up front

This is the first *The Independent Practitioner* for 2008. Another start, another year... I often find myself wondering about where time goes and what I've done with it.

Work takes up a large portion of my time. Work with clients, work for the division, work for home, work for my marriage... so that by the third day into January, it felt strange to STILL be wishing people Happy New Year. Nevertheless, it seemed to me to be an important part of this thing called relationship. So Happy New Year to you all, no matter how long you've been with us.

Resolutions. Things we resolve to do and then join in the clamour about breaking those same resolutions. It's like giving ourselves permission to fail, to think it's okay to fail, and to share our failures with a whole bunch of like-minded people.

Clients don't just do that at New Year, they do it in different ways, all year round... and then bring the failures to us, in order to try and get some reality back into their understandings of their lives and how they want them to be.

It's our job as practitioners to listen to where the breaks have happened in our clients' lives, and to help them to understand and see where or how they can take action to make a difference that they see as positive. When I was training to become a counsellor, I remember my lecturer telling us that he was aware of 416 different modalities of counselling/psychotherapy and thinking that I would never manage to learn them all, so would I be a competent counsellor. I expect there are at least as many again by now.

I wanted to be a competent counsellor, not a brilliant one, just someone who could maintain a framework within which my clients could come and work and I could be there with them. In the ensuing discussion, which went on around me but without me, I was still thinking about why there are quite so many ways of helping people through talking therapy. Was it that there were so many different types of life failure that we had to have a new modality to meet a specific need, or was it because we like to conform, as individuals, to what we believe we can agree on, but that we really only get involved in modalities for which there is training near where we live?

I also remember being told to be aware that once qualified, we were not to read learned journals and textbooks and get excited by some part of a new therapy being discussed and then apply it to our clients on the 'that bit would be wonderful if applied to client 37' as if it were a soothing balm. My resolution that year was to read and to wonder and to talk about the things I learned, to see how they might fit into what I already did, to help clients. Hmm!

Thus, my relationship with my work is always being changed, mostly in a positive way, and I do get the satisfaction of seeing clients taking up their own power again and getting that part of their lives back on track.

As with relationships and the need to review and ask the awkward questions that can take me further on my own journey as well as helping my clients to move on, so within AIP there is an executive team of whom I am immensely proud, for the way they have responded to the challenge of providing some of what BACP would call an 'agenda for change', who also need to review and ask awkward questions of themselves for AIP. This is our strategic goal for 2008, with professionalism as the change point.

Justine Oldfield-Rowell, AIP chair

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The deadline for inclusion in the next issue is 5 April 2008.

Regulation and the independent therapist

Justine Oldfield-Rowell interviews BACP chair **Nicola Barden** for clarification on just how regulation might affect independent therapists

In my column Up Front in the last issue of *The Independent Practitioner* I made the statement that at the recent annual conference Sally (Aldridge) had said that 'the "title" to be used hasn't been decided, but that it would only apply to those within the health service, so if you work outside there – as an independent – your work won't be affected. If your title clashes with the NHS title you would have to change your title.' This has caused some confusion and in an attempt to clear this up I interviewed Nicola Barden, chair of BACP.

JOR: Was I wrong then?

NB: I'm afraid that this is certainly something that Sally would not have said. Regulation may seem health-focused because it will be within the Health Professions Council, but it does not relate only to those working in the NHS. Statutory regulation covers anybody who uses the regulated title. We don't at the moment know exactly what the title will be, but let's say it is 'counsellor' and/or 'psychotherapist'. Anyone who calls themselves a counsellor or psychotherapist without being on the HPC's register, once it opens, will be breaking the law. Regulation is focused on what clients need. To a client it makes no difference if they see a volunteer, a private practitioner, a workplace counsellor or someone in the NHS. From their point of view they need to know that they are seeing a person they can expect to be competent, and about whom they can complain if something unethical occurs. This is why the HPC does not take any account of where we work or how many hours we might do or how much we charge – they simply want to protect the public.

Technically, people could call themselves something different – for example 'support worker' – and carry on without breaching the law, and counselling agencies could likewise become 'support centres'. But this is never something that we could recommend. It is neither ethical nor advisable. The purpose of regulation is to provide an improved level of protection to the public, and this will not happen if people simply find a way around it. As an Association I cannot think that we would support such an approach, and it would actually deprive clients of the protection offered under the HPC if members practise outside regulation.

JOR: Even for those who do not work for the NHS or EAPs?

NB: It really isn't a question of the NHS versus Others. All employers will be bound by the title, as will all those who are self-employed or work on a voluntary basis. This is of course very difficult for some people, particularly smaller voluntary sector agencies who cannot afford fully qualified counsellors. We are bringing these difficulties to the attention of the HPC.

JOR: What do you recommend for AIP members – what action should they be taking now?

NB: At the moment we know that being on a professional body register – in our case having BACP accreditation – is the safest route. We know that many members would qualify for accreditation but, for various reasons, have never applied. My best advice is to make it a priority to go through the accreditation process. The Professional Standards Department at BACP have been working hard to make the process more accessible and straightforward, so if you haven't taken a look at it for a while now is a good moment to do so; it might look more manageable than you think.

Other ways of getting on to the HPC register will open up during the 'grandparenting' period, which is usually a transitional time of two to three years between the register opening and then closing again, after which time the only way on will be through an HPC approved course. However, we do not yet know the

details of any 'grandparenting' arrangements, and the cost is likely to be in the region of £440, which is considerably more than the circa £40 required simply to transfer from the BACP (or other professional body) accredited register.

JOR: A great many of the AIP division are already accredited and keen to move into a regulated profession, but there are also members who are not accredited and not interested in becoming accredited. These members work purely privately and thus are not affiliated with a body that will require regulated status. The fear held by such members – that they won't be allowed to work unless regulated – offers a horrendous vision, particularly as many work from home so that they can offer a service at a cost affordable to those on low/no income. In other words, it's those not 'in employment' who have the concerns. I am keen to reassure them – with accurate information.

NB: You can reassure them that they will be able to access the HPC register, and that there will be some time for them to do whatever it is they need to do either to become appropriately qualified, or to demonstrate that they already are, in order to gain HPC registration. They can do this through gaining BACP accreditation, or waiting to see what the 'grandparenting' arrangements are to see if they will fit them. The HPC currently expects to open their register in 2010/11, so there is plenty of time to gain accreditation through one of the routes available, and the doors to grandparenting will close around 2011/13. The accreditation door will close at the moment the HPC register opens – everyone gets transferred in one great swoosh – which is why you do need to think about that a bit earlier. Accreditation itself will continue, but will no longer be related to the HPC register.

Your members are right in that they will have to be regulated to work; but the HPC's aim is to include everybody not to exclude them. We will make public any further information we have about what this may mean in practice as things are constantly developing. The worst thing any member can do is shut their eyes to regulation and think it won't apply to them. If you practise, it will apply. But BACP is involved as closely as possible in representing the good practice of our members to the HPC, along with all the concerns and difficulties of regulating this creative profession that has grown up in so many different ways. ■

AIP training conference

The executive team began the task of conference planning for 2008 before the 2007 conference, in order that the best speakers and venue could be identified and booked. We know, from feedback given at the last conference and from previous questionnaires, that 'supervision' is your hot topic. And as you know, our strategic plan from 2007 to 2009 focuses on professionalism as the day of regulation comes ever closer. It is with that in mind that we invite you to make suggestions to help shape the day. If you have previously experienced dynamic speakers who would be good for the conference, please tell us.

We need to hear from you as soon as possible, so that we can move forward with the shaping of the day and identifying of speakers and workshops. Contacting us couldn't be easier. Just look on page 1 and you will see the contact details of all your executive team members.

