UKCP
UK Council for Psychotherapy

New Psychotherapist

ISSUE 73 / SPRING 2020

ISSN 2516-7154 (PRINT)

Adverse Childhood Experiences

These ACEs are not a hand you wish to hold

THE MAGAZINE FOR MEMBERS OF THE UK COUNCIL FOR PSYCHOTHERAPY

Insurance cover for members of the UK Council for Psychotherapy

BALENS
Specialist Insurance Brokers

UKCP Individual Package Includes:

- Professional, Public and Products Liability Cover
- Limit of Liability of £6,000,000
- Multi Therapy Cover for over 3,500 activities *(subject to qualifications)*
- Cover for working abroad *(temporary trips abroad excluding USA and/or Canada)*
- Legal Protection Cover
- Policies also available in Europe

UKCP Premiums From:

£9.11 *Student*

£59.50 *Full Practitioner*

(including insurance premium tax and fees)

Pioneers for over 65 years!
Caring for the carers

Telephone: 01684 580771

Web: www.balens.co.uk

Email: info@balens.co.uk

Balens Ltd is Authorised and Regulated by the Financial Conduct Authority

New Psychotherapist
The magazine of the
UK Council for Psychotherapy

Editorial address: UK Council for Psychotherapy, America House, 2 America Square, London EC3N 2LU
Published by: James Pembroke Media, 90 Walcot Street, Bath BA1 5BG
Editor: Anna Scott, editor@ukcp.org.uk
Issue 73 consulting editors: Sarah Niblock, Martin Pollecoff, Sandra Scott, Helen Willingham
Head of design: Simon Goddard
Senior project manager: Marianne Rawlins, marianne.rawlins@jamespembrokemedia.co.uk
Advertising: Harvey Falshaw, harvey.falshaw@jamespembrokemedia.co.uk, 020 3198 3092
Subscriptions: *New Psychotherapist* is free to members of the UKCP. Non members can view the magazine at **psychotherapy.org.uk/join/the-psychotherapist**

PEFC/16-33-447

Welcome

ISSUE 73 / SPRING 2020

ANNA SCOTT
Anna Scott has been a journalist and editor for 20 years, writing about health, education and management issues. She also works part time with primary school-aged children, and has a keen interest in psychotherapy, along with psychology, completing a Bachelor of Science in Psychology in her spare time

'The truth about childhood is stored in our bodies and lives in the depths of our souls,' wrote the psychoanalyst, psychologist and philosopher Alice Miller in her 1990 book *Breaking Down the Wall of Silence*.

It was while running an obesity clinic in California in 1985 that Dr Vincent Felitti found that patients were dropping out of the programme, despite losing weight, because of childhood trauma. Usually the victims of sexual abuse, the patients had gained weight and wanted to maintain it in order to protect and comfort themselves.

The subsequent CDC-Kaiser Permanente Adverse Childhood Experiences (ACEs) Study, led by Felitti, was one of the largest investigations into the impact of childhood abuse, neglect and household challenges on later-life health and wellbeing. It found that as the number of ACEs children have increases, so too do the risks for chronic health conditions, risky health behaviours, low life potential and early death.

The traumas that occur in childhood often leave children and adults with complex and long-term needs and facing severe and enduring challenges. They require in-depth and therapeutic relationships to slowly begin to heal, repair their identities and build successful relationships with other people.

We have devoted this issue's Big Report to the subject of ACEs, outlining in depth what they are (page 14) and the work that the psychotherapy profession is doing to help people and raise awareness (page 20). We also speak to Children's Commissioner for England, Anne Longfield, about where the system is failing children with low-level and high-level mental health issues (page 26).

Hannah Sherbersky talks us through her career as a psychotherapist working with young people and families, including on the BBC Three documentary *I Blame My Parents* (page 48). And psychotherapist Cath Knibbs explains how she uses gaming to help children who have suffered trauma (page 36).

Elsewhere, psychotherapist Professor Brett Kahr takes us back over the past 125 years of psychotherapy, which has seen the profession go from experiencing ridicule, exclusion and anti-Semitism, to one that is lauded by Prince Harry and Michelle Obama, among many others (page 40).

There's much more to read in this issue of *New Psychotherapist* – we hope you enjoy it.

Anna

ANNA SCOTT
Editor

Get in contact

Share your views and ideas on our profession and this magazine:

editor@ukcp.org.uk
UKCouncilForPsychotherapy
twitter.com/UKCP_Updates
psychotherapy.org.uk
instagram.com/psychotherapiesuk

bcpc
PSYCHOTHERAPY AND COUNSELLING TRAINING

Psychotherapy MA Programme Director

(Salary 40k p.a. pro rata)

Bath Centre for Psychotherapy and Counselling is a long standing provider of accredited counselling and psychotherapy trainings in the South West. Founded in 1984, BCPC is now established in its own premises in the centre of Bath, enjoying an excellent professional reputation both locally and Nationally. Our commitment to excellence means we offer trainings that meet the exacting professional standards of UKCP and BACP. We are currently recruiting management staff.

This role description does not intend to present a prescriptive list but offers what is hoped will be useful guidance in terms of indicative responsibilities.

The person in this role will provide academic leadership for the course, ensuring that it reflects University and Organisational policy, practice and procedures, addressing and resolving issues relating to the quality of course delivery, student satisfaction, student progress and student retention.

They will liaise effectively and professionally with all members of the course team, and administrative staff to ensure that students receive high quality academic and professional support, and maintain appropriate quality assurance, support, supervision and appraisal within the team. Liaison with teaching colleagues will help to shape and enhance the course design and future curriculum development.

They will also liaise with external bodies and maintain working links with UKCP, attending College meetings to ensure that the course continues to meet the standards that maintain accreditation, whilst keeping abreast with current professional dialogues.
The MA programme Director will be outward facing in terms of recruitment and will take a lead in Open days and interview days, working closely with the office to be a key contact for prospective students wanting information about the MA.

The role will be part time and mainly office based– averaging out at 2.5 days per week and is compatible with a teaching role on the Psychotherapy MA – to be discussed depending upon the applicant's interest and experience.

The post will be for one year initially, and with a six-month probationary period.

The role carries an entitlement of 25 paid days holiday plus statutory bank holidays, pro rata. Holidays are to be taken outside term time.

The role will be accountable to and monitored by the Director.

Application deadline: Monday 2nd March; interviews in mid March 2020

For more information and how to apply, visit
www.bcpc.org.uk/join-us/jobs

Contents

ISSUE 73 / SPRING 2020

REGULARS

FEATURES

26 Children's Commissioner for England, Anne Longfield

On the Cover

This issue, we explore Adverse Childhood Experiences (ACEs) and their long-term impact

Join today!

UKCP membership is a recognised quality standard – being able to use the UKCP members' logo will demonstrate the calibre of your training and practice to potential clients and employers and among colleagues within the profession.
psychotherapy.org.uk/join

Get in contact

Share your views and ideas on our profession and this magazine:

editor@ukcp.org.uk
UKCouncilForPsychotherapy
twitter.com/UKCP_Updates
psychotherapy.org.uk
instagram.com/psychotherapiesuk

Bulletin

ISSUE 73 / SPRING 2020

News, CPD, reviews and member updates – here's what's happening in the profession now

TRAINING

Professionals working with children need to provide trauma-informed care, says charity

The effects of Adverse Childhood Experiences (ACEs) are rarely understood, according to a report

Training is needed to help adults working with children spot the signs of trauma

Young people displaying difficult behaviour due to trauma are too often misunderstood by support services, stopping them from getting the help they need, a report published by the charity YoungMinds claims.

The report, *Addressing Adversity*, shows how traumatic experiences can have a profound impact on a child's brain development and how they interact with people.

The report brings together the views of 47 leading academics, experts and health professionals. It shows that children with the most difficult upbringings are judged on their behaviour, which may be a normal response to what they've experienced. These children are more likely to be criminalised or excluded from school and less likely to receive the support they need, which can have a lifelong effect on their mental health.

YoungMinds is calling for all professionals who work with children, including teachers, social workers and police, to have training about the effects of trauma and guidance on how to enquire about traumatic experiences. The charity also suggests local health commissioners introduce trauma-informed care models that enable services to give effective support to young people who may have experienced it.

'Professionals need a framework so they know how to look at what's causing behaviours and feel confident identifying when a young person may be reacting to trauma,' says Dr Marc Bush, Director of Evidence and Policy at YoungMinds.

'For example, if a child becomes aggressive with a school nurse who is trying to give them an injection, it could be a response to violence or drug misuse in their family.'

UKCP Chair Martin Pollecoff agrees: 'If excluding disruptive children from school is the answer, then we aren't asking the right questions. Where is that child's behaviour coming from? Why can't they concentrate? Our understanding of the impact of ACEs changes everything,' he says.

Psychotherapists Dr Felicity de Zulueta and Dr Graham Music are among the speakers at Adverse Childhood Experiences: Igniting Resilience and Hope – Applying a Trauma Informed Approach to Adverse Childhood Experiences, taking place on Friday 20 and Saturday 21 March 2020 in London.
confer.uk.com/event/resilience.html

Get in contact

Let us know what you think of your redesigned member magazine:

- editor@ukcp.org.uk
- UKCouncilForPsychotherapy
- twitter.com/UKCP_Updates
- psychotherapy.org.uk
- instagram.com/psychotherapiesuk

The drugs don't work
How psychotherapy can help tackle the overprescription of psychiatric medicine
Pages 31-34

RIGHT: Staff shortages are preventing some young people from accessing the mental health support they need

STATISTICS

INCREASING NUMBER OF CAMHS APPOINTMENTS CANCELLED BY NHS

NHS England cancelled almost 25% more Child and Adolescent Mental Health Services (CAMHS) appointments in the last year compared with the previous 12 months, figures show.

According to data from NHS Digital, between August 2018 and July 2019, 405,479 under-18s were referred to the service, up from 343,386 the previous year (an increase of 18%). But during that same period, 175,094 CAMHS appointments were cancelled, an increase of 34,767 over the previous 12 months.

GPs have also noted a rise in the number of young people seeking mental health support – 90% of 1,008 doctors surveyed across the UK by mental health charity YoungMinds said more children were presenting with mental health issues than before. In addition, 76% said they did not feel confident that a referral to CAMHS would result in treatment.

According to the mental health charity Mind, which analysed the NHS Digital data, although service providers are seeing more young people than ever, the increasing number of people seeking mental health support means the system is struggling to cope with the demand, particularly in light of staff shortages.

'Despite mental health problems increasing among children and young people, many are simply not able to access support. Too often young people only get help once they reach crisis point,' says Vicki Nash, Head of Policy and Campaigns at Mind.

Jill McWilliam, Chair of UKCP's College of Child and Adolescent Psychotherapies, agrees that young people are required to meet excessively high criteria to even get an appointment – such as being close to, or actually making, a suicide attempt – which is too late a response and a waste of public resources. Early intervention is available to a carefully selected group with complex cases siphoned off the list, but it is unclear where they appear in official statistics.

'This leaves a significant band of need. Children and young people in that band are left with nowhere to go because money is diverted to top end or more easily measured cases,' McWilliam says. 'These young people are being offered too little, too late and the blame is then laid at the feet of CAMHS professionals or the client. It is a money and resource issue.

'UKCP practitioners find ourselves with the children and young people in that band because we are largely excluded from CAMHS,' she adds. 'Even though we are able to provide help.'

'These young people are being offered too little, too late ... It's a money and resource issue'

Source: NHS Digital. (2019). Waiting times for children and young people's mental health services, 2018–2019 additional statistics, bit.ly/38yl5du

From perversion to professionalism
Professor Brett Kahr looks back at 125 years of psychotherapy
Pages 40-42

POLICY

Changes needed to improve young people's mental healthcare

The NHS has set up a taskforce to improve specialist children's and young people's services in England for inpatient mental health, autism and learning disabilities, as part of its Long Term Plan.

Seeking to improve community services and reduce the over-reliance on inpatient care, the taskforce aims to link services more effectively with schools and councils. It will consider the best way to deliver 'compassionate care for acute need', including reviewing provision from both the NHS and the independent sector.

The taskforce will begin by making improvements in care over 18 months and recommendations for next steps.

The Children's Commissioner for England, Anne Longfield, will chair an independent oversight board of the taskforce's work to track progress, propose improvements in existing services and examine the best approach to issues such as inappropriate care.

'Far too many children are stuck in hospital for months or years when they do not need to be there,' Longfield said. 'I am pleased that this taskforce has been announced to change this unacceptable situation and I am delighted to Chair the Independent Oversight Group to amplify the voice of these children and their families, scrutinise progress, and hold the system to account.'

The NHS Long Term Plan aims to ensure all NHS services operate at safe, effective levels and improve quality of care through a series of measures over the next decade. This includes a commitment of £2.3 billion funding for community mental health services.

▶ Read our interview with Anne Longfield on page 26.

'Far too many children are stuck in hospital for months or years'

BELOW: An oversight board will meet to track the taskforce's progress and propose improvements

RESEARCH

PSYCHOTHERAPY TRAINING AFFECTS PRESCRIPTION OF ANTIDEPRESSANTS

Frontline medical providers in Nigeria trained in psychotherapeutic techniques are less likely to prescribe antidepressants to patients suffering with depression, a study has found. Two groups of 'lay health workers' (including nurses and health technicians) received training in 'recognition of depression and basic psychological and pharmacological interventions', in the study led by Professor Oye Gureje, Psychiatrist at the University of Ibadan, Nigeria.

The 'intervention' group received guidance in administering problem-solving therapy in the study, published in *The Lancet Global Health*[1], and just 13% of their patients received medication, compared with 32% of the patients in the control group. A year after the study, 76% of people in the intervention group and 77% in the control group had experienced 'remission' from depression.

Nigeria, like many low- and middle-income countries (LMICs), suffers an 'extreme shortage' of specialist mental health professionals and doctors. As a result, some LMICs are studying the effectiveness of interventions delivered by lay health workers.

'Incorporation of appropriate psychological treatment could potentially reduce the need for antidepressants in primary-care settings without compromising effectiveness,' the study's authors conclude.

1. Gureje, O, et al. (2019). 'Effect of a stepped-care intervention delivered by lay health workers on major depressive disorder among primary care patients in Nigeria (STEPCARE): a cluster-randomised controlled trial'. *Lancet Global Health*. 2019 (published online May 13. dx.doi.org/10.1016/S2214-109X(19)30148-2.)

COLLABORATION

New partnerships raise profile of psychotherapy

Professor Sarah Niblock, CEO of UKCP, writes about a key conference and academic partnerships

In the past two years, we've gone from being largely unknown outside the sector to featuring regularly in the UK and international news media as the go-to source on emotional and mental health and wellness.

Two particularly significant developments in UKCP's mission to raise awareness include our academic partnership with Imperial College London and our recent climate change conference. We have just completed teaching our first module at Imperial, Understanding Psychotherapy, which is hugely significant for psychotherapy given that Imperial is a world-leading science, technology and maths university. More joint teaching and research projects are at the planning stage.

Imperial's Grantham Institute for Climate Change partnered with us for our highly praised and well-attended conference, Sleepwalking into the Anthropocene. A show of hands among delegates revealed some 90% now encounter clients with fears about this global health emergency, confirming wider research that 75% of us are deeply concerned.

As a result, UKCP announced its own Climate Pledge:

- We will develop an Environment Policy towards achieving net zero carbon emissions by 2030
- A key strand of our policy/ communications work will be to advocate for improved access for all to high-quality therapies due to peer-reviewed evidence that climate events harm mental wellbeing
- We will look to how we can enhance our training and lifelong learning to ensure best clinical practice
- We will work closely with journalists to support ethical and accurate reporting on the human emotional impact.

Pooled data will allow new analysis of UK students' mental health needs

MENTAL HEALTH

Consortium aims to understand students' mental health needs

UKCP is working with six university counselling services and the British Association for Counselling and Psychotherapy (BACP) to build a robust evidence base that will assert the psychological needs of students in UK institutions, write Louise Knowles and Emma Broglia.

The Student Counselling Outcomes, Research and Evaluation (SCORE) consortium has pooled data from the institutions involved that includes outcomes for approximately 5,000 students. The growing dataset will allow new analysis of the mental health needs of UK students and how our services respond to these needs.

We are creating a unique opportunity to better understand the needs of students, and in doing so, we will collectively influence and shape the psychological services offered to students at both a local and national level. While there is a statutory obligation on the NHS to provide students with the same range of treatment options as the standard population, often these services fall well short of what we know students need. Students are on campus for short periods of time and as such, simply placing them on the waiting list for several weeks fails to meets their needs. Students' demographics can be fundamentally at odds with the needs of the local population and their needs can quickly become marginalised and not met.

With support from UKCP and BACP, the SCORE consortium will be able build on this sizable dataset by recruiting more institutions to contribute data and we will provide free training workshops and materials to do so. These activities will not only cascade skills across the sector but will also stimulate the debate and inform policy about the needs of students in UK institutions.

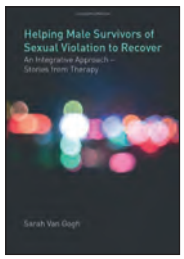
The organisations ambitiously aim to expand the consortium early this year.

Louise Knowles is a UKCP registered psychotherapist and head of Counselling and Psychological Well Being Service, University of Sheffield; Emma Broglia is senior research fellow at the British Association for Counselling and Psychotherapy

Reviews

Psychotherapists review new and recent work in their own fields, and recommend essential additions to your bookshelves

Helping Male Survivors of Sexual Violation to Recover: An Integrative Approach – Stories from Therapy



I came to this book with trepidation – knowing little about the topic of male sexual abuse. But like the experiences of the diverse clients portrayed in this brilliant book by Sarah Van Gogh, I have felt the warmth and humility that underpins her practice.

Van Gogh subtly explores both the past and present lives of her clients with an integrative and psychodynamic approach, which she uses with humanity and insight. She describes individuals such as Neil, an aspiring middle manager with low self-esteem, who initially welcomes the attention of a brash colleague – a man who eventually rapes him.

