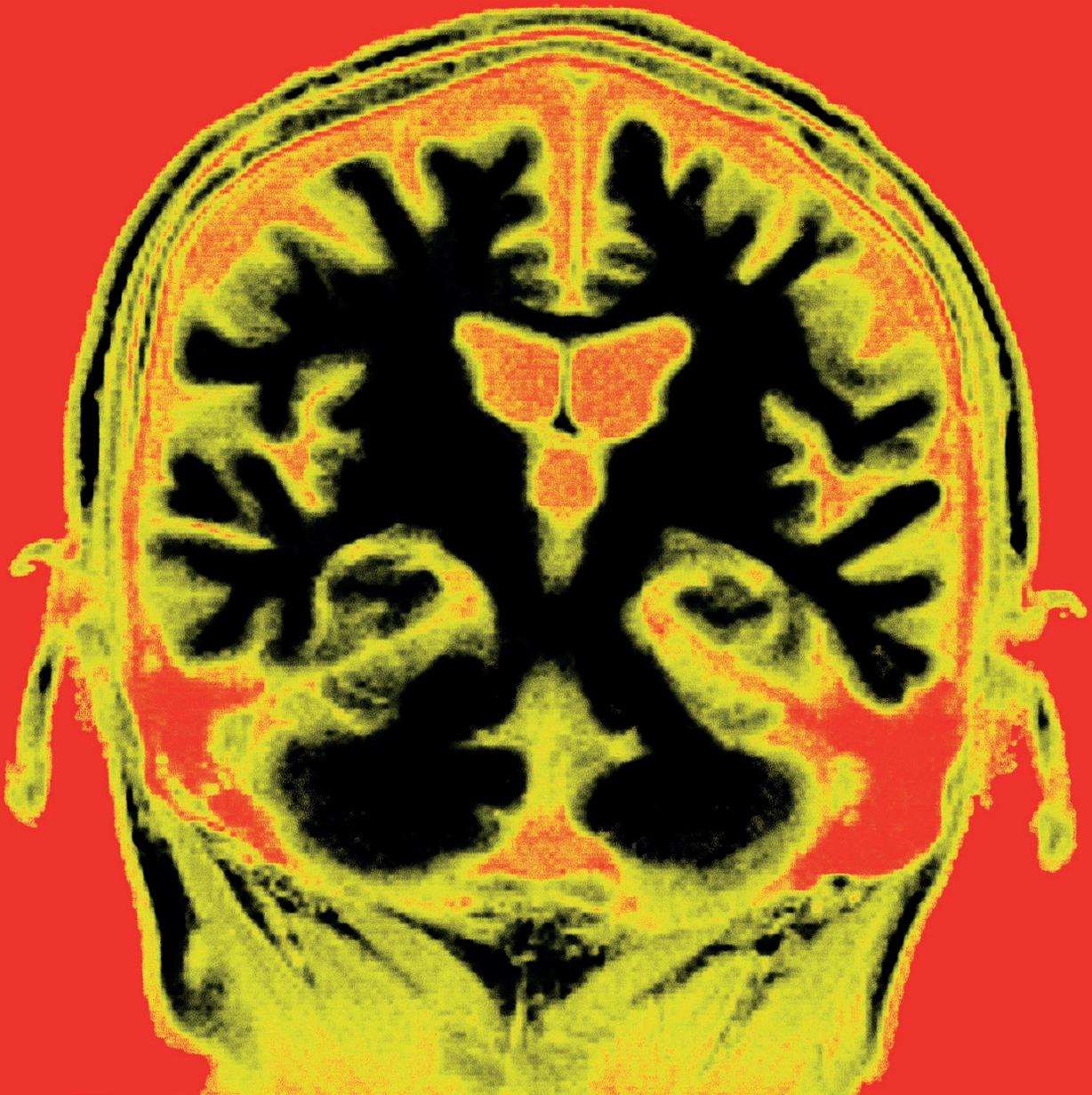


New Psychotherapist

ISSUE 78 / AUTUMN 2021

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New Psychotherapist

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Welcome

ISSUE 78 / AUTUMN 2021



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 idea that psychotherapy is not scientific has held strong for more than a century. From Freud's wrestling with methodologies to the dominance of behaviourism in psychology, psychotherapy has come to be seen as different - more 'art' than 'science'. As a result, quantitative, randomised controlled trials are pre-eminent in psychological research, and talking therapies awarded efficacy in this way are dominant in the NHS. Psychotherapists and psychotherapy are, to a significant extent, sidelined in public health.

But qualitative research approaches that can demonstrate the efficacy of psychotherapy are just as valuable as quantitative. Aikaterini Fotopoulou, professor of psychodynamic neuroscience at University College London, says that psychotherapy and science will always have their own epistemologies, traditions and

ways of discovering the truth. Science cannot displace or replace the 'truth' as we see in psychotherapy, but provide another level of description and reality instead, and the two disciplines can 'engage in mutually respectful dialogue', she says.

It's also a common mistake to assume psychotherapy is not 'scientific'. Neuroscience has become helpful at discovering the causal relations in psychotherapy and in the study of emotion, for example. This work allows psychotherapists to refine their techniques and demonstrate psychotherapy's huge worth as a mental health intervention. In this issue, we consider where psychotherapy and science meet, focusing on some of the groundbreaking work taking place in the fields of neuropsychology (page 20), psychedelic-assisted therapy (page 26) and virtual reality (page 30).

Elsewhere, we talk to Conservative MP Tim Loughton about public perceptions of mental illness and the importance of infant mental health (page 48). Psychosexual and relationship therapist and trauma psychotherapist Silva Neves explains why psychotherapists need to take a humanistic and pluralistic approach to compulsive sexual behaviour (page 42). We also consider the role of film and TV in therapy (page 36).

This is my last issue as editor of *New Psychotherapist*. It's been a pleasure working on the magazine and talking to so many of you. My very best wishes.

ANNA SCOTT
Editor

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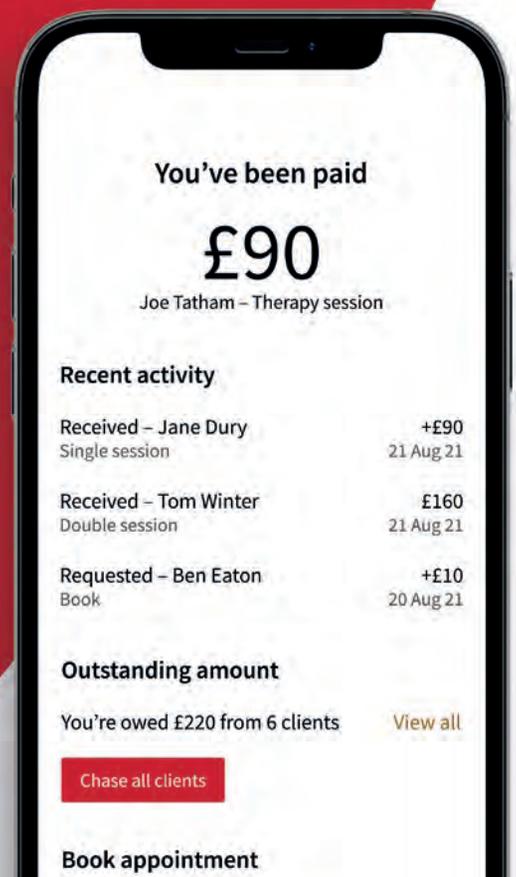
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Contents

ISSUE 78 / AUTUMN 2021

14 Exploring the ways in which psychotherapy is assessed



REGULARS

06 Bulletin

News, research and member updates to keep you informed

10 Reviews

Recommended reading and podcast listens

52 Spotlight

Eugene Ellis, integrative arts therapist and founder of the Black, African and Asian Therapy Network, discusses his journey in psychotherapy

54 On Screen

The roles of dreams and ghosts in the Netflix drama *Shtisel*

FEATURES

14 The outliers

We explore the interaction between science and psychotherapy

20 Behind the hardware

Could psychotherapists benefit by learning more about neuroscience? And what role, if any, should 'neuropsychotherapy' play in our practices?

52 Eugene Ellis reflects on why he was drawn to the profession

26 The psychedelic therapy renaissance

What new research into psychedelic-assisted therapy could mean for the profession

30 Working in other worlds

Using virtual reality in the therapy room

36 Making connections

The potential of TV and film as tools to use in therapy

42 A paradigm shift

Evolving our approaches to compulsive sexual behaviour

48 Political interview

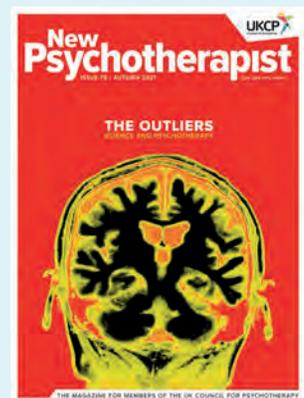
Conservative MP Tim Loughton on the importance of supporting maternal and child mental health



30 We examine the benefits of using virtual reality in therapy

On the cover

This issue, we focus on the science of psychotherapy



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Bulletin

ISSUE 78 / AUTUMN 2021

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



The report calls for action to tackle the impact that climate change is having on mental health

40-1

Number of cases of psychological trauma arising from a disaster can exceed physical injury by 40-1

2-3x

There is a 2-3x increased risk of dying during a heatwave for people with pre-existing mental illnesses

6

ECO-ANXIETY

Links between climate change and mental health 'need greater prominence' in policy

Report highlights evidence for the impact of climate change on mental health

UKCP has backed a call for urgent funding for training and research to meet the mental health impact of climate change.

A briefing paper from the Climate Cares Initiative – part of the Grantham Institute and the

Institute of Global Health Innovation at Imperial College, London – cites a clear relationship between global heating and the number of suicides, with a 1% increase in the rate of suicide for every 1°C temperature rise.

It demands joined-up action to tackle the worsening 'detrimental and multi-faceted impact' that climate change is having on mental health.

Training programmes should be developed to build greater capacity to prevent and respond to the mental health impacts of climate change, it says. Funded research is needed on people vulnerable to and with lived experience of climate change to inform development of interventions.

Mental health expertise should also be incorporated within disaster emergency responses.

UKCP CEO Professor Sarah Niblock, also a member of the Climate Cares Advisory Board, said: 'This study confirms yet again that business-as-usual simply isn't working. And it's disturbingly clear that those who are worst affected and most vulnerable are also least likely to access existing mental health services. I've said before that we are still sleepwalking into the Anthropocene – we need urgent funding and expansion of psychotherapeutic expertise now.'

Children, people of colour and women are particularly vulnerable to the mental health effects of extreme

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Reality bites

Using virtual reality in the therapy sphere

Page 30

'This study confirms yet again that business-as-usual simply isn't working'

weather events, as are people with prior experience of deprivation, those with less social support and people experiencing inadequate welfare or medical care.

The report also found that people who experience mental illness are more vulnerable to the effects of climate change on physical as well as mental health, with clear evidence of severe distress following extreme weather events.

It calls for collaboration and joint action by policy makers alongside research institutions, mental health practitioners, health services and non-governmental organisations.

'Health leaders who have taken account of these trends can better ensure that people, and health systems, are prepared to help limit the impacts of climate change on people's wellbeing,' said Dr David Nabarro, co-director of the Institute of Global Health Innovation.

Dr Neil Jennings, partnership development manager at the Grantham Institute, added: 'Policy responses can make multiple gains, or "co-benefits", by leveraging common solutions to the dual challenges of climate change and mental health. Such solutions include increasing the amount of green space in urban areas to absorb carbon dioxide, reduce the heat island effect, reduce the risk of local flooding and improve access to nature.'

The report, 'The impact of climate change on mental health and emotional wellbeing: current evidence and implications for policy and practice' can be found at tinyurl.com/climatechangeimperial

PUBLIC SECTOR

NHS to fund more trainee places in IAPT services

Investment of £20 million will be spent on high-intensity therapy posts in NHS

NHS leaders in England have made funded training places available for non-CBT therapy roles in IAPT.

They invested an extra £20 million in the training and recruitment of new high-intensity therapy posts in dynamic interpersonal therapy, counselling for depression, couples therapy for depression and interpersonal therapy. Successful applicants are now receiving training in the relevant therapy model. All posts are salaried and training fees fully funded.

It comes as part of the commitment in the NHS Long Term Plan to substantially increase the number of people accessing IAPT services.



The move will see more therapists in the NHS

In addition to the models of therapy more closely aligned with typical UKCP trainings, NHS England emphasised that it encouraged any interested psychotherapists and counsellors to apply for CBT roles.

'This is an opportunity we have been calling for and it was fantastic to see NHS England respond,' said Adam Jones, UKCP policy and public affairs manager. 'Increasing access to psychotherapy has long been a strategic objective and charitable goal for UKCP and we are determined that everyone should have access to a full range of psychotherapies, regardless of their circumstances.'

'And we hope this is only the start - UKCP will again lobby the government during its 2021 comprehensive spending review to provide HEE with funds to build on this success, not only in IAPT but also secondary care and children's services.'

'This is an opportunity we have been calling for'



Reframing compulsions

Is it time for psychotherapists to rethink 'sex addiction'?

Page 42

RESEARCH

Couple therapy reduces depression and anxiety, research finds

Short-term intrinsically systemic behaviourally-based therapy model underused in NHS, despite success

Researchers are calling for strengthened links between Improving Access to Psychological Therapies Services (IAPTS) and systemic therapists to tackle the underuse of couple therapy for depression (CTfD) in the NHS.

They found that, on average after having the NICE-recommended therapy, clients reported statistically significant reductions in depression and anxiety scores.

Systemic psychotherapist and consultant clinical psychologist, Melanie Shepherd, and clinical psychologist at East London NHS Foundation Trust, Lucy Butler, evaluated a CTfD service – a short-term intrinsically systemic, behaviourally-based interactional model of therapy – delivered to 81 couples within a large IAPTS in a diverse London borough.

Recovery rates were consistent with and sometimes exceeded the IAPT national target of 50%. Relationship satisfaction also improved, with a recovery rate of 42.9% for clients referred for CTfD and 45.5% for their partners. However, despite positive outcomes, only 1.85% of sessions offered in this IAPTS during the study were CTfD. This tiny proportion was higher than that offered nationally.

These findings are supported by another study that showed recovery rates from depression of 57% following CTfD, compared with 41% for all IAPT depression treatments.¹ Yet 33% of clinical commissioning groups did not offer CTfD in 2019.²

The researchers say one reason for the low provision of CTfD, despite its effectiveness, is training for mental health professionals that privileges individual work. 'A significant barrier to CTfD implementation appears to be the individually focused IAPTS culture,' the authors state.