Clarification

In an article in the winter 2007 issue of *The Independent Practitioner* about postpartum depression, the author Sara Walters stated that 'postpartum depression is a biological illness caused by enormous changes in hormone levels after a baby is born'. This statement should have been attributed to its source: Maternal depression and disrupted attachment, Diana Lynn Barnes, conference session La Leche League of Southern California/Nevada area conference May 2002. Apologies for this omission.

Visit the AIP website: www.aiponline.org.uk

Have you looked at our website lately? There are strands of interesting topics to which you can contribute – or you can start your own. This is an excellent way to lessen the isolation and keep in touch with your colleagues. A possible strand, offered by Janet Dandy: 'Do other counsellors working from home put any Christmas trimmings in the counselling room? I don't, but have had clients comment that they think I should.' Or: 'client' or 'patient'?What is your preference? What do you think of 'plient' as a compromise?

bulletin board

Supervision for individuals and groups Essex/Herts border. 14 years' experience counselling in statutory, voluntary and private sectors; five years' experience supervising. Caroline Powell-Allen MA, UKRC (Reg. Ind.), MBACP (Accred.), CPC (Reg.). Tel: 01371 873270.

NHS reform in England

BACP's **Louise Robinson** explores the implications for AIP members – our services, practice and clients

Practice-based Commissioning (PbC) and Improving Access to Psychological Therapies (IAPT) are terms you may have heard or read lately; of all recent Department of Health (DH) initiatives and reforms, these two have the greatest potential to influence counselling and psychotherapy service provision, both within and outside the NHS.

Introducing practice-based commissioning

Put simply, practice-based commissioning (PbC) is a new system for planning, contracting, funding and reviewing all NHS services. PbC also enables a greater flexibility in service provision, including commissioning services from the private, voluntary and independent sectors. The ultimate aim of PbC is 'to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare'.[1]

This is the vision set out by government but there is inevitably a gap between the political rhetoric and practical reality. PbC, as with most healthcare reform, is translated and implemented locally by over 150 primary care trusts (PCTs), in partnership with GP practices in their area. Implementing change at this level is challenging, particularly with limited funding. To expand one area of service provision a PCT has to make a saving somewhere else, and to bring in a new service provider may mean not renewing an existing contract.

After over a year of implementation, progress with PbC is patchy – some areas have seen rapid change, while others have experienced very little change. What we must hold in mind, though, is the evolutionary nature of this new system of commissioning. PbC is a continuous cycle of consultation, planning, implementation, evaluation and review around the life cycle of contracts, which are likely to be for one to three years. The shape of service provision will evolve further over time as more contracts come up for review and PbC becomes part and parcel of local planning.

Improving Access to Psychological Therapies

In November 2007 the government announced funding of £173 million for further roll out of the Improving Access to Psychological Therapies programme (IAPT) over the next three years[2]. Some of this money will be used to fund the development of 20 psychological therapy treatment centres across England to be operational by 2009. These treatment centres will be based on the vision presented by Lord Layard of rapid access to psychological therapy and/or support with the aim of helping people achieve improved mental health and wellbeing, thus improving their ability to gain and/or maintain employment[3]. The treatment centre model has been piloted in Doncaster and Newham[4]. Other projects that the IAPT programme is taking forward include work with commissioners and existing NHS services to develop best practice in providing services for children and young people, offenders, black and minority ethnic groups, perinatal care, older people, and people with long-term medical conditions and/or medically unexplained symptoms[5].

Implications of PbC and IAPT on counselling and psychotherapy

When considering the implications of PbC and IAPT for counselling and psychotherapy it is a good idea to bear in mind there is likely to be a general election in 2009, and whichever political party is in power, there is a likelihood of further political reform. It is also important to be mindful there are 152 PCTs in England, with differing local geography, social demographics, infrastructures and priorities; therefore, there will be huge variances in how PbC and IAPT affect services in each PCT area. In this changeable and variable context, how do we explore the implications of PbC and IAPT for counselling and psychotherapy? In the midst of current reforms and developments we can identify some trends (or guiding principles) that are coming to the fore. There are some indications that these trends are already influencing counselling and psychotherapy provision – arguably, they will become increasingly influential over time. The first trend we will consider relates to public awareness.

Increasing public awareness of the benefits of psychological therapy[6]

Our national media reflects a society that is increasingly concerned about our psychological health and wellbeing:

magazines such as *Psychologies*; health articles and supplements in national press; 'reality' television programmes that focus on improving participants' body image, behaviours, and/or relationships; debates on radio and a plethora of related websites and self-help books all raise awareness of the benefits of nurturing our psychological health. At the local level, PbC and associated consultation exercises are giving a voice to GPs and patients who are generally in favour of improving NHS psychological therapy provision.

National political debate is also embracing mental health, wellbeing and the provision of psychological therapies. Since the announcement in the House of Commons of IAPT funding in November, psychological therapy has been discussed in Prime Minister's Question Time and has recently become a key campaigning issue for the new Liberal Democrat leader, Nick Clegg. These are perhaps early indicators that psychological therapy provision could become a political battleground in the next general election.

Through this mix of national and local media coverage, local consultation and national political debate we can expect to see increased awareness of the benefits of psychological therapy among both NHS professionals and the general population. Furthermore, as the debate about service provision continues it will also go some way to 'normalise' or 'de-stigmatise' mental ill-health and other issues that people present in therapy. This reduction of stigma coupled with an increased awareness of the benefits of psychological therapy must be a good thing for society – making it easier for people to seek help, be that via the NHS, an independent practitioner, the voluntary sector, or their employer.

Increased demand for psychological therapy

Does this increased awareness mean there will be more demand for therapy? Quite possibly; but if the NHS does extend and develop state provision of psychological therapy services, what impact will that have on demand for existing services?

Technological advances, rising expectations, an increasing older population, lifestyle choices and improved education are just some of the factors affecting the demands that the population puts on the NHS; it is notoriously difficult for the NHS to meet all these demands. Research into the rates of mental ill-health indicates that GPs are in contact with many patients who might benefit from psychological therapy, but there is not capacity to refer all such patients within the NHS. This means that as new services are developed GPs will refer more patients and the new services will soon reach their capacity – GPs will continue to act as gatekeepers, making decisions on who to refer and who not to refer based on clinical judgment.

Given that state-funded supply of psychological therapies is unlikely to meet demand across the board, the impact of increased NHS provision will be patchy. If you work for a voluntary sector agency or have independent practice in an area that is being well resourced and is seeing increased NHS provision then you may notice a dip in enquiries but equally you could see an increase in enquiries as the new services generate awareness, expectation and demand that cannot be met. BACP has reports from two counselling services based around Doncaster where the IAPT pilot treatment centre has been up and running since 2006 – both services are reporting an increase in referrals.

Wider range of providers commissioned by the NHS

The NHS is becoming a more open market; already, through PbC, some Employee Assistance Providers (EAPs) and voluntary sector organisations have been successful in securing new contracts. If you work for a voluntary sector organisation as part of your current portfolio of work you may already receive NHS referrals; if this process is formalised through a commissioning contract between the organisation and the PCT this may have implications for the way the service is managed and aspects of your practice. Alternatively, you may work for a voluntary sector organisation or EAP that is embarking on an NHS contract for the first time; again this will have similar implications for your practice. There will be new referral protocols and considerations about note taking, confidentiality and clinical governance to take into account. If this applies to you, or your service, information sheets are available from BACP's Information Service Department that cover many of these issues.

