have read something you don’t agree with, or you are unsure about any aspect of how BACP works for you, please get in touch!

I hope that 2019 will be a great opportunity for all of us to really connect, get engaged and be more collaborative. We are all BACP.

Una Cavanagh
BACP Governor

BACP round-up

Our monthly digest of BACP news, updates and events

Tell us what you think about SCoPEd

We're approaching an exciting stage of our Scope of Practice and Education project (SCoPEd), as we ask for your views.

The groundbreaking project, which is being undertaken in collaboration with the British Psychoanalytic Council and the UK Council for Psychotherapy, is mapping the training requirements and practice standards that you're working to in the counselling and psychotherapy professions.

Head of Professional Standards at BACP, Fiona Ballantine-Dykes said: 'One of the aims of the project is to increase clarity for potential clients so they can easily access your help.

'We've completed the initial evidence-based framework and we'll be sharing it with you over the coming weeks, along with a survey to ask what you think the impact of the work might be.

'We really value your views, so please keep an eye out for the consultation, and of course we will keep you updated.'

Let's invest in relationships

We're working with Relate on a campaign to improve access to relationship support for everyone who needs it, regardless of income. People like Laura (her name has been changed to respect her anonymity) would benefit hugely from increased funding for relationship counselling. Speaking about her relationship with her husband, Laura said, 'I spent a long time convincing him that we needed relationship counselling only to discover we were unable to afford it... I want us to stay together because I know we truly love each other, as well as for the sake of the family, but desperate situations push people towards desperate measures, such as contemplating divorce.'

To spread the word, we hosted a fringe event with Relate at the Conservative Party Conference in September. We were lucky to hear from the chief executive of the Early Intervention Foundation, Dr Jo Casebourne, and MP Andrew Selous, as well as Professor Janet Walker of Relate and our own President, David Weaver. There were insightful discussions about the importance of counselling in helping couples experiencing a relationship breakdown and the effects of relationship conflict on young people.

You can show your support for the campaign by signing our petition at **bit.ly/2CE5snc**

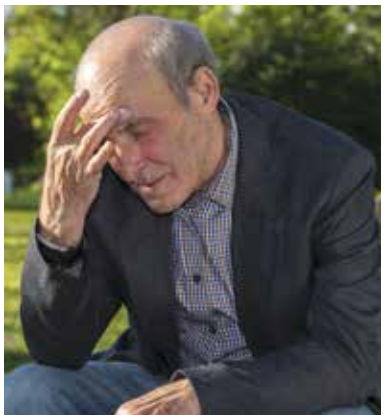
Tackling loneliness

The Government has launched its first loneliness strategy, which follows on from the work of the Jo Cox Commission and the appointment of the first Minister for Loneliness.

The strategy for England focuses on prescribing social activities, increasing digital literacy, and a public health campaign as ways to combat loneliness.

In our submission to the strategy consultation, we emphasised the need to recognise and address the intrinsic relationship between loneliness and depression.

As part of our work focusing on older people, we met with members in Cardiff to discuss how counselling can support mental wellbeing in later life and what



barriers are preventing older people from accessing therapy.

We sent our findings to the Older People's Commissioner for Wales. The Scottish and Welsh Governments have said they will publish their own loneliness strategies in the future. To find out what members at our round-table meetings across the UK say about working with older people, search 'older people' on our website.

Our revised professional conduct procedure

We've been working to update our professional conduct procedure (PCP) in consultation with our members, other stakeholders and the Professional Standards Authority (PSA). We'd like to thank everyone who's been involved.

You'll find some important changes. There are now more ways to resolve a complaint at an earlier stage without the need to proceed to a full adjudication hearing. Making a complaint is distressing for all involved, and this new process will reduce the time it takes to deal with a complaint while still offering the same level of protection to the public.

The new PCP will be formally adopted on 1 December 2018. Any complaints received before this date will be processed under the old procedure. There's more information about the new PCP on our website and in the November issue of *Therapy Today*.

Supporting supervisors

Our telephone support service for supervisors can help if your supervisee presents with an ethical dilemma. The service has now been up and running for six months and we're pleased that it's helped many supervisors so far.

Stephen Hitchcock, our ethics consultant, said: 'In most cases, supervisors have been seeking reassurance that they are acting ethically and appropriately, and that they are leaving no stone unturned as they consider the options open to them. I have been impressed by their desire to act with professionalism and integrity, and by their genuine concerns for both their supervisees and their supervisees' clients.'