'The culture of IAPTS is based around individual interventions. CBT and counselling training focus on intrapsychic rather than interpersonal processes. Supervision often encourages the same perspective,' they add. 'Therapists' beliefs about depression are reinforced, and individual interventions become the default position. Depression is not viewed through a lens that takes into account a client's relationship context.'

Many IAPTS offer no CTfD. Those that do, deliver it on a minimal scale. Scarcity of CTfD staff results in isolation and poor representation in decision-making contexts, which influences funding and service development.



Couple therapy for depression is effective yet underused

They add: 'To change IAPTS culture, leadership is required, from commissioners, those who generate and monitor IAPT targets, Trust senior management and IAPTS directors. Targets for CTfD implementation are needed, with monitoring of delivery. All IAPTS should provide CTfD, and capacity needs to be greatly developed. We suggest an initial minimum of two therapists delivering CTfD full-time, supervised by appropriately qualified couple therapists, plus monitored annual increases in the proportion of CTfD delivered to achieve equivalence with counselling within 10 years.'

'Depressed clients deserve equivalent access to CTfD as to individual therapies,' they conclude. 'Referral criteria for CTfD should be depressed clients in a relationship, rather than relationship distress: allocation between therapies would then become more even and patient choice widen.'

The study, 'The underuse of couple therapy for depression in Improving Access to Psychological Therapies Services (IAPTS): a service evaluation exploring its effectiveness and discussion of systemic barriers to its implementation,' is published in the *Journal of Family Therapy* (2020).

References ● (1) Baucom, D, Fischer, M, Worrell, M, Corrie, S, Belus, J, Molyva, E and Boeding, S (2018). 'Couple-based intervention for depression: an effectiveness study in the National Health Service in England.' *Family Process*, 57: 275–92. doi.org/10.1111/famp.12332 (2) Tavistock Relationships (2019) Data received in response to a freedom of information request submitted to CCGs, mental health trusts and other providers. Contact rmeier@tavistockrelationships.org for information. (3) NHS Digital (2018): digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2016-17-further-analyses

CHILDREN AND YOUNG PEOPLE

Mental health support teams in schools ‘should include psychotherapists’

More clarity needed on how children’s increasing mental health needs are met, professionals say

Educational psychotherapists have called for greater involvement in newly created mental health teams in schools designed to address the increase in mental health difficulties among children and young people because of the pandemic.

As part of a £79 million programme announced in the NHS Long Term Plan to invest in young people’s mental health services, NHS England will create 400 mental health support teams covering 3,000 schools in England by 2023, speeding up the programme because of the increase in difficulties such as anxiety and depression over the last 18 months.

Patricia Reid, psychotherapist and chair of trustees at the Caspari Foundation, said that increased funding for and awareness of the growing mental health needs of children and young people and their families is to be welcomed. But she added: ‘There has to be a more ambitious restructuring

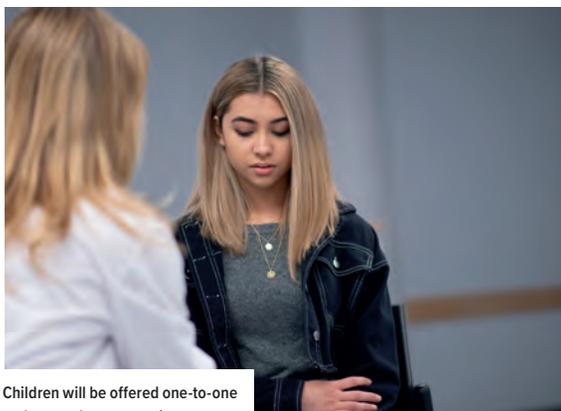
of mental health services for children and young people; robust teams, embedded in schools with health practitioners and educational professionals working closely together, is the way forward.’

Under the plans, referrals to the mental health teams can be made by teachers or GPs or by young people themselves using a texting service. Children will be offered one-to-one and group therapy sessions. There are currently 183 mental health support teams operational and a further 103 teams are in development. More mental health teams will be commissioned this year.

‘Educational psychotherapists would

welcome greater emphasis on providing mental health support in schools and the earlier this support happens, the greater the chances of improved long-term outcomes,’ Reid added.

Systemic and family psychotherapist Joanne Hipplewith said it’s not clear if the growth in demand is due to the pandemic or this was an increasing need anyway. ‘It is essential to look behind the numbers of the extra funding to what this means in practice, in terms of modalities of treatment and efficacy – access, location, platform, number of sessions, and cultural needs – so the teams can make a meaningful difference to our children’s futures,’ she added.



Children will be offered one-to-one and group therapy sessions

POLICY

SMHP MEETING WITH NEW SCOTTISH MENTAL HEALTH MINISTER

The Scotland Mental Health Partnership (SMHP), of which UKCP is a member, has met with the new Scottish mental health minister, Kevin Stewart MSP, to discuss the Scottish government’s plans for mental health over the next four years.

The partnership comprises 17 professional bodies and mental health third sector organisations. Its members represent, among others, those with lived experience, providers, clinical professionals, carers, community support networks and the wider third sector. Each organisation contributes its direct experience and unique perspective to create an informed collective voice on mental health.

As part of a dialogue with representatives of the partnership’s member organisations, the newly appointed minister addressed a number of issues around mental health in Scotland and the government’s plans.

The minister stated that stigma would be a major priority for the government. He also discussed the government’s plans to deliver on its student mental health action plan, the increased role of GPs in mental health following the pandemic, the importance of peer support workers in mental health services, and the need for the Scottish government to address the impact on mental health of economic harms caused by COVID-19 – though he said that some of these policy areas fall outside the devolved remit.

Closing the meeting, the minister agreed he would continue to meet regularly with the SMHP to remain engaged in these and other issues.

Reviews

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

The Race Conversation: An Essential Guide to Creating Life-Changing Dialogue

This timely, moving book captures in an accessible and practical way the essence and depth of the trauma and psychodynamics of race. Over eight chapters the book maps the construction of race through the centuries, the language and social constructivism around race, the nature of embodied trauma and how it manifests in the here and now.

Through transcripts of dialogue between the author as a Black man and colleagues, friends and acquaintances, the book outlines how to talk about race. Some conversations reflect on shared experiences and heritage, and others are about cross-racial and cultural heritages and how these are experienced within and between people.

Rather than being model examples of how to have dialogue about race, these are

illustrations of how to open up the space between people when the emotional experience of doing just that is conflicted.

The book also satisfies a hunger for knowledge, with facts, theory and reflections. Ellis explains constructivism, embodied trauma, intergenerational transmissions, neuroscience and scripting at a digestible pace.

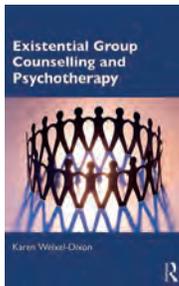
I can perhaps imagine that the engaging style means that some readers might miss the research and intellect behind the writing. In other words, as with transactional analysis, accessible language does not mean a lack of depth or substance, and if it is judged in this way then something profound has been missed.

● See *Spotlight*, page 52



Details

- **Reviewed by:** Karen Minikin, psychotherapist and trainer
- **Author:** Eugene Ellis
- **Publisher:** Confer Books
- **Price:** £13.99
- **ISBN:** 9781913494261



Details

- **Reviewed by:** Paul Gordon, psychotherapist
- **Author:** Karen Weixel-Dixon
- **Publisher:** Routledge
- **Price:** £24.99
- **ISBN:** 9780367092883

Existential Group Psychotherapy and Counselling

In this country at least, group therapy has been dominated by the group analytic approach. Karen Weixel-Dixon, an experienced existential practitioner, sets out a very different approach.

The main difference between the two has to do with the primacy of being as opposed to doing. The existentialist therapist is called on to be as authentic as she can; she cannot take refuge behind the role of the expert or detached therapist. The group grows through all its members being as open and honest as they can be, not just about themselves but with each other and, in particular, their differences. Relatedness is a way of being that we cannot avoid even though we may wish to.

The existential approach in therapy is not, as some think, an easy option.

Drawing extensively on her own work, Weixel-Dixon shows it can be more demanding of those involved and, as a result, much richer in its rewards.

She covers a lot of ground, outlining the theories underpinning the approach, both philosophical (for instance, Heidegger and Sartre) and therapeutic (Yalom, Foulkes, Rogers and others), and what concepts like embodiment, anxiety and spatiality mean in practice.

Weixel-Dixon summarises her own approach well. Challenged about how she proposed to run a new group, she found herself saying: 'We can reflect on and explore how we are together, with each other, and how our relationships – that is, any of them – affect us, our existence, and the way in which we live our lives.' (p.166)

The Divided Therapist: Hemispheric Difference and Contemporary Psychotherapy

Neuroscience is creeping into the therapy world, and its most interesting offering is the divide between the left and right hemispheres. Many therapists develop an intuitive sense of these differences from their encounters with the human psyche.

Yet simplistic understandings are common, so this book, bringing together perspectives of therapists, psychiatrists and others, is timely. It presents a tapestry of views on the hemispheres and the significance of the right hemisphere, in particular, in therapy.

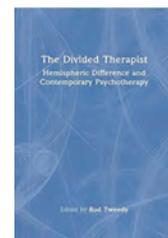
The book starts with Rod Tweedy's introduction to the subject, and continues with contributions from writers who will be familiar to neuroscience-inclined therapists – Allan Schore, Iain McGilchrist, Louis Cozolino, Dan Siegel and Alexander Siegel.

Further chapters explore hemispheric perspectives on group therapy,

experiential therapy, psychoanalytic theory, early development and language. We read of research into alexithymia, repression and dissociation – among many other topics.

The subject sometimes gets technical, risking trying to understand the right hemisphere from the perspective of the left. Nevertheless, Barbara Dowds, for example, writes about working in embodied and experiential ways with the right hemisphere, helping us get a feel (right) for the subject, as well as an understanding (left) of it.

The divided therapist is also the therapist who can bridge the divide by combining their right hemisphere's embodied wide-angle take on what is happening in the room with their left hemisphere's attention to detail. The practice of therapy helps to develop the use of both hemispheres alongside each other – which is, perhaps, why we do it.



Details

- **Reviewed by:** Peter Afford, UKCP-registered psychotherapist and author of *Therapy in The Age of Neuroscience*
- **Author:** Rod Tweedy
- **Publisher:** Routledge
- **Price:** £24.99
- **ISBN:** 9780367504427



Details

- **Reviewed by:** Nick Campion, integrative psychotherapist
- **Author:** Silva Neves
- **Publisher:** Routledge
- **Price:** £26.99
- **ISBN:** 9780367465483

Compulsive Sexual Behaviours: A Psycho-Sexual Treatment Guide for Clinicians

What's striking about Silva Neves' book on working with compulsive sexual behaviours is his clarity of vision. At the start, Neves sets out the different models of dealing with sexual compulsivity and why he fundamentally, but respectfully, rejects the sexual addiction model.

He makes cogent arguments using research, theory and case studies and he presents these arguments unequivocally. At times, I wondered if the presentation of a range of evidence and viewpoints would be useful – for example, around the issue of pornography, where his view is that it is not harmful, which many would contest.

But this is a treatment guide and so the clarity of approach makes perfect sense, as Neves constructs his argument for sex positivity, pleasure, consent and self-understanding in the treatment of those

with compulsive sexual behaviours. His is a humane and thoughtful approach and the book resonates with kindness, curiosity, empathy and acceptance.

This is not to say it is without rigour: his position is well-researched and the case studies are excellent adjuncts to the detailed practical advice and ideas. He describes some powerful and moving sessions with clients and it is valuable to see the process in action. Therapists will find a huge range of possible interventions to consider as they take their learning into their own client work. Ultimately, however, this is not a manual of interventions but a call for a new approach to sexual compulsivity that centres an empathic, non-shaming, trauma-informed perspective that honours every client's unique sexuality.

● See feature, page 42.



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Therapy in the Age of Neuroscience: A Guide for Counsellors and Therapists

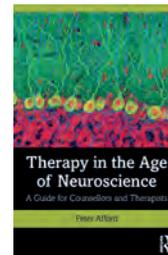
Peter Afford has skilfully fulfilled an ambitious brief to make the key findings of neuroscience palatable and digestible for therapists. He has managed not only to condense a vast amount of scientific knowledge on the nervous system into an easy-to-read account, but also to argue a case for how and why therapists can benefit from this knowledge.

The beauty of this book is that it is neuroscience written for therapists by a therapist. Afford has judged his readers well, anticipating their ambivalence and their partial scientific knowledge. He has obviously used skills learnt from more than 25 years' client and training work to address our doubts and uses language we can understand. He has refused to accept the electronic analogies of 'circuits, wiring and coding' loved by neuroscientists. He reminds

us that brains are the work of nature and chooses instead to speak of natural images such as pathways and forests.

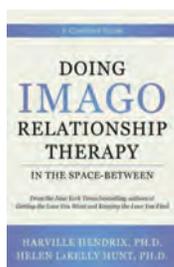
For me, a book on neuroscience will never be an easy read, but this is an important one. Afford insists that an understanding of the science can offer a new perspective on the client's difficulties and how to resolve them. He looks at areas which are particularly pertinent for therapists – relationships, emotions, anxiety, depression and trauma, to name a few.

Afford argues that it is vital to understand the impact of our interventions on a client's nervous system, as well as appreciating the working of the brain. He also provides valuable guidance on how to use this knowledge in a therapeutic setting, not as theory, but as a quiet confirmation that what we do actually works.



Details

- **Reviewed by:** Elisa Morris, integrative psychotherapist
- **Author:** Peter Afford
- **Publisher:** Routledge
- **Price:** £24.99
- **ISBN:** 9781138679351



Details

- **Reviewed by:** Ian Tomlinson, psychotherapist and couples therapy trainer
- **Authors:** Harville Hendrix and Helen LaKelly Hunt
- **Publisher:** WW Norton
- **Price:** £32
- **ISBN:** 9780393713817

Doing Imago Relationship Therapy in the Space Between: A Clinician's Guide

Harville Hendrix and Helen LaKelly Hunt have spent the past 40 years figuring out why couples fight. One of the results of their exploration is Imago relationship therapy; a structured way of working with couples in the therapy room based on Imago theory.

The book handholds the practitioner through every step of the method, splitting it into four parts: Imago metatheory; Imago clinical theory; Imago clinical processes; and Imago clinical practices.

The relational paradigm postulates that the connection between the partners is what transforms them both. In Imago relationship therapy the

therapist facilitates this connection using the Imago dialogue process. The dialogue process takes the focus away from the therapist and onto the 'space between' the couple. It's a transformative and magical experience for couple and therapist alike.

After the 'why' the book gives you the 'how', explaining each part of the Imago method stage by stage. The examples, exercises and worksheets help the therapist integrate Imago into their practice quickly. Add to that a deep theoretical understanding of why couples get stuck in the first place, and it makes this book essential reading for all therapists who work with couples.