The range of providers is also growing due to considerable change in the charity, voluntary and community sectors – sometimes called the third sector. Government is encouraging the development of new not-for-profit business models, such as community interest companies and social enterprises. The social enterprise model could be used by local independent practitioners to collaborate with one another and prepare tenders for NHS contracts[7]. The benefit to independent practitioners and small services in collaborating in this way is the pooling of resources, ideas, skills, knowledge and contacts.

Collaborative working

This notion of collaborative business models leads us on to the more general notion of collaborative working. In any given locality there is a range of services that people can access when they are looking for help, but many people do not access all such services because the providers of those services do not collaborate or communicate effectively. Good practice is where social workers, housing officers, GPs and counsellors, be they working for a local authority, charity, or the NHS, collaborate to ensure that all needs of the individual are met. There is a commonly held view that good services evolve around the person – rather than the person navigating their way through a complex and unclear system.

Perhaps with the exception of independent practice, all counsellors and psychotherapists need to be

aware of mechanisms for collaborative working with colleagues. If you are working for a service that takes NHS referrals you should know, or be able to find out, how to approach a GP or social worker if appropriate. That said, independent practitioners would still do well to know what other services are available locally even if they do not directly communicate or collaborate with such services. It is always useful to know what other help may be available to clients.

Efficiency and competition

Current reforms are, for the most part, driven by the pursuit of efficiency in the NHS; if the details of these reforms change, the pursuit of efficiency will almost certainly remain a key priority. One way to try to improve efficiency is to increase competition.

Under PbC, competition will focus on price and quality. Services will be funded on the basis of the work they do – described as 'units of care'; in the context of psychological therapy 'units of care' are therapy sessions. The mid- to longer-term vision for PbC is commissioning on the basis of outcomes (outcomes-based commissioning) where services are paid based on achieving the desired outcome for each individual patient.

Regardless of whether outcomes-based commissioning does evolve as a formal system, we can expect competition among services based on their ability to demonstrate good outcomes. When services go to tender, comparing outcomes is a key way to differentiate between services. For AIP members working in the voluntary sector or an EAP tendering for NHS contracts, or for those working direct for GP practices as lone practitioners or as part of a collaborative, audit and evaluation will be increasingly important for continued NHS funding.

There is potential that in some areas increased NHS provision may impact on other services. Consider this scenario: you are a human resources manager in a small to medium sized company and a psychological therapy treatment centre is provided in your area through the NHS with links to the government Pathways to Work[8] programme – would you fund an EAP programme for employees? It would certainly make you think about what an EAP provider can offer that your employees would not have access to via the public sector, and so increasing provision in the NHS may make other sectors more competitive on both quality and cost.

For those who are enterprising there is also the opportunity to become part of the jigsaw of state-funded provision. For example, the EAP ICAS is currently partnering with Ultrasis, interactive health care specialists, to offer CMP Direct. 'The purpose of CMP Direct is to offer providers of Pathways to Work a means of enabling their participants immediate access to the latest range of evidence based computer and telephonic interventions, delivered within a vocational rehabilitation framework.[9] This is just one example but there are many more ways that NHS reforms will bring both opportunity and challenge for the workplace counselling sector[x].

Increased awareness of public protection and standards

While catching up on which multi nationals and rogue traders are duping which unwitting members of the public (I am referring to BBC1's Watchdog programme based on consumer rights) do you ever think perhaps customers need to be more careful? 'Buyer beware' is a sad necessity but a true one. The problem is that as customers we do not always know what to look out for – you cannot ask about things you do not know, and the service provider or manufacturer is in a position of power.

If we relate this back to the context of counselling and psychotherapy provision, lack of state regulation places the emphasis on service providers and practitioners to self-regulate, largely through professional memberships and adhering to an ethical framework. It also puts an emphasis on employers, commissioners and clients to educate themselves when seeking a therapist – knowing what to look for, what to ask and how to identify safe, ethical and effective practitioners. BACP has set standards that employers sometimes refer to – the NHS often specifies BACP accreditation, or equivalent, in employment criteria. Members of the public who have some awareness of how professional associations work may seek out therapists with appropriate membership and perhaps ask about training, but this is by no means the majority and many people are unaware and vulnerable.

The increased attention that we can expect psychological therapies to get in the media and press, the less taboo the subject of seeking therapy becomes, the more accessible state-funded provision becomes and ultimately, as state regulation comes into force – the more aware commissioners, employers and clients will become of what to look for and what to expect from their therapist. The inevitable increased awareness of commissioners, employers and clients about standards of practice has the potential to impact on all practising UK counsellors and psychotherapists, from those offering therapy in independent practice for just a few hours per week, to those who have a broad portfolio of work across different sectors. We must anticipate more questions from commissioners, employers and individual clients about training, experience and registrations. If you are reading this journal then you are probably a member of BACP and AIP so you are no doubt conscientious about these things. When clients become more aware of standards to look for, if you are able to demonstrate these in your practice and promote them effectively, clients are more likely to find you than to find themselves in difficulty with a rogue therapist!

In summary, those are our six main trends – they all come with the health warning that these are my interpretations based on evidence and information gleaned from reading and the people I am in contact with. It is fair to say there is a lot of uncertainty at the moment but by

What can you do?

In response to the six trends highlighted in this article, common considerations for counsellors and psychotherapists across the board, regardless of their portfolio of work, are: How can I evidence that I am effective? What will my future commissioners/employers/clients want from me in terms of expertise, experience and standards of ethical practice? How will I demonstrate that I am working to those standards? What additional training might I need?

Beyond those key considerations, how you prepare for the challenges ahead very much depends on your portfolio of work and developments in your locality. You can find out what progress is being made locally by: referring to local media, searching on the PCT website for the Local Delivery Plan or requesting a copy from your PCT, attending public PCT meetings and asking questions of colleagues and the GPs you are in contact with.

If you work as a lone practitioner in a GP surgery and the PCT decides to invite tenders for a new service, your contract might not be renewed. If you think this is a possibility, now or in the future, one option you might pursue is to form a collaborative (perhaps a social enterprise) with other lone practitioners in your area. You can then pool your resources and evaluation of outcomes in readiness for preparing tenders to gain new NHS contracts. You might be tendering against competition, but you will have strengths that the PCT and GPs might be looking for. You already know the local systems, you have established relationships with GP practices and you have an existing client base. If you can also demonstrate good outcomes and the ability to offer reliable service, your tender has the potential to succeed.

With regards to independent practice, it may well be that current changes in the NHS do not have a significant impact on this aspect of your work. If there is an impact it could be a reduction or increase in enquiries. It is important to be aware of developments in service provision in your locality so you are able to see what is on the horizon and are more able to adapt if necessary, and continue to offer a service that people want or need regardless of changes in NHS provision. Over time you can also expect clients to come with a better understanding of psychological therapies and perhaps higher expectations as awareness about standards in practice grows.

thinking these scenarios through and discussing them we are better prepared for what does unfold. To close we will consider how all the above will affect your clients and practical action you can take to prepare for the challenge and opportunity ahead.

Effect on clients

The NHS is working towards equity in provision but it will remain something of a postcode lottery for a while. Some clients will have more choice about where they access services; this may include choice of psychological therapy and/or guided self-help with a mental health worker. Choice and access will be limited, however, and based on the needs of each NHS patient – for example, there may be a time limit on the psychological therapy, or only one modality of therapy offered. We know that some clients will want a longer course of therapy and that one modality does not suit all clients; so while they might get more access and choice through the NHS it will not necessarily meet all their needs. Some clients prefer an independent practitioner or private therapist because they do not want that information held by the NHS on their healthcare record. There is real potential for more clients to gain improved access via the NHS but this will always be limited and there will still be a need for counselling and psychotherapy provided elsewhere.