We also meet the highly defended George, who presents as confident, 'impressing with ease and assurance'. He comes into therapy ostensibly with concerns about his son but is ultimately, gently, led to confront his own buried experiences of abuse at boarding school.

Then there's larger-than-life Stu, now in his 40s having 'survived' a chaotic early childhood. He's a 'survivor' in name only, having been preyed upon by a group of paedophiles while aged around 10. His touching rapport with Van Gogh emerges as a token, though very real relationship, in his current struggles with addiction and self-harm.

This book captures the bald reality of abuse. It destroys the notion that sexual violation belongs to a homogenous group. It is a book that represents the despair of abuse, yet is ultimately a book of hope, representing the remarkable possibilities of therapeutic change. I believe that because of the implicit silence surrounding sexual abuse, this compelling work is a book all therapists should read.

Details

- **Reviewed by** Norma Yam, psychotherapist and counsellor
- **Author** Sarah Van Gogh
- **Publisher** Jessica Kingsley 2018
- **Price** £20.69
- **ISBN** 9781785923630

PODCASTS WE'RE LISTENING TO

THE MENTAL ILLNESS HAPPY HOUR WITH PAUL GILMARTIN

Paul Gilmartin is used to navigating the neuroses of an audience's mind; he spent years working as a TV host and comedian across America. But in 2011, he took his belief in healing through humour to an altogether more intimate medium: the podcast. *The Mental Illness Happy Hour* was born and within a year it had clocked up more than a million downloads. Every week, Gilmartin skilfully interviews friends, artists and members of the public, plus the occasional psychotherapist. Topics explore all varieties of negative thinking and mental illness.

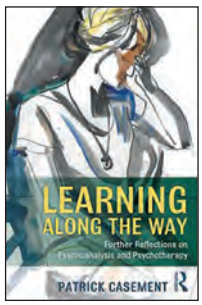
This is not a comedy show and it doesn't pitch Gilmartin as any form of mental health professional; as host, he presents himself as an empathetic and funny man on a mission to destigmatise mental health. Gilmartin's stand-up background and self-professed struggles with addiction and depression help make it a safe space for some humour, but mostly his manner creates an honest conversation. He's not afraid to hold a silence and allow guests to finish their, often painful, thoughts.

This format lends itself to the longform podcast, which, in a world pressing for evermore bite-sized opportunities, may not suit everyone. But listen to almost any episode and you'll understand why the show's army of devoted followers clearly think it's worth making time for.

Details

- **Reviewed by** Kirsten Bickford, trainee psychodynamic therapist
- **Creator** Paul Gilmartin
- **Address** mentalpod.com

Learning Along the Way: Further Reflections on Psychoanalysis and Psychotherapy



Details

- **Reviewed by** Chris Powell, group analyst
- **Author** Patrick Casement
- **Publisher** Routledge
- **Price** £29.99
- **ISBN** 9781138343542

Patrick Casement's *On Learning from the Patient*, published in 1985, remains invaluable reading for any therapist or supervisor. Three further books have cemented his contribution to psychotherapy, particularly on the centrality of being available to clients, and what they tell us they need (consciously and unconsciously), rather than being driven by our models or preconceptions.

The spark for this latest book came following an 'unexpected reprieve from a near-fatal cancer' (described in the final chapter of this book), which inspired Casement to assemble a synopsis of his thoughts about psychoanalytic practice. That synopsis provides the lucid heart of this book.

The first chapter, 'On being in touch', contrasts practice that emphasises correct procedure with his view of allowing a process that stems from the patient. A moving example of his work illustrates his proposition and similar accounts illuminate other chapters. There are chapters on supervision, problems in psychotherapeutic training, how psychoanalysts impact on the therapeutic process and the difficulties of retaining an open mind. I was particularly struck by the chapter 'Keeping in mind' and the importance of this for both client and therapist. The book also includes two interviews, showing more of Casement the person.

This book is readable, inspiring and challenging. It focuses on dyadic psychoanalysis but the clarity of Casement's writing, the significance of his ideas and his engaging examples make this work accessible to any psychotherapist. This book is as useful to as wide an audience as his original classic.

PODCASTS WE'RE LISTENING TO

NEW BOOKS IN PSYCHOANALYSIS: VALERY HAZANOV, THE FEAR OF DOING NOTHING, NOTES OF A YOUNG THERAPIST

New Books in Psychoanalysis (part of the New Books Network) is a series of hour-long interviews conducted by therapists with authors of books on psychoanalysis. In this episode, trainee psychoanalyst and psychiatrist Sebastian Thrul talks to Valery Hazanov, who holds a doctorate in clinical psychology, about his book, *The Fear of Doing Nothing*.

Hazanov boldly discusses his experience of the conflict between theory and practice as a trainee psychotherapist. He gives voice to the uncertainty, the doubt, the frustration of what is not happening for the client. What do you do with the client that does not change week after week, month after month? Hazanov emphasises seeing the person beyond method.

It is the interviewer, Thrul, who at the end of the interview brings in the word 'relationship'. I was curious about this. Whether the theory fails us or we fail the theory, isn't it the therapeutic relationship that takes centre stage? Isn't the relationship often why clients return when there is no obvious change? Are we too scared to turn away from theory and 'just be' in a relationship with our clients? This thought-provoking interview has left me with more questions than answers. But I think that was the point.

Details

- **Reviewed by** Sunita Rani, trainee psychotherapist
- **Creator** Sebastian Thrul
- **Address** bit.ly/2Ph5JIK

Have your say
Tell us what you think of this issue. Email editor@ukcp.org.uk

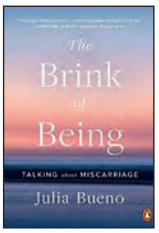
The Brink of Being: Talking About Miscarriage

Julia Bueno's book is a valuable antidote to the widespread ignorance surrounding the experience of miscarriage.

Bueno begins by unpacking people's experiences of losing a baby in the first trimester, when the vast majority of miscarriages occur. She then moves on to look at the physically more demanding – and rarer – cases of late loss, when the miscarriage teeters on the edge of being classed a 'stillbirth', and considers the potential effect of any miscarriage on partners and family.

She weaves her stories with historical and psychological research, as well as reflections upon her own four miscarriages, while also being gently polemical: she sees a dire need for better understanding of this disenfranchised grief. And while medical staff need more training, counsellors and psychotherapists would do well to learn more too.

Visit bit.ly/2YJ0hvq to listen to an interview with Julia Bueno.



Details

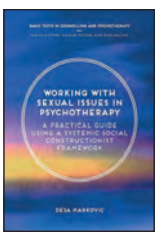
- **Reviewed by** Jane Edwards, psychotherapist, supervisor and trainer
- **Author** Julia Bueno
- **Publisher** Virago
- **Price** £9.99
- **ISBN** 9780349010762

Working with Sexual Issues in Psychotherapy: A Practical Guide Using a Systemic Social Constructionist Framework

Desa Markovic's book presents Multidimensional Open-minded Sex Therapy (MOST) as a way of working with sexual issues. It's a model she's developed through her clinical work as a systemic psychotherapist and sex therapist. The model describes the six dimensions of experience: emotional, cognitive, physical, behavioural, relational and cultural.

The book offers a practical guide to addressing sexual issues through meaningful conversation, backed by theoretical and practical frameworks. It fills a gap in psychotherapies by offering an inclusive approach to working with individuals and couples.

The book is a vital read for students and for practitioners in all fields looking to increase their knowledge and resources for working with clients.



Details

- **Reviewed by** Annie Turner, systemic psychotherapist and clinical supervisor
- **Author** Desa Markovic
- **Publisher** Red Globe Press
- **Price** £28.99
- **ISBN** 9781137582225

Feedback

We want to hear your stories, news and views, so please get in touch

Taking action

Thank you so much for the latest edition of *New Psychotherapist*. The articles are great and it addresses my biggest concerns. It also gives me things to do about them. I have now joined the Climate Psychology Alliance, and I can start by sharing some of the excellent articles with a CPD group I go to (of largely non-UKCP members). The issue is practical, immediate and really useful. Thank you very much.

Kate Graham
UKCP-accredited psychotherapist and supervisor in training, Ilkley Psychotherapy

Do Not Miss! One-Off Event for 2020!

New Developments in Motivational Interviewing

in London or via Webcast

WITH PROFESSOR STEPHEN ROLLNICK

Are you signed up yet for "the most exciting training event of 2020"?

Hype is common in our field... the latest theory, the newest therapy. Sometimes it's true, sometimes it isn't. However, if you haven't yet blocked out 2 April 2020, do it now - because I am talking about **Professor Stephen Rollnick's Masterclass: New Developments in Motivational Interviewing (MI).** Steve is the author of over 40 books in 9 different languages, and Motivational Interviewing has transformed psychotherapists' work in every field from Depression through to Trauma.

Influenced by Person Centred Therapy and Self Determination theory, MI has been established for over 30 years. Whether you're a "newbie" or already use it in your work, this is an event that you can't afford to miss.

Why is it so significant?

Firstly, there are very few "Founder-Creators" of the major psychotherapies who are still around; Professor Stephen Rollnick is one of the very few. Secondly, when he DOES train he never strays from Cardiff except to international conferences. This London event is extremely unusual. Miss him this time and you'll probably never have another chance. But if you can't make London, don't panic; you can still participate and work directly with him by Interactive Webcast. Thirdly, this isn't just a rehash of the basics. New Developments in Motivational Interviewing says it all. Want to know where MI is going in the future? If so, you really need to sign up now. Finally, don't leave it 'til later. Apart from a limitation on places; you'll pay more. There's an Early Bird Price, but it's not around forever.

Book your place now!

2 April 2020, King's College, London or via Live Interactive Webcast from anywhere in the world

Book and save £30 off the regular price!

To benefit from this offer use this link: bit.ly/UKCP_M_2020

+44 (0) 1825 763710

RADHIKA HOLMSTRÖM LOOKS AT WHAT THE PROFESSIONALS HAVE TO SAY ABOUT ADVERSE CHILDHOOD EXPERIENCES, AND THEIR POTENTIAL FOR INFLICTING LIFELONG DAMAGE

THE CHALLENGE OF ADVERSITY

'The vast majority of children and young people we see in CAMHS have experienced at least one, and probably more, Adverse Childhood Experiences,' says Kate Waters, who is the chair of UKCP's College for Family, Couple and Systemic Therapy and also works in a paediatric setting. 'The impact may not always be predictable either; it may manifest later in life, in a way that isn't necessarily psychological.'

Adverse Childhood Experiences (ACEs) are not new. The original CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study – one of the first and largest investigations into the impact of childhood abuse, neglect and household challenges and later-life health and wellbeing – was conducted over 20 years ago, from 1995 to 1997. 'The official original ACEs research was on an initial sample of 18,000+ predominantly white, middle-class Americans,' explains Dr Graham Music, consultant child and adolescent psychotherapist in The Tavistock and Portman NHS Foundation Trust. 'What was surprising was the number of people who had four or more ACEs – and how this seemed to be the tipping-point for a cascade of poor outcomes. That suggested an epidemic that hadn't been dealt with.'

Successive studies since then have looked at ACEs and their effects; confirming the finding that as the number of ACEs a child has increases, so too does the risk for chronic health conditions, risky health behaviours, low life potential and early death. But it's only relatively recently that ACEs have become a recognised public health issue, cited by government and taken up by professionals working with children and young people in many different capacities[1].

DEFINITION, SCALE AND IMPACT

There is not, in fact, an 'official' definition of ACEs, although most of them are fairly self-evident. They are widely agreed to include verbal, physical and/or sexual abuse; physical and/or emotional neglect; parental separation; mental illness, domestic violence, drug and/or alcohol abuse within the household; and having a household member in prison[2]. A recent report from mental health charities YoungMinds, the Anna Freud Centre, and Body and Soul extends the definition to discrimination, household substance misuse and bereavement, while making the point that the term 'trauma' refers to the ACE's impact on mental health[3].

'A lot of the ACEs that I see are actually relational, in the sense that the experience of the child is that "someone else does something",' says Waters. 'Many of these are events that are outside of the child: often acts, or lack of acts, on the part of someone else.'

Overall, it's estimated that a significant proportion of the UK population has experienced at least one ACE; survey results for Wales and England suggest it is around one in two[4]. In 2018, the Office of the Children's Commissioner estimated that at least 690,000 children aged 0–5 in England live in a household with an adult who has experienced domestic violence and abuse, substance misuse or mental health issues[5]. 'Children with physical disabilities and/or chronic illnesses are potentially more likely to experience ACEs, not least

BODYNAMIC INTERNATIONAL

Somatic Developmental Psychology

The development of Narcissism from a body-oriented perspective

The role of early attachment in the development of Narcissism

With Michael Rupp

21-22 March 2020
Terapia, The Bothy, 17A East End Road, Finchley, London, N3 3QE

In this workshop we will be exploring, using Bodynamic principles, how failure in bonding and co-regulation in infancy and early childhood can elicit in the child a survival defence, disconnecting them from their own body, their core self also called Body Ego.

This leads to the development of a self, devoid of deeper sensations feelings and self-value and the creation of a kind of "empty shell" or armour.

It is precisely this empty shell, and the inner meaninglessness and even desperation as well as the absence of intrinsic self-value that lie at the core of the narcissistic personality.

Early Bird £220 when paid by 31/1/2020. After then £250.

The workshop is offered to a maximum of 30 people on a first come first served basis.

For information and booking please contact the Bodynamic UK Coordinator at bodynamic.uk@gmail.com

The Bodynamic Foundation Training The Character Structure Model and Developmental Trauma

The Foundation Training is the basic training of the Bodynamic Somatic Developmental Psychology education. Further three years will then provide certification for Bodynamic Practitioner. Certification recognized by the European Association for Body Psychotherapy (EABP)

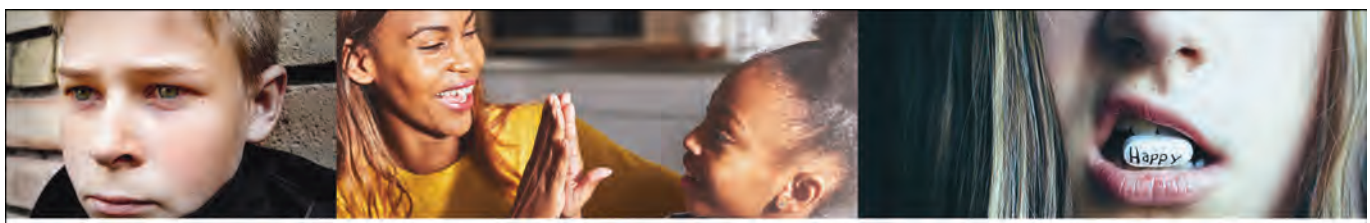
In this training we will learn how the child responds in the different developmental phases on the psychological/ emotional and muscular/motoric level in relation to adverse conditions or traumatic experience. On the muscular level hypertonic or hypotonic responses will lead to the formation of a characteristic body posture with a corresponding expression, mimics, gestures, believe systems, behaviour and more.

To recognize and treat Character Structure and the underlying Developmental Trauma we will specifically train body reading in different settings.

Module 1: 12-16 August 2020, Ditte Marcher.
Module 2: 11-15 November 2020, Michael Rupp.
Module 3: 3-7 March 2021, Michael Rupp
Module 4: 30 June 4 July 2021 Michael Rupp

£3400. Early Bird £3100

The training will be held in London, Shoreditch, at Toynbee Hall, 28 Commercial Street E1 6LS



CENTRE FOR CHILD MENTAL HEALTH

UPCOMING CONFERENCES 2020

The CPD go-to place for anyone who cares deeply about child mental health

Saturday 2 May 2020 (10am-5pm, cost: £183)

The Use and Misuse of Psychiatric Diagnoses: ASD, ADHD, FAS, OCD, ODD, Conduct Disorder, GAD and Major Depressive Disorder. How to feel competent in challenging misuse and educate about alternative frameworks

Professor Sami Timimi and Dr Margot Sunderland

Saturday 13 June 2020 (10am-5pm, cost: £183*)
*Special Offer: book 13 June and 14 June 2020 together for £350

How to Help Children, Teenagers and Adults Tell Their Stories in Order to Heal Emotionally

Professor Leslie Greenberg (International Guest Trainer, US), Sue Hughes and Dr Margot Sunderland

Sunday 14 June 2020 (10am-5pm, cost: £183)

How People Change: Healing Painful Emotion with Emotion (memory reconsolidation and the process of change in healing troubled minds)

Professor Leslie Greenberg (International Guest Trainer, US)

Saturday 27 and Sunday 28 June 2020 (10am-5pm, cost: £350)

The Science of Love. Changing Lives: The Neuroscience of Connectedness, Trust and Feeling Safe

International Trainers Dr Stephen Porges and Dr Sue Carter

Day 1: Mental Health Through the Lens of the Polyvagal Theory

Day 2: Oxytocin Hypothesis - The Biochemistry of Love and Trust

Saturday 11 July 2020 (10am-5pm, cost: £183)

When You've Been to Hell and Back: Breaking the Cycle of the Intergenerational Transfer of Trauma

Dr Valerie Sinason, Lemn Sissay, David Taransaud, Tracy Godfroy

CCMH THE CENTRE FOR CHILD MENTAL HEALTH

More details, all events and to book:
www.childmentalhealthcentre.org
e: info@childmentalhealthcentre.org
t: 020 7354 2913
venue: 2-18 Britannia Row, London N1 8PA

Disease risk

THE CELLULAR LEGACY OF CHILDHOOD TRAUMA

ACEs are associated with increasing biomarkers for inflammation and shortened telomeres (caps at the end of each DNA strand), which indicates a direct effect on chronic diseases such as cancer, and cardiovascular respiratory diseases[11]. A 2015 meta-analysis of 25 studies (and over 16,000 people) found that childhood trauma can affect the immune function, leading to increased levels of inflammation in the system. This may be one major factor in why people who have experienced childhood trauma are more prone to physical and mental health problems in later life, since high levels of inflammation are associated both with psychiatric disorders and with conditions such as Type 2 diabetes and cardiovascular disease. Researchers also found that different types of trauma are associated with different biomarkers; physical and sexual abuse are associated with one factor, while parental absence during early childhood is associated with another[12].

because their parents are more likely to divorce and also because children with disabilities are more vulnerable to all forms of abuse,' Waters adds.