Intersections of Privilege and Otherness in Counselling and Psychotherapy

Dwight Turner's book is a very timely text – presenting an in-depth understanding of the role of privilege, and of the unconscious experience of privilege and difference within counselling and psychotherapy. Turner the activist shines through, bringing social, cultural and political contexts to the consulting room. The book is the powerful embodiment of his lived experience of intersectionality and otherness and how this manifests in the unconscious enactment of privilege in our profession.

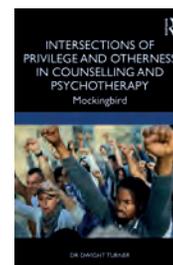
As Kimberlé Crenshaw stated, 'intersectionality was always a lived reality before it became a term'. Turner has not only reintroduced the term to all of our bookshelves, but he has really brought intersectionality alive in a new way, citing privilege as having its part in constructing otherness. At the beginning of the book, his relational and open style sets the scene

by naming his intersectional identity and sharing his experience of otherness.

This in itself is stirring and moving, inviting the reader and practitioners to consider their own intersectional identity consciously and unconsciously and their place within systemic oppression.

The chapter on 'Death of the Other', describing the unconscious enactment of privilege and otherness, is particularly powerful. The mini deaths experienced by minority cultures on a daily basis and thus the killing off of the other, in order to comply with white supremacy and normative culture. This has stayed with me and is palpable, as both the oppressor and oppressed within my identity.

The success of the text speaks for itself, I'm not sure I've ever seen so many copies amongst colleagues and peers or heard of a book more talked about. The challenge now is how we live this evolving awareness.



Details

- **Reviewed by:** Victoria Baskerville, transactional analyst psychotherapist and founder of TA East London Institute
- **Author:** Dr Dwight Turner
- **Publisher:** Mockingbird
- **Price:** £29.99
- **ISBN:** 9780367426774



PODCASTS WE'RE LISTENING TO

THERAPY ON THE FARM, COURAGEOUS MUMMA PODCAST

Created by author and consultant Madeleine Stanimeros, the *Courageous Mumma* podcast covers a range of issues and interviews about parenting. In this episode, UKCP psychotherapist Hannah Clarke is interviewed while walking around the farm she owns and uses in her work as an animal-assisted therapist.

Clarke spoke of her love of animals which developed in

her childhood spent in Jersey and her dream of 'having a menagerie' – she currently has a pig called Colin, a goose called Delores and five feral guinea pigs. She has completed formal training in equine-assisted therapy, having witnessed the benefits to a friend's autistic son.

Stressing the importance of initial assessment and safety considerations, especially for people who have not come into contact with larger animals such as Colin, Hannah offers a gradual introduction to the animal(s) they are 'drawn to'.

Therapy takes place in her outdoor therapy room with swing chairs and includes both verbal and non-verbal communication. One instance being the use of the animal's experience, for example: 'Colin is suspicious of people he doesn't know – do you feel like that sometimes?'

My only small criticism is that the podcast focuses on Clarke's therapy with children, though the work could easily be adapted for adult clients, too – offering benefits to clients with such issues as depression, low mood, lack of confidence and anxiety.

Details

- **Reviewed by:** Jan Baker, UKCP-registered transactional analyst psychotherapist and supervisor
- **Creator:** Madeleine Stanimeros
- **Available:** [courageousmumma.podbean.com/e/therapy-on-the-farm/](https://podbean.com/e/therapy-on-the-farm/)



THE BIG
REPORT 
THE SCIENCE OF
PSYCHOTHERAPY

THE OUTLIERS

TRADITIONAL SCIENTIFIC APPROACHES TO MENTAL HEALTH AND
PSYCHOTHERAPY HAVE A LOT TO CONTRIBUTE TO ONE ANOTHER.
BY JOY PERSAUD

Psychotherapy has 'never been subjected to rigorous scientific scrutiny,' wrote the authors of *Evidence-based psychotherapy: the state of the science and the practice in 2017*¹.

A view has emerged over the last century and a half that psychotherapy is not scientific and therefore does not hold the same legitimacy as more empirical approaches to studying the human condition. The consequences of this include a public mental healthcare service which prioritises scientific approaches based on randomised controlled trials (RCTs) and fewer psychotherapy roles in the NHS. Just 21% of UKCP members work in NHS-funded services, despite 57% of the membership expressing an interest in working in such roles².

Because of its influence over public and private mental health provision in the UK, the National Institute for Health and Care Excellence (NICE) plays a major role in the perceived hierarchy of treatments and evidence. Even though NICE mental health guidelines state that it is 'open to researchers using either qualitative or quantitative research methods to evaluate the efficacy of specific treatments', it is clear in the formulation of guidelines, such as >

‘NICE plays a major role in the perceived hierarchy of treatments and evidence’

the adult depression guideline currently in development, that RCT data is given greater precedence in determining treatment recommendations.

Psychotherapist Michael Friedrich says that NICE ‘gives the impression of being more wary of qualitative data. NICE is generally working within a medical model and probably has a bias towards scientific, standardised, measurable methods and data.’

As Friedrich says, for an institution tasked with measuring the efficacy of treatments for illnesses such as cancer and cardiovascular disease, such a bias ‘is understandable’. However, given the clear differences in measuring mental and physical health treatments, it remains a great source of frustration for many therapists and researchers that NICE continues to privilege RCT data, seemingly at the expense of qualitative data. Indeed, this tension has played a central role in UKCP’s campaign, as part of a coalition of more than 40 mental health organisations, for NICE to alter its methodology in developing its depression guideline. Among the central critiques of NICE’s approach is the exclusion of qualitative data around patient experience, meaning the voice of service users has not been considered in determining what treatments should be recommended – and ultimately accessed through the NHS and other pathways.

Despite the fundamental differences between pharmaceutical and talking treatments, some psychological therapies are better suited to the objective measures of quantitative research. Friedrich points out that CBT aspires in practice and research to use the methodology of natural science. ‘In

the consulting room, the CBT therapist is the expert who rationally critiques the patient. However, CBT and other reason-based psychotherapies are, in all probability, barking up the wrong tree, because the material of psychotherapy is mental content – emotions, the unconscious, memories, dreams, which aren’t usually reason-based.’

INSPIRATION FROM SCIENCE

One confounding issue is the lack of agreement about psychotherapy’s goal and therefore what constitutes a good therapeutic outcome, says psychotherapist Dr Kathrin Stauffer. ‘It seems to me that much of what gets framed as a “lack of an evidence base” for psychotherapy in medical or health outcomes terms is an ideological and political question, and the narrative about the lack of an evidence base is disingenuous.

‘There absolutely is an evidence base for the efficacy of psychotherapy for anyone who looks for one. And it is likely that, for those who do not like the narrative of psychotherapy as a treatment for psychological distress, there will never be enough of an evidence base to change their minds.’

But it’s important to point out that there is considerable research evidence to show that psychotherapy works. Nearly 40 years of meta-analyses of psychotherapy outcomes have demonstrated the clear, clinical benefits of psychotherapy³. For example, the effects of psychotherapy have been found to be longer-lasting than those of medication⁴.

According to UKCP’s policy and public affairs manager, Adam Jones, UKCP’s strategy to influence provision of psychotherapy is therefore two-fold. ‘We know there is a great deal of evidence to show the effectiveness of psychotherapy and indeed the NHS and NICE do recognise some of this. So, our short-term strategy relies on that evidence as we argue that, even within the existing parameters of the system, there is great potential to expand the

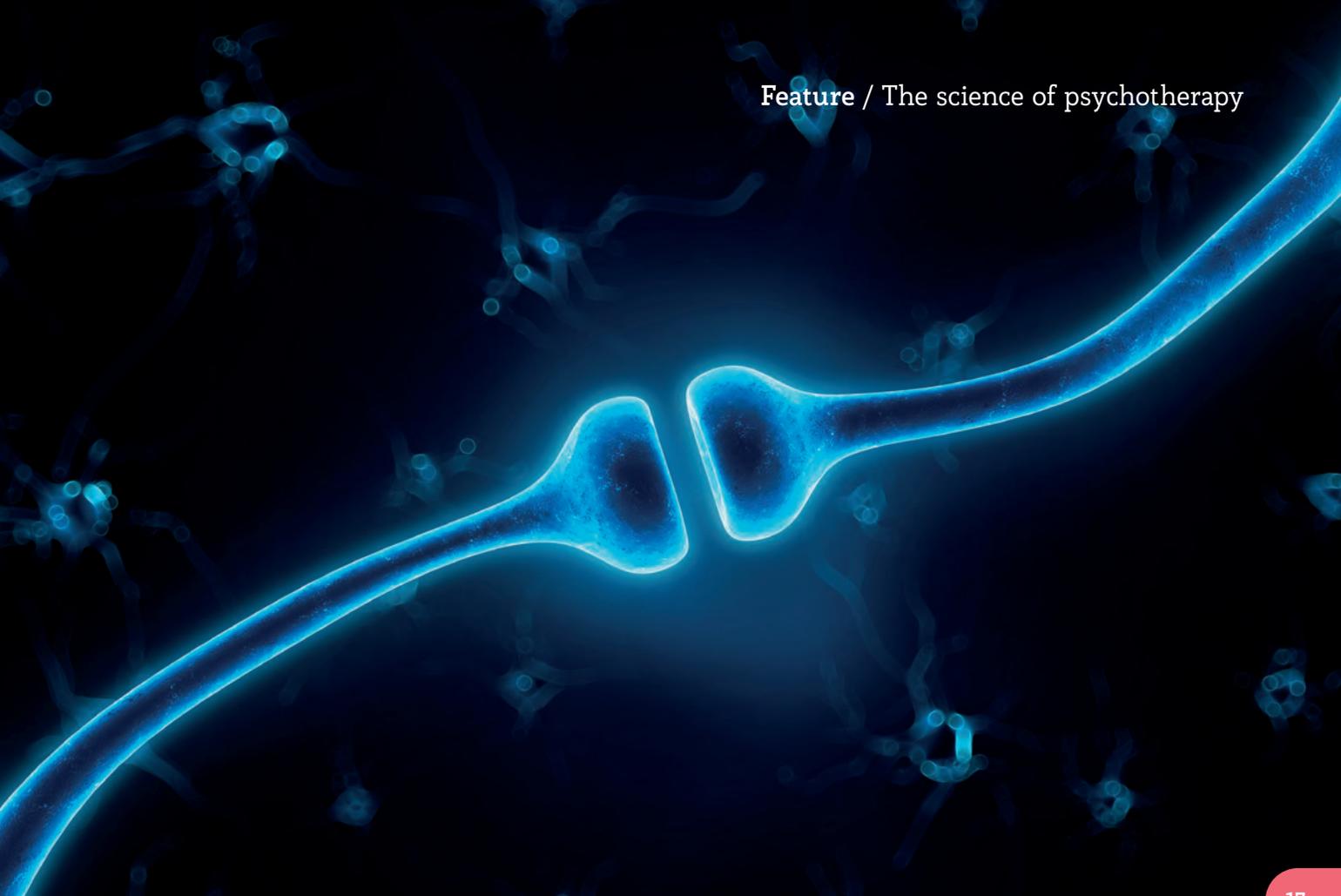
provision of psychotherapy in the NHS and beyond.’

However, according to Jones, UKCP’s longer term strategy is focused on a bigger scale of change. ‘In the long term, we want to see fundamental changes to the way NICE develops its guidelines, including much greater incorporation of practice-based evidence and qualitative data. This will require political will, a culture shift within NICE, and more funding for psychotherapy research. However, it will also require the psychotherapy profession to become more comfortable in using research tools such as outcome measures. That’s why, as well as putting pressure on NICE, the government and the NHS, we are focused on expanding our academic partnerships, including our exciting new partnership with the University of Sheffield.’

There are other developments in research that give cause for optimism, such as the growth of empirical research into aspects of psychotherapy. For example, up until the 1980s and 1990s, there was very little study of emotions within psychology and neuroscience. This has changed. ‘Interoception is something we can study in a lab,’ says Aikaterini Fotopoulou, professor of psychodynamic neuroscience at University College London. ‘This is how people physiologically, but also in conscious awareness, regulate the bodily signals that accompany emotions.’ It’s also possible now to scan two people at once, to see how brains respond to each other. ‘[We’ve found that] in moments of emotional connection, the body, including the brain, actually physically synchronises,’ Fotopoulou adds.

DEFINITIONS OF TRUTH

‘I think this is a tremendous opportunity for psychotherapy, but with opportunity comes risks and responsibility,’ she adds. ‘What is happening, and we don’t want it happening, is the idea that “science” holds some kind of privileged shining light over “truth”. It’s about the two



fields teaching each other. It's about getting inspiration from science and potentially getting these ideas in the epistemological and practice tools we have in psychotherapy, and assessing them. We shouldn't just be naively importing ideas from science. We have to put them under scrutiny.'

However data is gathered, it must be reliable, valid and 'as far as possible, approaching truth', says Friedrich. Natural science and hermeneutics will always differ in relation to the former's desire to create generalisable laws and the latter's focus on attention to individual case studies, but 'qualitative and quantitative methods are complementary and, when they're appropriately used – the right tool for the right task – depending on what kind of data is being used, both qualitative and quantitative methodologies provide useful information,' he adds.

It's useful to look at subjectivity and objectivity in the same way. 'The fundamental tension between subjectivity and objectivity has been there since the beginning of

human civilisation, and it's not going to go anywhere,' Fotopoulou says. 'Nobody is going to solve it, whether psychotherapist or scientist, but it is important that we understand it and engage in it. One discipline explores subjectivity and the other explores objectivity. They will also have their own epistemologies, their own traditions, their own ways of discovering the truth. Science cannot displace or replace the "truth" we see in psychotherapy, but it can provide another level of description and reality.'

The conceptual split between mind and body has dominated the histories of psychotherapy and science. In de-medicalising the treatment of 'madness' and facilitating confidential conversations with his patients, Freud evoked animosity from his medical

contemporaries, who were committed to the notion that insanity resulted exclusively from brain degeneration⁵.

At the same time, the development of a more functional clinical medicine during the nineteenth century that moved away from Hippocratic medicine's theory that the mind was influenced by the body, meant more of a separation of mental and physical health, according to academic, journalist and author, Catharine Arnold. 'While excellent in many ways, leading to breakthroughs in surgery, anaesthesia and epidemiology, the mind and body split came at the expense of the mind,' she adds.

This division has had an impact on research funding. 'Scientists only investigate areas where they can get funding and they shy away from the

'We want to see changes to the way NICE develops its guidelines, including greater incorporation of practice-based evidence and qualitative data'

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Case study

A neuroscientist's view

Oliver Turnbull, professor of neuropsychology at Bangor University, whose scientific interests include the neuroscience of psychotherapy, says there is no reason why, despite the variables, psychotherapy can't be tackled in the same way as any scientific problem.

