up front

Writing for the front of a journal is nerve racking. I can write about what is current but by the time you read it, it will be old hat. I could write about the future but I don't have a time machine. I suppose I could write about the past but would you read it? At times I am moved to wax lyrical because I still have the passion of the past, for the present and its future. It matches the journey of the client, I suppose: their present and its future, coming from their past and their passions in it. Does it get me anywhere? Yes it does, but that requires thought, to recognise and assimilate and do something with.

We finally have our CORE Net pilot, with a signed contract and volunteers. The first training has occurred and when you read this, we will be up and running for the next six months. The outcomes of this will provide a wealth of information in all directions, gained from our own members, about something that may well be of critical importance in the future. CORE Net is still evolving but the hope is that it will prove useful for independent practitioners. We do not intend to recommend the CORE Net system to you over any other; but come regulation and commissioning, we need to be able to show our worth and to show our clients how they can use the system as part of the self-learning that happens in good client-counsellor work. This is one possible means of achieving these outcomes.

Recently I asked new members to make contact with me and indeed some of you did just that. We all have a base core level of who we are, brought about by our membership of BACP itself, which we will need more and more as the Government machine rolls on. At our conference last December we ran a workshop on the latest information regarding regulation. The concern, worry, uncertainty and flow of questions were enormous and thrown at the speaker with great feeling. She answered all that she could. You don't have to wait for regulation to happen, or for commissioning to pass you by, because you can use AIP itself, through the executive and this journal, to flag up areas that concern you. You don't even have to share your real name – you can use a pen name or remain anonymous, although to do the latter you need to give your real name to our editor and ask that the piece remain anonymous.

This journal is your journal, not just to pick up off the mat and read, but to put in questions, concerns, requests and offerings that we can use to help and support each other. There are still huge numbers of counsellors belonging to BACP who are not in any division as yet, but of those in divisions, in December 2008 we had the third largest membership – approximately 1,455 members. I give you this information not to blow the AIP trumpet but to illustrate what size voice we have if we harness it and use it. The executive continues to work on ideas gleaned from members at conferences and through the journals, but in the next 12 to 24 months, things will begin to move forward and we want and need to play a part in that.

Please think about your future, how you are going to meet new challenges and still provide quality interventions for your clients: what you believe you will need for that future needs to be articulated *now*. We are keen to hear your views at AIP and our executive team are listed, with contact details, on this page. Not everything has to be recorded in the journal, in case you are having palpitations already. We work behind the scenes as much as we do in the spotlight.

So my earnest request is that if you are in AIP because you thought it was right for you, then make contact, ask your questions, make your suggestions, identify problem areas to us, and let us use our combined force to help drive regulation, where possible.

Justine Oldfield-Rowell, AIP Chair

AIP executive contacts

Justine Oldfield-Rowell, Chair
Tel: 0191 284 8179
email: jor@bacp.co.uk

Margaret Akmakjian-Pitz, Deputy Chair and Editor
Tel: 01994 232142
email: makmakjianpitz@googlemail.com

John Crew
email: jopacs@tiscali.co.uk

Wendy Halsall
email: wehalsall@yahoo.co.uk

Susie Holden Smith
Tel: 01322 558798
email: susan.holdensmith@btinternet.com

Tony Hutchinson, Finance Officer
Tel: 0870 405 1833
email: tony@softersolutions.co.uk

We welcome your letters and emails.

Email Margaret Akmakjian-Pitz at makmakjianpitz@googlemail.com or write to Coed yr Iwan, Meidrim, Carmarthen SA33 5NX

The deadline for inclusion in the next issue is 15 April 2009.

Home thoughts from the jungle

BACP vice president **Esther Rantzen** reflects on her loneliness and isolation during her time on 'I'm a celebrity... get me out of here!'

My worst experience happened on the second day in the jungle, when the loneliness hit me. Far worse than any cockroach or deadly spider (after all, they had experts to deal with those and make sure there was no real risk), was the realisation that every emotional umbilical cord had been brutally and suddenly cut. If you had asked me beforehand what I would miss most during the two weeks, I might have said hot bathwater or the occasional chocolate. But I did without both those body pleasers.