The effects can be profound. 'The body keeps the score,' says Dr Felicity de Zulueta, Emeritus Consultant Psychiatrist in Psychotherapy at the South London and Maudsley NHS Foundation Trust. 'If the attachment function is damaged, this changes the way the brain functions in order to protect the individual, with the emphasis on power and control.'

Overall, the evidence shows that children who experience ACEs (especially four or more) are more likely to perform poorly in school, develop antisocial behaviour and be involved in crime. 'People manifest catastrophised thinking, as the result of experiences of catastrophe,' says Dr Marc Bush, Director of Evidence and Policy at YoungMinds. 'They'll always go to the "worst case" scenario, where everything is falling apart.' Or ACEs might result, he suggests, in a child who's constantly falling asleep in class, because they are exhausted from taking on adult responsibilities; or someone who's overly aggressive towards their peers and distrusts comfort, because they are used to violence and/or abuse. And, he points out, behaviours may be an entirely logical response to what they have experienced. 'Some people with anxiety have witnessed someone dying, or been emotionally neglected – which is why they believe that if the worst thing happens there will be nobody there to support them. These things we might call anxiety or an attention deficit might be related directly to the trauma.'

OTHER LEGACIES

Physical health can suffer too. As one group of researchers puts it: 'Individuals who have ACEs can be more susceptible to disease development through both differences in physiological development and adoption and persistence of health-damaging behaviours.'[6] It's a complex mix of different forms of damage (or at least potential damage), which again escalates sharply for people who have experienced four or more forms of ACE. Two recent meta-analyses from 2017 and 2019 of studies on the health effects of ACEs have very much supported these findings'[7,8].

There is a direct physiological response, points out Music (see panel, left). 'Our immune system often goes into overdrive if it's been threatened. If people see danger around every corner, their bodies echo this.' In addition, it is no surprise that people who have experienced ACEs are more likely to ignore health advice and take risks with their health: and this too, Music argues, is quite logical in its own way. 'There's also evolutionary predisposition to go into more risk-taking activities that speed up the metabolic system, if the environment is dangerous – in fact this is a very adaptive response to a dangerous environment.'

The effects of ACEs, and their consequences in adult life, have huge implications for an individual's mental health and for society as a whole; to take just one example, one 2015 study suggests that 12% of binge drinking, 14% of poor diet, 23% of smoking, 52% of violence perpetration, 59% of heroin and crack cocaine use and 38% of unintended teenage pregnancy prevalence nationally could be attributed to ACE experience below the age of 18[9]. What's more, these effects also become self-perpetuating.

What do you think?
Share your thoughts and opinions by emailing:
editor@ukcp.org.uk

People who had ACEs can find their own parenting affected (although this is not inevitable). Indeed, in small babies, 'trauma' is more an issue of a disturbed relationship with the parent/carer, and this frequently leads back to the parent's own childhood.

MORE THAN A CHECKLIST

Importantly, these effects are not inevitable. Bush is keen to make it clear that this should not be considered a straightforward scoring exercise, whereby everyone who has experienced an ACE will be damaged and four is the trigger for further damage. 'This isn't a dogmatic exercise of counting the number of ACEs you've had to see how distressed you are. It's a tool for understanding children, what they present with and how their behaviours or ways of thinking might relate to the trauma they have experienced.'

Kathy Evans, chief executive of Children England, backs this up. 'I first came across ACEs at an NSPCC conference. The real significance for me was the powerful connections between ACEs and their correlation with lifelong chronic conditions; not simply mental health ones but also physical ones. However, I do have some concerns about the way it can become translated into scoring systems. That's formulaic, and doesn't do justice to the people who have experienced, say, fewer than four ACEs. And some of my concern is not about the framework at all, it's about the fact this falls into a system that isn't very person-centred. Instead of being a different way to look in a more human way at a person who may be in difficulty, a way to change your attitude

AFT – the Association for Family Therapy and Systemic Practice

presents

Symposia days 2020

Friday 1 May
Hosted by West Country AFT

Working with couples: Navigating difference and sustaining connections

Venue: Mercure Hotel Holland House, Redcliffe Parade E, Bristol BS1 6SQ

Keynote speakers: Janet Reibstein and Reenee Singh – *Constructing connections across cultures, creating connections within couples: The Intercultural Exeter Model*

Workshops: There will be a range of workshops in the afternoon with the key theme of couples

Cost: Members early bird until Friday 31 January) – £90, full fee – £95, Student and unwaged members – £85, Non-members – £110

Friday 18 September
Hosted by Manchester AFT

Trauma – the emotional demands it makes on us as clinicians and the resources we draw on in our systemic practice to support families

Venue: The Renaissance Hotel, Blackfriars Street, Manchester M3 2EQ

Keynote Speakers: Ben Furman, Gerrilyn Smith and Jeremy Woodcock

Workshops: There will be a range of workshops exploring trauma

The AGM will take place in the early afternoon.

Bookings open Spring 2020.

AFT

For more information on these and many other family therapy and systemic practice training courses and CPD opportunities, please see the **Events** page of the AFT website: **www.aft.org.uk**

BEING TOGETHER RETREAT

16th – 20th Nov 2020
(Monday 4pm to after lunch on Friday)
Launde Abbey

Geoff Hopping and Jane Tillier are hosting a 4-night therapeutic retreat that offers an opportunity to learn and grow through being together in the beautiful setting of Launde Abbey, a retreat centre in the heart of England that is open and welcoming to all. laundeabbey.org.uk

Jane has over thirty years of experience offering soul space for individuals and groups in a variety of settings including hospice, church and university. She is in the process of completing her MSc in TA Psychotherapy and her Certificate in Transactional Analysis at the Metanoia Institute. soulbody.co.uk

Geoff is a well-regarded and highly-qualified psychotherapist and supervisor (Training and Supervising Transactional Analyst and psychoanalytic psychotherapist) with decades of experience working in mental health and psychotherapy settings. Latterly he has worked in a high security prison as a Consultant Psychotherapist specialising in Group Work. He is reconnecting to a passionate interest in spirituality and is currently in training with One Spirit Interfaith Foundation. geoffhopping.com

Both Geoff and Jane work with grounded warmth, empathy, intuitive insight and experiential wisdom. They are enjoying the fruitful exchange of ideas around relational psychotherapy, mental wellbeing and spirituality and offer retreat participants a precious opportunity to experience 'being together' as a way of soul relaxation and personal renewal. If you are interested in booking a place and/or for more details, please email us. **The cost will be £695 (full board and all sessions) – with the option of paying in instalments.**

jane@soulbody.co.uk

'Offering Bowl' by Katharine Hall, used with permission

ghopping@outlook.com

and practice, it's becoming a framework by which people find out what category to put them in.'

Bush also stresses: 'The important thing to remember is that if you've faced something adverse you do not automatically have a mental health problem.' Transactional analysis psychotherapist Emma Swales agrees. 'Working in women's refuges, I've seen time and time again that the children that were least damaged were the ones with a strong relationship with their mothers. If you have an attuned loving relationship with a primary care-giver, I think it insulates you from the effects of ACEs,' she says.

TACKLING THE ISSUE

Equally, when ACEs do inflict damage, it is not irreversible. Even if people have lacked protective factors in the past, it's possible to put protection in place. As the 2014 national household survey of ACEs and their effects concludes: 'Interventions to reduce ACEs are available and sustainable.'[10]

Psychotherapy is one route, as our feature on page 20 explores, but it's not a solution in itself. 'It is possible to use ACEs research to blame parents, especially mothers,' says Music. 'But we find more ACEs in areas of socioeconomic deprivation. We find more psychosocial stress when there are economic downturns, more inequality, and more racial discrimination. This is a social issue.'

Joanne Hopkins, director of the support hub ACE Aware Wales, takes this further. 'I've done a lot of work in immigration, thinking about the impact of broad adversity, and there is a place as well for considering the context in which adversity happens and getting a broader understanding of how people cope in circumstances of extreme poverty, natural disaster, conflict – when they're having to manage everyday survival and/or travelling across continents away from their families. This is ACE work in a completely different context, yet we expect people who've gone through things like this to "get on with it", regardless.'

It is, however, crucial that this work is conducted – and that ACEs should be a concern for people working across the entire lifespan. 'When I first came across ACEs, I felt they had the potential to shift the whole paradigm of physiological health and long-term chronic conditions,' says Evans. 'Finally, it was something that the NHS overall needed to address. I am in some ways surprised and disappointed that the people most concerned with ACEs are still mostly in the children's sector.'

This is why psychotherapy has a crucial role to play in helping people manage ACEs and live fulfilling lives free of trauma. Psychotherapists with many different philosophies work with both children and adults, individuals, couples and families in systemic, analytical, creative and many other ways to help people build resilience and learn to live with ACEs.

Definition

CHILDHOOD TRAUMA GUIDELINES

ACEs are broadly agreed to include:

Abuse
– Emotional
– Physical
– Sexual

Household dysfunction
– A member of the household in prison
– A parent with a mental health condition
– Domestic violence
– Growing up in a household in which there are adults experiencing alcohol and drug use problems
– Parental abandonment through separation or divorce

Neglect
– Emotional
– Physical

References

- (1) publications.parliament.uk/pa/cm201719/cmselect/cmsctech/506/50602.htm
- (2) House of Commons Science and Technology Committee. (2018). *Evidence-based early years intervention: Eleventh Report of Session 2017–19*, The Stationery Office, London
- (3) Brennam, R, Bush, M and Trickey, D with Levene, C and Watson, J. (2019). *Adversity and Trauma-informed practice: A short guide for professionals working on the frontline*, YoungMinds, Anna Freud Centre and Body and Soul, London
- (4) bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-72
- (5) childrenscommissioner.gov.uk/wp-content/uploads/2018/07/Vulnerability-Technical-Report-2-Estimating-the-prevalence-of-the-toxic-trio.pdf
- (6) ncbi.nlm.nih.gov/pmc/articles/PMC3232061/
- (7) thelancet.com/action/showPdf?pii=S2468-2667%2817%2930118-4
- (8) thelancet.com/action/showPdf?pii=S2468-2667%2819%2930145-8
- (9) instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf
- (10) bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-72
- (11) thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(19)30145-8.pdf
- (12) kcl.ac.uk/ioppn/depts/pm/research/perinatal/news/childhood-trauma-gets-under-the-skin1

REPAIRING AND HEALING

OFFERING DEEP THERAPEUTIC RELATIONSHIPS IS JUST ONE REASON PSYCHOTHERAPY PLAYS A CRUCIAL ROLE IN HELPING PEOPLE WHO HAVE EXPERIENCED ACEs. **RADHIKA HOLMSTRÖM** EXAMINES WHAT WORK PSYCHOTHERAPISTS ARE DOING IN THIS AREA

The complex and long-term effects of Adverse Childhood Experiences (ACEs) are not in doubt. Psychotherapy can do a great deal to tackle them, because in-depth, therapeutic relationships help children to begin to heal: to repair their identities, their self-image and their capacity to function and build successful relationships with others. So what work is being done 'on the ground'? And how does psychotherapy need to link in with other provision?

THE ROLE OF PSYCHOTHERAPY

Psychotherapeutic approaches play a key – many would say central – role in helping children and adults with ACEs. 'They recognise the complexity of the human being,' says Jill McWilliam, Chair of UKCP's College of Child and Adolescent Psychotherapies. 'We have a plurality of approaches, but they are all relational – most, if not all, of the adverse effects occur because attachments are broken, or not formed, or badly formed – and they are also all reflective, which allows for perception and seeing either side.' Kathy Evans, Chief Executive of Children England, goes even further: 'To my mind, psychotherapists are the only practitioners who can intervene at that point in order to avoid lifelong trauma.'

As McWilliam points out, one strength of psychotherapy is the fact it spans a whole range of approaches. Jocelyne Quennell is the Chair of UKCP's Faculty for the Psychological Health of

Children. 'We have an "eco-systemic" approach, providing different types of therapies, which include child and adolescent psychotherapists, people working with very complex needs, one-to-one work, long-term work, and so on,' Quennell explains.

'Overall, one of the things in the child arena at the moment is that we are recognising and have extended our range [of approaches],' adds McWilliam. 'We have a wider range of practitioners, very deliberately, and a range of ages.' That includes introducing standards for infant-parent work (see panel, page 24) which is a relatively new area, and work on child therapeutic wellbeing practice.

'I think we are seeing the multiplication of resource-generating, soothing, caring, loving practices, balancing the different issues of "let's look at the difficulty", "let's look at the conflict", "let's look at the threatening thing",' says child and adolescent psychotherapist Stephanie Hellawell.

Within this range, practitioners do touch on particular practices or approaches that they feel have particular value. Transactional analysis psychotherapist Emma Swales is one of the people who feels that bodywork should be one important element. 'The impact of trauma and of misattunement leads to dysregulation, which leads to a whole range of difficulties (when people are using the behaviours that damage, that is part of their attempt to self-regulate). Because of this dysregulation, bodywork needs to run through all ACEs work. I think people can become fragmented, disconnected from their bodies: it's about reconnection and integration.'

EXPLICIT AND IMPLICIT

'Talk therapy is very useful, but we do have to understand that we're working very much with the explicit and memory that can be recalled; yet we also need to be able to work with the implicit, including the somatic, the impact on the nervous system and the survival mechanisms that get re-enacted,' adds integrative psychotherapeutic counsellor Deborah Spratling. 'People need to learn to understand their survival responses and the way they manage their overwhelm.'

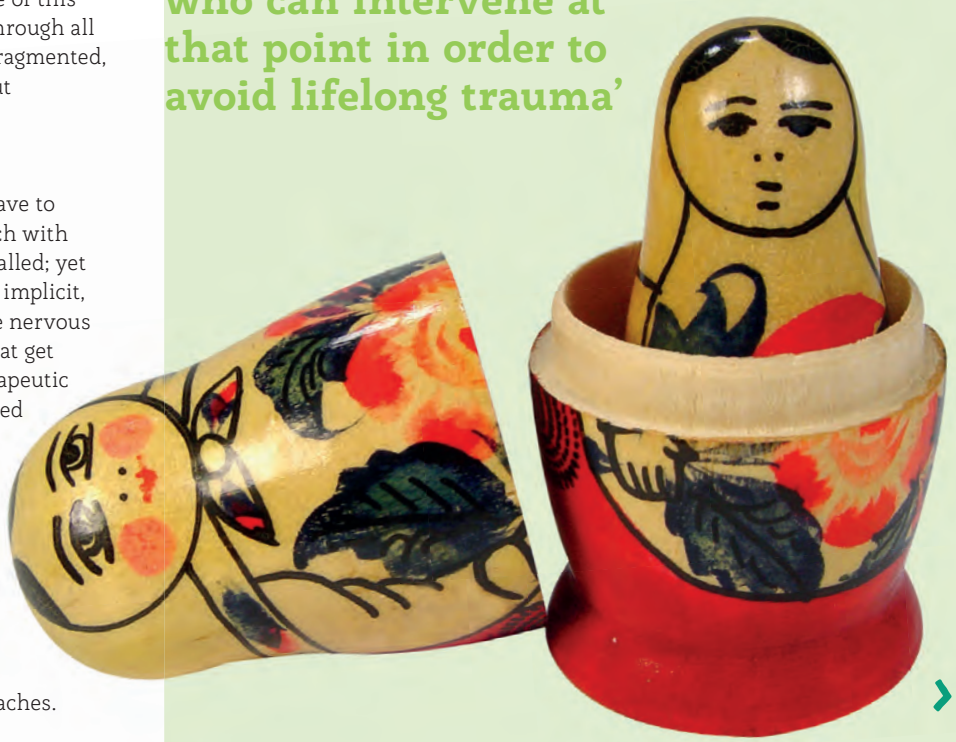
Kate Waters, Chair of UKCP's College for Family, Couple and Systemic Therapy, explains that working with the whole family (possibly including extended family members) and other involved parties can also be very useful, especially when bringing in other approaches.

'If I take the example of domestic abuse: very often you're working with the child/ren and, one would hope, the non-abusing parent to help them make sense of what did happen. These issues are very hard to talk about, and enabling a family to have a safe conversation about things that happened in the past enables the child to verbalise, and also to speak to other family members; it gives them the language, the words, and that I think is the work that a lot of CAMHS practitioners would recommend. It can be productive to use a mix of approaches too; that to me is really important. It would be extremely arrogant to think we have all the answers as family therapists, and working with other modalities is both interesting and a pleasure, and also clinically useful.'

THE CENTRAL RELATIONSHIP

Whatever the modality, however, one huge benefit of psychotherapy is the therapeutic relationship itself. 'Just a little bit of interest in someone's background makes a huge difference to how they feel about

'Psychotherapists are the only practitioners who can intervene at that point in order to avoid lifelong trauma'



‘Just a little bit of interest in someone’s background makes a huge difference to how they feel about themselves’

themselves, right down to physiological level,’ says Dr Graham Music, consultant child and adolescent psychotherapist at The Tavistock and Portman NHS Foundation Trust. ‘If you have a sensitive “mind-minded” parent, that’s linked with better heart rate variability or vagal tone; and that is, I think, what good relationships and also good therapy do.’

Integrative arts psychotherapist (UKCP) and Course Director at Trauma-Informed School and Communities UK, Ellie Baker, points to the ACE-related research into resilience and protective factors. ‘Very briefly, the researchers found that one of the main protective factors is having emotionally available adults: someone who listens to the child and whom they can trust. We learn about relationships through being in them. Part of how I practise in the room is supporting people in what it is to be human and in relationships. For me, it’s about being a human being first and foremost. There is always hope. We can get and learn secure attachment at any time in life, through our relationships. You never know what an important role you might play in a person’s life as the emotionally available adult. We go on healing, if we are open to it, forever.’

WORK ON THE GROUND

There is some formal, dedicated support for children with ACEs, especially in Wales, where Joanne Hopkins is Director of the ACE Support Hub, ACE Aware Wales. ‘In Wales, ACEs are a very important part of the work tackling all children’s experiences and start in life, and there are elements of psychotherapy in a lot of the material we produce.’