'[The variables mean] people might view psychotherapy as more of an art than a science, but ultimately it's a measurable part of reality like any other,' he says. 'It just happens to be a bit more complicated than the trajectory of balls, or whatever you're measuring in physics.'

Turnbull talks about the predictors of psychotherapeutic outcome and says the 'number one' predictor is the therapeutic alliance, based on whether the therapist and patient can develop a good working relationship.

Second most important is openness to change – does the patient want to change or are they there because their spouse told them to go – in which case, he says the chances of improving are 'not immense'.

He adds, 'Whether you use CBT or whichever therapy, these aren't the most powerful predictors; those other two are. And it's important that those first two seem much more emotion-related, or at least emotion regulation-related, than any other variable.'

'You can see why some people are naturally better therapists than others. Now, that's not because it's an art, it's because the person brings to their therapeutic relationship their history as a human, including their development and their attachment relationships.'

'If that's true, you can predict what the outcome of therapy is for reasons that are more emotionally important than people give this credit for.'

'When I'm asked, "If a member of your family was going for psychotherapy, which one would you recommend?" My advice is: choose whichever approach you feel most confident about. If you and your therapist can't develop a good working alliance, then, as the number one predictor of outcome, you're on a hiding to nothing.'

"metaphysical"; says UKCP chair and psychotherapist Martin Pollecoff. 'That split has stopped curiosity and ambition in mental healthcare. Of course, there are great strides made in neuroscience, but they do not translate easily into actions that heal. They tend to prove our point that it's relationships that make the difference, they show that us humans are hardwired to connect.'

RESEARCH FUNDING

There's a great deal that medicine can learn from psychotherapy, particularly in the NHS. 'All GPs could learn to be better listeners. Some recognise that physical illness goes deeper than the physical symptoms, but alas they do not have enough time or energy to take the deep interest in every patient that a psychotherapist can. In an ideal world, both medical doctors and psychotherapists would be able to view their patients holistically,' Arnold says.

Ellen Dunn, UKCP's policy and research officer, argues that steps need to be taken to ensure GPs are better equipped to support patients with mental health difficulties. 'It is important to provide GPs with better tools to support mental health needs, including awareness of different referral pathways,' she says. That psychotherapy is often more effective than medication for treating emotional issues shows 'we need to advocate for widespread use and demonstrate clinical effectiveness', says Charlotte Fox Weber, psychotherapist and head of psychotherapy at the School of Life.

This is why research funding for applied psychotherapeutic research is so crucial. 'There is far more funding for scientific research,' Fotopoulou says. 'It is terribly important that we have more funding for applied psychotherapeutic research because we need to answer: what [therapy] works and why.' Understanding the answers allows different therapies to be targeted to different people, to see

what works best for people, to guide psychotherapeutic training.

Dunn is keen to emphasise the connection between research and mental health provision, especially in ensuring that service users have access to a choice of treatments, and a better chance of finding what works best for them. Changing the composition of the NHS workforce is key to this. 'It is imperative that the NHS workforce is expanded with more psychotherapists and counsellors,' she says. 'Funding for psychotherapy research is also vital, given the need to continue to build evidence to demonstrate the unique value of psychotherapy and the importance of patient choice in mental health outcomes.'

Innovative research evolves psychotherapy through the exploration of new ways to assess psychotherapy and the investigation of the therapeutic process. Dunn concludes: 'Practice-informed research and research-informed practice are key to this evolution, with the integration of the two essential for the future of psychotherapeutic research.' ●



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BEHIND THE HARDWARE

AS WE FIND OUT MORE ABOUT HOW THE BRAIN WORKS, COULD PSYCHOTHERAPISTS BENEFIT BY LEARNING ABOUT NEUROSCIENCE?

RADHIKA HOLMSTRÖM INVESTIGATES

20

The intersection between the mind and the brain has been the subject of serious debate for centuries. How far are we the mind and how far the body?

Are we, on the one hand, the product of our experiences and/or our unconscious; or is everything we think and feel actually the result of electrical impulses – is it all down to neurones, the cells within the brain which carry information along? How far should drugs or (still) electro-convulsive therapy contain and/or control mental distress? In recent years, the major advances in neuroscience and neurosurgery in charting exactly which parts of the brain are linked to our behaviours and actions have pushed this debate further.

Indeed, it is frequently pointed out that Sigmund Freud started his career as a neuroscientist; and today, with increasing research uncovering the mechanics of the brain and how this affects not just cognitive function but mood, is it time for all psychotherapists

to learn more about the brain and how it works? And indeed, is it time to consider specific ‘neuropsychotherapy’ – using neuroscience as an element of the therapy being delivered to a client?

Psychotherapist and visiting lecturer in neuroscience for therapists at Regent’s University London, Peter Afford is the author of *Therapy in the Age of Neuroscience*. Unsurprisingly, he feels

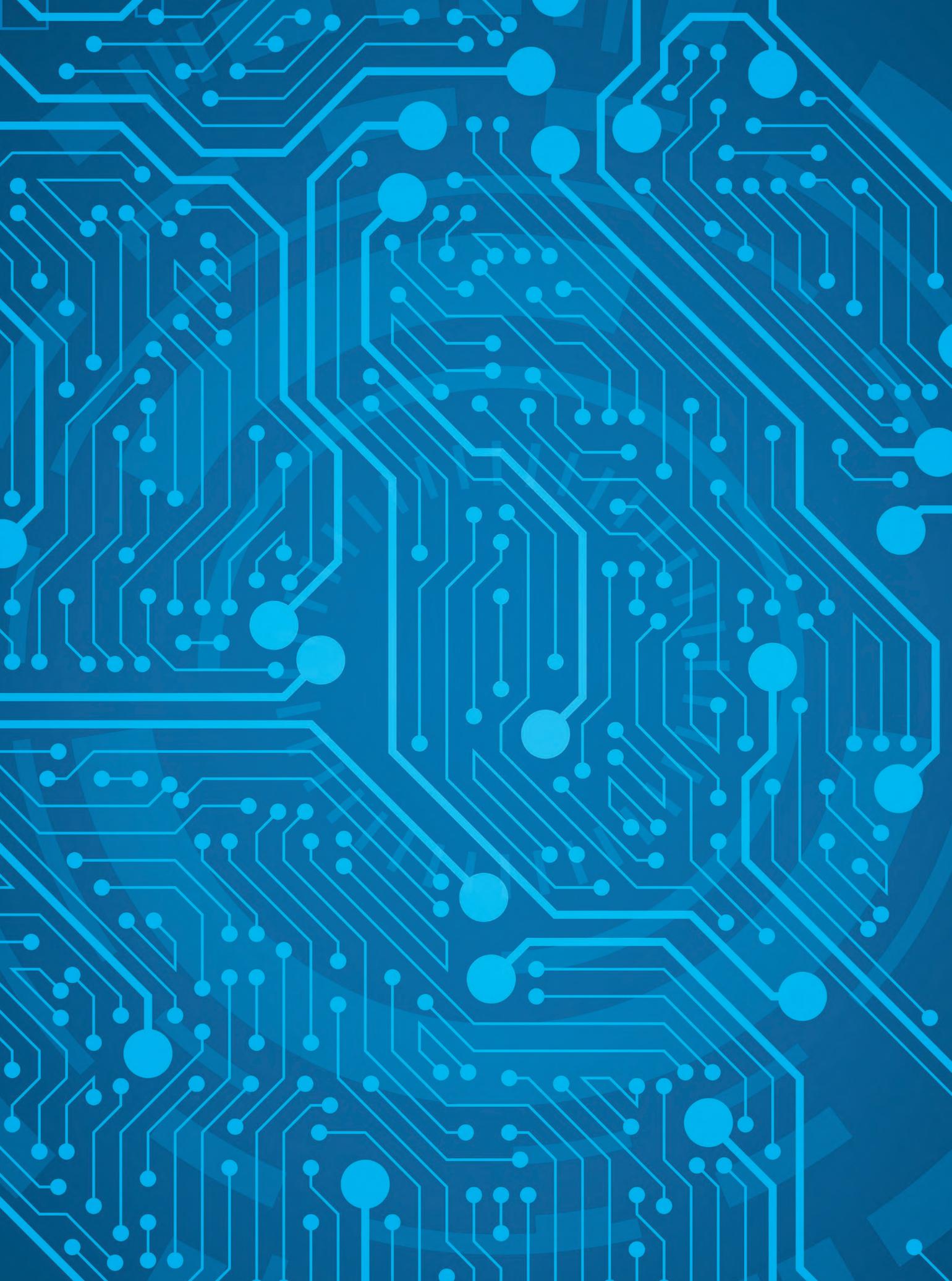
‘Neuroscience has direct relevance to the theory and practice of psychotherapy’

it’s increasingly important for therapists to get a working knowledge of this area. ‘Neuroscience is a burgeoning area with a direct relevance to the theory and practice of psychotherapy; it’s a whole new body of knowledge, much of which is directly relevant to the work we do. We’ve had psychological theory, our experience and intuition to guide us. Now we have science as another reference point.

‘The better we understand the rudiments of neuroscience and the nervous system, the better we can understand the mind. Therapists find that learning about the biology sheds light on a lot of areas and makes sense of a lot of the stranger things that happen in therapy rooms.’

A DISCIPLINE IN ITS OWN RIGHT?

Afford points to some particular areas where neuroscience has contributed to therapeutic practice. An obvious one is trauma, where practices such as Eye Movement Desensitisation and Reprocessing (EMDR) have become widely



taken up. 'If you take a neurobiological view of the psyche, we're in a much stronger position to think about how we treat trauma. Polyvagal theory (PVT) is also really catching on in the therapy world for treating trauma. PVT describes and explains different states of the nervous system – for example, the concept of psychological safety, and the need to work with a client in a state of safety rather than one when they've gone into a state of danger – and the therapist can link this knowledge with their experience in the therapy room and what they observe in the client. PVT makes it very clear and explains a lot of things that both therapist and client are confronted with, which is often a huge relief for the client as well.'



At the Centre for Arts and Wellbeing at Edge Hill University, Professor Vicky Karkou's team has also been involving neuroscience in its work (see panel, below). 'We're trying to combine hard-core evidence with softer, more creative work and see what links exist between these different types of evidence. Ultimately we are studying who we are as human beings and how we relate. We're also doing a lot of research into the body, dance, the arts more widely, and their involvement in psychotherapy, including dance movement psychotherapy. Neuroscience forms part of this.'

A number of practitioners are taking this further and identifying a specific area of 'neuropsychotherapy'. Practitioners may be trained in different schools or approaches, but what they have in common is the aim of identifying changes in the activities >

'We're trying to combine hard-core evidence with softer, more creative work'

Case study

Bringing it all together: work at Edge Hill's Research Centre for Arts and Wellbeing

One of the areas that researchers at Edge Hill's Research Centre for Arts and Wellbeing have been investigating is the effectiveness of dance movement psychotherapy for children on the autism spectrum, including the neurological basis of 'embodied cognition'. 'This is where neuroscience research meets practice,' Professor Vicky Karkou, director of the centre and psychotherapist, explains.

Researcher in dance movement psychotherapy Supriya Aithal adds: 'Embodied cognition theory takes into account the interplay between body, mind and environment. We were using the technique of "mirroring", used to validate a person's emotions and build connections. We also wanted to look at the ways in which those connections are established; how it is working, and

what is the technique of mirroring doing within the brain'

Stergios Makris, a deputy director for the centre and senior lecturer in psychology, adds: 'A few years back, researchers identified that primates and humans have mirror neurones in the brain. When we observe an action, those neurones are firing, and our brains respond as if we were performing the action ourselves. This theory extends to the way we develop language, to empathy, and to how we form social bonds. From a biological perspective, our relationship with others comes down effectively to these neurones. There is a lot of evidence that mirror neurones also play a part in neuroplasticity and enable the brain to develop new pathways.'

'So with dance movement therapy and this mirroring effect, we were looking at how

children on the autism spectrum might be able to build up social bonds. We wanted to see if this improvement has a biological basis using Transcranial Magnetic Stimulation (TMS), a non-invasive neuroscientific device, as an assessment tool,' says Makris.

Themis Karaminis, senior lecturer in psychology, continues: 'In a different study, the emphasis has been on examining the effectiveness of mindfulness for children with autism. It investigates its effects on the way children perceive the world and how their brain processes information received through the senses.'

Joanne Powell, neuroscientist, agrees that psychotherapy has the potential to modify dysfunctional neural circuits in those with mood and/or neurodevelopmental disorders. 'Neuroscience research offers a promising future for

psychotherapy more broadly,' she says, 'as it allows us to capture the dynamic interaction between our biological hardware, that is the brain, and our environmental input. By imaging the brain, we can observe neural plasticity or, more specifically, brain changes that are sculpted through psychotherapeutic interventions. Understanding which neural networks are modified via intervention can shed light on the mechanisms through which the psychotherapy is working and this knowledge can be used to guide psychotherapeutic interventions.'

For these reasons, 'creating interdisciplinary research groups is vital', Karkou argues. 'Bringing together psychotherapists and neuroscientists can confirm good practice with a range of client groups and advance new areas of work, benefiting the people we serve.'

REFLECTIVE PRACTICE IN ORGANISATIONS

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of the brain. They are not doing this in the same way as neuroscientists, or even as clinical psychologists, but through their therapeutic practice, using neurobiological information to underpin their overall approach. Edge Hill's MSc in Psychotherapy and Counselling – Contemporary Creative Approaches, for example, 'draws upon psychology, neuropsychotherapy, neuroscience and biosciences to reflect the scientific content required in psychotherapy training'.

QUERIES AND DISSENTING VOICES

However, Afford is one of the people who take issue with the term 'neuropsychotherapy'. 'I don't know where the term originally came from,' he says. 'It may be related to neuro-psychoanalysis, but there are no courses that are specifically about neuropsychotherapy – and that's a good thing. It's more important that neuroscience makes its way into all therapy practice and teaching, so that, along with psychological theory, students are also taught some neuroscience. I'd ban the term, simply because it's so long and techy. The average person who brings their issues to therapy doesn't want neuropsychotherapy. It's a complete distraction.' It's perhaps indicative that the International Association of

Clinical Neuropsychotherapy is now called the International Association of Applied Neuroscience.