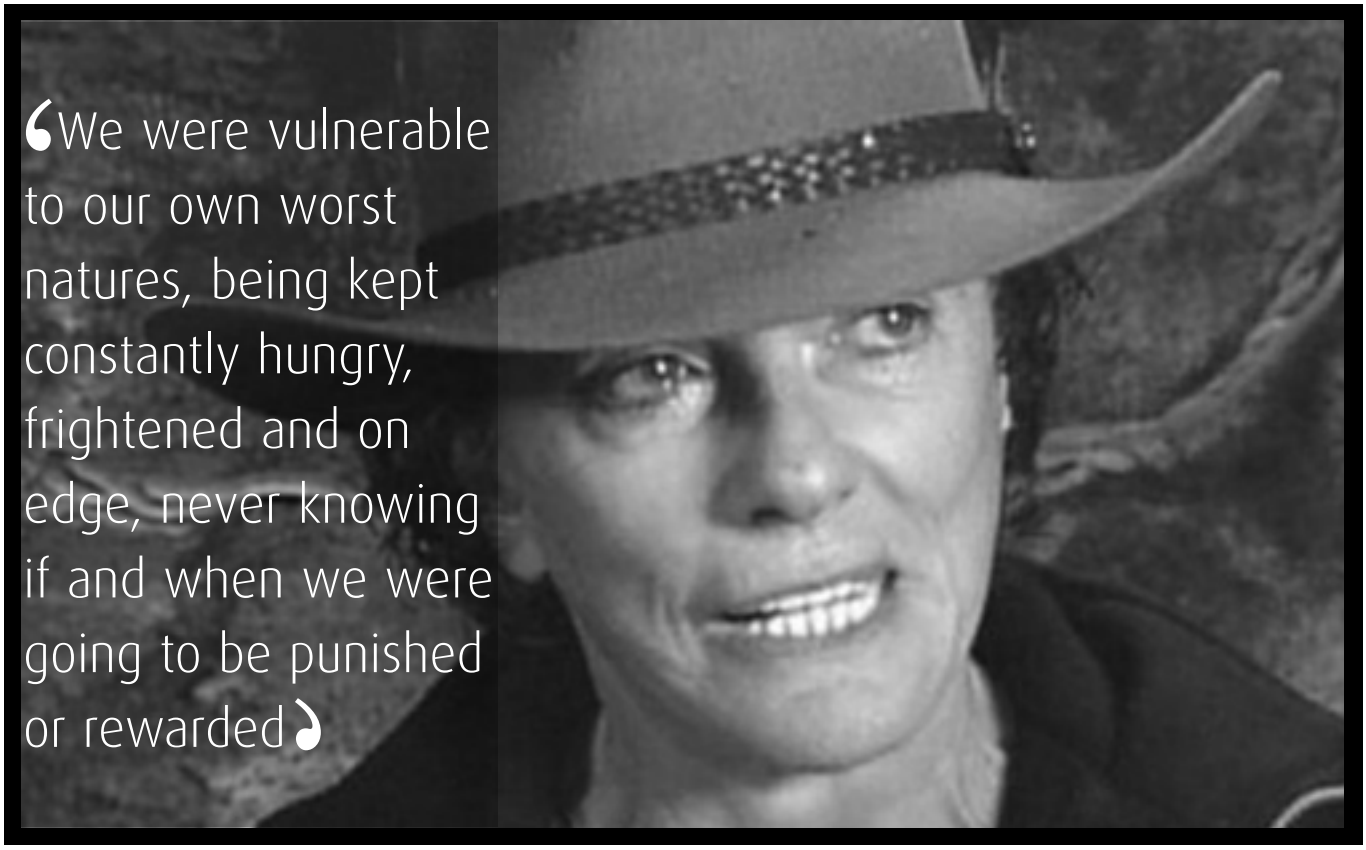
My mind suffered far worse deprivation when I realised that all the people I love, my friends and family, were completely out of touch. They, I now know for sure, are the network that support my life. I need them desperately. For one thing, I'm an addicted talker.