The hub is working with schools to provide ‘train the trainer’ sessions, which are ‘cascaded’ down to staff. ‘We have been compiling materials for all staff working in primary and secondary schools – tackling the practical issues of what they can do,’ says Hopkins. ‘Educational psychologists are involved in devising and delivering that training, and where possible they continue to be involved. The Welsh Government has funded this hub for the past three years and we have eight staff with a remit of covering the whole of Wales.’

Hopkins continues: ‘In schools at the moment there are clear protocols, and if a child hits a threshold that requires action there is a referral. We are not asking for more referrals, though, but for broader understanding of those children who are not hitting the thresholds but are manifesting disturbing behaviours. There may be other factors involved, and there may be ways to address them other than the referral path. We’re also working with other departments and organisations to make sure they understand the impact of ACEs and how they could be averted. Our emphasis is not on counting ACEs or assuming a predestined path to disaster, but to understand experiences and how these have an impact. Remember, we are operating in the context of many communities that have

been isolated and/or struggling for years – as well as others that are newly arrived in this country. Yet also, within those communities, there are people doing really good work and we need to be able to support them.'

Work in London is at an earlier stage, explains Simon Partridge, co-chair of the London ACEs Hub. 'We have a core group of 10, so far all contributing on a voluntary basis, providing the only London-wide focus for multi-sectoral, multi-level ACEs activity in London, including survivors,' he says. 'We aim to encourage the development of a body of professionals, including psychotherapists, who are "trauma-informed", and a refocusing of much psychosocial policy so that trauma and attachment issues become part of the common sense of our society.'

ACCESS AND OTHER AGENCIES

However, as McWilliam points out, there are some major and very obvious barriers before this can happen – especially at the level of school identification and provision. 'My observation, and what people are telling us, is that the money isn't there,' she says. 'Head teachers are being forced to choose between a teaching assistant and a counselling service.' What's more, she adds, some of the children and young people with the most complex needs may not be suitable for an in-school service; so these young people are, as she put it, 'disenfranchised' – along with those who do not quite meet the threshold for a service, yet are very obviously in need of some help.

Dr Marc Bush, Director of Evidence and Policy at YoungMinds, agrees. 'In England, the NHS is only going to reach about one in three children with a mental health need or diagnosed condition. Only about a quarter of schools will have additional expertise to deal with mental health problems. This means that the majority of children with an emerging mental health need won't be supported by their schools or the NHS. That's why it's important all professionals working with these children have some knowledge of ACEs and trauma, and can, ideally, start supporting children in being able to make sense of their situation and teach them the skills to cope with it.'

All the practitioners agree with Bush's point that psychotherapy should only be one of a range of trauma-informed interventions: partly for practical reasons, if psychotherapy is not available to everyone, and partly because other services should come from this perspective in any case. 'A trauma-informed model needs to be embedded in all sorts of other elements of society, from schools to prisons,' says Spratling. 'It's a public health issue and all agencies need to be aware,' Swales adds. 'We need preventative work, supporting young families and supporting attachment.'

Practitioners stress the fact that this cannot be simply a matter of ticking off the number of ACEs a child or young person has. Some will have experienced far more than four, yet have the protective factors and the resilience that means they have not been damaged by those experiences. Others may have just one but carry the effects and legacy into adult life. There's also the need to reconsider what experience may constitute an ACE, Bush explains. 'The original US formulation around ACEs said that a perpetrator of abuse had to be older; now, with the increased concern about peer-to-peer sexual violence, that has changed. You can say the same regarding gangs, asylum, institutional racism or substance misuse. That's why we say that adversity- and trauma-informed work isn't just an issue for practitioners. It's a public health project for society as a whole.'

Evans takes this further. 'If you want to prevent serious incidents becoming lifelong, we'd put three-

Intervention

THE EARLIEST DAYS

An optimal window of opportunity to intervene

Parent-infant work is relatively new in this field, yet 45% of serious case reviews in England relate to babies under the age of one and, in England and Wales, babies are eight times more likely to be killed than older children[1].

The first 1,001 days from conception are widely acknowledged, by the World Health Organization and others, as offering an optimal window of opportunity to intervene in a child's life; and it is also a period when parents who might not usually be in contact with services are being seen by practitioners. Yet, specialised interventions which focus on the parent-infant relationship are commonly not available in universal services, CAMHS or perinatal mental health teams and only 29 teams currently exist in the UK.

It often falls to other experts and organisations to provide care to parents and infants. For example, the Parent Infant Clinic, established in 1990, is staffed by psychotherapists working with a wide range of problems in infancy and later childhood, including difficulties feeding and sleeping, bonding and separation.

The clinic takes a psychodynamic approach, using therapies such as child and adolescent psychotherapy, play therapy, art and music therapy, parent-infant therapy and family therapy.

quarters of our resources into intervention. At the moment, there's an understanding that intervention only comes when things have got as bad as they can. On a resource basis but also on a "willingness to intervene" basis, we're drawn towards the most traumatic versions of dealing with difficult events. Instead, we need to make a strategic commitment to tackle trauma before it actually becomes traumatising.'

Quennell also elaborates on the significance of child therapeutic wellbeing practitioners in this context. 'What defines these practitioners is that they work in context, outside the consulting room. They do multi-agency key working, building a relationship with that child and coordinating the multidisciplinary teams around them. The problems children face are co-created within families, within social contexts – poverty, discrimination, violence – and in institutional contexts. What's different about child therapeutic wellbeing practitioners is they are as likely to make an intervention within the relational developmental context as with the child.'

GETTING IT RIGHT

It may be complex and it may be expensive, but tackling ACEs is also the cost-effective thing to do. 'Half of all enduring mental health conditions manifest by the age of 14, and 75% by young adulthood. The majority of adult mental health conditions have their origins in childhood experiences,' says Bush. 'If that is the case, the most important time to offer support is when difficulties first present themselves, to equip people with the skills and knowledge either to make sense of what they're experiencing or manage their condition over time. We don't want to leave people in crisis, either till they reach a diagnostic threshold or are desperately looking for support.'

McWilliam concludes, even more simply: 'Children and young people would have the opportunity to repair damage to their internal world, and rebuild inner effective working models for life; and, potentially, maximise their potential before it's taken away from them.' ●

References and reading

■ (1) Cuthbert, C, Rayns, G and Stanley, K. (2011). *All Babies Count, Prevention and protection for vulnerable babies.* NSPCC. library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C3380

Emotionally Focused Therapy Courses in Britain 2020-21

Run by Sandra Taylor, PhD, & Helene Igwebuike, ICEEFT Certified EFT Trainers

Learn the science of love and attachment that can revolutionise your work with couples.

Emotionally Focused Therapy (EFT), developed by Dr Sue Johnson, can transform the way you work with couples, individuals and families and strengthen relationships in your own life. It is a humanistic-systemic therapy model that is attachment driven. Training will involve immersion into the science and power of attachment, emotion and relatedness that can shift the way you understand couples in distress.

The EFT Externship

This four-day foundation course is the foundation of the training required towards becoming a Certified EFT therapist. Training methods include presentations, video clips, exercises, experiential group work, 'live' couple therapy session in adjoining room video-linked to group, etc.

Dates:	***London***	***March***	***23rd - 26th 2020***
	Manchester	***November***	***16th - 19th 2020***
	London	***May***	***17th - 20th 2021***

For London Externships, www.acreefttraining.com or email AcRE.EFTTraining@gmail.com
For Manchester Externship, contact Sarah McConnell: sarahmcconn@gmail.com

EFT Core Skills Workshops

Core Skills training is completed following the Externship and is one of the requirements towards EFT certification. Work in a smaller group to develop your skills and knowledge.

Manchester Core Skills training 2020:

Core Skills 1 - February 24-25 2020
Core Skills 2 - May 18-19 2020
Core Skills 3 - September 14-15 2020
Core Skills 4 - December 7-8 2020

For more information, contact Sarah McConnell: sarahmcconn@gmail.com

London Core Skills training 2020 - 2021:

Core Skills 1 - June 8-9 2020
Core Skills 2 - October 12-13 2020
Core Skills 3 - January 11-12 2021
Core Skills 4 - April 19-20 2021

For more information, contact Helene Igwebuike: helene@counselling4couples.co.uk

Sandra Taylor is an experienced ICEEFT certified EFT therapist, supervisor and trainer. Before discovering EFT Sandra was a Person Centred counselor, supervisor and trainer.

ICEEFT

Helene Igwebuike is an Integrative counsellor specialising in EFT. She is an ICEEFT certified EFT therapist, supervisor and trainer

Courses endorsed by the **International Centre for Excellence in EFT (ICEEFT)** and supported by the **British EFT Centre (BEFT)**

ANNE LONGFIELD
Children's Commissioner for England
Formerly chief executive of the charity 4Children, Longfield was appointed Children's Commissioner for England in March 2015. The role is to bring about long-term change and improvements for all children, and in particular the most vulnerable, with a special focus on those in care. She received the OBE in recognition of her contribution to children's services in the millennium honours

‘It should **not** take a child **making** the **headlines** before we **help**’

AS CHILDREN’S COMMISSIONER FOR ENGLAND, **ANNE LONGFIELD OBE** SPENDS A LOT OF TIME TALKING TO CHILDREN, MANY OF WHOM HAVE EXPERIENCED TRAUMA. SHE TELLS **ANNA SCOTT** WHERE THE SYSTEM IS FAILING

‘In both current provision and government vision there is a chasm between what children need and what is currently provided,’ says Anne Longfield, Children’s Commissioner for England. ‘This is particularly the case with community and school-based mental health support.’

Despite findings from the most recent (2017) national survey of children and young people’s mental health that one in every eight children in England, aged from 2 to 19, has some form of ‘mental disorder’[1], between April 2017 and March 2018 just a quarter of those who need help accessed CAMHS, Longfield says[2]. And in the following 12 months, up to March 2019, more than 405,000 children were referred to the service, but only 33% received treatment within the year, 34% were turned away and 34% were still waiting at the end of the year[3].

‘A failure to provide care to those with lower-level mental ill-health, such as anxiety and emotional disorders, will have clear consequences,’ she says. ‘And local and lower-level intervention services are, on the whole, patchy and inadequate.’

The situation for in-patient child mental health services is slightly better: NHS data from 2018 shows improvement in CAMHS in most areas of the country, with acceptance of referrals increasing, and the amount of time spent in in-patient settings decreasing[4]. ‘But worrying trends remain around the local variability of this improvement,’ Longfield says. ‘Three areas had an average waiting time of less than three weeks, while 18 had an average waiting time of three months or more.’

POSTCODE LOTTERY

Provision and funding of services is complex and variable – schools in some areas are providing targeted help, in others NHS Clinical Commissioning Groups will fund it, while some local authorities fund mental health care through the High Needs or Public Health budgets[5].

‘This means there is an enormous postcode lottery for children requiring mental health support, and there is very little in the way of accountability or transparency between bodies,’ Longfield says. ‘Gaps in our knowledge remain about who is supposed to be providing low-level mental health support, and what is expected of each agency.’

This has a huge impact not just on children with low-level behavioural, emotional and mental health issues, but also on those who have experienced trauma through Adverse Childhood Experiences (ACEs). As Children’s Commissioner for England, Longfield has a legal duty to promote and protect the rights of all children, particularly those in and leaving care, living away from home or receiving social services.

‘My role is to listen to children growing up in adverse and chaotic environments,’ she says. ‘They may be born into families troubled by addiction, mental health issues or domestic abuse; or raised away from their families, bereaved, abandoned, excluded from school – the list is long.’

Many of these adversities often cluster in children’s lives, and inevitably any of these factors will profoundly affect a child’s emotional wellbeing, school life and relationships. ‘These children are forced to find ways to cope and often grow up too quickly, making it much harder to be happy, healthy and succeed in life.’

Children may not meet the expected levels of language and communication, they are more likely to be excluded from education and leave school without qualifications and, as they grow into adolescence, they are more vulnerable to gang violence and sexual exploitation.

‘We know that the number of kids involved in violent gangs is on the

Become a UKCP member

UKCP membership is a recognised quality standard. It shows potential clients and employers the calibre of your training and practice.

As a member, you'll be part of a community of over 8,000 therapy professionals, giving you the opportunity to tap into online networks and special interest groups.

By being a member of UKCP you help strengthen the voice of the psychotherapy profession and shape its future.

We will keep you up to date with the latest news and developments in the profession through regular email updates and resources including the *New Psychotherapist* magazine.

We have membership grades to suit wherever you are in your career, as well as membership opportunities for psychotherapy or psychotherapeutic counselling training and accreditation organisations.

To find out more visit our website:

www.psychotherapy.org.uk/join

UKCP
UK Council for Psychotherapy

rise, 50,000 are not in any kind of education, the age profile of kids entering care is rising, and the suicide rate among girls aged 15–19 is at an all-time high,' she adds.

Schools themselves are not necessarily helping. 'I have seen a worrying rise in the use of "zero tolerance" behaviour policies in schools – such as isolation booths – which are not accommodating of children who have experienced trauma and may be displaying challenging behaviour as a result,' Longfield says, adding that she is concerned that Ofsted's new inspection framework makes no mention of individual children's needs in the behaviour criteria. 'I want to see behaviour policies that look at the reasons underlying challenging behaviour, and do not set certain children up to fail,' she adds. 'The children I speak to are tough and resilient, but most are simply unable to thrive in structures that are not designed to support them.'

A JOINED-UP SERVICE

And herein lies one of the problems. Longfield welcomes some of the government's commitments set out in the NHS Long Term Plan – including a promise to treat an additional 345,000 children a year and the introduction of waiting time targets – and some of those in the 2018 Green Paper, *Transforming children and young people's mental health provision*. 'However, the NHS Long Term Plan disappointingly echoes the Green Paper in its lack of ambition to deliver truly joined-up CAMHS, from low-level intervention to high-needs patient provision,' she adds.

The government promises to provide mental health support teams in or near schools in between a quarter and a fifth of the country by 2023–2024, but this is neither fast nor ambitious enough, Longfield says. In addition, the Green Paper only commits to 20% implementation of a plan to use Mental Health Support Teams, supporting clusters of schools that aim to meet the needs of the one million children with 'diagnosable mental health conditions' and the one million with 'pre-diagnosable' conditions.

'The NHS suggested in evidence to the Public Accounts Committee that it would revisit the possibility of full implementation after 2024. But even then the majority of children would see little improvement over the course of their secondary school life. I don't think children should have to wait five years before plans are revisited,' she adds.

THERAPY IN SCHOOLS

The goals set out in the Long Term Plan can only be achieved if they come alongside significant investment in school-based and community provision. UKCP is currently part of Health Education England's workforce stakeholder group, which offers the opportunity to push for adequate provision of psychotherapists and counsellors in the People Plan – the workforce document supporting the delivery of the Long Term Plan.

And, in the *Manifesto for Children* published by Longfield's office in September 2019, she calls for a counsellor in every school. 'From speaking to children, parents and professionals, it's clear that convenient and high-quality therapy provision in schools would go a long way in removing the stigma from mental ill-health and support,' she adds. 'Children and parents want access to mental health support quicker and more conveniently and it's also clear that many kids would prefer to get help in schools, where it would attract less stigma.'

Therapy should come alongside high-quality education on mental health in schools, Longfield says, to address the additional pressures brought on children by 24-hour access to the internet and social media. 'A counsellor would be a huge aid for kids with mild to moderate mental health issues such as anxiety, mood and behavioural difficulties. I hear from many young people who tell me that these "lower-level" issues can be crippling,' she adds.

Longfield also believes school-based counsellors are well-placed to act as a referral function for children in need of more intensive CAMHS support.

And for those who don't go to school? 'All children should by right have quick and easy access to mental health care, regardless of their circumstances or where they live,' Longfield says. 'Indeed it should be a matter of routine that all custodial settings have counsellors attached to them.'

FUTURE PLANS

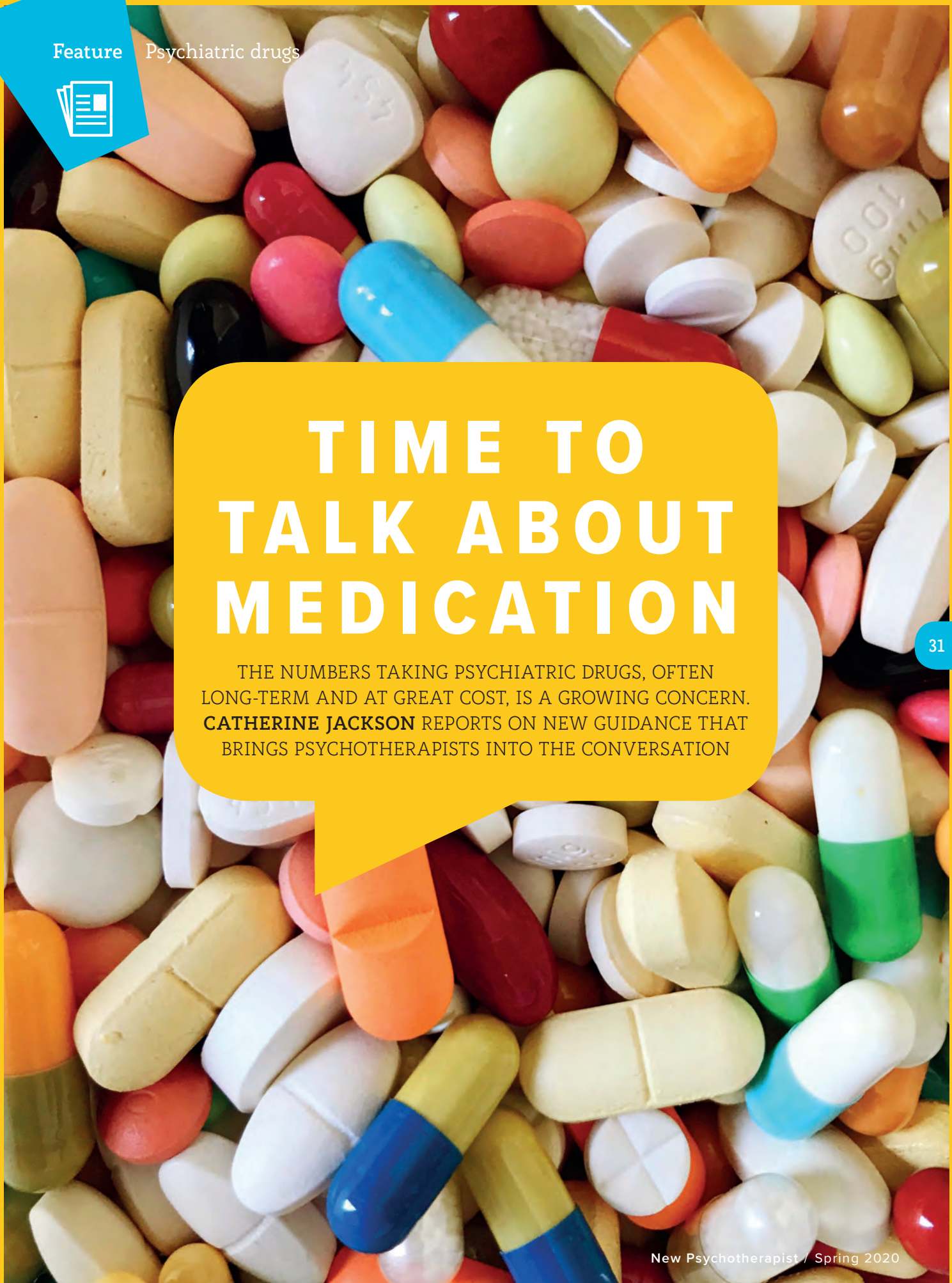
The last two years have seen Longfield collating data from every clinical commissioning group in England, the Director of Children's Services and the Director of Public Health. She has found that the current system is patchy, inconsistent and lacking in clarity.