Supervisors who have used the service find it valuable. One said: 'The advice and information you provided was really helpful and I feel much more confident in knowing how to proceed now and what advice I need to give my supervisee. I hope this pilot scheme gets the go-ahead. It has certainly been of great value to my practice.'

The service is free, and you can book your 30-minute telephone consultation with Stephen via our ethics hub.

Apply for a PhD studentship

We're once again offering the chance to apply for one of our PhD studentships. These give financial support for students undertaking PhD research on topics related to our strategic aims.

The bursaries will cover part-time PhD fees and some expenses up to £7,500 per academic year, for a maximum of five years. If you're interested, the closing date to apply is 31 January 2019. Visit our website for more information.

EVENTS CALENDAR

12 December
Making Connections
Blackpool

8 February 2019
Professional development day
Working safely and therapeutically with domestic abuse
Glasgow

9 February 2019
Children, Young People & Families conference
London

13 February 2019
Professional development day
Integrating artwork into your counselling practice
Exeter

20 February 2019
Professional development day
Beyond homophobia: contemporary responses to lesbian, gay, bisexual and transgender people
Belfast

23 February 2019
Student event
Bridging the gap – our career development fair
London

8 March 2019
Professional development day
Erotic transference and countertransference
Southampton

8 March 2019
Making Connections
Ashford

19 March 2019
Working in...
supervision with the impact of trauma in a healthcare setting
Glasgow

25 March 2019
Professional development day
Culturally and linguistically sensitive supervision
Birmingham

17–18 May 2019
Annual Research Conference
Shaping counselling practice and policy: the next 25 years
Belfast

10-11 October 2019
Let the Voices be Heard!
An international conversation on counselling, psychotherapy and social justice
Belfast

BACP round-up

OBITUARY

George Buckton 1930–2018

George was born on 20 June 1930 in Washington, County Durham, and died at home in Cornwall on 19 September 2018. He is survived by his wife, Pamela.

Past BACP Chair Lynne Gabriel's words (right) capture what so many people remember of George. Counsellor, educationalist and BACP Fellow, he was a man who inspired deep respect and affection in equal measure, both for himself and for his contributions to the counselling profession.

George started his career in school teaching but, after some 20 years, qualified as a counsellor at University College Swansea in 1971 and got a job heading up the student counselling service at Plymouth Polytechnic, as it then was, where he worked until 1992. He then moved to work in a consultancy role with the Post Office occupational health and subsequently welfare service, where he set up its counselling supervision structure. He also had a private practice as a counsellor and supervisor.

Alongside, he was an external examiner/assessor on numerous counselling courses and consultant to several student counselling services, as well as to organisations including Yorkshire Water and the British Council. Kathy Raffles first met George in 1994 when she asked the BAC (as it then was) Course Accreditation Committee for advice about applying for accreditation for a college diploma course she was establishing. BAC put her in touch with George, who was based locally to her in the south west. They worked together for the next 19 years, developing and running training courses in the region and nationally. She says: 'I will always be grateful for George's passion for education, particularly his desire to improve choices for counsellors in the south west.'

'George was a canny North Easterner with great integrity, strong values in relation to ethical practice and a great Geordie sense of humour. He was a principled man who saw the best in folks'

George was a member of the Association for Student Counselling from the late 1970s, and of the BAC from 1990, when the ASC became a division of the larger organisation. He held numerous honorary positions, initially with the education department as Chair of the BAC Working Party on the Recognition of Counselling Skills Courses and a member of the Training Sub-Committee. He was a trustee on the Board of Governors from 1995 to 2001 and an Approved Member of the UK Register for Counsellors (the precursor to the current BACP Register) from 1997. He was made a Fellow in 1998 and served on BACP's Professional Conduct Panels from 2003 up until 2016.

Heather Dale and Tessa Roxburgh were often fellow Panel members. They recall: 'George chaired all the Professional Conduct Appeals. He was generally genial with everyone but, if the moment called for it, he could be fierce, especially if he thought that a lawyer was getting out of hand. However, he was always attentive and just to complainants and counsellors alike.'

Kathy Raffles also remembers: 'He was an ardent and faithful supporter of BACP, though no pushover, and would challenge the Association when he believed it was necessary. He worked tirelessly as the Chair of Appeals with the staff of the Professional Conduct department and contributed enormously to the upholding of professional standards on behalf of the Association.'