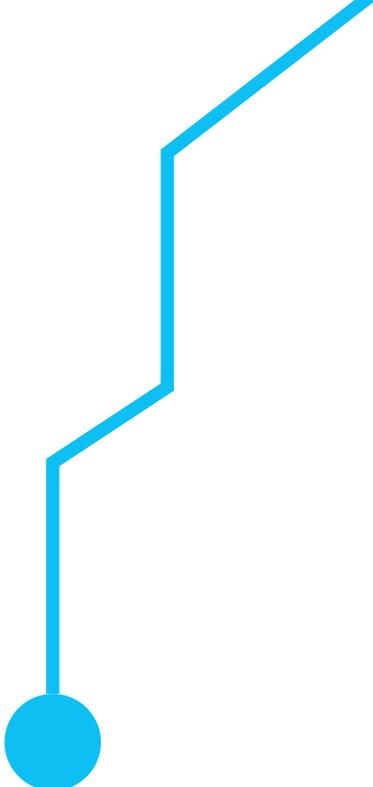
But psychotherapist and UKCP vice chair Andy Cottom is distinctly sceptical about the focus on the brain at all. 'I think learning the mechanisms of how we think and feel doesn't answer the question "why". I went to medical school for a brief period and I have an understanding of neuroscience; I think the brain is broadly misunderstood, and clearing up some of the mysteries makes us feel more secure, but I'm happier to go down other pathways rather than have a formula that starts with the biomedical model: symptom ABC means diagnosis D and cure E.'

'That's not the way most psychotherapy in the UK works, and it's interesting that neuropsychotherapy was brought up by someone who is primarily a psychologist. We like uncertain thinking because that encourages us to look a bit deeper for what might be multiple causes for each effect. If you have an expectation of the results, you will have an unconscious bias to prove yourself right.'

Cottom is far from dismissive of science, though, and is more interested in endocrinology (how hormones affect the body and, by extension, the mind). 'Just because I know the mechanism by which people think, and understand about neuroplasticity, that's not particularly pertinent to how this individual client's mind works and the effects that their life experience has had on them. It goes back to that lovely quote, "don't ask what's wrong with me, why don't you ask what's happened to me?"'

A MIX OF PRACTICES

In the UK, at least, that 'uncertain thinking' to which Cottom refers is certainly going to continue to have its place, even for those therapists who feel that neuroscience needs to be part of the toolbox. 'The interesting thing is the current state of play with neuroscience making its way into the therapy world,' says Afford. 'I think it's very slow progress, and my concern is that therapists may learn just a few bits



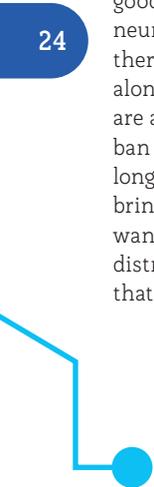
'My concern is that therapists may learn just a few bits of neuroscience'

and pieces of neuroscience. You need an understanding of the basics.'

What is clear is that psychotherapy is not a static model still based on fixed theories. It's a dynamic and specialised practice that, like many medical professions, innovates and cross-refers with other disciplines.

However, the funding available for innovation in psychotherapeutic practice is minimal compared to physical health, which is possibly missing a trick given how cost-effective psychotherapy can be in the medium term by preventing worsening health.

'We need to put the bits of the puzzle together and to see what's the next area that we need to explore,' Karkou concludes. 'This complexity can only be captured if we can work together, bringing together different perspectives.' ●



'We need to put the bits of the puzzle together to see the next area to explore'



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THE PSYCHEDELIC THERAPY RENAISSANCE

WITH RESEARCH ONGOING AND THE UK'S FIRST PSYCHEDELIC-ASSISTED PSYCHOTHERAPY CLINICS OPENING THIS YEAR, COULD THIS BE WHERE THERAPY IS HEADING? **CHARLOTTE HAIGH** FINDS OUT

At first glance, it doesn't look like a hospital room. It's softly lit with pink salt lamps, the walls are hung ceiling to floor with pictures of trees, and the bed is made up with fresh sheets, an eye mask sitting on the pillow. This was the setting for the recent Imperial College trial comparing psychotherapy plus psilocybin, the psychoactive component in magic mushrooms, with the Selective Serotonin Reuptake Inhibitor (SSRI) escitalopram for depression – and some believe it could be the future for therapy.

A raft of new research has picked up where the studies of the 1950s and 1960s into psychedelics left off, and has been exploring the mental health potential of these substances – including the 'classic' psychedelics, such as psilocybin and LSD, plus MDMA (better known as ecstasy) and ketamine, as well as Peruvian brew ayahuasca, used traditionally by shamans in the Amazon basin. The recent Imperial trial found psilocybin performed as well as escitalopram and worked faster¹, and followed on from the team's 2017 research, which showed psilocybin sessions seemed to 'reset' the brains of those with treatment-resistant depression².

The Bristol Imperial MDMA in Alcoholism (BIMA) trial showed psychotherapy with MDMA was safe, well-tolerated and significantly more effective than other treatments. In the US, research at Johns Hopkins University found psilocybin led to substantial drops in depression and anxiety in people with terminal cancer, along with a rise in quality of life, a sense of meaning and optimism³. Another US study found MDMA-assisted psychotherapy was an effective treatment for PTSD in army veterans, police officers and firefighters⁴.

And it's ketamine – a well-established anaesthetic more recently used as a party drug – that will be used at the new Awakn Clinics (awaknlifesciences.com). Ketamine has shown promise for treatment-resistant depression⁵ and for PTSD⁶. Crucially, while it will be used off-label at the clinic, it's already licensed as a medicine – the other psychedelics are not only categorised as Class A substances, they're also Schedule 1, which means they require a special licence from the Home Office to investigate, something that made research difficult. However, says psychiatrist Dr Ben Sessa, Chief Medical Officer at Awakn and lead on the BIMA study, 'MDMA is in phase 3 trials at the moment so we can expect to

see it licensed in about two years, with psilocybin a couple of years after that.'

CHANGING MINDS

'Psychedelic substances all give different experiences but when used as a tool in combination with psychotherapy, they share something in common: they induce altered states of consciousness that allow people to tackle rigid schema in a way they may not have been able to do with non-drug therapy,' says Sessa. Psychologist Dr Rosalind Watts, who was the lead on the recent Imperial study, explains psychedelics temporarily deactivate the default mode network (DMN), the part of the brain that can keep you trapped in ruminating on negative thoughts. 'It seems that temporarily deactivating the DMN in a psychedelic session may lead to decreased rumination and more psychological flexibility,' she says. 'We also know from MRI scans that,

'On psychedelics, parts of the brain that weren't communicating start connecting'



Case study

‘PAP lifted a weight from me’

Dave Pounds, 58, is from south Leicestershire.

‘When I was 12, my mother was murdered at home. Dad was away, giving a lecture. Mum worked in a restaurant and had invited a colleague in for a cup of tea after he gave her a lift home. He got the wrong idea, and when she turned him down he stabbed her multiple times and raped her. Afterwards, he came upstairs, his breathing panicky, and watched me while I pretended to be asleep. Eventually he left and I lay in bed frozen until Dad came home, a couple of hours later. We discovered Mum’s body together. It was like something out of a horror film.

‘We got on with life as a family but at 18 I started experiencing panic and flashbacks. Drinking became a problem. I tried all the

prescription medication and probably over 50 therapies and therapists, as part of my relentless research – in books, medical papers and the internet – looking for a cure.

‘Two years ago, Dr Ben Sessa got me involved in the BIMA trial. We had several therapy sessions first, which helped ease my nerves. In the first drug session, I lay on the couch with the headphones and eye mask on. A moment of anxiety quickly passed and I felt serene. What came up was a vision of the perpetrator in my warmly lit bedroom. I sat up, looked at him and said, “I know what you’ve done downstairs but I want you to know I’m no longer frightened of you.” Mum was in the room. We told the man there was a reason he’d done it and said he needed help, then had a hug. I wasn’t

hallucinating – I felt very sharp – but was able to visit this image in my mind. Once the drug wore off, I had food, stayed the night, and had a follow-up in the morning. I remember walking to my car afterwards, feeling peaceful and cossetted, which stayed with me for days. A day or so later I went for a run, and for the first time really noticed the rich smell of the earth and the green of the grass.

‘The second MDMA session brought up a lot of strong emotions, but it was cathartic. I’m less locked into the fear. I’m more resilient and can appreciate enjoyable things in a way I couldn’t before. It isn’t just emotional, either – something physical has changed. I feel I have some relief from an oppressive weight.’

** Full permission given for this case study*

on psychedelics, parts of the brain that weren’t communicating start connecting.’

While the substances are key, psychotherapy is at the heart of these treatments. ‘What’s often neglected is that psychedelic-assisted psychotherapy (PAP) always involves non-drug sessions, which is where people are helped to understand and make sense of the psychedelic experience,’ points out Sessa. ‘Other clinics offer ketamine infusions, with the emphasis on the antidepressant effect afterwards. The ketamine experience itself is sometimes seen as a bit of an inconvenience. What we’re doing is using the ketamine experience to encourage people to go within, then helping them integrate it all in therapy afterwards.’ Awakn will offer 11 sessions, four of which are ketamine-assisted, while the other seven are non-drug preparation and integration sessions.

The UK researchers and the Awakn team use psychotherapy rooted in acceptance and commitment therapy (ACT), explains psychologist Dr Laurie Higbed, who’s developed the programme for Awakn. ‘It’s a natural fit with psychedelic work because both aim to enhance psychological flexibility through being present, open and acting according to values. There’s scope to try different models, though.’ Watts has developed her own Accept Connect Embody mode for the psilocybin research. ‘It’s based on psychological flexibility rooted in ACT,’ she says. ‘It’s important to be willing to look at difficult stuff and this approach really embeds that.’

Preparation is key. ‘With psychedelics, it tends to be resistance that causes challenging experiences and can mean people don’t get as much as they could from a session, so we spend time with them first, answering questions and preparing them for their psychedelic session,’ says Watts. ‘Before a psilocybin session, we do a visualisation

‘The integration sessions afterwards are where we start to explore what came up’

UKCP’s position

Micro-dosing psychedelics is illegal and neither endorsed nor regulated by UKCP. Our registrants must abide by the UKCP Code of Ethics and Professional Practice. Failure to do so is likely to lead to proceedings under the Complaints and Conduct Process. There are a number of clauses in the Code that are relevant to this.

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encouraging them to picture themselves diving into the ocean, looking for pearls. If something scary or stuck comes up, where in their body can they feel it? If there are strong currents, what does that bring up? Can they let themselves go with it? We encourage them to pick up those spiky shells on the seabed, prising them open, looking to see what's in there. All of this prepares them for what might happen in the psilocybin session so they can get the most from it.'

The drugs sessions vary, depending on which compound is being used. 'Psilocybin tends to lead to a lot of internal focus so the person won't usually talk much at all, and the therapists are there for support and safety, whereas with MDMA, there is more interaction and it induces more of a sense of connection and empathy,' says Higbed. 'We try to encourage people to be with the experience. The integration sessions afterwards are where we start to explore what came up and what meaning they can take from it.'

IN THE REAL WORLD

Andy Cottom, psychodynamic psychotherapist and vice chair of UKCP, specialises in trauma so has been following the research closely. 'What causes trauma is an extraordinary experience, and I can see psychedelics being useful because they also offer an extraordinary experience, something that can't be explained, which can give people a new sense of perspective,' he says. He has clients who've used psychedelics (outside a legal setting). 'I think they attract creative, questioning people, those who are willing to experiment and are comfortable with uncertainty,' he says. 'I can't see everyone being happy to use them but perhaps, as time goes on and their use in a clinical setting becomes more normalised, that will change.' Higbed agrees PAP may not be for everyone. 'Traditional therapy and to an extent SSRIs work well for some, but for those who don't get the benefits, psychedelic compounds could be a great addition to our toolkit.'

Of course, the main barrier is that PAP isn't widely available at the moment. A course of ketamine-assisted psychotherapy

at Awakn costs £6,000 and the only other option for anyone wanting to try PAP is to get onto a trial. 'At least at the moment we can help some people, and contribute to the evidence base, which will hopefully convince the government PAP should be available on the NHS,' says Higbed.

For now, like Cottom, you may find yourself with clients who've taken it upon themselves to try psychedelics. While psychedelics are currently prohibited substances in the UK, the growing popularity of their therapeutic potential is leading many people to use psychedelics on their own rather than waiting for legal medical access. But without targeted psychotherapy to integrate the experiences, people may – at best – not get the most from psychedelics and, at worst, may be left disturbed and vulnerable.

The world of psychotherapy is becoming more accepting, says Sessa. 'There was kickback when I started this work 15 years ago but now more psychologists and psychotherapists are understanding that a few sessions with psychedelics can get people off the daily psychiatric drugs,' he says. If you're interested in training in this work, he recommends getting onto one of the research studies, which comes with its own training. 'I sometimes wonder whether we'll look back in 20 years and marvel that we ever did therapy without psychedelics.' ●



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A BRIEF HISTORY OF PAP

1938

Swiss chemist Albert Hofmann synthesises LSD.

1943

Hofmann accidentally ingests LSD, experiencing its effects on a bike ride home (19 April 1943 is known as Bicycle Day in psychedelic lore). He continues to use it throughout his life, convinced of its importance as a 'sacred drug.'

1950s

Psychiatrist Humphry Osmond and colleagues give LSD to alcoholic patients, including AA founder Bill Wilson. They have a 50 per cent success rate, with many, including Wilson, quitting alcohol completely.

1960s

Czech psychiatrist Stan Grof tests the effects of psychedelics on the psychology of terminally ill patients. At the same time, Harvard psychiatrists Timothy Leary and Richard Alpert begin their infamous experiments.

1966

US states, worried psychedelics are fuelling the counter-culture and anti-war protests, start to ban the substances. Other states and nations swiftly follow. Hampered by the law, medical research begins to slow.



WORKING IN OTHER WORLDS

RADHIKA HOLMSTRÖM EXPLORES THE USE OF VIRTUAL REALITY IN THERAPY, FROM PHOBIAS TO BODY IMAGE

30

More and more, technology mediates our personal relationships,' says integrative psychotherapist Dr Aaron Balick. 'Each form has different architectures which either enable or disable certain psychological ways to be in the world, and it's really important to understand how any specific technology and the way it's delivered mediates different aspects of an individual's psychology.'

In the past 18 months, there's been a lot of focus on the way that psychotherapy has had to be delivered

online. Yet this is far from the only technological innovation. Virtual reality (VR) – operating in a computer-generated world, either in a simulation of the real world or in a completely made-up environment, using a helmet with a screen and gloves with sensors – has moved from the world of computer gaming to therapeutic interventions.

RESEARCH AND TRIALS

In the past 10 years, a substantial body of research has been looking at how VR can be used to work with people in order to manage pain, phobias, PTSD and anxiety symptoms. 'There are quite

a few studies that prove the efficiency of the treatment for people with PTSD and substance abuse,' says Gestalt psychotherapist Kamila De Nadai. 'It's possible to control the environment that they experience and things won't happen without your knowledge.'