In order to address the lack of transparency she will convene a senior-level group to address questions of expectations and accountability in the provision of low-level services. And she remains committed to listening and responding to the needs of children who have suffered trauma. Difficult childhoods become difficult adulthoods and the costs 'ricochet through society', she says.

'Children who fall through the cracks will eventually make themselves heard. It should not take a child making the headlines before we help.' ●

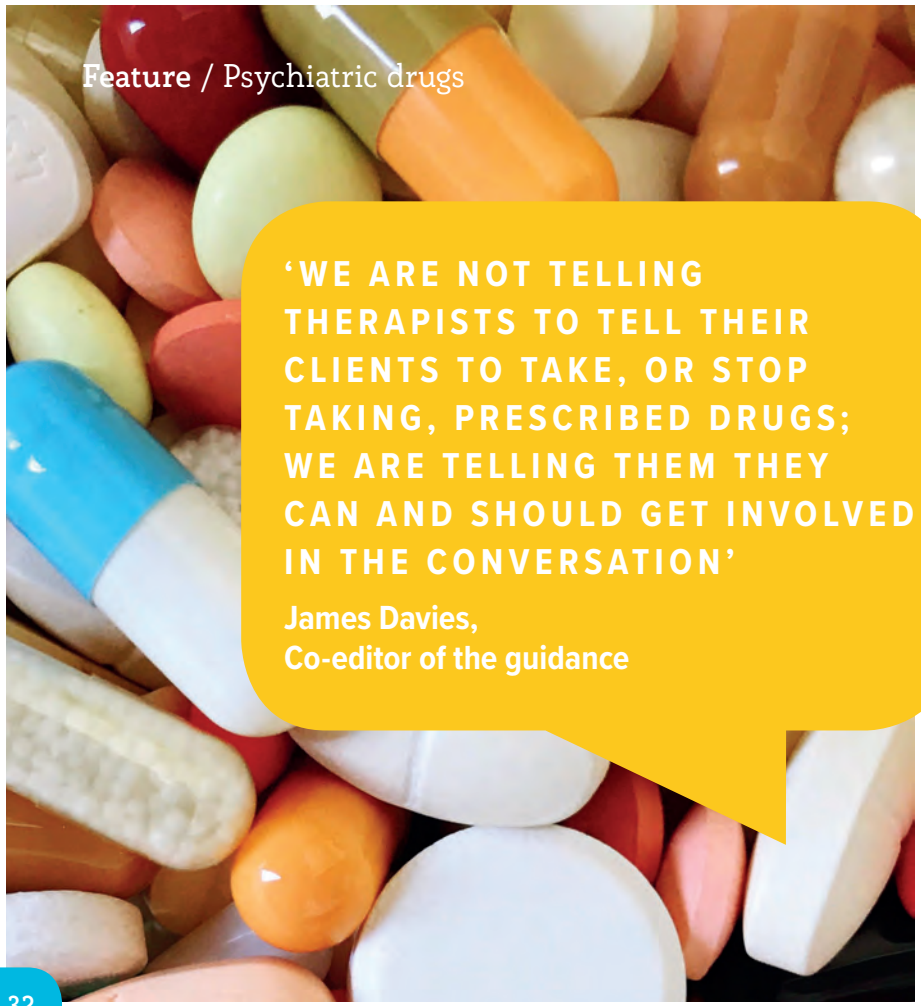
References and reading

- (1) NHS. (2017). *Mental Health of Children and Young People in England, 2017.* digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017
- (2) and (5) The Office of the Children's Commissioner for England. (2018). *Children's Mental Health Briefing.* childrenscommissioner.gov.uk/wp-content/uploads/2019/02/childrens-mental-health-briefing-nov-2018.pdf
- (3) NHS Digital. (2018). *Waiting times for children and young people's mental health services.* digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/waiting-times-for-children-and-young-peoples-mental-health-services-2018---2019-additional-statistics
- (4) NHS. (2018). *2018 CAMHS Project.* nhsbenchmarking.nhs.uk/news/2018-camhs-project-results-published



TIME TO TALK ABOUT MEDICATION

THE NUMBERS TAKING PSYCHIATRIC DRUGS, OFTEN LONG-TERM AND AT GREAT COST, IS A GROWING CONCERN. **CATHERINE JACKSON** REPORTS ON NEW GUIDANCE THAT BRINGS PSYCHOTHERAPISTS INTO THE CONVERSATION



> **'WE ARE NOT TELLING THERAPISTS TO TELL THEIR CLIENTS TO TAKE, OR STOP TAKING, PRESCRIBED DRUGS; WE ARE TELLING THEM THEY CAN AND SHOULD GET INVOLVED IN THE CONVERSATION'**
>
> **James Davies, Co-editor of the guidance**

In 2019, Public Health England (PHE) published a major evidence review highlighting growing concerns about dependence and withdrawal from psychiatric drugs, such as antidepressants, benzodiazepines and so-called z-drugs (gabapentin and pregabalin), and opioid painkillers[1].

It found that 7.3 million people (17% of adults) were taking antidepressants in 2017 to 2018; 5.6 million (13%) opioid pain medicines; 1.5 million (3%) gabapentinoids; 1.4 million (3%) benzodiazepines; and 1 million (2%) z-drugs. Rates of prescribing were higher for women (1.5 times), and generally increased with age. Prescription rates also tended to be higher in deprived areas. Around half of patients across all medications had received a prescription continuously for at least 12 months. Between 22% and 32% had received a prescription for at least three years.

The review concluded that, while prescriptions for benzodiazepines and opioids have fallen, those for the z-drugs and for antidepressants are increasing – more people are taking them, and for longer. 'This means more people are at risk of becoming addicted to them or having problems when they stop using them. It also costs the NHS a lot of money, some of which is wasted because the medicines do not work for everyone all the time, especially if they are used for too long,' the report says.

All these medications are associated with dependence, meaning they provoke unpleasant, debilitating and sometimes dangerous physiological withdrawal reactions when they are stopped, due to the body having adapted to their continued use. All, except antidepressants, are licensed for short-term treatment only (2–4 weeks) – although PHE suggests some people need long-term antidepressants to maintain benefit and avoid risk of relapse. Among its recommendations is a call for more and better support for patients experiencing dependence on or withdrawal from prescribed medicines.

PSYCHOTHERAPISTS' ROLE

Against this backdrop, the All-Party Parliamentary Group (APPG) for Prescribed Drug Dependence has produced guidance for psychotherapists to help halt the steady rise in the numbers of people taking prescribed psychiatric medicine[2].

Endorsed by UKCP, the British Association for Counselling and Psychotherapy (BACP), the British Psychological Society (BPS) and the National Counselling Society (NCS), the guidance urges psychotherapists to learn more about the psychiatric medication their clients may be taking – its potential benefits, risks, effects and side-effects – so that they are better informed to make a decision about whether and how they can talk with clients about their drugs.

Co-editor of the guidance, psychotherapist and psychologist, James Davies, says: 'As a psychotherapist, I was trained to believe these were two very separate dimensions – doctors look after drugs and therapists keep well away from it all. But it's not so clear-cut. Most clients have some experience of drugs and therapists need to have the information to manage these situations more skilfully.

'We are not telling therapists to tell their clients to take, or stop taking, prescribed drugs; we are telling them they can and should get involved in the conversation – although we could be more bold in calling out our medical colleagues on this, because what they are prescribing our clients is having an impact on what we do.'

Currently in the UK there are no national services working with dependency and withdrawal issues; the services that do exist cover less than 3% of the population. In a survey last year, the UKCP, BPS and BACP asked members what percentage of their clients were taking prescribed psychiatric drugs: 27% said between 25–50%, 23% said between 50–75%, and 31% said more than 75%.

'We know that many psychological therapists are already working with a proportion of those who are likely to be dependent on these drugs and have no access to other services,' says Anne Guy, psychotherapist, co-editor of the guidance and chair of the steering group that produced it. 'Therapists do not need to be "specialists" in order to be helpful. The content of the guidance will allow them to consider whether and how to begin integrating issues related to prescribed drug dependence in their routine practice,' she adds.

WHY PRESCRIBE?

In her response to the PHE report, Professor Helen Stokes-Lampard, outgoing Chair of the Royal College of General Practitioners (RCGP), says: 'GPs don't want to prescribe medication long-term unless it is essential ... if we are to reverse the prescribing trends outlined in this report, GPs need better access for our patients to alternative therapies in the community.'

Bryan McElroy is a GP with a strong interest in mental health who has, for many years, been trying to persuade his fellow GPs to make less use of antidepressants. He is now based in England but previously practised in Ireland, where he undertook a Quality in Practice (QiP) project to research antidepressant prescribing in his locality and piloted an antidepressant-prescribing protocol to guide colleagues. The protocol is, essentially, a checklist that ensures the GP has fully explained to patients the benefits, side effects, withdrawal effects and how antidepressants work before prescribing them, to ensure the patient is giving fully informed consent. Disappointingly, he says, use of the protocol resulted in minimal change in his colleagues' prescribing practices.

McElroy has also written a leaflet he gives to patients that sets out the benefits, risks and alternatives to medication, and concludes by looking at what might happen if they don't take an antidepressant. According to research, people with mild-to-moderate depression often recover spontaneously within six to eight months without medication, and there is good evidence too that treating depression inappropriately with drugs can do more harm than good. 'My approach doesn't work with everyone,' he says, 'but I am continually surprised by the number of people who, when we meet again, report a significant shift in their mental and emotion wellbeing, without medication.'

He says that a therapist in every GP practice would make a huge difference: 'If people could be recommended to see the counsellor first, even before they see the GP, I believe this could reduce prescribing. In the pressure cooker of the GP consultation, with a stressed-out GP and stressed-out patient, turning to antidepressants is a foregone conclusion.'

He also points out that GPs are, in fact, only following NICE guidelines on the management of depression in adults, which until very recently minimised the withdrawal effects from antidepressants. In October, NICE finally conceded to pressure from the APPG, the Council for Evidence-based Psychiatry and the Royal College of Psychiatrists and removed its previous statement that antidepressant withdrawal is usually mild, self-limiting and resolves within a week. It now warns that, while many people may experience only mild withdrawal, there is 'substantial variation' in experience, 'with symptoms lasting much longer (sometimes months or more) and being more severe for some'.

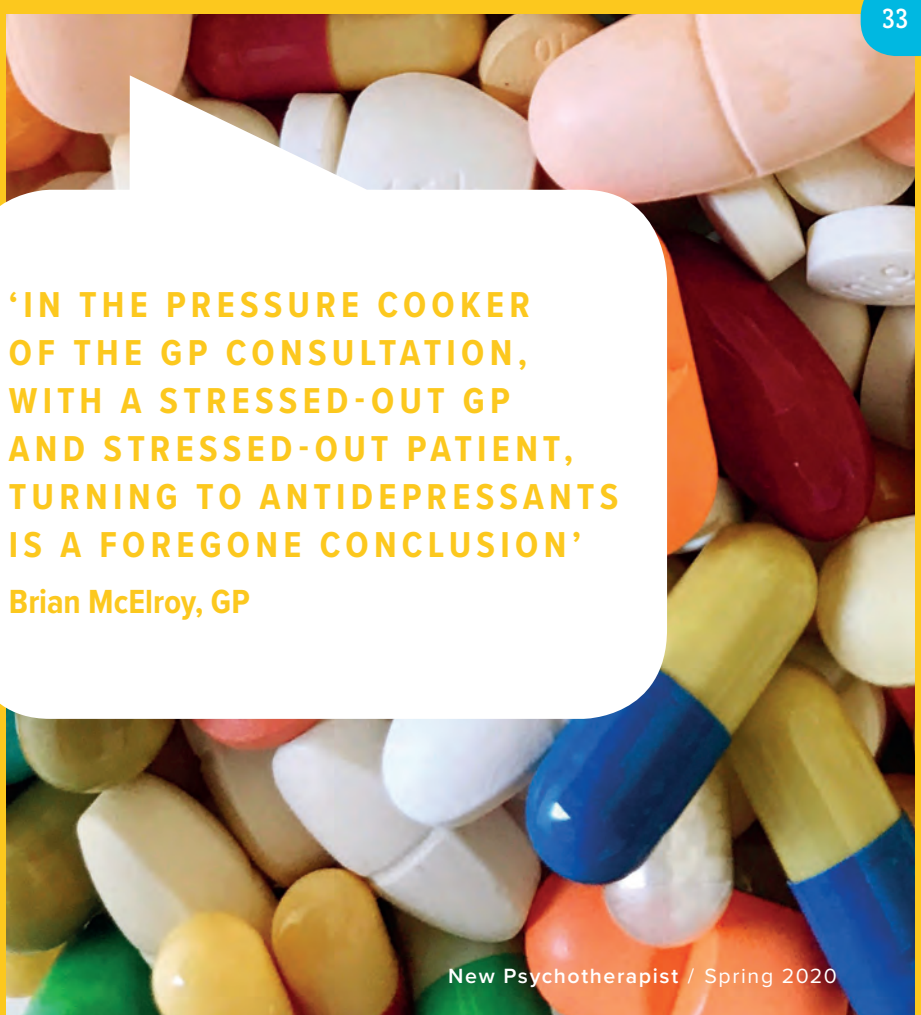
'DISEASE MODEL'

This is a major breakthrough, because, as the guidance says, very often symptoms that emerge when an antidepressant is stopped or reduced are seen as a return of the depression, and the response from GPs has usually been to put their patient back on the drug, or increase the dose. This can lock a person into continuing to take the medication indefinitely, as withdrawal effects tend to worsen the more times a patient has tried to come off it.

Psychiatrist Joanna Moncrieff, author of *A Straight Talking Introduction to Psychiatric Drugs*, has long campaigned for better understanding of the effects of psychotropic medication on the brain and to expose the fallacies in the 'chemical imbalance' hypothesis[3]. This is the theory that mental 'illnesses' arise from reduced levels of particular chemicals (serotonin or dopamine) in the brain. Drug companies have used this theory to market their psychiatric products, and many GPs still use it to explain to patients how antidepressants work.

She describes this as the 'disease model', which assumes that psychiatric drugs work by treating an underlying 'disease'. There is, she points out, no research to support

›



'IN THE PRESSURE COOKER OF THE GP CONSULTATION, WITH A STRESSED-OUT GP AND STRESSED-OUT PATIENT, TURNING TO ANTIDEPRESSANTS IS A FOREGONE CONCLUSION'

Brian McElroy, GP

‘PEOPLE EXPECT MEDICATION AT TIMES OF DISTRESS AND GPs EXPECT THEM TO EXPECT IT. THERAPISTS CAN HELP PEOPLE EXPLORE OTHER WAYS OF MANAGING DISTRESS’

Joanna Moncrieff, Psychiatrist

it. By contrast, the drug-centred model, which the guidance adopts, asserts that psychiatric drugs – like any other psychoactive substance – work by producing physiological and psychological alterations that the patient may experience as beneficial. But they do not act on the actual cause of the problem.

Moncrieff has been working for years to raise awareness of this critical difference and the importance of explaining it to patients. Antidepressants, reviews of clinical trials show, are barely if at all more effective than placebos, and yet we continue to take them. ‘These drugs are changing the brain in ways we do not understand and never anticipated. We need to wake up to the fact that we are doling out these powerful chemicals when there is no thorough research on the long-term effects and what happens when we come off them.’

The PHE report points to the scarcity of high-quality studies of prescribed medication dependence and withdrawal, and says there should be more information for clinicians on prescribing of medicines that can cause dependence or withdrawal, better guidance for clinicians, patients and carers, and more research on the prevention and treatment of dependence on and withdrawal from prescribed medicines.

Moncrieff sees the reliance on prescribed psychiatric drugs as symptomatic of a prevalent attitude towards dealing with life’s problems in society in general. ‘The medical profession has created this whole culture whereby people expect medication at times of distress and GPs expect them to expect it. Therapists can help people explore other ways of managing distress. Putting across other, non-medicalised ways of understanding distress – how our emotions are a response to our circumstances, how we can exert control over them – is important. We can change how we deal with emotions, though maybe not overnight. Highlighting how there are other ways of conceptualising distress and how we respond to it could help to take some of the pressure off doctors and support them when they say an antidepressant isn’t the right way to go and that there are other approaches.’