We do live and work in exciting and challenging times for counselling and psychotherapy. I have outlined some of the challenges but I ask you to consider the growing potential for members of AIP and BACP to contribute to the emotional health of society. We always knew that potential existed and we know that it is being realised in some areas, but as the media and political spotlights grow, and access to state-funded psychological therapies grows, we can expect to see more recognition for the contribution of counselling and psychotherapy and a wider impact on the emotional health and wellbeing of society. ■

Future issues of The Independent Practitioner *will cover AIP members' personal experiences of this issue. If you would like to contribute, or if you have any questions, please contact Louise at BACP on 01455 883311.*

BACP is holding seminars in London and Manchester in May and June this year – see advert on the back cover.

References

1 Department of Health. Health reform in England: update and commissioning framework. July 2006. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137226&chk=D2YSig

2 See interview with Lord Layard on IAPT in March *therapy today*.

3 Lord Layard and the business case for improving access to psychological therapies: www.lse.ac.uk; IAPT: www.mhchoice.csip.org.uk

4 Doncaster and Newham IAPT demonstration sites: www.mhchoice.csip.org.uk/psychological-therapies/demonstration-sites.html

5 IAPT pathfinder sites: www.mhchoice.csip.org.uk/psychological-therapies

6 Psychological therapies is an all embracing term preferred by the NHS to include the broad range of talking therapy modalities.

7 Social Enterprises: www.socialenterprise.org.uk

8 Pathways to work: www.dwp.gov.uk/welfarereform/pathways.asp

9 CMP Direct: www.icasworld.com/cmp

10 Robinson L. Health reform in England. Counselling at Work. Summer 2007;14-17.

Being clear about boundaries

Jonathan Coe outlines an initiative designed to raise awareness of boundary violations, and provides some tips for practitioners on managing boundaries

One of the most challenging areas of practice is the art of establishing and maintaining professional boundaries. This is an area in which WITNESS has been working since it was founded as the Prevention of Professional Abuse Network (POPAN) in the early 1980s. It is also an area that has attracted increasing attention following a series of reports into abusive behaviour by health professionals in recent years. In response to these inquiries, the Council for Healthcare Regulatory Excellence (CHRE), funded by the Department of Health, has recently developed new information about sexual boundaries as part of its 'Clear Boundaries Project'.

Clear Boundaries Project

The CHRE Clear Boundaries Project was developed in the context of the White Paper, *Trust, assurance and safety: the regulation of health professionals in the 21st century*[1]. The accompanying document, *Safeguarding patients*[2], includes a chapter on boundary transgressions. The Clear Boundaries Project encompassed an extensive literature research survey, culminating in a report with recommendations on professional training and education, information for patients and regulators and information for registered practitioners[3].

Among the recommendations of the Clear Boundaries Project is that regulator panels that undertake inquiries into the fitness to practise of registrants (eg the General Medical Council or Health Professions Council) should be properly trained in understanding the dynamics of boundary violations by healthcare professionals. An understanding of the dynamics of power, dependency and trust in professional relationships is seen as essential when coming to judgment in such cases.

Research

The project's review of the empirical research literature[4] between 1970 and 2006 on abuse by health workers found unequivocal evidence of harm to patients/clients related to sexual boundary violations. Key findings were that:

- sexual boundary violations by health employees commonly result in significant and enduring harm (eg see box below)
- clear sexual boundaries are crucial to patient/client safety
- the majority of reported sexual boundary violations involve male employees and female victims
- client vulnerability is associated with a higher prevalence of boundary violations
- a greater awareness of guidelines and sanctions, and targeted educational and training programmes reduce prevalence rates.

Training and education

The CHRE report revealed that training on professional boundaries is frequently not provided either at graduate level or as part of continuing professional development. The survey of training institutions that was conducted as part of the project found almost universal support among

Sexual boundary violations by professionals commonly result in significant and enduring harm

Kenneth Pope[5] lists the following symptoms as common in people who have had sexual contact with their therapist, but not appearing always and in each person.

- Ambivalence/psychological paralysis
- Cognitive dysfunction
- Emotional lability
- Emptiness and isolation
- Guilt
- Impaired ability to trust
- Increased suicide risk
- Role reversal and boundary disturbance
- Sexual confusion
- Suppressed anger

respondents for introducing this element into teaching programmes. The report notes particular areas of focus for education and outlines some possible methods for effective learning. Such training should cover: the differences between personal and professional relationships, the differences between boundary crossings and boundary violations, the dynamics of abuse, the 'slippery slope' of boundary violations, and the spectrum of professional behaviour, from boundaried, professional therapeutic behaviour at one end to severe boundary breaches, unprofessional and non-therapeutic behaviours at the other. This core training has recently been undertaken by some statutory regulators as well as NHS and social care providers.

Guidance and information

The CHRE project documentation[6] includes definitions of sexual boundary violations, describes the damage they cause, and provides guidance on the

ALL THERAPISTS (n = 84)

DISCIPLINE	Psychotherapist	Counsellor	Psychologist	Hypnotherapist
number of patients	41	27	9	7
per cent	48.8	32.1	10.7	8.3

BOUNDARY TYPE	Sexual	Psychological	Financial
number of patients	31	59	3
per cent	33.3	63.4	3.2

SETTING	Private practice	Centre/NHS
number of patients	51	20
per cent	71.8	28.2

GENDER	Female	Male
number of patients	29	49
per cent	37.2	62.8

Boundary type	Psychotherapist	Counsellor	Psychologist	Hypnotherapist
Sexual				
number of patients	12	12	4	3
per cent	38.7	38.7	12.9	9.7
Psychological				
number of patients	30	17	8	4
per cent	50.8	28.8	13.6	6.8
Financial				
number of patients	2	1	0	0
per cent	66.7	33.3	0	0

Table 1. Boundary violation reports to the WITNESS helpline, 2005/06

responsibilities of healthcare workers as well as possible corrective actions they and their organisations can take.

There is now almost universal agreement that sexual relationships between healthcare workers and their current patients constitute unethical practice, and the guidance is unequivocal on this point. However, there is much less certainty about the situation regarding former patients, and the guidance takes a line that stops short of zero tolerance, instead recommending a balanced approach where sanctions should be proportionate to the vulnerability of the patient and should relate to the particular nature of the professional relationship.

The work of WITNESS

WITNESS has been a member of the CHRE Clear Boundaries Project board as well as a member of the Health Professions Council professional liaison group on psychological therapy and an advisor on regulation to the 'We Need to Talk' campaign[7]. WITNESS works to promote safe boundaries between professionals and the public, and to improve public protection through raising awareness, lobbying for improvements in policy, and providing training and education. We also run a helpline for anyone concerned about breaches of trust in health or social care services. The WITNESS helpline routinely takes calls relating to boundary violations by health and social care professionals (see table 1). Calls to the helpline have encompassed a wide range of concerns, including:

- people being encouraged to take no significant decision without their therapist's approval
- sexual contact for 'therapeutic' reasons
- clients undertaking building and reception work for their therapist
- therapy terminated after several years with no warning
- breaking of confidentiality without good cause
- therapist talking about their own problems in a client's session
- sessions extended significantly with no extra charge
- sessions extended with extra charge
- sessions arranged with no charge.