Daniel Freeman, professor of clinical psychology at the University of Oxford, says, 'VR has been used for over 20 years to treat mental health problems, but it has always been simply an aid for a therapist. People can experience carefully graded recreations of their difficult situations, which brings on their symptoms, but then be coached in the



most helpful ways to respond. The actual delivery of treatment has depended on a skilled therapist.'

Freeman and his colleagues at the University of Oxford have been exploring more 'standalone' VR, in order to reach far more people who could be helped by this kind of intervention. 'What you don't want is a lot of poorly evaluated VR that doesn't work.' In 2018 they published the results of a research project, 'I can do heights', treating 100 people who self-referred for therapy to tackle their acrophobia¹. In six 30-minute VR sessions delivered over a fortnight, a 'virtual coach' took each person through a series of exercises, with the aim of building up their 'memories that being around heights is safe'. The results, says Freeman, 'were even better than we'd hoped, and the clinical benefits were better than we'd expect from the best face-to-face therapy. Most of the people in the trial had a history of over 30 years of a fear of heights, yet they all responded to the VR treatment. On average, fear of heights came down by two-thirds.'

He is now heading up another group which is conducting a clinical trial, gameChange, to test VR-based psychological therapy for people with severe mental health conditions such as schizophrenia. Again, the aim is to enable people to reengage with everyday life and its demands. The trial is funded by the National Institute for Health Research; over 400 NHS patients across five sites will take part, half receiving VR therapy and half not. 'We've just finished recruitment, and have 350 patients with psychosis,' Freeman reports. 'Our first results are encouraging.'

However, importantly, this project is not involving psychotherapists. 'Our choice is the professions most involved in psychosis services,' Freeman explains. 'The point, really, is that we want to reduce the reliance on highly-skilled therapists. We still need them, but far too few people with psychosis get access to them. We're very interested in the lived experience, and our target is getting people to be out and about.'

While psychologists may be finding VR an acceptable way to change what might be deemed problematic behaviours, psychotherapists use VR with the intention



'IT'S INTERESTING SEEING THE DIFFERENCE IN THEIR EMBODIMENT, AND HOW THEY RETURN NOT IN THE SAME STRESSED STATE'

of getting to the root cause to deliver life-changing, long-lasting transformations in health and wellbeing. This, say proponents, is a far cry from a behavioural approach, which won't necessarily tackle the reasons for the presenting symptoms which may recur or present in other ways.

PSYCHOTHERAPEUTIC INVOLVEMENT IN VR

Two psychotherapists using VR innovatively with children and young people are Arianna Pulsoni and Catherine Knibbs. Pulsoni, who is a child and adolescent psychotherapist and lecturer in the Department of Psychosocial and Psychoanalytic Studies at the University of Essex, has conducted an entire pilot project (*see panel, page 34*) using VR as a specific therapeutic tool.

Knibbs, a child trauma psychotherapist, who has a long-standing interest in computer games and VR herself, uses different VR games in her practice with adolescents. 'They choose a particular game and I watch on the screen what the client is doing. It's like youth work, or a form of "walk and talk" therapy: the same way of de-escalating that intense

stare from a therapist or teacher. It's an intervention to lessen their fear and the stress of being stared at and questioned.'

In addition, Knibbs explains, clients are acting out their fantasies or what is happening in their lives more directly. 'The conversation starts with which games they've picked and why: what does the client have within their life? Why that person, why that avatar? One client in their late teens had experienced some quite horrendous childhood issues, and we talked about their choice of games where they were able to wield a lot of power and rescue others. With another, conversations about their choice of avatar revealed that they were being groomed. I can explore that virtual environment and ask "the right questions". Not every session involves putting the headset on.'

She also uses VR in her work with adults, via a programme that takes them to a peaceful environment. 'The sound and the visuals are immersive and, effectively, they're leaving the room for seven minutes. It's interesting seeing the real difference in their embodiment, and how they return not in the same stressed state.'

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IMPLICATIONS AND LIMITATIONS

VR has huge potential for the future of therapy, but there simply isn't the much-needed funding for services or research that could transform lives. 'I would love to be able to explore it further,' says De Nadai, who works within the NHS. 'Right now, we don't have enough staff or employees to be able to get a result as fast as we'd like.'

Even Freeman, whose work is pioneering automated VR for serious mental illness, certainly agrees. 'The technology of virtual reality is not a remedy in itself. It is a tool that has to be used correctly. The content matters hugely, and it's crucial that each VR treatment is tested in a rigorous clinical trial. And therapists delivering psychological treatments, with compassion and care, will always be needed. VR can only be one part of mental health care, and not the whole system.'

As Balick points out, automation is certainly not a panacea. 'There will always be new ways of interrelating, but we mustn't lose the necessary skills of personal, face-to-face interactions. The fear is that because it's easier for a lot of people to interact in a mediated fashion, we might have people reluctant to engage in the hard work of interpersonal engagement, and that would be a tragedy.' ●

**All case studies are composites*



Case study

Child psychotherapy in the digital age

Arianna Pulsoni, child and adolescent psychotherapist and lecturer in the Department of Psychosocial and Psychoanalytic Studies at the University of Essex, explains a pioneering intervention that she and her colleagues Norman Gabriel, Vito De Feo and Katerina Bourazeri have been working on, combining child psychotherapy and VR.

This intervention is named 'Be Yourself (BeYOn) the screen' – a virtual Reality environment for assessment and prevention in children and adolescents with early signs of body image disorder. The idea was to bridge child psychotherapy with VR and to reposition child psychotherapy in the digital age, designing a short intervention looking at body image difficulties, body shaming and body image disorders; originally we focused on gender identity issues and then widened out to body image difficulties more generally.

'There are six sessions: the first three assess early signs of disturbances about body image and the second three are about reflecting on the emerging issues (main themes) and preventing these issues from developing further,' she explains. 'It can easily be implemented in different settings and by different professionals, as long as they are trained properly in how to carry it out, and can be adapted to be either a one-to-one or group intervention.'

The pilot was run with a group of 21 children aged around nine who were very worried about

skin colour, body image and so on. 'They started very quickly, focusing on the two or three aspects of themselves that they felt characterised them – it could be their hair, their nose, skin colour or anything else. After that, they usually moved on to what they felt they looked like overall – their internalised image of themselves, which took them the longest; and then they would add in something associated with one or other parent, showing how they internalised and identified with their mothers and fathers,' Pulsoni adds.

'Finally they'd move on, adding accessories (hats, mask, glasses, bags) or pets, or they'd change clothes: and it was clear that this represented their relevant emotional experiences projected into significant objects. One boy, for instance, said he added a mask because he didn't want to be looked at. Children were very comfortable with the process, and clearly felt at home with VR, as they were using it all the time in other ways.'

'After the first three sessions, I worked with them to discuss the significant themes that had emerged, and what I'd observed from the way they built their avatars. I would ask, for instance, why they had selected a mask or glasses. And then, finally, they went back and rebuilt their avatars from scratch again. There were a lot of differences from the first time: a boy who'd started with a mask and sunglasses decided he didn't need the mask anymore; a girl with a fighting bird got rid of it.'

**Informed consent has been given for these case studies*



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Feature TV and film



MAKING CONNECTIONS

MANY OF US INCREASED OUR TV AND FILM VIEWING DURING LOCKDOWN TO ESCAPE FROM THE ANXIETIES OF LIVING THROUGH A PANDEMIC. **HAZEL DAVIS** ASKS WHETHER VISUAL MEDIA CAN ACTUALLY BE HELPFUL TOOLS IN THERAPY



When the BBC aired the TV adaptation of Sally Rooney's novel *Normal People* back in 2020, it got a lot of people talking in some depth.

For child and family therapist Elaine Rose, it was the perfect therapeutic tool. The serial follows the complex friendship and relationship between two teenagers into adulthood. 'It's all about relationships and attachment styles, the tragedy of failing to communicate effectively,' Rose says. 'It's so true to life and spoke particularly to female viewers who identified with the issues, while men could also identify with the dilemmas.' Rose regularly uses dramas in her therapy to help her clients do everything from face fears, focus on problems and rethink negative thoughts to develop creativity.

Many of us increased our television and film viewing during the recent lockdowns and have sought great escapist comfort in visual media. In fact, the amount of time we spent in front of screens increased by 31% in the last year¹. Even outside of the therapeutic process, movies can be powerful catalysts for identifying and expressing troublesome emotions, helping us see where our unhealthy attitudes, patterns and behaviours will lead us if we don't change.

CREATIVITY IN FILM THERAPY

Psychotherapist Bernie Wooder, author of *Movie Therapy: How it Changes Lives*, has seen first-hand the power of films in his treatment room. 'Take Mac, a 6'3 Scotsman,' he says, 'He came into the room, checked every window for a means to escape – the quintessential image of an SAS soldier.'^{*}

Mac described his father to Wooder as a terrifying monster, threatening and unpredictable and regularly beating up his mother. One day, Wooder explains, 'Mac watched his dad beating up his mum and something clicked. He looked him in the eye and said, "No more". His dad swore and walked away, but Mac trembled when he told me the story.'

Watching *Watership Down* (Wooder had asked him to watch any films he enjoyed) Mac had an epiphany. When Bigwig faced up to General Woundwort, a dominating and ruthless character,

Mac began sobbing because it matched the moment he stood up to his father: 'It was such a traumatic moment and a psychological epiphany,' Wooder says. After that, Wooder worked with Mac on his inner critic, using *The Lord of the Rings* as a prompt. 'I was able to use this very successfully to get him to understand, let go of the terror and become free,' he says.

Another of Wooder's clients was able to demonstrate to her husband her difficult relationship with his mother via the film *Rebecca*, principally the main antagonist Mrs Danvers.

Therapists can get quite creative with movie therapy. 'I'm a Gestalt therapist, so I bring myself into the room a lot,' says Katerina Georgiou. 'I share images and films that are springing to mind and use this as a springboard for dialogue and experimentation in the room.' She might invite a client to draw a character, or rewrite a scene, or experiment with 'being' a particular protagonist in the room and see how it feels. Or, she says, 'I'll do a piece of two-chair work and invite them to put a film character in a chair and talk to them.' She'll also get them to picture a prop from the scene, like a mirror, or a chair or desk, and to retell the story from the perspective of that prop.

METAPHORS

Wooder says he would never suggest a film to a client. 'They're the expert on them. I don't prescribe films.' He merely asks them to bring them as a prompt.

Rose says she doesn't either, though she might recommend a book.

However, says Georgiou, there is something also quite powerful about suggesting films to clients. 'It can give a client a sense that they're being kept in mind and thought about or taken seriously, which can be incredibly healing for some. Especially if the film really hits the spot for them, they can feel really seen and heard in a way that just words sometimes aren't enough to articulate.'

'Often stories, metaphors and images can tell you something about the client's world that you're picking up, or can have some meaning about the relationship between the two of you in that moment,' says Georgiou.

Georgiou says she doesn't set out to use movies as a goal, 'but when a client is speaking to me, sometimes a film (and it can even be a book, a song, a piece of theatre, too) might spring to mind – maybe a specific character, or a certain scene.' When this happens, she pauses and says to the client, "As you're saying that, a scene from the film, X, springs to mind," and I'll offer it back to them.'

Sometimes this can lead to connecting to the film, or a desire to see the film. Other times, she says, 'Once I've got to know a client over some time, I'll get a sense of their journey and narrative and might more explicitly recommend them watching a certain film and letting me know what they make of it. Sometimes, clients recommend their favourite films to me and I'll go away and watch them if they want me to, and I'll come back and we'll explore that together too.'

WOULD THAT HAPPEN IN REAL LIFE?

Being in the room can be important, agrees Rose. 'You do need to decide whether you sit and watch a film with someone. A lot of young people are left to their own devices with a TV in their bedroom. What are they watching? Having someone to help you process what you're looking at is important – asking the question, "Would that happen in real life?"'

The 'would that happen in real life?' question is a big one. For Rose, more accuracy on TV has been a bonus. She works a lot with people who've suffered sexual abuse and says, 'Increasingly, TV is interested in the trajectory of how someone becomes a sex abuser or the impact of sexual abuse on someone,' and this is really positive, but accuracy is important: 'Failure in accuracy can be really unhelpful.' Rose also works with young people in care and people who have

adopted children. 'I spend a lot of time telling people, "Your child is not going to become this character."'

'A lot of the work is gauging where the client is at and making interventions that are ethical and appropriate in the moment,' says Georgiou, 'So I'm unlikely to go all gung-ho in session one before having built up a relationship of trust, but if I've been seeing a client for some time, I might take a risk and say, "Let's experiment with something."'
For Georgiou, suggestions become a



'IF THE FILM REALLY HITS THE SPOT FOR THEM, THEY CAN FEEL REALLY SEEN AND HEARD IN A WAY THAT JUST WORDS SOMETIMES AREN'T ENOUGH TO ARTICULATE'

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collaborative effort, a process that the client can opt into, or reject or refine for themselves.'

And, while movie therapy can be extremely effective, it's not for everyone, says Wooder. 'A lot of my clients don't see films or aren't interested in them, but I ask what they're interested in and then it's an opening to ask if there's a film that moves them.'

COPING STRATEGIES

As video and film become an inescapable part of 21st century life, various tools are emerging to incorporate the medium into therapy. The 'I Was There' creative-expressive tool was developed to enable veterans to reflect on their experiences and jointly create short artistic films that articulate various aspects of their lives and traumatic events, gaining agency and affiliation². 'Making a film of a person's life – forming your own view about something – can be very powerful,' says Rose, 'and I've done life story work with adopted children and young people, using this technique with great success.'

Both watching and making movies helps with the development of creativity, as well as the processing of difficult issues. 'Different perspectives you see in movies can change your mental schemas and push you to be more creative, flexible and innovative,' Rose says.

Recent research has shown that engaging in frightening fictional experiences can act as simulations of actual experiences from which individuals can gather information and model possible worlds³. Exposure to horror films allows the viewer to practise effective coping strategies that can be beneficial in real-world situations.

'Feeling scared, but in a contained way, where there is no "actual" danger

**'EXPOSURE TO HORROR FILMS
ALLOWS THE VIEWER TO PRACTISE
EFFECTIVE COPING STRATEGIES
THAT CAN BE BENEFICIAL IN
REAL-WORLD SITUATIONS'**

present, can bring them into the present,' says Georgiou, 'Clients have reported feeling very alive, or that nothing they watch could ever be as scary as what's in their head. There is also the fact that films deal with storytelling, and much of this draws on archetypes, which clients can connect to.'