FACING LIFE’S PROBLEMS

Rosemary Rizq, Professor of Psychoanalytic Psychotherapy at the University of Roehampton and co-editor of the guidance, says that one of the more challenging areas is how to explore with clients their emotional reliance on medication.

‘What most concerns me is that people are sometimes drawn to the use of psychiatric medication as an easily available answer to some of life’s more complicated problems. Of course, we shouldn’t forget that, for some people, drugs can be useful. They can have an important role in supporting a diagnosis that people feel gives them a place in the world by recognising their suffering. Psychologically, that can be very, very important. But where it shades off into avoiding looking at problems in living, problems in relationships and other more serious emotional problems, then I worry. Not all emotional problems can be solved with drugs.

‘We’ve tried to help therapists by supporting them to work with clients in a way that takes account of their drugs but doesn’t avoid the psychological distress that brought them to therapy in the first place. It’s important to remember that, if all emotional problems could be resolved with a pill, we would surely all be happy by now. And we’re not.’ ●

Catherine Jackson is editor of Therapy Today. *Copies of the guidance and further information can be found at* ***prescribeddrug.info***

References

- (1) Public Health England. (2019). *Dependence and withdrawal associated with some prescribed medicines: an evidence review.* London: Public Health England.
- (2) Guy, A, Davies, J, Rizq, R (eds). (2019). *Guidance for psychological therapists: enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs.* London: APPG for Prescribed Drug Dependence.
- (3) Moncrieff, J. (2009). *A straight talking introduction to psychiatric drugs.* Ross-on-Wye: PCCS Books.

CCPE

CENTRE FOR COUNSELLING AND PSYCHOTHERAPY EDUCATION

Diploma in Transpersonal Supervision

This HIPC recognised supervision training is for qualified therapists who wish to train as an individual and group supervisor from an integrative and transpersonal perspective. The training includes experiential, theoretical and practicum components and offers 120 hours of CPD on completion of the award.

Diploma in Transpersonal Couples Counselling & Psychotherapy

This one-year p/t post-graduate course offers a holistic and integrative approach to working with couples and takes place over nine weekends.

Post-Graduate Trainings in Dreamwork

under the auspices of CCPE's Dream Research Institute

One-year Dreamwork Certificate (Essentials and Advanced) and
one-year Lucid Dreaming Certificate

All the above courses are part-time and commencing January 2021.

Weekend Seminars 2020

29th Feb/1st March	Alchemy of Transformation
21st/22nd March	Alchemy, Archetypes and Personal Unfoldment
25th/26th April	Psychology of Accomplishment
6th/7th June	Healing with Breath and Sound
20th/21st June	Creative Imagination
19th/20th September	Life Crisis
17th/18th October	Facilitating Spiritual Growth
7th/8th November	Alchemy of Relationships

Cost:
£230 per workshop
(non-refundable deposit £100)

Times:
Sat / Sun 10am – 5pm

CCPE, Beauchamp Lodge, 2 Warwick Crescent, London, W2 6NE
info@ccpe.org.uk, www.ccpe.org.uk, Tel: 020 7266 3006

PLAYING GAMES

PSYCHOTHERAPIST **CATH KNIBBS** EXPLAINS HOW USING GAMING IN THERAPY CAN PROVIDE USEFUL METAPHORS FOR CHILDREN AND YOUNG PEOPLE WHO HAVE EXPERIENCED EMOTIONAL TRAUMA

Take a deeper look at the nature of the therapeutic relationship and it becomes clear that it tends to be about 'how to be with' a client. Sometimes this involves an aspect of not talking – silence, watching, noticing, waiting, non-verbal empathy and, in the case of my therapy as a child, adolescent and adult psychotherapist, using creative and play-based interventions (some or which may involve talking).

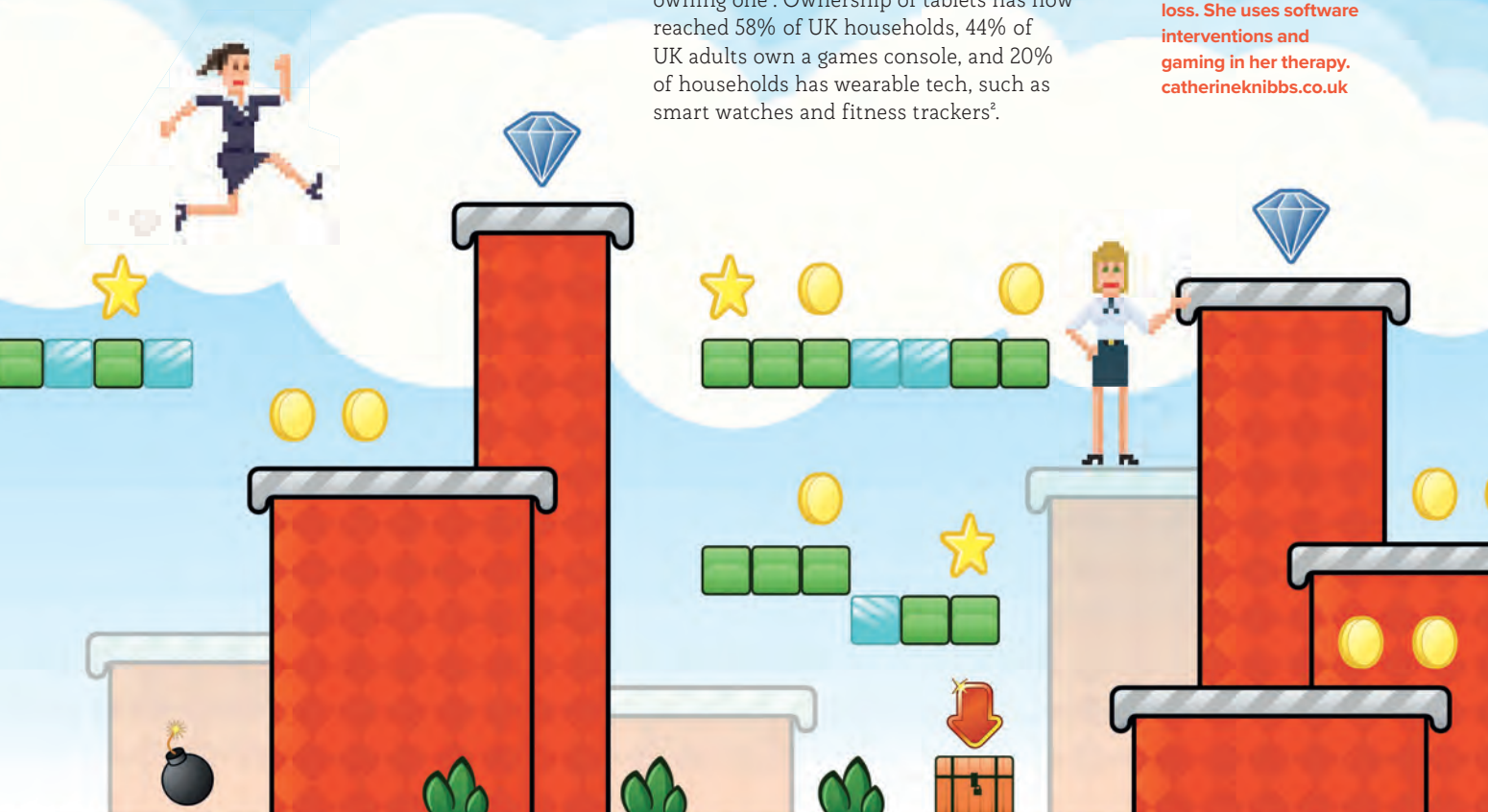
Technology in therapy may seem an invasive tactic, something alien and not of the theoretical landscape of many of the approaches and interventions we have trained with. It can feel an interference into the 'humanness' of the therapeutic alliance and not of this world.

A NEW WORLD

Many of the theories we learned during our training were written for a corporeal world where our humanness was finite and final. As we start a new decade in 2020, this is no longer the case. Technology, and the use of it in therapy, can help us transition to this new world that our clients inhabit, especially if they are under 30.

Computer-based gaming is not a new concept: if you think back to the invention of the arcade machines of the 1970s, this technology has been around for 50 years. What is new, however, is the proliferation of consoles, devices and PCs that exist in our clients' homes. The most popular internet-connected device is the smartphone, with 78% of adults in the UK owning one[1]. Ownership of tablets has now reached 58% of UK households, 44% of UK adults own a games console, and 20% of households has wearable tech, such as smart watches and fitness trackers[2].

CATH KNIBBS
is dual-registered with UKCP as a child psychotherapist and adult psychotherapist. She is also a clinical researcher into cyber trauma, therapeutic interventions for children and young people who are victims of trauma, abuse and loss. She uses software interventions and gaming in her therapy.
catherineknibbs.co.uk



The age of the 'digital ignorant' has passed and we are all users of tech: while some of you may be reading this in ink-and-paper format, you are likely to be within six feet of an internet-ready device.

So why wouldn't we use technology in therapy? It is part of our culture and our language, and has been around for more than a century in varying formats. Within my clinical work and research I have used gaming: it can be used for almost any issue a client presents with, if you can be creative with it, and it can help to facilitate the therapeutic relationship, especially with children and young people.

GAMING FOR GRIEF

The way we work with grieving children has changed thanks to the proliferation social media, and computer games have helped. Some of the responses from young clients experiencing grief reflect their confusion about the finality of death and still being able to see people who have died online:

- **'But she'll respawn, right?'**
- **'He's posted on Facebook so surely he can still answer in heaven?'**
- **'His gamertag is still there.'**
- **'What happens to the XP points?' [signifying progress in a game]**
- **'I don't want to see my memories of him, he did that, he ended his life.'**

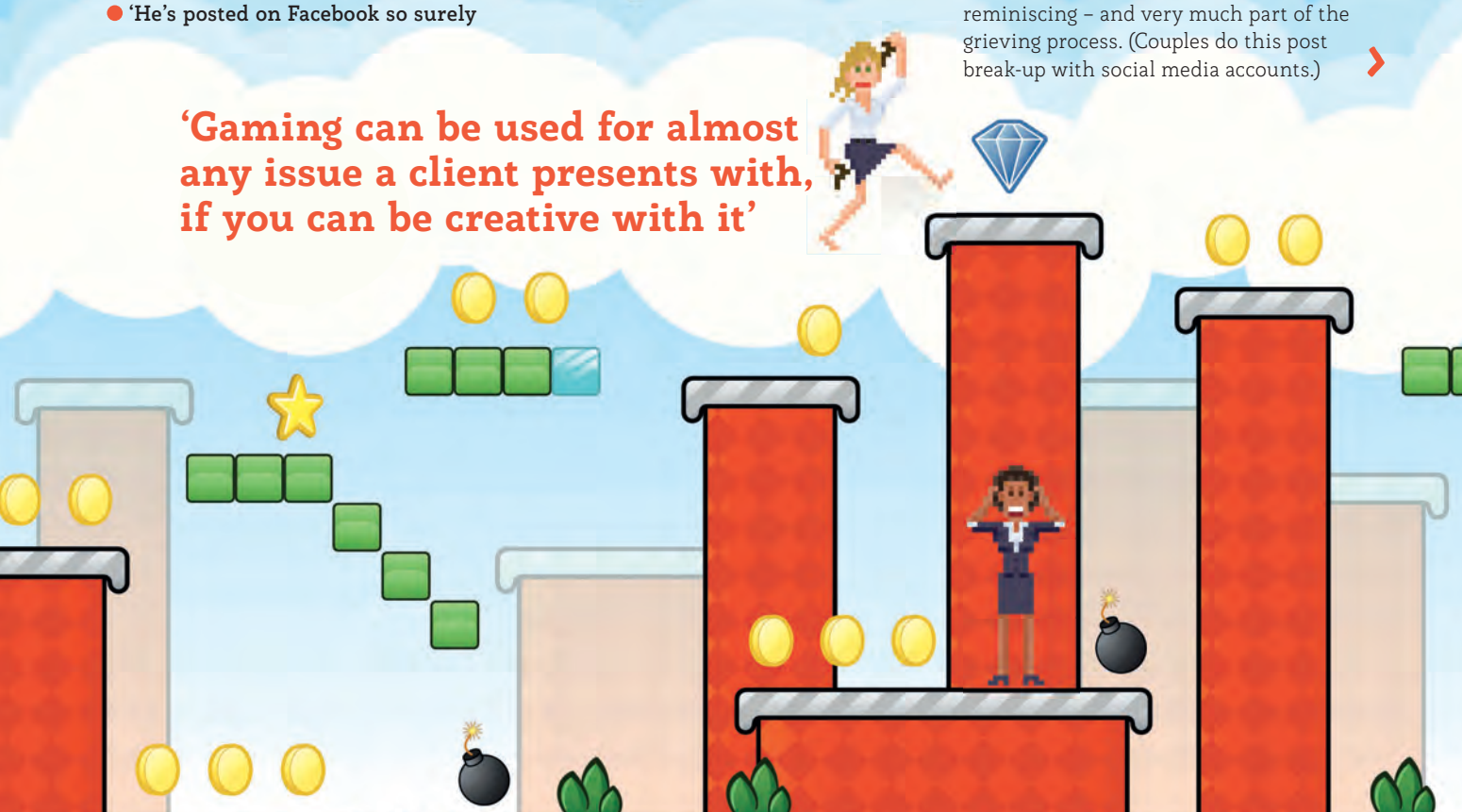
My initial intervention is to ask if they want to play a computer game. The Virtual Sandtray (VST) app is based on sand tray therapy. Obviously, as a somatic intervention, the digital version is not equivalent to the physical version in terms of visceral feedback, but it allows for much more exploration, such as changes in object size, the ability for the floor or background to be changed and for the sand to be painted. It can also be used by people who are allergic to sand, or dislike the feel of it.

We also play variations of role-playing games (RPGs) or adventure-style games in which levels are completed through solving puzzles or quizzes which result in a reward. Games such as *Lego Star Wars*, *Oddworld*, *Warhammer* and *Zelda* have a strong story element, which helps to facilitate the intervention. We might speak of the character's feelings, why the player chose one character over another, what it was like to kill the enemy and why, when you die in certain games, you can begin again – or 'respawn' – unlike in the real world.

The permanency of characters when the game is closed is also discussed, and the progress of characters from the early days of gaming, such as Lara Croft. This leads to conversations about how digital technology can be used to store photos and videos of people who have died, so that you can always carry them with you – something that cannot be done with a physical photo album.

I was touched by the reflections young people made about being able to repeatedly revisit, through this virtual space, those they had lost. This is much more about remembering and reminiscing – and very much part of the grieving process. (Couples do this post break-up with social media accounts.)

'Gaming can be used for almost any issue a client presents with, if you can be creative with it'



The difference for me is that the collages were made up of digital images or posts of the deceased – a sort of variation on a memory box or jar – rather than an art-based creative image or item used in therapy to access the memory through a conscious and/or unconscious process. The digital content is a person's image or post rather than a metaphor, or the externalisation of the psyche, energy or process.

A POWERFUL TOOL

There are limitations and challenges. The therapist must understand the mediums, and the risks associated with each: monitoring apps can enhance anxiety, be tracked and contravene GDPR; there may be age limits for apps and games that are not fully understood; and platforms can be accessed by strangers.

Gaming can be used as a tool to introduce life concepts: what the game represents; what it means phenomenologically to the child or young person; and why they chose it – whether it's a first-person shooter or RPG. Specific games and apps can be used for biofeedback, to assess and work with physiological symptoms in children who have experienced trauma (see panel). And the success and mastery that games require can help children and young people improve their autonomy, as they track their progress and monitor their own agency and awareness.

Gaming is a mechanism that children and young people can use to identify with on-screen characters and scenarios, ultimately helping them with mental health issues. ●

What do you think?
Share your thoughts and opinions by emailing: editor@ukcp.org.uk

Case study

Biofeedback for psychopathologies and trauma

Biofeedback is a form of technology that measures some aspect of physiology, such as Heart Rate Variability (HRV). When in balance it is aligned with breathing rates that keeps our autonomic nervous system in a homeostatic 'window of tolerance and health'

I met Tommy* aged nine when he was referred by the school for 'being distracted' in class and 'kicking off easily for no apparent reason'. He had queried diagnoses of ADD, ADHD and ASD due to his behaviours in school and at home. Upon assessment, the narrative surrounding Tommy was his parents' abusive marriage, which resulted in a rather difficult divorce that timed with Tommy's behaviour manifestations.

In our early session, Tommy told me he liked computer games and we discussed what types of games, who he played with and what his favourite game was. He had a passion for *Sonic the Hedgehog* and, while I didn't have it at the time, I was drawn towards suggesting a game I did have – a form of biofeedback with a similar play experience, because it involved collecting gold rings.

I had assessed Tommy as likely presenting primarily with trauma and of the many interventions for this issue, I decided the biofeedback could help with his biological/emotional responses to the trauma while we talked, and this would help with the psychological and educative aspects.

I explained to Tommy that the game would measure his heart rate through a small device attached to his earlobe. The device would detect the small pattern variations in his heartbeat, and he could change these (at the micro level) through controlling his breathing. We would need practice levels to begin with so he could understand that getting these two physiological systems in 'coherence' meant balancing them in relation to each other. This would show up on the game as a score, a colour and sound so that he could track his progress.

Tommy began to play and, as expected, he was non-coherent to begin with, however, as with many of the children and young people who play these games, he wanted to increase his score – and quickly. He listened to his body and learned what was an appropriate breathing rate for him, learned to navigate the keyboard and ideas behind the game, and was soon collecting gold rings while his heartbeat and breathing were balanced.

As Tommy played each week he would enter this state faster. He was able to talk to me about the issues at home and he was managing to self-regulate using techniques he was learning through the game; for example, he started to understand that getting excited changed the balance of his heartbeat and breathing, leaving him unable to focus. This was mirrored in school and at home when he found himself frustrated or excitable about a TV programme, topic, question or game in physical activity time.

In fewer than six months, the self-regulation skills that Tommy learned silenced the psychopathological diagnoses and began to look more like the trauma response that he was now gaining control over. He had taught himself to do this through feedback from a system of print, images and sound, and because he could see the real-time feedback, Tommy was able to see what his body was doing. Ultimately, he was in control.