Of course, not all boundary crossings lead inexorably to serious violations. However, such violations become more likely when early boundary challenges are not discussed with the client, or with a supervisor or colleague. Moreover, when serious boundary transgressions occur they are almost always preceded by lesser boundary crossings of various kinds, often in a predictable order. American psycho-analyst and psychiatrist, Robert Simon[8], provides a useful inventory of this 'slippery slope' (see box right), beginning with changes such as small 'erosions of neutrality', moving gradually into sessions becoming more social and less therapeutic, through self-disclosure and touching to full social or sexual relationship. Some elements of his scheme are not relevant to UK practitioners (who would not, for example, prescribe medication) or practitioners working in less traditional modalities. Also the use of first names would not constitute a boundary crossing for the great majority of practitioners here.

The 'slippery slope' to boundary violation[8]

1. Therapist's neutrality is eroded in little ways
2. Therapist and patient address each other by first names
3. Therapy sessions become less clinical and more social
4. Patient is treated as 'special' or as a confidant/e
5. Therapist self-discloses, usually about current personal problems and sexual fantasies about the patient
6. Therapist begins touching the patient, progressing to hugs and embraces
7. Therapist gains control over patient, usually by manipulating the transference and/or negligent prescribing of medication
8. Contact occurs outside the therapy sessions
9. Therapy sessions are rescheduled for the end of the day
10. Therapy sessions become extended in time
11. Therapist stops charging a fee
12. Therapist and patient have drinks/dinner together
13. Therapist-patient sex begins

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Potential non-sexual boundary violations

- Excessive self-disclosure
- Special fee arrangements (low or free)
- Extending time beyond what was initially agreed
- Allowing telephone calls between sessions
- Extra-therapeutic business relationships
- Socialising with the client
- Calling each other by first name
- Treating the patient as a friend or confidant/e
- Touching or frequent hugs

Grey areas

Clear boundary violations include sexual contact, financial exploitation, breaking confidentiality without good cause, and deliberately fostering dependency. In our experience, twice as many calls to our helpline relate to non-sexual as sexual boundary violations (see box above). However, there can be instances, which are not necessarily clear-cut, in which boundary crossings may be beneficial, depending on the relationship, the situation and their meaning to the client. These might include limited self-disclosure, the use of touch, or contact outside sessions.

There are also situations that give rise to boundary crossings that would not normally occur and would not be seen as harmful – as illustrated in the following two cases.

Case 1. After two sessions, practitioner A unexpectedly offers his client a lift to the nearest tube station, saying 'I wouldn't do this for everyone'. Some time after the fifth session, the same client reports an achievement and receives a bottle of champagne from the therapist. There are no subsequent similar behaviours and no attempts to seduce.

How might this client have felt? How might the practitioner have felt? How might this have affected the dynamic? What could the practitioner have done post hoc to attend to the issue?

Case 2. Client D reports struggling between her weekly sessions, and feeling that she needs more contact with her counsellor. The counsellor gives her a polished stone, saying, 'This is to help remind you of me'. The same client gets panicked as her counsellor's holiday approaches. The counsellor gives the client her mobile number and tells her that she can ring her in Spain if things get very bad.

How might the client feel about this? How would you feel (as a practitioner) if this client came to you for help? What effect might these actions have on the future relationship between this client and her counsellor?

What can practitioners do?

WITNESS has developed a simple model – the 'RISC model' – to help practitioners and supervisors identify areas of possible concern. This provides a framework for examining boundary-crossing behaviours both before and after they may have occurred:

Role – the professional's role
Impact – the impact of the behaviour on the client
Setting – the context of the work
Client's needs – relevant needs of the client.

Using this model as a starting point, practitioners (and supervisors) may usefully ask themselves following questions:

- Is there a clear reason for this boundary-crossing action based on my client's need?
- Does my behaviour towards this client differ from my behaviour towards other clients?
- Am I reluctant to discuss some things about my work with this client with my supervisor?
- Am I working beyond my training?
- Am I concerned about how my client may be experiencing my actions?
- Am I checking that my actions are for my client's benefit?
- What will my action mean to the client?
- What might the effects be?
- Might the client feel 'special', different from other clients?
- Will the relationship remain clearly a professional one, or might it become ambiguous and uncertain?

Establishing and maintaining safe boundaries from the first session right through a therapeutic relationship is a key skill, or set of skills. WITNESS would like to see training on professional boundaries embedded in all psychological therapy curricula, so that this skill set is the norm for all practitioners, and the risk of boundary violations is significantly reduced. ■

Jonathan Coe is the chief executive of WITNESS.

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What does a typical AIP member look like?

Part one of the analysis of the 2006 AIP membership questionnaire

We are a diverse lot. Apparently about all we have in common is that we are counsellors or psychotherapists (or both), we belong to BACP and AIP, and we took the trouble to fill in the AIP profile questionnaire last year. Unfortunately, only 5.3 per cent of our (then) 730 members responded to the request, but possibly some conclusions can be drawn.

Because it is such a small sample and because the ranges are so diverse, it does not seem useful to give averages, but rather to give ranges for the various answers. For example, in question one (How long have you been a member of BACP?) the answers range from 'just joined' to 28 years. The median (as many answers above as below) is nine years. Similarly, for question two (How long have you been a member of AIP/PRG/PRSF/PSMFT?) the answers range from 'just joined' to 25 years, and the median is two years.

Not many of the respondents log on to the BACP website (range: 0-10 times a month) and even fewer log on to the AIP website (range: 0-8; median: 0). Client hours per week range from two to 23, with a median of nine, and fees charged range from zero to £100, with a median of £32.50. The age range of members is harder to pinpoint as the options were themselves given as ranges. However, only one respondent is in the 20-30 range; seven are in the 31-40 range and 12 in the over 60 range. Which means the majority (9) fall into the 51-60 range.

One quarter of the respondents also belong to other divisions of BACP. The majority of respondents (27 to 12) are accredited counsellors, though only four are accredited supervisors. The number of years in practice ranges from 'just started', to 39 years, with a median of eight years. The distance travelled for supervision varies from none (telephone supervision) to more than 70 miles.

Half the respondents work (as therapists) in organisations in addition to working in private practice, and half (not necessarily the same people) have non-counselling paid work in addition to their counselling work.

Our diversity really reveals itself in the number of orientations and speciality areas each respondent listed. Seventeen different major orientations were given by the 39 respondents: Adlerian, behavioural, CBT, eclectic, existential, Gestalt, humanistic, integrative, interpersonal, NLP, PCA (evidence based), person centred, psychodynamic, reality therapy, shamanic, solution focused, TA, and transpersonal. And no fewer than 30 different specialities were listed, ranging from abuse and violence, through adoption, cultural issues, death and dying, decision making, life coaching and relationships, to sexual minorities and trauma.

Respondents are equally well spread over the UK, including Northern Ireland, and one from overseas. Predictably more respondents live in and around London than anywhere else. Fifteen respondents practise in urban areas, five in rural areas, with the remaining 19 working in mixed areas. Only 10 respondents rent somewhere to practise; the majority see clients at home (the therapist's home, presumably, for the majority).

The widest spread occurs in how respondents' working time is broken down. There is no pattern at all: some respondents do far more EAP work than anything else, some do more supervision than therapy, and some do more non-counselling work than anything else. All of which simply emphasises how very diverse our membership is.