UKCP is calling on policymakers to invest more funds in research into the efficacy of techniques such as these. At a time of high GP antidepressant prescribing rates, perhaps a dose of TV or film therapy might work as, if not more, effectively. ●

**Consent has been given to reproduce this case study*



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A PARADIGM SHIFT

PSYCHOTHERAPISTS NEED TO MOVE AWAY FROM THINKING ABOUT COMPULSIVE SEXUAL BEHAVIOUR AS AN ADDICTION TOWARDS A MORE HUMANISTIC AND PLURALISTIC FRAMEWORK, WRITES **SILVA NEVES**

42

The topic of ‘sex addiction’ has long been controversial as therapists argue about its validity. It is undeniable that many people struggle with unwanted, repetitive sexual behaviours, yet clinicians have been battling with trying to define this complex clinical presentation for decades. There have been many attempts at terminology, but ‘sex addiction’ is definitely the most-used term so far.



SILVA NEVES is a COSRT accredited and UKCP-registered psychosexual and relationship psychotherapist and a trauma psychotherapist working in private practice. He is the author of *Compulsive Sexual Behaviours: A Psycho-Sexual Treatment Guide for Clinicians* (Routledge, 2021). He is a course director for CICS (Contemporary Institute of Clinical Sexology).

Despite its popularity, ‘sex addiction’ is not clinically endorsed. There was no agreed definition of the problem until 2018 when the International Classification of Diseases – 11 (WHO) brought forth the term: Compulsive Sexual Behaviour Disorder (CSBD)¹. It is currently the only recognised diagnostic criteria that we have. CSBD has been classified under impulse control, not addiction, because the crucial components which clinically define an addiction have never been observed in sexual behaviours, according to multiple scientific research.

The ICD-11 made it clear that CSBD and ‘sex addiction’ are not meant to be used interchangeably because they are substantially different frameworks. The Diagnostic and Statistical Manual of Mental Disorders – 5 also explicitly rejects the notion of ‘sex addiction’ because of lack of evidence². Moreover, a thorough review of the ‘sex addiction’ studies over the last 25 years found that they were conducted with poor methodologies³. Indeed, the conceptualisation of ‘sex addiction’ and its treatments are entirely based on anecdotes, sensational stories and personal opinions lacking in the knowledge of contemporary sexology.

DETERMINING TREATMENT

Challenging old-fashioned beliefs for new scientific thinking is hard because it takes courage to decide to change the foundational knowledge of our practice to offer clients better care. Our profession has done it before. We successfully shelved old-fashioned terms such as ‘hysteria’ and ‘manic-depression’. Perhaps it is more pertinent to remind ourselves of the term ‘homosexuality’ which had been used to unduly pathologise normative sexual desire, arousal and behaviours as a disorder. That term was only taken off the ICD in 1990, by which time it had harmed – and killed – a great number of people. Unduly pathologising sexual behaviours because of the misunderstanding of human sexuality has its dark precedent.

Adopting the endorsed terminology matters because formulations determine treatments. If a therapist believes in ‘sex addiction’, they will employ a ‘sex addiction’ treatment. The typical ‘sex addiction’ treatment is primarily concerned with sexual behaviours and aims to stop the unwanted, repetitive behaviours as a priority. This method makes perfect sense if you believe that sex is







'Rushing to stop a sexual behaviour without first understanding its unique functions can be counterproductive'

44

addictive, because it follows the tried and tested process of addiction treatments.

Stopping the problematic behaviours as a primary goal with people addicted to drugs and alcohol is important because the client's brain is impaired by the substance, which is why most addiction programmes require sobriety as a condition for treatment. However, with the sexually compulsive population, the brain is not impaired. A client who takes drugs 10 minutes before a session wouldn't be focused enough for the session, but someone who has been watching pornography and masturbating just before their therapy appointment can absolutely be coherent for their session.

Sexual compulsivity is distressing for people because their behaviours are not aligned with their values and it obviously hurts their partner(s) too, but rushing to help them stop a sexual behaviour without first understanding its unique functions can be counterproductive. Sexologists know that the more we try to repress sexuality, the stronger it gets.

RELIGIOSITY

The typical 'sex addiction' treatment highly recommends 12-steps fellowship

programmes such as Sex Addicts Anonymous (SAA) and Sex and Love Addicts Anonymous (SLAA) to support clients' recovery⁴. However, those programmes have problematic dogmas. They are heavily rooted in the religious tradition of Alcoholics Anonymous (AA), they incorrectly claim that 'sex addiction' is a progressive disease and a 'character defect', as stated by the ICD-11 diagnostic criteria. Although SAA and SLAA are hailed as successful there is very little evidence of their effectiveness^{5,6,7}. Moreover, a study by Chasioti & Binnie reports that 'commitment to abstinence, framed by the notion of recovery and relapse, was found to be a major factor for maintaining distress'⁸. Chakrabarti et al. demonstrate that masturbatory guilt can lead to severe depression⁹.

Unfortunately, in my clinical practice I see many people who state that they have been traumatised by 12-step programmes for being told that some of their normative behaviours were a disease because they didn't fit within what those programmes deemed as 'healthy' (which is basically committed monogamy). It means that an enormous portion of the population identifying within gender,

sex and relationship diversity (GSRD) may be considered 'diseased' under those programmes' beliefs about sex and relationships.

It is unsettling as it is strongly reminiscent of 'homosexuality' being pathologised, and it has an uncomfortable flavour of 'conversion therapy'. Given that the SAA and SLAA movements offer such a problematic dogma, I think it is imperative that psychotherapists become more accountable for their recommendations to those fellowship programmes, and think more carefully about whether they might send their clients to harmful practices.

Religiosity has infiltrated the psychotherapeutic space with textbooks promoting the power of prayers to overcome 'sex addiction', confusing religious guidance with psychotherapy^{10,11}. 'And fundamentally, true faith in an almighty God who offers the strength you lack, and perhaps works miracles, can be trusted to beat any addiction. Prayer is an important discipline for many in recovery, whether they have a religious belief or not (...) Prayers can be thought of as a way of expressing struggles to someone, or something, who won't judge or give advice.'

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'The greatest gift that science gives us is the freedom to change our mind'

This may be coercive for clients who do not prescribe to a religion. If clients want a psychotherapy treatment but end up getting religious guidance for their problems, it begs the question as to how much they are empowered to make an explicit and informed consent about their treatment. It is only in the treatment of 'sex addiction' that we see prayers being recommended. We don't see such covert religious guidance in psychotherapy texts for the treatments of other problems such as OCD, eating disorders, depression, anxiety and self-harm.

A PLURALISTIC LENS

The origins of compulsive sexual behaviours are complex and multi-layered; therefore, it is important to assess them from a pluralistic lens, rather than a single framework. Many clients who come for help suffer from acute sexual shame and self-diagnose with 'sex addiction'. These people have an erotic conflict between their sexual desire, arousal and behaviours pulling them in one direction, and their sexual and relational commitments or values pulling them in another direction. We can all relate with the human experience of competing needs. We want to eat the delicious chocolate cake and we know we should eat the apple instead.

For other people, their sexual compulsivity has the function to soothe a chronic stress, to manage underlying emotional disturbances, or to alleviate symptoms of post-trauma stress. If this is the case, it is crucial not to help clients with stopping their unwanted behaviours before adding new resources for them, because we might take away their primary way to regulate themselves.

Psychotherapists can offer effective treatments by helping their clients to thoroughly map their unique erotic landscape. Then, we can help clients face their erotic self fully, whilst emotionally

regulating themselves so that they can make better decisions about their behaviours (this is an evidence-based method for the treatment of compulsive behaviours)⁵.

For some clients, treating unresolved trauma or underlying sexual and relational problems may be needed too. Psychotherapists need to be equipped with knowledge of contemporary sexuality (including being kink-aware), integrative psychotherapy and trauma therapy. The typical treatment of 'sex addiction' helps clients be erotically avoidant (avoiding 'triggers'), but the treatment of sexual compulsivity helps clients be fully erotically aware and meaningfully integrated.

MOVING TO AN EVIDENCE BASE

The ICD-11 diagnostic criteria are fairly recent; it is understandable that the mindset about 'sex addiction' will take a long time to change. However, the change starts with us, the psychotherapists who want to be working with current scientific knowledge as our guide. I believe it is the duty of our profession to challenge what is clinically incorrect and promote what is evidence-based. It keeps our profession in integrity.

The greatest gift that science gives us is to allow ourselves the freedom to change our mind. It is also the biggest lesson in humility. With new scientific knowledge and the expanding field of sexuality, it is time for a paradigm shift in the conceptualisation of sexual compulsivity.

Since the CSBD inclusion in the ICD-11, the term 'sex addiction' has become almost extinct amongst sexologists and sex researchers in the worldwide scientific communities. Now, it is time for the psychotherapy profession to follow the paradigm shift. Psychotherapy has strong values in being ethical and evidence-based. It is time to make the transition from anecdotes and personal opinions to science and knowledge. It might be challenging for us as a profession, but our clients deserve it. ●



What do you think?

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A close-up portrait of Tim Loughton, a middle-aged man with short, light brown hair, looking directly at the camera with a neutral expression. He is wearing a dark grey suit jacket, a light blue and white checkered shirt, and a blue tie with a white bird pattern. The background is a soft, out-of-focus mix of light and dark tones.

TIM LOUGHTON,
Conservative MP for East
Worthing and Shoreham
Loughton chairs the All Party
Parliamentary Group (APPG)
for Conception to Age Two, as
well as the charity Parent Infant
Partnership, and co-chairs the
APPG for Children.



‘Too often, intensive psychotherapy is seen as a solution if all else fails’

WE TALK TO **TIM LOUGHTON MP** ABOUT PUBLIC PERCEPTIONS OF MENTAL ILLNESS AND THE IMPORTANCE OF SUPPORTING MATERNAL AND CHILD MENTAL HEALTH

In September 2003, *The Sun* newspaper found itself in trouble with its readers. Not always known for their liberal tolerance, a number of people nevertheless were in strong support of the mental health charities outraged by the headline ‘Bonkers Bruno Banged Up’, after Frank Bruno had been sectioned under the Mental Health Act.

By the second edition of the paper, editor Rebekah Wade had realised how badly she had misjudged popular perceptions of mental health, and changed it to ‘Sad Bruno in Mental Health Home’, with the accompanying story labelling him a ‘hero’. Still not good enough: but better. And for Tim Loughton, the Conservative MP for East Worthing and Shoreham, it marked ‘a kind of tectonic plate moving moment’ signalling the shift in attitudes to mental health.

‘It’s not a taboo subject any more,’ Loughton points out. ‘People talk about it much more, the government is doing much more, and additional work has gone on with schools and perinatal mental health. I think attitudes have

changed hugely, even though services have a long way to go.’

PERSONAL COMMITMENT, GOVERNMENT ACTION

Loughton, who has sat as a Conservative MP since 1997, admits frankly that his own interest in mental health started ‘almost by accident’. ‘In 2001, I was put on the front bench in the shadow health team, taking on responsibility for children’s issues and mental health. As so often happens, you find yourself with a completely new challenge, but it became a really interesting issue for me. And coupled with a lot of constituency cases, it became a large part of my brief: quite by accident at the start, but fascinating since then.’

In fact, two years ago he launched a site collating mental health information and resources for his constituents (adurandworthingmentalhelp.org.uk). It is aimed at providing the kind of signposting that someone might need if they were suddenly faced with a mental health issue, spanning their rights, the healthcare that should be available to them, and the

local provision from different sectors and providers. ‘It was really putting something into place to show people they’re not alone.’ It also supplies Loughton with real-life data and cases that he can discuss with the chief executive of Sussex Partnership Trust (of whom he speaks very highly). ‘It’s good to be able to feed back where the problems are. So as well as being an information source, it’s also a portal for people to let me know about their experiences and I can take these forward.’

CHILDREN AND FAMILIES

Loughton’s main focus is on perinatal mental health and on children and families: he chairs the All Party Parliamentary Group (APPG) for Conception to Age Two, as well as the charity Parent Infant Partnership, and co-chairs the APPG for Children. He’s passionate about the importance of supporting mothers from pregnancy onwards, and the implications for them and their children if this is not available. ‘The Maternal Mental Health Alliance has calculated how much maternal mental health costs, along with child

'If we had happier mothers, their children would be in a much better position'

neglect. Spending a fraction of that in support for pregnant women and the first couple of years would solve a heck of a lot of problems,' he says. 'If you've got a 15- or 16-year-old at school with depression or mental illness, there's a very high chance that their mother also had a mental illness. If we had happier mothers, their children would be in a much better position.'

The pandemic, obviously, has exacerbated this, and Loughton is very concerned about the impact on that cohort. 'We've had mums and babies who weren't able to be mums and babies, unable to see family or go to groups and exchange experiences with others. Babies aren't meeting other babies at such a formative time of their lives, and that has a considerable impact. There were so many lessons coming out, about how important human interaction is at an early stage. It's not all about preventing transmission: you have to look at the other implications.' Both the APPG for Conception to Age Two and the Parent Infant Partnership have close ties to the increasing number of UKCP-accredited parent-infant psychotherapists. There is a growing recognition among healthcare providers of the long-term benefits of good infant mental health, given both its vulnerability and malleability, and Loughton aims to bring this to Parliament.

He extends this to older children, pointing to the well-documented rise in mental health problems for school-age children and young people during the pandemic and how much 'ordinary life' that age group has missed out on. 'Part of growing up is about socialising and learning to engage with others, and when you are cooped up there is a huge impact. The first concern was about kids lagging behind academically, but we're starting to see the effects of being deprived of social, as well as academic, contact. In all the catch-up we are doing we need to get



Loughton: 'We have got to have a much bigger choice of treatments. Too often, it's what is available rather than what's appropriate'

those kids back in a place where they are mentally and academically more capable. It's not just about time in the classroom, it's about getting back to being kids again and all the things that growing up involves.'

So what, in his view, can address those issues and, indeed, the ones that predate the pandemic? He's keen on the potential for 'family hubs' and their ability to reach out into deprived communities, 'across the thresholds of people who need support'. One important mechanism for doing so, he argues, is health visitors, who routinely provide support to families where parents have a range of mental health problems, including severe mental illness². 'One of the big successes of the Coalition Government was the creation of 4,000 new health visitor posts. That was really important because health visitors are a part of the service who do get across the threshold. If you are a vulnerable family and the first knock on the door is from a social worker, instantly the hackles go up. On the other hand, if it's a health visitor they are usually welcomed in. So these are the professionals who can be early eyes and ears for safeguarding

issues, as well as encouraging parents to go to other services they might need.' However, he points out, the number of health visitors has declined sharply since 2015 and this needs to be tackled. 'They are the frontline for so many mental and other health issues.'