**This case study is a vignette composite*

References

● (1) and (2) Ofcom. (2018). *Communications Market Report*. ofcom.org.uk/__data/assets/pdf_file/0022/117256/CMR-2018-narrative-report.pdf

The difference for me is that the collages were made up of digital images or posts of the deceased – a sort of variation on a memory box or jar – rather than an art-based creative image or item used in therapy to access the memory through a conscious and/or unconscious process. The digital content is a person's image or post rather than a metaphor, or the externalisation of the psyche, energy or process.

A POWERFUL TOOL

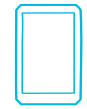
There are limitations and challenges. The therapist must understand the mediums, and the risks associated with each: monitoring apps can enhance anxiety, be tracked and contravene GDPR; there may be age limits for apps and games that are not fully understood; and platforms can be accessed by strangers.

Gaming can be used as a tool to introduce life concepts: what the game represents; what it means phenomenologically to the child or young person; and why they chose it – whether it's a first-person shooter or RPG. Specific games and apps can be used for biofeedback, to assess and work with physiological symptoms in children who have experienced trauma (see panel). And the success and mastery that games require can help children and young people improve their autonomy, as they track their progress and monitor their own agency and awareness.

Gaming is a mechanism that children and young people can use to identify with on-screen characters and scenarios, ultimately helping them with mental health issues. ●

References

■ (1) and (2) Ofcom. (2018). *Communications Market Report*. ofcom.org.uk/__data/assets/pdf_file/0022/117256/CMR-2018-narrative-report.pdf



What do you think?
Share your thoughts and opinions by emailing:
editor@ukcp.org.uk

Case study

Biofeedback for psychopathologies and trauma

Biofeedback is a form of technology that measures some aspect of physiology, such as Heart Rate Variability (HRV). When in balance it is aligned with breathing rates that keeps our autonomic nervous system in a homeostatic 'window of tolerance and health'

I met Tommy* aged nine when he was referred by the school for 'being distracted' in class and 'kicking off easily for no apparent reason'. He had queried diagnoses of ADD, ADHD and ASD due to his behaviours in school and at home. Upon assessment, the narrative surrounding Tommy was his parents' abusive marriage, which resulted in a rather difficult divorce that timed with Tommy's behaviour manifestations.

In our early session, Tommy told me he liked computer games and we discussed what types of games, who he played with and what his favourite game was. He had a passion for *Sonic the Hedgehog* and, while I didn't have it at the time, I was drawn towards suggesting a game I did have – a form of biofeedback with a similar play experience, because it involved collecting gold rings.

I had assessed Tommy as likely presenting primarily with trauma and of the many interventions for this issue, I decided the biofeedback could help with his biological/emotional responses to the trauma while we talked, and this would help with the psychological and educative aspects.

I explained to Tommy that the game would measure his heart rate through a small device attached to his earlobe. The device would detect the small pattern variations in his heartbeat, and he could change these (at the micro level) through controlling his breathing. We would need practice levels to begin with so he could understand that getting these two physiological systems in 'coherence' meant balancing them in relation to each other. This would show up on the game as a score, a colour and sound so that he could track his progress.

Tommy began to play and, as expected, he was non-coherent to begin with, however, as with many of the children and young people who play these games, he wanted to increase his score – and quickly. He listened to his body and learned what was an appropriate breathing rate for him, learned to navigate the keyboard and ideas behind the game, and was soon collecting gold rings while his heartbeat and breathing were balanced.

As Tommy played each week he would enter this state faster. He was able to talk to me about the issues at home and he was managing to self-regulate using techniques he was learning through the game; for example, he started to understand that getting excited changed the balance of his heartbeat and breathing, leaving him unable to focus. This was mirrored in school and at home when he found himself frustrated or excitable about a TV programme, topic, question or game in physical activity time.

In fewer than six months, the self-regulation skills that Tommy learned silenced the psychopathological diagnoses and began to look more like the trauma response that he was now gaining control over. He had taught himself to do this through feedback from a system of print, images and sound, and because he could see the real-time feedback, Tommy was able to see what his body was doing. Ultimately, he was in control.

**This case study is a vignette composite*

125 PSYCHOTHERAPY

From perversion to professionalism: YEARS OF

PROFESSOR BRETT KAHR has worked in the mental health profession for over 40 years and been a UKCP registrant since its inception. He is a Senior Fellow at the Tavistock Institute of Medical Psychology in London and works full-time with both individuals and couples in independent practice

NOW BOASTING THE POPE, MICHELLE OBAMA AND PRINCES WILLIAM AND HARRY AS ADVOCATES, PSYCHOTHERAPY HAS COME A LONG WAY IN A SHORT TIME. **PROFESSOR BRETT KAHR** EXPLAINS

In 1993, the UK Standing Conference for Psychotherapy became the UK Council for Psychotherapy, our nation's first fully representative registration body for practising psychotherapists. At that time, our fledgling organisation occupied a tiny office, no bigger than a rabbit warren, staffed solely by a former student of mine, who spent much of her day stuffing envelopes by hand.

Fortunately, over the past 27 years the UKCP has grown tremendously and now boasts a membership of over 10,000 members – an increase of approximately 200% since our creation. The psychotherapy profession has, in my lifetime, flourished beyond my wildest imagination. I certainly never suspected that Princes William and Harry would one day become such outspoken, public champions of the 'talking cure'[1].

'CHARLATANS'

Colleagues entering our profession today may not fully appreciate that, in previous decades, our predecessors endured unparalleled hatred and suspicion, regarded by medical practitioners and members of the public alike as unscrupulous 'trick cyclists'[2] and sexually perverse charlatans.

Certainly, no one endured more vitriol than Professor Sigmund Freud. As the physician who removed his traditional white laboratory coat and cast aside the prescription pad, de-medicalising the treatment of 'madness', and

as the man who facilitated confidential conversations with his patients, Freud evoked considerable animosity.

During the late 19th century, psychiatrists would frequently perform hysterectomies, ovariectomies and, even, clitoridectomies upon females suffering from psychological distress. Some would also sanction castration for mentally ill males[3]. Freud, by stark contrast, never touched his patients' bodies and offered, instead, a comfortable divan upon which to recline, and a private setting in which long-standing anxieties could be verbalised.

Unsurprisingly, this more humane approach to treatment and its foregrounding of the sexual secret evoked considerable hatred among many of Freud's medical contemporaries who had, for decades, committed themselves to the notion that insanity results exclusively from brain degeneration.

So when, in 1896, Freud addressed the *Verein für Psychiatrie und Neurologie* in Vienna about his work with hysterical patients, the venerable German-born psychiatrist, Professor Richard von Krafft-Ebing, lambasted the discoveries of the young Jewish doctor as a '*wissenschaftliches Märchen*' – a 'scientific fairy tale'[4].

As the decades unfolded, the Viennese continued to humiliate Freud. According to Dr Hanns Sachs, an early disciple, many regarded the father of psychoanalysis as little more than 'a rather disgusting freak'[5]. Similarly, Dr Fritz Wittels – one of the very first clinical psychoanalysts – recalled that many contemporaries considered Freud as nothing less than '*teuflisch*' – the German word for 'Satanic'[6]!

GROWING CRITICISM

Medical professionals from other European countries also denigrated the progenitor of the talking therapies quite viciously. For instance, the German psychiatrist, Professor Wilhelm Weygandt, humiliated the Freudians at a gathering of physicians in Hamburg in 1910, caricaturing psychoanalysis grotesquely as little more than the massaging of a patient's genitalia[7].

The hatred towards Freud and his fellow psychotherapy practitioners spread quickly across the Atlantic. As late as the 1930s, American institutions of higher education greatly feared the corrupting influence of psychoanalysis and psychotherapy. Dr Roy Grinker – a noted neurologist and psychoanalyst – recalled that the psychology library at the University of Chicago actually kept Freud's books locked in a back room, and that readers would require special permission to consult these ostensibly dangerous tomes[8].

ANTI-SEMITISM

Perhaps no group of people vilified Freud more snidely than the British. Dr Charles Mercier, a distinguished forensic psychiatrist, would refer laughingly to his great Austrian rival as 'Fraud'[9]. Even more strikingly, Mercier's colleague, Dr David Thomson, while serving as President of the Medico-Psychological Association (the precursor to the Royal College of Psychiatrists), mounted a virulent assassination of the talking therapies in *The British Medical Journal*, sneering about 'the dirty doctrines of Freud, Jung and Co', and lambasting them for their 'pornographic abominations'[10].

Owing to the large percentage of Jewish adherents among psychoanalytical circles, many critics attacked the talking therapies in an overtly anti-Semitic manner. In 1939, an anonymous correspondent wrote to Freud – newly settled in London – spouting murderous venom: 'It is to be regretted that the Gangsters in Germany did not put you into a concentration camp, that's where you belong.[11]'

The suspicion and nastiness towards the psychotherapies – whether psychoanalytically orientated or not – persisted not only in the pre-Second World War era but across much of the latter part of the 20th century as well. Throughout the 1960s and 1970s, Professor Sir Peter Medawar, a Nobel

'Many regarded Freud as little more than "a rather disgusting freak"'

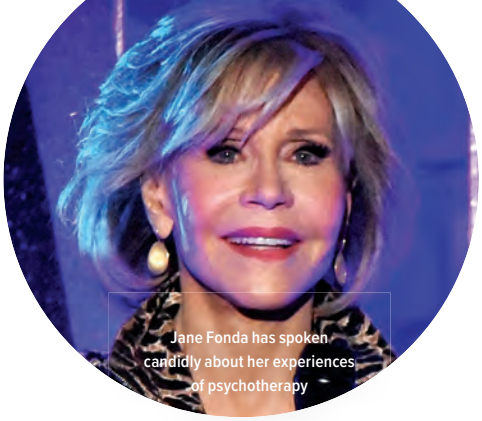
The Pope, Prince Harry and Michelle Obama have all spoken about the benefits of psychotherapy

Prize-winning scientist, often dismissed Freud's work as sheer 'nonsense', akin to 'a dinosaur or a zeppelin'[12]. Likewise, Professor Hans Eysenck, for many decades the leading clinical psychologist in the UK, besmirched the reputation of every single psychotherapist, claiming us to be 'prostitutes' who charge by the hour[13].

Given the hatred towards the talking cure over nearly an entire century, it amazes me that psychotherapy has not only survived and that membership of the UKCP has nearly trebled, but also that psychotherapy continues to prosper globally. Those early critics who accused our ancestors of being pornographers and prostitutes deserving of incarceration in concentration camps have now, mercifully, become but mere footnotes.

Cheeringly, throughout the latter half of the 20th century, numerous bold and pioneering British psychotherapists worked tirelessly to protect and promote our profession, and to document its efficacy through copious publications and increasingly sophisticated empirical, longitudinal research.

Dr Donald Winnicott pioneered psychologically orientated radio broadcasting; Dr Ismond Rosen promulgated psychotherapeutic ideas on the British TV programme *Fantasies of the Night*, as early as 1955; and Dr Susie Orbach, co-founder of the Women's Therapy



Jane Fonda has spoken candidly about her experiences of psychotherapy

Centre, has made numerous contributions to newspapers and, more recently, hosted an innovative radio series, *In Therapy*. Researchers, such as Professor Anthony Bateman and Professor Peter Fonagy, have provided impactful psychotherapy outcome research. And many landmark colleagues have created new sub-divisions within our profession, such as John Rowan, who fostered the growth of humanistic psychotherapy; Dr Stella Acquarone, who launched the first Diploma in Infant Mental Health; Dr Valerie Sinason, who pioneered disability psychotherapy; Dr Estela Welldon, who formalised forensic psychotherapy; Dr Wilfred Bion, who developed group psychotherapy; and Dr Robin Skynner, who helped to create family psychotherapy. Anna Freud, Melanie Klein and Dr Margaret Lowenfeld championed child psychotherapy; Enid Balint laid the foundations for couple psychotherapy; and Professor Andrew Samuels has encouraged greater integration of the different strands of our profession. These creative thinkers have provided the bedrock for the newer generations of psychotherapists to begin tackling technostress, climate change, and even terrorism.

INTERNATIONAL SUCCESS

Not only must we acknowledge the numerous colleagues who have conducted game-changing, blue-sky work, but, also, we should derive great comfort from our growing stream of internationally celebrated spokespeople, who have 'outed' themselves in recent years as grateful consumers of psychotherapy. I recommend that UKCP might consider electing Prince Harry, His Holiness the Pope and Michelle Obama as honorary fellows in recognition of their exceptional influence as worldwide de-stigmatisers of the psychotherapeutic profession.

I hope that we may all derive considerable comfort and pride knowing that we have survived more than a century of attacks and now have a more secure base from which to continue our growth and our impact. After decades of vicious attacks, psychotherapy has, at last, become almost 'cool'!

But we dare not rest on our laurels. We still have much to accomplish. Not only must we begin to integrate our rather split and splintered professional bodies, but we shall have to work hard to improve access to psychotherapeutic services, not only across the UK, but also overseas.

'After decades of attacks, psychotherapy has, at last, become almost "cool"!'

A young colleague from Tehran recently told me that he knows of several fellow Iranians who attend psychotherapy appointments at 2am or 3am, so that no one will discover this ostensibly shameful secret. Having come to learn that psychotherapists in Iran practise in the small hours of the morning reminded me of an anecdote which the late Dr Brendan MacCarthy, a child psychiatrist at London's Tavistock Clinic, confided to me decades ago.

MacCarthy once had the privilege of offering classical psychoanalysis to an MP. As this particular politician feared that a journalist might discover that he required 'therapy', the patient insisted that MacCarthy treat him late in the evening, in total darkness, so that no one could possibly see him entering the building! Fortunately, we now boast several peers in the House of Lords, such as Baron Alderdice and Baroness Hollins, who, prior to their careers in government, had distinguished themselves as brilliant psychotherapeutically orientated psychiatrists. Politicians need no longer feel ashamed of undergoing psychotherapy or, indeed, of having trained in psychotherapy.

But let me leave the very last words to none other than Jane Fonda, one of the first internationally adored Hollywood celebrities to speak quite candidly about her experiences in psychotherapy, in spite of the disapproval of her equally famous father, film icon Henry Fonda. As Ms Fonda explained about her psychotherapy some years ago: 'My father says I need it like a hole in the head, but I believe in it very strongly. Why waste a lot of time feeling guilty as so many of us do? It's helped me a lot and I know it can help others. That's why I'd like my father to go. Any man who's had four wives must be unhappy.'[14]

References

- (1) MacLellan, K, and Chopra, T. (2017). *Britain's Prince Harry Sought Counseling More Than a Decade After Mother's Death*. Reuters. UK Edition. uk.reuters.com/article/uk-britain-royals-harry-idUKKBN17J0KL.
- (2) Muirhead, C. (1987). *The Diary of a Bomb Aimer*. Speldhurst, Tunbridge Wells, Kent: Spellmount.
- (3) Brown, IB. (1866). *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*. London: Robert Hardwicke.
- (4) Freud, S. (1896). Letter to Wilhelm Fliess. 26th April. In Sigmund Freud (1986). *Briefe an Wilhelm Fliess 1887–1904: Ungekürzte Ausgabe*. Jeffrey Moussaieff Masson and Michael Schröter (Eds.), pp. 193–194. Frankfurt am Main: S. Fischer / S. Fischer Verlag.
- (5) Sachs, H. (1944). *Freud: Master and Friend*. Cambridge, Massachusetts: Harvard University Press.
- (6) Wittels, F. (1924). *Sigmund Freud: Der Mann. Die Lehre. Die Schule*. Leipzig: E.P. Tal und Compagnie Verlag.
- (7) Jones, E. (1955). *The Life and Work of Sigmund Freud: Volume 2. Years of Maturity 1901–1918*. New York: Basic Books.
- (8) Grinker, R, Sr. (1985). *A Memoir of My Psychoanalytic Education*. Jay Martin (Ed.). Psychoanalytic Education, 4, 3–12.
- (9) Stoddart, WHB. (1940). *Sigmund Freud*. Journal of Mental Science, 86, 190–192.
- (10) Thomson, DG. (1917). *Psycho-Analysis*. British Medical Journal. 6th January, pp. 32–33.
- (11) Anonymous. (1926). *Evidence or Opinions Reflecting Upon Absent Practitioner: Want of Legal Remedy*. The Lancet. 9th January, p. 79.
- (12) Medawar, PB. (1969). *A Reply*. Encounter, 33, Number 5, 90–94.
- (13) Eysenck, HJ. (1985). *Decline and Fall of the Freudian Empire*. Harmondsworth, Middlesex: Viking / Penguin Books.
- (14) Freedland, M. (1988). *Jane Fonda: A Biography*. London: Weidenfeld and Nicolson / George Weidenfeld and Nicolson.

A FRESH APPROACH

‘WALK AND TALK’ THERAPY WITH NEUROLOGICAL PATIENTS HAS SOME VERY POSITIVE RESULTS, EXPLAINS **DR HELEN MOLDEN**

DR HELEN MOLDEN is a UKCP-registered integrative psychotherapist and chartered counselling psychologist specialising in long-term health conditions and based in a neuro-rehabilitation setting. She has 20 years’ experience working in psychological services across the NHS, private and charitable sectors

‘Illness is the night side of life, a more onerous citizenship,’ wrote Susan Sontag. ‘Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.’[1]

Working with people living with a diagnosis of a neurological condition involves re-examining brain and body in the most fundamental sense. Questions such as ‘How can I no longer move my hand to make a cup of tea?’ are psycho-social dilemmas often experienced in sharp contrast with the medicalised environment and agenda of recovery.

One of my inpatients, 90-year-old Emily*, was under the care of a multi-disciplinary team (MDT) for neuro-physiotherapy, occupational therapy and psychological input after experiencing a major stroke and two subsequent falls, leaving her with paralysis and further complications.

In her own words an independent, ‘feisty, stubborn lady’, she found time away from home and her local community difficult. Emily said she missed her garden at home and the outdoors in her local community, near the sea. While she did manage ‘to escape’, as she put it, during some rehabilitation sessions, the majority of her life was spent indoors – a huge change from how she was used to living her life, and a contributory factor to her low mood.