In 2003–05 he was part of a small team tasked with going out and promoting the new *Ethical Framework*, produced by Tim Bond, to the membership. Heather and Tessa were part of this pioneering group: 'Some of our best memories are of running the workshops throughout the UK to explain the *Ethical Framework* and demonstrate how it was applied. We all played our part, of course, but George's unfailing patience and good humour stand out. George was wonderful, caring and compassionate, brilliant, fierce, meticulously prepared, and never to be forgotten.'

BACP events/CPD

Last call for CPD hub special offer

If you haven't already done so, now is a great time to sign up to our CPD hub. There's currently around 110 hours of video and audio available, with new content added each month. It's also the last month to sign up for the special introductory price of £25, which ends on 31 December 2018.

This month, we're focusing on children, young people and families, with new presentations about attachment disorders, core conditions offered to young people with behavioural and attachment issues, and the language of difficult behaviour.

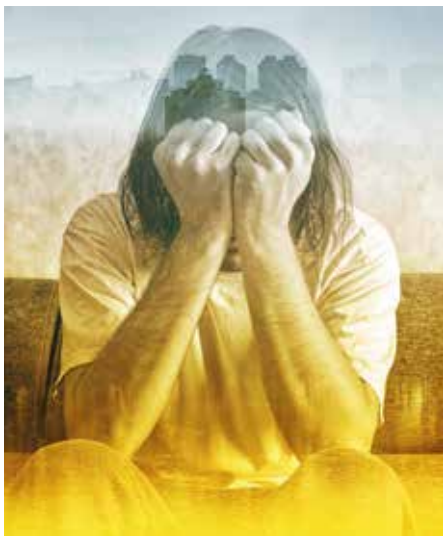
Lots of members are already enjoying the benefits of the hub. Michelle, an individual member, said: 'It's an amazing resource that you can access without paying a fortune on travel, hotels and other expenses.' Kay, a registered member, said: 'It's easy, convenient and affordable access to CPD.' Sign up via the website.

Join us at the BACP student event

Our student event 'Bridging the gap' will help you choose your steps from graduation to becoming a qualified professional.

The event is on 23 February 2019 in London and will be a packed day of workshops delivered by experienced counselling professionals sharing their own experiences from years in practice. Each speaker comes from a different background and offers a unique perspective on life working in the profession. They'll also let you in on the things they wish they'd known when they graduated.

You'll be able to tailor your experience by creating your own workshop schedule, giving you a day that best suits you. You can also visit the exhibition area, attend open taster talks, and book one-to-one appointments with exhibitors.
Visit the website to check out the conference programme. bit.ly/2q8ZH9t



Working with trauma in supervision

At this event you'll learn about the experiences of counsellors working with trauma in a healthcare setting. You'll consider how to work with complex trauma in supervision and the differentiating factors between vicarious trauma and burnout.

The conference takes place on 19 March 2019 in Glasgow. It costs £95 to attend and just £60 to student members. Find out more and book on the website.

Book your place for the research conference

Our annual research conference returns on 17–18 May 2019 with the theme *'Shaping Counselling Practice and Policy: the next 25 years'*.

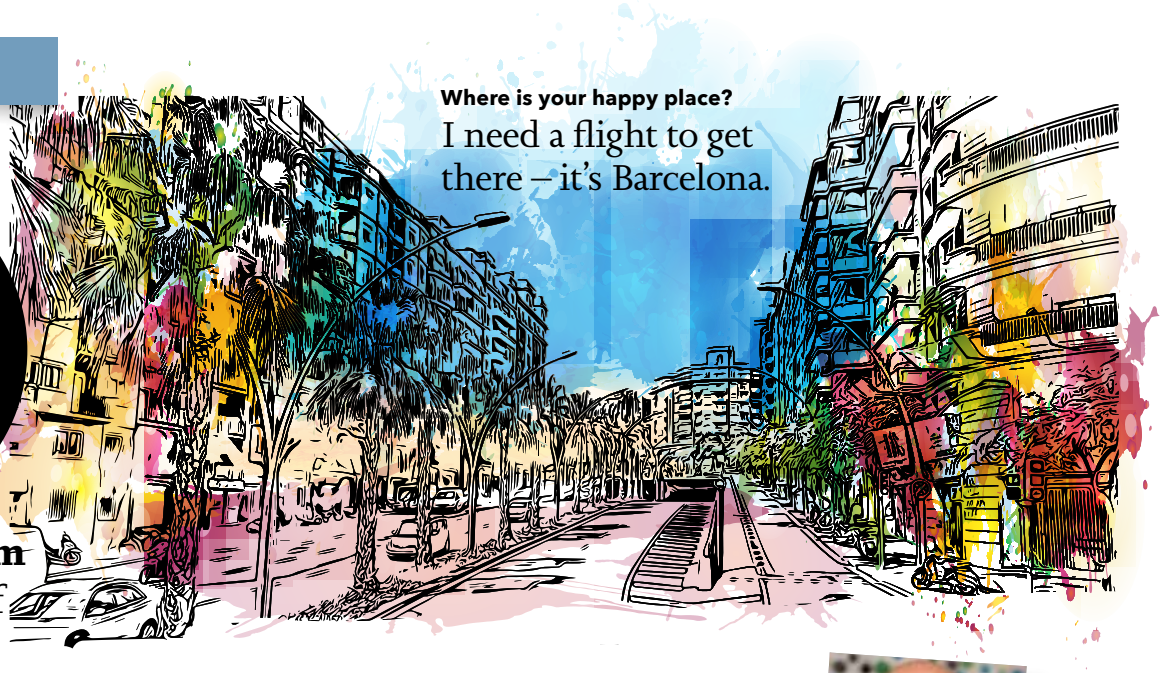
For the past 24 years, the annual research conference has brought together researchers, students, practitioners, academics and trainers from different backgrounds and traditions for lively exchange and critical debate.