Part two of this analysis – featuring respondents' personal thoughts and wishes – will be published in the summer 2007 issue of *The Independent Therapist*. ■

Margaret Akmakjian-Pitz

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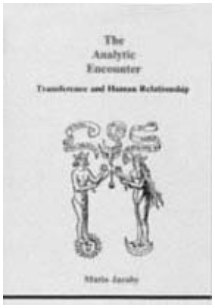
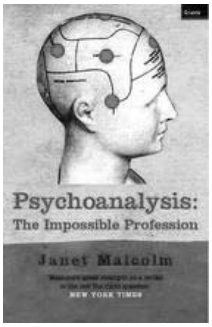


The analytic encounter: transference and human relationship. Mario Jacoby. Inner City Books, Toronto, 1984

This revealing study (it's too small to be a 'book'), addressed to both layman and professionals, attempts to answer the question, *What are the psychological dynamics behind the therapeutic encounter and how do they differ from what happens between two people in any situation?* While not explicitly addressing the question of therapeutic boundaries, it does go some way toward explaining what is likely to happen that gives rise to the need for boundaries.



Psychoanalysis: the impossible profession. Janet Malcolm. Vintage, New York, 1982

Almost a classic by now, Malcolm's journalistic peering into the reclusive world of psychotherapy does an excellent job of demystifying the relationship between therapist and client, and what therapists say about each other – especially in the area of therapist/client out-of-therapy relationships. Says Christopher Lehmann-Haupt of the *New York Times*, 'Miss Malcolm asks the questions that every patient has ever wanted to ask but knew it was hopeless ... More momentous still, Miss Malcolm's questions get answers.'

Margaret Akmakjian-Pitz

Discovering who you

Reflections on the ancient typology

The mind of the average person may be pictured as an unruly horse that jumps and kicks and throws anyone that tries to ride it. Masters of the world are those who have mastered themselves and mastery lies in the control of the mind. If the mind becomes your obedient servant, the whole world is at your service.
(Sufi Master)

The Enneagram gives insightful information that can help sort out core personality traits and identify areas of weakness that can be given extra attention to gain such mastery. The typology has a deeply spiritual origin and was first made up of collated wisdom of elders as far back as 1000BC. The Jesuit monks were said to have worked with the Enneagram during the 16th and 17th centuries and it was made popular during the 1960s by Oscar Ichazo, who had a mystical school in Peru. Others developed the Enneagram as a personality test and it is widely used today by many diverse cultures.

The Enneagram is a geometric figure that shows nine basic personality types. Books written by experts in the field, such as Don Richard Riso and Russ Hudson, contain a detailed personality test. There are nine types: type one, the reformer – principled, purposeful, self-controlled and perfectionist; type two, the helper – demonstrative, generous, people pleasing and possessive; type three, the achiever – adaptive, excelling, driven and image-conscious; type four, the individualist – perceptive, innovative, secretive and isolated; type five, the investigator – observer, thinker and reductionist; type six, the loyalist – engaging, responsible, anxious and suspicious; type seven, the enthusiast – spontaneous, versatile, distractible and scattered; type eight, the challenger – self-confident, decisive, wilful and confrontational; type nine, the peacemaker.

The diagram opposite shows the types and how they are linked to certain emotional types. As you can see, groups two, three and four are feeling types and are concerned with image. Groups five, six and seven are thinkers who tend to be fearful. One, eight and nine are relating people who mask their inner rage.

My recent attendance on an inter-faith spiritual guidance programme held in Amsterdam did not begin by determining the personality type, but instead gave an outline of each one. The participants were asked questions at the end of each description which helped each person to gain insight and understand aspects of the shadow in their personality. These I share with you now and invite you to think about each one carefully and meditate on the question at the end. (Another way to do this exercise is to work in pairs with a trusted partner and each ask the repeated question for 10 minutes.)

The feeling group

Type two: the helper

This type encourages the dependency of others. They tell themselves that people need their love in order to survive. As children they get love by being mother's helper, being pleasing and flattering. This is how they learn to manipulate. They are extremely concerned with how people see them, and often adapt to the needs of other people, losing touch with their own needs in the process. At some point in their lives they wonder who they are themselves. Often they have needy immature parents whom they can manipulate to get things the way they want them to be. As

are through the enneagram

by **Susie Holden Smith**

they lose their own identity they are often drawn in partnership with more flamboyant types and bathe in reflected glory. They believe their partner needs them totally to be successful and could not make it without them.

They look for control by being helpful. For example, 'I do not need anybody, they need me'. They are giving in order to receive and are very disappointed when nothing comes back.

The helpers can sacrifice themselves for someone else, lose their identity and crave freedom. They often become the victim of their own strategies.

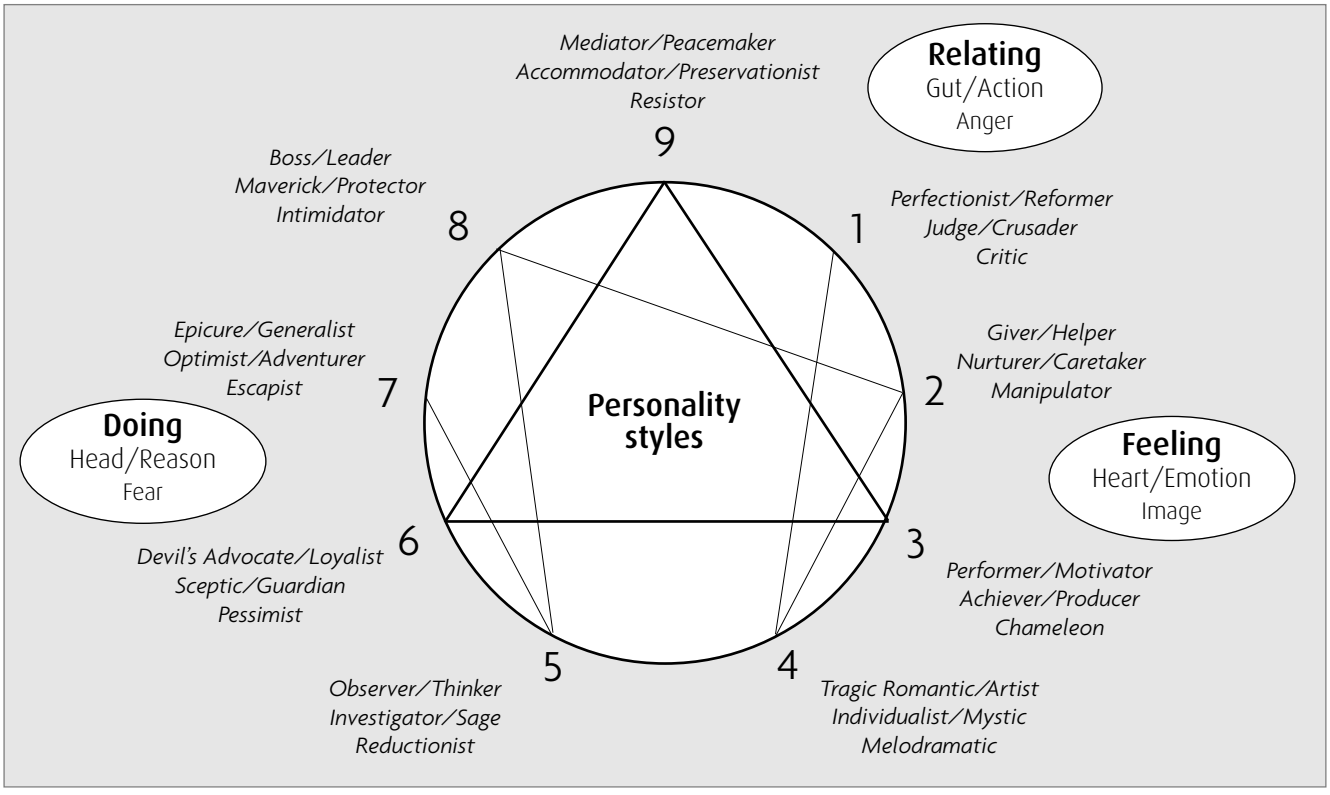
Sexually they can be teasers. They tempt but do not give anything. They have a fear of intimacy. They do not trust and develop a false self to try to control their universe rather than developing faith in divine freedom.