The therapeutic work I did with Emily led me to develop ‘walking and talking’ as an option for clients, on an individual and group basis, in the countryside surrounding the neuro-rehabilitation centre, and subsequently undertake a piece of practice-based research into the lived experienced of four patients.

PLANNING

The research was part-funded by the Metanoia Institute, through its staff research grant fund, and in the first instance considered how we might keep matters confidential in the outdoor space that was agreed. It varied from finding a bench in a private spot to how we would treat encounters with others, who may or may not be known to the client, given the outdoors space was familiar to them.

The committee for ethical approval also requested that risk assessments were conducted at the initial assessment of the patients, with specific questions as part of the intake and information form, plus discussions with the referring personal therapist. Risk assessments were also undertaken before each therapy session, according to the weather conditions, outdoor space and context. This was especially important when working with patients with physical challenges.

Clinical supervision was given through regular one-to-one discussions with a counselling psychologist and healthcare professional who had experience of working therapeutically outdoors.

THE PATIENTS

The patients were referred for therapy and the project by their physical therapist. This was mostly because they had reached a point of ‘stuckness’ in

*This is a composite case study.

some way in their physical therapy treatment, and psychotherapy provided another perspective for MDT working practices. As the psychotherapy sessions were free to participants, there was no conflict in terms of monetary investment, only time.

The question for the MDT in this neuro-rehabilitation out-patient setting was whether incorporating nature – embedding the work in the client's ecosystem – could play a helpful part in the therapeutic process and have an impact on recovery.

Four people already attending the neuro-rehabilitation centre opted to have six individual outdoor talking therapy sessions. Two had Parkinson's disease: Sandra+, 51, had recently been diagnosed and had good mobility; Jeff+, 75, had lived with Parkinson's for several years and had some difficulty walking and 'freezing'. Jane+, 56, had a recent diagnosis of multiple sclerosis but had experienced balance, fatigue and visual symptoms for two years. Ted+, 86, came for physiotherapy 18 months after a series of strokes and previous heart surgery.

I began by building a picture of the patients' 'ecological story' – their beliefs, involvement with and interest (or not) in the outdoors. This assessment meant the best places for outdoor sessions emerged naturally depending on what the participants were familiar with and felt some connection to. For the less mobile participants, we chose a focal point such as a bench as a destination during the walk and talk.

As sessions began, and the working alliance between therapist and client developed, very little direction was needed in terms of stated exercises or interventions: each participant instinctively led the way and therapeutic intervention emerged out of the context.

When encouraging Jeff to see possible connections between his sense of resilience in facing his health challenges and how he faced difficult times as a boy, we stopped near running water and a bridge. His face lit up as he remembered scrambling over tricky rocks, being chased by friends and splashing and running through water as a boy. Bearing witness to Jeff's reminder of the youthful nature of his body, he drew himself up to stand taller in the here and now, with a new energy, while remarking, 'I don't usually talk about myself – this is a strange process!'.

At the end of session two, Jeff said he found talking and walking was a welcome distraction from pain, and valued 'being listened to while walking at my own pace'. This was particularly important given the fact that his voice was affected by the Parkinson's and it was hard for him to be heard – he had experienced being 'somewhat ignored, as communication could be tricky', adding to his sense of social isolation.

'AT MY PACE'

All participants cited the therapeutic power of having another person walking with them side-by-side at their pace. As a clinician working outdoors, I pay particular attention to my client's phenomenology, and to the turn-taking, not just in the verbal dialogue

Case study

'I don't want to be a burden'

Initially reluctant to engage in any kind of talking therapy, but 'sent' by his wife, Ted gradually gained greater mobility.

Sitting on a bench, the flow of consciousness darted between past, present and future in our dialogue, prompted by nostalgia of days spent enjoying cricket.

Ted commented that the ability to discuss themes such as physical decline and the fear of death were both intensified and set into relief. Looking at the late afternoon sun catching the wicket, we visualised him at different life stages – bowling to his young children, drinking beers with the village team.

We explored the shame and embarrassment for him around being ill – 'I don't want to be a burden' – and social anxiety when 'meeting up with friends when I can be stuck sitting down in the corner'.

Case study

'I can do more than I think I can'

Prior to therapy, in addition to coming to terms with her diagnosis, Sandra had been busy with work, the daily demands of her children and going through some relationship difficulties.

Overwhelmed by the weight of responsibilities and fear for her future health, she felt unable to allow herself the space for the regular physiotherapy sessions and daily practice, and arrived at therapy feeling depressed, anxious and low in motivation.

We decided to go ahead despite overcast conditions, both of us battling raindrops on glasses. By being out in this landscape, the session served to emphasise that there is no perfect guarantee: the stark yet reassuring existential message conveyed that nature and life cycles carry on regardless.

Sandra primarily used the sessions to express her anger over losing her imagined future, and fears of what living with the condition might mean, and by the end of our sessions, dry and fine or dispiritingly cold and damp, the exercise had brought colour to our cheeks and seemed to re-energise Sandra, who said, 'I can do more than I think I can!'

Consideration is given to body placement and movements when walking side-by-side with clients

'The work outdoors seems to bring together a shared psychogeography for client and therapist'

but also in an embodied sense – where do I place my step, my body, my arms, my head when walking next to my client?

This was particularly important with Jane, who experienced difficulties with balance, fatigue and sight issues. Her shudder as we were overtaken on several occasions by people on mobility scooters was palpable. She was reluctant to accept her recent diagnosis, while grateful for an explanation. We talked about the sense of stigma and horror she felt at what mobility aids mean for her in her current state of already-reduced mobility.

As a therapist, I was able to gain an understanding and helpful data set about my client that was arguably more vivid than what is achievable in therapy, and I could explore it in the here and now. Jane, in some sense, was also held by the therapeutic relationship taking place in the calmness of a familiar setting, as she often spends free time enjoying countryside walks and garden centres.

INSIDE, OUTSIDE

The work outdoors seems to bring together a shared psychogeography for client and therapist – there is a gentle indifference of the individual, and the bodily state they may or may not be in, as a result of the wildness around us. This proved to be a stark background for walking beside clients as they struggled with their emotions around acceptance and rejection of diagnosis.

In contrast to the relative sterility of the therapy room, where the patient's life and presenting problem is helpfully focused into microcosm through the therapeutic dyad, here the scope is open-wide.

The MDT noticed improved take-up and sustained practice of the exercises recommended by all four participants. One joined the gym and three 'actively engaged more in the goals and outcomes of their physiotherapy over the treatment period, including individual and group work'.

Talking therapy outdoors was generally seen as a supportive function, and the MDT observed increased client empowerment and autonomy when discussing exercises. The language of the world of physical therapy and occupational therapy is usually very goal-focused – 'shoulds' and 'oughts', with the explicit request for patients' compliance to exercises in session and followed up at home. The participants stated that they enjoyed the opportunity to break away from the routine of the treatment regime, to reflect and feed that back into the recovery process.

The findings add to the debate on how we continue as a society to integrate our healthcare services for the benefits of improved patient experience, and how we open up the possibilities for each person of a healthier life well lived.

+All participants gave their written consent for their case studies to be published with their anonymity preserved and consent was confirmed again verbally at the last session from each participant. Ages, names and identifying details have been changed.

References and reading

- 1. Sontag, S. (2002). *Illness as a Metaphor* and *AIDS and its metaphors*, Penguin Modern Classics.

About the project

This project was given ethical approval by the Metanoia Research Ethics Committee (MREC) in 2017.

It reviewed all the project documentation from project proposal to participant information sheet, consent form and risk assessment. Once the project was underway, the consent form was signed at the beginning with the understanding that the results of the project would be published in an anonymised form, and all four participants gave their consent, keen to promote understanding of psychosocial aspects of neuro-rehabilitation. However, the consent form remained uppermost in mind as a dynamic process throughout the project, as discussion was had between the researcher and participants at each stage. This included each participant's final session where it was again stated that the intention was to publish the project and consent was given for their experiences in anonymised format to form part of the write up.

Are you considering a career in psychotherapy?

Being a psychotherapist or a psychotherapeutic professional can be a rewarding experience.

You may be working with individuals, couples, families or groups. Or specialising in working with children and young people.

You could be using any of the different types of psychotherapy from traditional Freudian analysis to dance or art therapy, or hypno-psychotherapy.

But most importantly, you will be helping people express their feelings, find better ways to cope with the challenges that life can bring, and improve their emotional and mental wellbeing.

Our organisational members run UKCP accredited training courses in different parts of the country. And during your training you may be eligible to join UKCP as a student or trainee member.

To find out more about the different types of psychotherapy and our training visit our website:

www.psychotherapy.org.uk

UKCP
UK Council for Psychotherapy

Registered Charity No 1058545. Company No 3258939. Registered in England

RIGHT: Sherbersky: 'Therapy is by its nature a creative process'

'Therapy can help us to draw on our own spontaneity'

WITH A CURRENT ROLE SPANNING THE NHS, PRIVATE PRACTICE, TEACHING, TV WORK AND STUDY, **HANNAH SHERBERSKY** IS BUSY. SHE EXPLAINS HER MOTIVATIONS AS A THERAPIST

Hannah Sherbersky has had a long, varied and illustrious career in mental health. She trained as a mental health nurse originally, a profession that informs her work now as a systemic psychotherapist and university lecturer specialising in work with young people and families.

She played a pivotal role in the BBC Three short documentary broadcast in 2019, *I Blame My Parents*, holding an emotional and frank therapy session in which Dammy, a 23-year-old woman suffering anxiety, finally confronted her mother about their difficult communication. Sherbersky is currently involved in discussions with Channel 4 about a possible documentary idea.

I learned so much being involved in the short TV documentary. Obviously, the first areas I thought about were the ethical considerations and the notion of informed consent. I talked through the issues with my supervisor and professional body, the Association for Family Therapy and Systemic Practice (AFT). The BBC Three team was also very thoughtful and respectful, not only when it came to the ideas and considerations I had for the programme, but also towards the contributors.

The most interesting aspect of that process was the challenge of distilling an idea and making it intelligible and understandable for the general public. The programme featured an edited extract of 18 minutes from a three-hour session of family therapy. I found myself becoming interested in how we crystallise the salient points in a therapy session and uncover the very essence of someone's story.

I am keen to demystify therapy and promote systemic ways of thinking, so it has been very helpful for me in thinking about my work generally – what is at the very heart of the work I am trying to do?

Therapy is by its very nature a creative process. We can all be creative and bring forth new stories and possibilities. Therapy can help us to draw on our own spontaneity. I strongly believe that we often learn more in our embodied experience of one another and there is something about working creatively that taps into that embodied experience.

Therapy is in the family and in many ways I started my training very young. I have vivid memories as a child of waiting in the staff room of a psychiatric hospital for my dad to finish his shift. He was then a psychiatric social worker before later training and working with Robin Skynner as a group analyst. This was the late 1970s, when all psychiatric nurses smoked and wore corduroy! I would sit quietly in the corner of the room, listening to the staff talking about their patients and I think my interest in people's stories really ignited at this point.

I qualified as a mental health nurse 23 years ago and my mental health nursing identity is still very important and grounding for me. In particular, it helps me with the practical application of therapeutic ideas and gives me credibility with trainee colleagues. The fact that I can draw on my own experience of being on the front line as a mental health nurse gives me the authority to be challenging. Understanding the wider system also enables me to come alongside trainees who might be working in incredibly difficult and challenging situations.

As a family therapist, I work one day a week in an NHS adolescent inpatient unit. I have a small private practice with my husband, who is also

a psychotherapist. We see families for therapy, provide supervision and do extra teaching and training. The rest of my week, I work as programme and academic lead within the clinical education development and research department (CEDAR) of the psychology unit at the University of Exeter. The courses include a qualifying course in family therapy, clinical psychology, systemic practice and family interventions for psychosis input. In my spare moments, I am finishing my doctorate on notions of home within adolescent inpatient units.

Working with high levels of complexity sometimes requires simplicity as a response. In a family context, within services that are themselves complex, I believe we need to be really clear, to prioritise and remain tenacious. I started working in an inpatient unit 20 years ago and thought about how much needed to change therapeutically, but it has taken me all these years to get to a position where I have the authority and expertise to now organise training for inpatient staff. We need to be tenacious!

Adult mental services sometimes struggle to be very compatible with a systemic way of thinking. Ten years ago, I co-developed the Exeter Model with Professor Janet Reibstein, which uses behavioural and systemic ideas within couple therapy to treat depression. We ran a couples clinic, have trained many people in the model and it was delivered as one of the adult IAPT programmes. It's still ongoing – we recently developed an adaptation to the training for perinatal services and mother and baby units in the South West.

I feel proud of the teaching and training that I do, particularly the recent inpatient training programme. It's a very complex and politically sensitive area to work in – the stakes are so high for young people and there is so much to do to improve services. I believe using a systemic framework can help us tackle some of the difficulties we face generally. Almost all the young people I work with are responding appropriately and understandably to incredibly difficult life circumstances. We need to contextualise mental health, within both the family and wider society. Psychotherapists as compassionate people can come alongside others and tolerate their distress. I continue to learn so much about families from students and my own children. Ultimately, we are all relational beings in families and live in a relational world. ●

Find out more at ***changetree.co.uk***

Timeline

HANNAH SHERBERSKY'S JOURNEY IN PSYCHOTHERAPY

1997 Began work as a mental health nurse in Brighton Primary Care Trust. Completed a Certificate in Group Analysis.

1999 Worked as a registered mental health nurse in Devon Partnership Trust.

2001 Became a sex and relationships educator within the Exeter Primary Care Trust, and started studying Family Therapy.

2005 Worked as a community psychiatric nurse within CAMHS, Devon. Completed a certificate in Dramatherapy.

2009 Qualified as a family therapist.

2010 Started work as a couples therapist at the Mood Disorder Centre at the University of Exeter. Also undertook a Diploma in Creative Supervision.

2011 Started her role as a systemic family psychotherapist at a region inpatient unit. Also started co-delivering the MSc in Psychological Therapies.

2013 Became academic lead for the Systemic Family Practice Child IAPT programme and tutor on the Doctorate in Clinical Psychology.

2016 Became programme lead for the systemic supervision course and the family interventions for psychosis course.

2018 Became programme lead for the CAMHS inpatient training programme and continues with doctoral research.

On Screen

Will is a working-class genius who is persuaded to have therapy when his life starts to unravel. ***Tony McSherry*** *considers the portrayal of therapy in* Good Will Hunting

Dr Sean Maguire

Good Will Hunting

Have you ever grabbed your client by the throat? Gone for a walk together? Shown him your heartfelt grief? Shown him the door? The therapist, Sean Maguire (Robin Williams) has. The client, Will Hunting (Matt Damon) doesn't complain to anyone. What made it work, or is it just Hollywood?

Now nearly 23 years old, *Good Will Hunting* is still one of the most well-known representations of a therapeutic relationship – demonstrating authenticity by showing a journey made not just by the client, but by the therapist. But the authenticity of the representation fails with the violence between therapist and patient.

ABOVE: After a rocky start, Will and Sean manage to build an effective therapeutic relationship

Will is a polymath, loyal, hard-working, rebellious. Physically abused in orphanages, now he takes refuge in loyal friendship. His genius is discovered by clandestinely solving complex maths problems while working as a janitor at Massachusetts Institute of Technology. In trouble, he is vouched for by the maths professor on condition he attends therapy.

We see Will demolishing two therapists. As a last resort, the professor calls on his disaffected friend, the bearded, bespectacled Sean. In the first session, Will plays the same trick he has on other therapists – getting personal. He insults Sean's beloved deceased wife and Sean grabs Will by the throat.

What strikes me (apart from the obvious issue of assault) is that some respect emerges for Sean from Will, not from the violence but from Sean's courage to show his vulnerability. Therapy is not necessarily a 'nice' place. Waves of emotion and significance can crash around the room if we are open to ourselves and the client. But whether we show our responses to those emotions appears to be moment-specific.

'Despite the altercation, Sean and Will's relationship continues'

It appears to me that this is an important point which indicates that therapy works when we do not flinch away from what the client invokes in us. The previous therapists flinched – one from homosexual feelings, the other from humour. Both were professionally vain but Sean is not, which enables him to learn from his client.

Despite the altercation, Sean and Will's therapeutic relationship continues. Through a number of sessions, Sean's voice, which shows through his being what he desires in his work and who he is, eventually helps Will to speak for himself.

The final session is one of mutual self-disclosure: Sean reveals he too was physically abused. He impresses upon Will that what happened as a child was not his fault. Will experiences a cathartic release from a pathological sense of responsibility. If only it were that simple.

There are obvious problems with the portrayal – not least the assault and discussions about Will with the maths professor – but the film is an advertisement for the talking cure, still as relevant today as it ever was. Sean's approach sets the example that we need to have genuine integrity, sensitivity to the client, and self-awareness to be effective, no matter what our modality.

What have you seen on screen that has annoyed or inspired you? We'd love to hear your stories. Email editor@ukcp.org.uk

2-DAY WORKSHOP | 12 HOURS CPD

Treating Trauma, Complex PTSD and Dissociative Disorders

Presented by international expert and author

KATHY STEELE, MN, CS

3-4 APRIL 2020 | LIVE IN LONDON

SAVE £100 with code KSTNP20-100

Information & bookings

W: https://bit.ly/2TuP40W

T: 01235 847393 | E: info@pesi.co.uk

Limited availability, reserve today!

PESI® UK

A Non-Profit Organisation

2-DAY WORKSHOP | 12 HOURS CPD

Healing the Fragmented Selves of Trauma Survivors

Transformational Approaches to Treating Complex Trauma

Presented by internationally renowned trauma expert

JANINA FISHER PhD

27-28 MARCH 2020 | LIVE IN LONDON

SAVE £100 with code TNPJF-100

Information & bookings

W: https://bit.ly/2YDokMc

T: 01235 847393 | E: info@pesi.co.uk

Limited availability, reserve today!

PESI® UK

A Non-Profit Organisation