The conference will take place in Belfast and is co-hosted by Ulster University and Queen's University Belfast. It will also be available as a webcast for those unable to attend in person.

Find out more and book your place on our website.

Analyse me

Pretish Raja-Helm speaks for himself



How did you become a therapist/counsellor?
I was teaching and living in Barcelona as one last desperate attempt to change something in my life. I couldn't settle and returned to London. I stumbled into therapy and quickly realised that training to be a psychotherapist was the way forward.

What is your specialist interest?
I wouldn't say I have a specialism. I have a keen interest in and work closely with individuals with multiple oppressed, marginalised and stigmatised identities.

When and why did you last see a therapist?
I have been in therapy since January 2012. I felt lost in life and didn't know who I was. I finished with my therapist this summer.

Why do you think therapy works?
Through my personal experience of therapy, I have found myself to be in a better place. My own experience is fundamentally what gives me faith that therapy works.

What advice would you give to someone entering the profession?
Keep being curious and working on yourself, through personal therapy, CPD, films, art, reading and any other creative ways you can think of. You are your greatest resource.

What is the future for counselling and psychotherapy?
My hope is that we will embody less Eurocentric ways of working and reflect the rich communities we live in.

What do you do for self-care?
Cuddle lots with my dog, Baba. He has an amazingly calming energy.

What, for you, is the most challenging issue that clients bring?
The loneliness that we all face.

What gives your life meaning?
I'm starting to realise it's about authentic and deep connections, whether through shared laughter, sadness or pain.

What do you think happens when we die?
I'm a practising Hindu. Most Hindus believe that humans are in a cycle of death and rebirth called Samsara. When a person dies their Atma (soul) is reborn in a different Jiva (being), based on their previous life's Karma (intentional action).

What's the most recent book on therapy you've read and can recommend?
Intercultural Therapy: Themes, Interpretations and Practice by Jaffa Kareem and Roland Littlewood.

What book do you most often recommend to clients?
Covering: The Hidden Assault On Our Civil Rights by Kenji Yoshino. It's about the pressures on black people to 'act white' and women to 'play like men' at work, and the tensions between civil rights and identity politics.

What is your favourite piece of music, and why?
So many, but currently 'Promises', by Calvin Harris and Sam Smith. It's a great song to dance to.

What's the most recent CPD activity you've undertaken?
Nick Totton on 'Power in the Therapy Room', held at Aashna. He's a phenomenal facilitator.

What's the longest period you've seen a client for?
I'm still working with a client from my training, so coming up to five years.

What's the shortest – and why did it end?
One session. It was my first-ever client in private practice. They had very complex needs and let's say my anxiety got the better of me.

When will you retire?
I hope to work in some way as long as my mind, body and soul allow me to. ■

About Pretish

Now: integrative psychotherapist, co-founder of Aashna Counselling & Psychotherapy, London.

Once was: secondary school science teacher.

First paid job: working in my family's newsagents. I earned my keep from a very young age.

Who would you like to answer the questionnaire? Email your suggestions to the Editor at therapytoday@thinkpublishing.co.uk