The type two looks for symbiosis in relationship. Some twos are grandiose and others more modest and in the background. They often feel helpless and do not like to be alone. They need to be with someone who needs them. Giving so much they can feel exploited by others, and do not realise they are allowing this to happen to them. These individuals need help to appreciate their own needs and to develop humility themselves. An example of an archetype to illustrate this type is the all-consuming Jewish mother.

Question for reflection: Tell me how you manipulate in order to get love?

Type three: the achiever

S/he is very successful and will do anything to be successful. Achievers can be like chameleons, adapting to the environment to determine what is the most desired behaviour to be appreciated by others. That is how they earn love. This type craves to be seen and valued as a public figure and is ready to work hard for it to be possible. They do not have much free time. They like themselves and get a lot of admiration – in fact they can be idolised. They imitate intimacy and attract people but do not find lasting relationships easy. Real creativity needs space, which they do not allow. They need a place where they can relax and be receptive. Type threes often appear youthful and eternally young. They have to force their success and often learn psychological or spiritual language successfully enough to become teachers. They cannot relax and have to make themselves busy at all times. These individuals need compassion to understand how they got that way. As a child they were often praised for performing and continued to nourish their ambition to become shining stars. The type



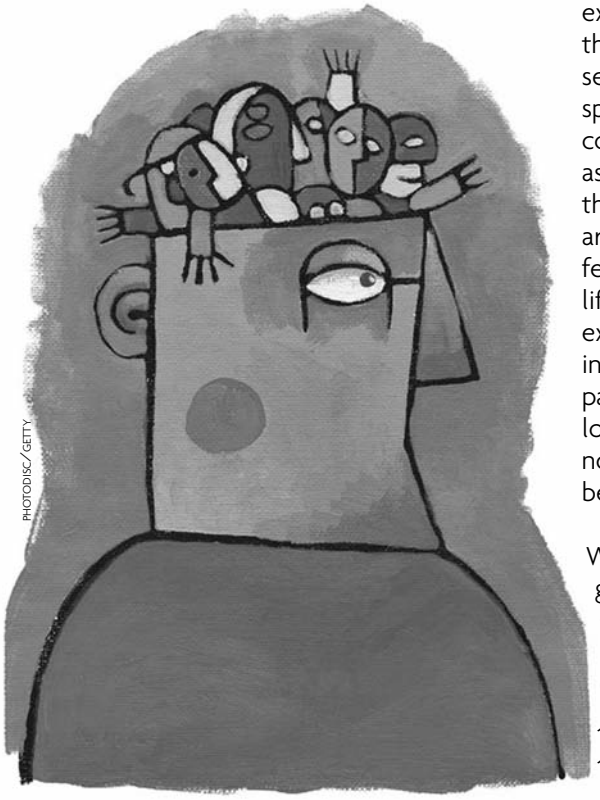
three loses sight of their truth as they will do anything for kudos. They are not open and vulnerable, but image conscious.

It is necessary for therapists working with this type to get the achiever to observe themselves and get in touch with deeper feelings. Being vain, they find it hard to own negative feelings and therefore never feel truly accepted. It is difficult for type three people to spend time alone and if they go on training courses or spiritual journeys they always have to remark on how the teacher or guide was more famous than any other. They are extremely competitive and overestimate their abilities very easily. They have a tendency to brag and confidently sell themselves to others.

Question for reflection: Tell me something that's true about you now.

Type 4: the individualist

This type wants to be original, creative and special. They are steady and sensitive, but feel something essential is missing, something that others have. They often feel abandoned, and are hungry souls that have not been nurtured – the glass is half empty. They get jealous very easily, and envy what others achieve and discredit it. They are socially insecure and feel left out of groups. They are constantly comparing and insisting that what they have is better. Type fours have a rich imagination and as a result this group includes many artists. Emotionally sensitive, they do not enjoy life enough – something important is always missing. They see themselves as special and other people do not match up – they are considered boring. As a result, they always long to be with 'exciting' people. Fours have a deep value of beauty, but this image type do not see their own beautiful qualities, and can hate themselves for not living their life in a true way.



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They can be intense and unstable – breaking boundaries and being arrogant in their own work. Others are not special enough to reveal themselves like them in their ivory towers. They want to live up to their own ideal and then feel deep shame when this isn't possible. They can be condescending towards others because they feel superior. They create a cycle whereby they want something and if they get it feel they do not want it after all and feel disappointed. What they are jealous of is contentment. What they have lost is the feeling of the unique expression of the divine within themselves whether other people see that or not. They can express spiritual insights, but fake having deep convictions. This group need others as a mirror for what they cannot see themselves, hence actors and artists are prominent in this group. Grateful feelings for everyday simplicities of life can be difficult. Often fours experience manic phases or sink into brooding despair. This can be so particularly when they are involved in love affairs. Often the fantasy does not live up to the reality. Fantasy can be perfect whereas reality is gross.

When they work on themselves, this group have to learn equanimity. Can surrealism open to reality?

Questions for reflection: How do you deal with your preferences? Do you envy people on a spiritual path? The spiritual broader look for this group may be 'wherever I look I see thy face' – developing gratitude by recognising divine beauty in the simplest of things.

Types two, three and four are concerned with image. Do you recognise yourself within this group?

The doing group

Type five: the investigator

This type feels not understood, not seen. They privately draw into their own corner. They are afraid to be overwhelmed. Perhaps their own mothers overwhelmed them. Their passion is avarice, greed – and their virtue detachment. They usually have a mental head and observe and understand rather than participating. There is a tendency to be autonomous – a great desire for independence. Fives feel greedy to take care of themselves only, and do not want to share. They are not emotional and show great control. They do not have body balance and remain 'in their head'. Their view is that thinking is the same as experiencing, so they desire more than they can consume just to be sure they can feel secure. These people want to control how much interaction they have with others. They prefer one-to-one contact and do not like groups. Conflicts are to be avoided at all costs and their defence is to withdraw into themselves. When they speak they talk in a dry way with no feeling. Trust is a big issue, as they have lost touch with the outside world and live mainly in their heads. Their spiritual challenge is to trust that the Divine knows the answers. Sadly they feel isolated and not a cell in a cosmic body. Fives fear surrendering and opening up to others and the world. As a defence they withdraw and have difficulty admitting their vulnerabilities, especially not knowing something.

Their challenge is to make attempts to integrate more with their body and spirit, to make connections and attachments. Their heart is hardened as it is overcrowded with facts. True love is not just being attached to someone and not a preference as to

how things should or shouldn't be, ie love someone but do not possess. Fives may think of this as indifference but there is a fine line between the detached heart and freedom, and space for the loved one. Love but do not grab. All needs cannot be met, so grieving desires not achievable in relationship is a challenge to this group.

Question for reflection: What is your relationship with detachment?

Type 6: the loyalist

This type find the world threatening. They do not trust authority. It is difficult for them to believe in God. They are in constant doubt and mistrust. They believe everyone is out for themselves, and the outside world is malicious. Their inner world is peaceful because they are run by instinctive motives. They often expect the worst scenario and are afraid of danger or they look for danger. Their attitude can be 'I'll show them', or 'they won't get me'. This type should realise that if you look through the lens of fear, vision is distorted. They feel helpless in the struggle for life. How to survive in the jungle blocks their spontaneity.