WIDENING PROVISION FOR ALL

Loughton feels that, as well as more trained health visitors, the UK needs more trained mental health professionals working in statutory provision. 'The recent emphasis on children and schools is very good, but why are certain boroughs really good on mental health services and then others not so much? There's a disconnect because the government has promised a lot. A big problem is the lack of professionals to provide those services. We need to be doing a lot more to get people going into mental health, from psychiatric nurses through to ancillary services. We need better recruitment for professionals.'

The government's disproportionate focus on more basic mental health interventions for children, delivered by child wellbeing practitioners and

education mental health practitioners, has long been a concern of UKCP's, particularly given the incredibly stringent criteria for admission to CAMHS in most parts of England. 'UKCP members, if better deployed by the government, could not only address these workforce supply issues, particularly in CAMHS, but also bridge the growing gap between lower level interventions and the most specialised services,' says Adam Jones, UKCP's public and policy affairs manager.

Loughton agrees with the broad UKCP position that the provision on offer should encompass psychotherapy and other talking therapies. 'We have got to have a much bigger choice of treatments. Too often, it's what is available rather than what's appropriate. We've got to get to a place where GPs are better trained, and have a bigger range of options to refer people. People will present in different ways at different stages, and, too often, intensive psychotherapy is seen as a solution if all else fails. There's a reluctance to acknowledge the value of bringing high-quality psychotherapy in early. This is part of making a full range of interventions widely available, not just concentrated in specific places.'

One of the driving forces behind UKCP's ongoing joint campaign to secure changes to the NICE depression guideline for adults is a desire to see the importance of patient choice reflected in the recommendations. Loughton got involved in this campaign in 2019 by co-signing a letter to the NICE Chair at the time, Andrew Dillon, in support of the methodological challenges raised by UKCP and its coalition partners.

SHIFTING PERCEPTIONS

And yet, along with this postcode lottery, the impact of isolation and the dearth of professionals, Loughton does feel that as a society we are moving towards a greater acknowledgment that mental health issues affect us all – and that it's fine to seek help for mental health problems. Along with his other mental health commitments, he co-chairs the Mindfulness APPG and is interested in how schools' adoption of mindfulness has knock-on effects on attitudes towards mental health more generally. 'It's useful for kids being able to engage, but it's also

non-stigmatising and it's available to everyone. And the studies are starting to show that outcomes are improving in those schools. But beyond that, it's getting kids used to the idea that getting support is a good thing: why wouldn't you want to do it? If we're training kids to see it in that non-stigmatising way, it makes it more possible for them to open up when they do have more stigmatising issues.

'I spent over a year on the Mental Health Act back in 2005, which was fascinating because we visited a lot of professionals and services, and went through a long and complicated Bill. But at its heart, it focused on how we can confine, in different ways, people who are potentially dangerous. In reality, that is a tiny minority. For most people it's about how we support and engage with them, rather than constrict them.' In its joint response to the government's consultation on reform of the Mental Health Act earlier this year, UKCP called for mandatory trauma-informed training for mental health staff and all other staff who are involved in enforcing the Act, as well as the provision of a wider range of trauma-informed therapies for patients detained under the Act. Loughton is keen to emphasise the importance of this more compassionate approach to people's suffering.

He concludes: 'We need a mental health approach which is all about access and support, at all different levels, and guaranteeing people's rights to treatment. At least the principle has been conceded in terms of access. We have some way to go in which legislation can play a part in getting mental illness onto a level playing field with physical illness, but we're gradually getting there.' ●



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Timeline

TIM LOUGHTON MP'S CAREER

1984

Started work as a fund manager with Montagu Loeb Stanley (which became part of Robert Fleming Merchant Bank) in the City of London.

1997

Elected to the new constituency of East Worthing and Shoreham.

2000

One year as Shadow Minister for Environment, Transport and the Regions.

2001

Two years as Shadow Health Minister.

2003

Seven years as Shadow Children's Minister.

2006

Served on Mental Health Bill 2006, Children and Adoption Bill and Safeguarding Vulnerable Groups Bill.

2010

Two years as Parliamentary Under Secretary for Children and Families, served on Children's Schools and Families Bill.

2014

Elected to Home Affairs Select Committee. Currently a member of APPGs on: Children, Mindfulness, Conception to Age Two – the first 1001 days, Looked After Children, Parents and Families, Victims of Crime, among others.



‘There is quite a lot of interest in Black mental health right now’

EUGENE ELLIS, INTEGRATIVE ARTS THERAPIST AND FOUNDER OF THE BLACK, AFRICAN AND ASIAN THERAPY NETWORK, DISCUSSES HIS JOURNEY IN PSYCHOTHERAPY

52

Starting his working life at Pink Floyd’s studios in London, Eugene Ellis worked his way up to sound engineering – mixing albums for musical collective Soul II Soul. In his early thirties he trained as an integrative arts psychotherapist and founded the Black, African and Asian Therapy Network (BAATN) in 2003, which aims, among other things, to address the inequality of access to appropriate psychological services for Black, African, South Asian and Caribbean people. His book, *The Race Conversation: An essential guide to creating life-changing dialogue*, is out now.

In my late twenties and early thirties I was doing quite well – I was successful in my career, money wasn’t an issue. In some ways I should have felt great. Fear, however, was the thing that was inhabiting me, really. I felt like I needed to address this. I looked in *Time Out*, found a therapist up the road in Islington, and started my own therapy. After about a year, my therapist referred me for group therapy at the Metanoia Institute. I found therapy really helpful, it gave me a conscious awareness of my own oppression. Most of the work in therapy was done on my internal life oppression. I felt like I got a

bit more control in my life, I felt more of my power and felt more creative.

Psychotherapy training felt like a very natural place to go. I did a one-year course at the Institute for Arts in Therapy and Education, which was also the first year of a three-year psychotherapy diploma. That turned into an MA. While I was training to work with adults, I worked with children in schools on the Islington Schools Project. I began to meet a few Black men who were psychotherapists – Lennox Thomas, in particular. I felt, ‘If he can do it, why can’t I?’

In private practice I started to work with children and adults.

An adoption agency asked me to see a client they had – a young Black man – for a few sessions, just to see what kind of therapeutic relationship we could develop. I was the only Black therapist the agency knew. While I was doing this I was exposed to the idea of working with families. I became quite interested in the idea of working with the whole family and even the extended family – of teachers and other professionals, the whole system when you work in adoption. I’ve been working in

adoption for 17 years, often with severely traumatised children and their families.

I noticed a shift from the focus on oppression with the family system (familial abuse, for example) to oppression outside the home and what social oppression does to mental health. Family life could be adequate or even fine, but people still have mental health difficulties. Making that connection between outside, as well as inside, oppression was a big lesson for me. I was quite influenced by Claude Steiner’s radical psychiatry movement that considers what mental health is and what influences it, including alienation from culture, nature, ourselves.

Setting up BAATN was also more of a chain of events, rather than a single moment. After I finished my training I would get requests to find Black or Asian therapists. I didn’t know many at that time. I thought there must be a directory or something, but there wasn’t one, even in the US. I got some funding, built an online database and placed adverts with UKCP, BACP and BPS journals inviting therapists of colour to join the register. About 100 people joined and we held a small conference. People talked about what needed to happen for people of



Ellis: 'This last year has been the biggest challenge of my career'

colour to have access to therapy and to become psychotherapists.

One of BAATN's purposes is to support people from African, Caribbean and Asian heritage, if they're students, to support them in studying to become therapists; if they're therapists, to support them in practice, linking theory to practice and working therapeutically with people from those heritages. We also encourage ordinary people from those heritages to actually take up counselling and psychotherapy. We have support groups for students and practitioners as safe bases to work through inner conflicts based on the heritage people are in the therapy profession. Over the years, more groups have developed – Asian practitioners, multi-heritage practitioners, gender, sexuality and relationship diversity practitioners groups.

We've got about 1,200 active members now. BAATN was always a side project that I was doing while I worked as a therapist full time. Now I do one day a week in private practice and spend the rest of the week on BAATN. We get a lot of people saying: 'I'm not sure I'd have done my training if it wasn't for BAATN.' I'm proud of creating

Timeline

EUGENE ELLIS' CAREER JOURNEY

1984

Began working at Pink Floyd's studios.

1996

Began three-year MA in integrative arts psychotherapy at the Institute for Arts in Therapy and Education.

1998

Worked with children in schools as part of the Islington Schools Project.

1999

Began private practice.

2003

Founded the Black African and Asian Therapy Network.

'BAATN became a place where people came to seek refuge in the intense aftermath of George Floyd's murder'

that environment. In the last year, BAATN became a place where people came to seek refuge in the intense and overwhelming aftermath of George Floyd's murder. I feel now the energy has shifted from outrage to wanting to push things forward – from overwhelming to action. There is a really strong drive to contribute, whether that's picking up a banner, supporting an elementary programme or writing a blog.

This last year has been the biggest challenge of my career. The four-year Buddhist study programme I have been doing with a group of men has really helped me, seeing the cycles that we go through with racism, meditating and spiritual practice, and being with other people who are feeling the same way. Writing my book has really helped too. The period of writing covered Donald Trump's US presidency. If we didn't know already, many of us began to see race much more clearly. It really helped ground me.

There is quite a lot of interest in Black mental health right now. It appears that there is much more of a narrative around looking after your mental health in these communities and people actually seeking therapists or looking proactively at their mental health. As the narrative [of racial justice] has become more pressing, people are looking at different ways of managing their emotional lives. In the therapy profession, there is more attention on how we are going to be more inclusive – that conversation seems to be very loud right now. I think there is still a way to go, however, in what we actually do to tackle this. ●

On Screen

Humanistic and integrative psychotherapist Ruth Gilbert considers the roles of dreams and ghosts in the Netflix drama Shtisel

Michael Aloni as Akiva Shtisel

Set in an ultra-orthodox Jewish community in Jerusalem, Israeli television drama *Shtisel* provides a poignant and sometimes funny depiction of families, dreams and ghosts.

The residues of death permeate *Shtisel*. As ghosts haunt the inner worlds and homes of the living, these 'kitchen table ghosts' epitomise an uncanny convergence of the familiar and strange.

Throughout each series, the character Akiva Shtisel's identity is (re)formed in relation to a sequence of such ghost visitations by his dead mother, a wraithlike boy and, later, his dead wife. It is as if, psychotherapeutically, these ghosts enable a gradual process whereby his tendency towards melancholia shifts to mourning¹.

Psychoanalysis is intrinsically concerned with the ghosts who linger within the human psyche². In these terms, ghosts can be understood as intergenerational reverberations as well as manifestations of unconscious, repressed or split-off parts of the self. Freud's theories are clearly foundational in this respect: 'In analysis, a thing which has not been understood inevitably reappears; like an un-laid ghost'².

While many traditions value the symbolism of dreams, the Jewishness of *Shtisel* brings a particular cultural inflection to this mode of understanding. As the Talmud puts it, 'A dream not interpreted is like a letter unread.' The imperative to interpret is, therefore, compelling. Following a dream in which he meets his mother's chilly ghost, a destabilised Shtisel asks his father, Shulem, 'What do these dreams mean?' The question remains unanswered.

Shtisel is replete with such moments, which illustrate the cryptic nature of spectrality. The viewer, as well as the characters, might try to make sense of



'Psychoanalysis is intrinsically concerned with the ghosts who linger in the psyche'

these mystifying spectral sequences but, ultimately, they elude analytical interpretation. So, as in many modes of psychotherapy in which both client and therapist learn to sit with uncertainty, no singular or definitive meaning can be imposed. As they inhabit the psyches of the haunted, *Shtisel*'s ghosts become internalised therapists, opening the way to moments of realisation.

This opaque process is exemplified in series two when Shulem dreams of his dead mother's ghost. She is knitting with a tangle of cassette tape while singing an imaginary family song. From a classic psychoanalytical perspective, the symbolism evokes the earliest interconnected moments between mother and baby. Shulem, the bereaved son, is momentarily soothed by his dream. In some ways, the ghost-knitting of the tape, a jumbled cord of communication, has temporarily healed the primary umbilical rending; but the navel remains a bewildering scar.

As Freud observed: 'There is often a passage in even the most thoroughly interpreted dream which has to be left obscure... at that point there is a tangle of dream-thoughts which cannot be unravelled... This is the dream's navel, the spot where it reaches into the unknown'³.

And, in this reaching down into the unknown, the navel of the dream, *Shtisel* suggests that perhaps there is no need to tie up loose ends. Instead, we meet our own ghosts, along with our clients' ghosts, in the profound uncertainty of human experience. ●

References

- (1) Freud, S (1917). 'Mourning and Melancholia'. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916)*: 237-258
- (2) Frosh, S (2013). *Haunting: Psychoanalysis and Ghostly Transmissions*. Palgrave Macmillan
- (3) Freud, S (1900). *The Interpretation of Dreams*. Franz Deuticke, Leipzig & Vienna

What have you seen on screen that is ripe for therapeutic analysis? We'd love to hear your ideas.

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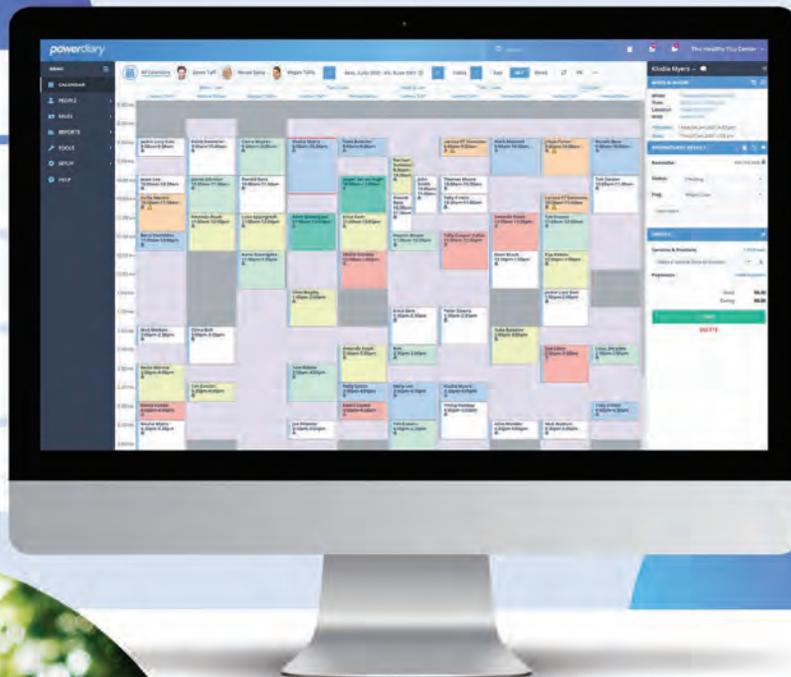
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