Sixes often project their unacceptable feelings out onto other people. For example, they experience others as humiliating or despising them when they themselves have repressed guilt or shame. They often deny their sexuality, putting down other people who display sexual confidence. Sixes compensate by feeling grandiose. They scapegoat and project their disgust onto others. As a therapist working with a dominant six you may be accused of wanting to change them. What is needed is a quiet presence to facilitate them to be more open and change the imprinted idea within themselves that they are not good enough. The feeling of emptiness can become a feeling of facilitating space. The virtue of this group is courage to overcome fears and go beyond their previous imagination. Create positive experiences and own them, ie you are more than your body or your thoughts. Challenge the orthodox non-belief. If you don't dare to feel your fears then you don't enable yourself to open up the possibilities. Sixes accept the messages of the superego and will not fight them. They are very fearful of the future. Often they have a history of unreliable parenting.

Questions for reflection: What are you afraid of? Tell how you are courageous.

Type 7: the enthusiast

For this type, paradise was lost when the breast, the source of love, was removed and they had to feed themselves with the spoon. They enjoy excitement, kicks and want pleasure and fun. The difficulty is they have to organise it by themselves. If bored, they may go to the fridge rather than face what really matters. They do not reach their deeper self. They have a passion in their urge for consumption: drugs, food, alcohol, sex. They do not digest and do not want to feel emptiness. Often these people like to be the centre of attention at parties and functions. They are show-offs and often the *Puer Atermus*. They fill themselves with food and books – anything as long as it comes from the outside. They have an addiction to excitement and are eternal students, not digesting. They are in need of constant stimulation.

Their virtue is sobriety – ie to see the truth of things and yourself. This type does not trust life to be exciting just as it is. They have to learn to recognise life within themselves. They believe they can programme their development. They organise exciting things, but they are not felt as satisfying and more is needed. Sevens do anything rather than face the truth in themselves. This type often become depressed when not stimulated. Sobriety is needed – a clear presence in order to experience serenity. Truth is more important than feeling good. It is okay to experience pleasure but do not get hooked. It could become destructive as you are not really there for yourself.

This type is avoiding something important. True feelings have to be experienced and responsibility taken, eg pain you have caused to others. Often the seven can be seen as a great organiser at spiritual gatherings but they are losing something on their spiritual path. They need the grounding of ideas and to learn to live with paradox and to sacrifice their own interests for people that they love. In therapy they need to make space for reflection and contemplation. It is important to organise a structure which will make life easier to do what is really wanted and makes them feel good, ie a balance of work and play.

Questions for reflection: What effect does your need for excitement have on others that care for you? What do you need to put into practice to improve your health?

The relating group

Type eight: the challenger

This type has a great lust for life. They tend to be materialist and like to fill their time with something tangible rather than looking within. Vulnerability and weakness are taboo. They claim to be independent and not need anybody, and within their spiritual faith, if they feel the divine isn't giving them what they need, they tend to force unity by addictions. They are seen as powerful leaders both in their family and work. The challenger does not care whether people approve of their decisions. There can be denial of illness which is seen as weakness. Everything has to be organised by them. Often this type has had weak parents and has learned early to do everything. They tend to be authoritarian and see themselves as protectors of the underdog. There is an illusion that they can make things right.

Type eight can be mean, sadistic, punishing to the environment and themselves. If they believe in God it is a God of revenge. This type dominates and needs to cultivate the virtue of innocence.

Challengers have leadership qualities and can be seen to have integrity, however this is often distorted to be cruel and harsh. In therapy, eights try

to take the lead – you can see the battered child protecting his innocence. They need to be helped to recognise paradoxes as they think in extreme ways. This type can be enabled to realise they have choices to relax and be open to the uncertainty of life.

Question for reflection: Tell me a way you deal with weakness.

Type nine: the peacemaker

Type nine individuals do not like conflict. They do not think of themselves as important or special in any way. The peacemaker does not take the initiative and likes to disappear into the background. If they try to say something they are not heard because it lacks assertion.

This type likes a quiet life and in therapy it can be a challenge to get them moving.

Often they have been the child in the family who is overshadowed by others' needs. Alice Miller in her book *The drama of the gifted child* shows that adaptation becomes necessary so as not to cause trouble in the family. As a result these individuals can think they are boring and not important. Feelings of failure are at the forefront so they are not enthusiastic. There is no vision as to how they can value themselves and reap abundance in their lives. Often, however, they read self-help books but nothing is internalised.

This type have the most repressed anger and can be experienced negatively by others (passive aggressive). They are aggressive to themselves and withhold energy towards others. Sufi poet Hafiz has a saying 'it is not weakness that scares you, it is your power that scares you'. Both two and nine are observers, but nine does not want to be seen for that.

Nines can make great storytellers and their creative imagination is high. They like clarity and do not want to be confrontational. If there is disharmony in a situation they tend to withdraw. However, they can make good mediators.

Nines can compensate by having an extremely busy life so that they can avoid feeling anything. They need to become more aware of their anger and act on it before it becomes destructive. When stressed, they often become paralysed, and stay on the past rather than moving on to new experiences. They need to develop the virtue of doing-becoming active in their lives and making changes.

Questions for reflection: Tell me a way that you experience yourself as really lazy. What at this moment is important for you to do with your life?

Type one: the reformer

This individual has been an obedient child. S/he behaves in the 'right' way and expects to receive the same behaviour from others. Being good all the time is hard work but is the way this type earns love. The world is desired to be perfect and when it is not, the individual gets angry with the spiritual ideal because they feel it is not working to their advantage. S/he has a mission to improve the world and correct humanity. S/he has an illusion of what perfection is, and judges those who do not fit their vision. The reformer's ideal self is pure and does not have any animal instincts, and therefore does not succumb to lust and other considered lower drives. This type judges those who are uninhibited.

Type one needs to gain insight that s/he is not so perfect in order to calm their inner and outer world which is in conflict. They have no idea what an angry impression they make on people. They can be very polite but ice cold. The only way to enable them to become more balanced about life is to help them release their anger and rage. This type has a deep fear of shadow/unconscious qualities. If anything touches their shadow they are super-sensitive. They enjoy giving advice even when it is not needed, but do not like receiving anything that resembles criticism of themselves. They can be irritatingly polite and not in touch with feeling. The reformer can also be compulsively orderly and find chaos difficult to cope with. Their sexual identity is split, ie Madonna or whore. Type one needs to learn more about paradoxes and discernment as the idea that there is more than one truth is difficult.

Reformers can be found in all walks of life. The judge is present uttering phrases such as 's/he'll shape up'. Spiritually, type ones like being in the higher place where everything is immaculate. Spiritual directions away from life are very appealing such as joining a monastery. In life ones can be socially unadjusted as they have little judgment as to what lurks beneath the surface of their own image of perfectionism, ie what they see as perfect can be different from what others view as perfect. This type need help to become more aware of who they are and to guide them to accept themselves without too much self-criticism. They need to learn that there is not only one truth, it is all relative. Those who shine the greatest light often have the greatest shadow, for example spiritual leaders who abuse children.

Question for reflection: Tell me something you resent in others?

The wisdom of the enneagram's message is that integration of all the personality types is needed. Transformation happens when our ordinary perspective shifts and we attain a new understanding of our essential selves.

My gratitude is given for the teachings and spiritual guidance of Dr Atum O'Kane and Dr Cora Slieker. ■

Books on the enneagram

Enneagram for beginners. Helen Palmer. ISBN 902159677.

Understanding the enneagram. Don Richard Riso. ISBN 0395520266.

The enneagram. Helen Palmer. ISBN 006250683.

The enneagram of passions and virtues – finding the way home. Sandra Maitri. ISBN 1585424064.

Facets of unity. AH Almaas. ISBN 936713143.