> 'My friends and family, I now know for sure, are the network that support my life'

Nothing is processed unless I can share it. My late husband Desmond Wilcox and I used to speak on the phone to each other six or seven times a day, even when we had left home together, and would be together again that night. He was a documentary maker, and even when he went filming in remote places, we still managed to speak to each other. He was once in the middle of American army manoeuvres, with the parachute regiment dropping onto a barren prairie all around him, when he noticed a little door cut into a tree trunk, opened it, saw a phone inside and rang me. Late one night he was being breathalysed in a police station when he rang me to complain that the police officer, seeing he had difficulty peeing into an official receptacle, had said 'Ah well, that's life!' That call came at two in the morning, and I'm afraid I wasn't all that sympathetic. So not to be able to ring anyone, or email them, or listen to a recorded message from them, was very frightening.

That emotional isolation is something that anyone who works alone probably feels from time to time; certainly as a writer I have had to find ways to deal with it. My previous job in television as a producer/presenter entailed being part of a big energetic team, and I love that. But now as a freelance I spend far more time alone with my computer, relying on my own brain for company. I have had to find ways to augment it. Music sometimes works, so I encourage my word processor to play my favourite tracks while I struggle with a deadline. Emails are simulated company: friends swap virtual jokes that break the vacuum, though even at my loneliest I don't welcome the intrusion of spam. Nor do I enjoy the computer voice that phones me to offer me some money-saving deal; the fact that I am being contacted by a soulless machine adds insult to the injury caused by the interruption. But unlike the jungle, while I'm working alone in my Hampstead office I can always arrange a meal break with a friend, or ring one of a dozen people who will share the moment with me. The 'I'm a celebrity' production team had made sure that my mobile phone had been confiscated, the computer had been locked away in the hotel safe, even my watch had gone. We 'celebrities' were searched to ensure we didn't cheat in any way. We were alone with each other and a forest of cameras and microphones; there was no hiding place.

I was once told by a prison governor that if we as a society really want



our prisons to become effective deterrents and prevent recidivism, everyone would be sentenced to one night inside. That first night, he said, is when the shock and deprivation are at their worst. From day two, prisoners start to become acclimatised to the routine and loss of freedom, and then institutionalised. We jungle prisoners did too; from day three I looked at the mud around us, and the tiny bowls of rice and beans, and decided I would simply have to put up with it. I didn't mind the boredom, which afflicted some of the others. The jungle was so beautiful, the sounds of the creek and the cicadas so relaxing, that I consciously enjoyed it. As for company, I had to make do with what was provided for me, the other celebrities. Not that it was always easy. There were bullies in the group, loud-mouthed and argumentative. There was one particular trouble-maker who pretended to be even-handed and patrician, but in fact spread poison and bad-mouthed all of us behind our backs. When I emerged into the real world I was fascinated to discover that viewers had seen through him instantly. It took me far longer.

Most difficult of all was the way the group split into gangs, 10 against two. True, we were manipulated into it by the highly skilled production team; we were vulnerable to our own worst natures, being kept constantly hungry, frightened and on edge, never knowing if and when we were going to be punished or rewarded. But that's a salutary lesson in these recessionary times. Society is going to be hungry, frightened and on edge. Will we, too, split into gangs? If so, as I found in the jungle, it's the ones who arrive late and look different, the Timmy Malletts, the asylum seekers and immigrants, who will be victimised. Try as I did to stand firm, to refuse to join, to defend the bullied, I failed, and I regret that failure. How much worse will I fail in the real world, I wonder, when poverty starts to bite, and we turn on the most vulnerable in our own society?

Then there was the Stockholm syndrome. Starved of intimacy, we began to trust the faceless voice we could confide in, the hostage-taker, the producer who spoke to us via the 'bush telegraph.' I knew intellectually that it was not a genuine friendship, just a programme device designed to seduce us into indiscretion. But it was difficult not to succumb.

Any long-term effects? Certainly. I long to return to the quietness, the greenness, the remoteness and simplicity. On my return I learned that the constant company of email, BlackBerry and telephone keeps my brain jangling, whereas the jungle had allowed deep emotions slowly to emerge into the sunlight. Constant distraction may be fun but it doesn't allow introspection or a real appreciation of life as it passes. So now I'm thinking of plotting another retreat, as the poet Marvell said, 'annihilating all that's made to a green thought in a green shade'. I may find myself another jungle, another bedroll under the stars, to feel the cool rain on my face. Just as long as I can be sure someone else is dealing with the deadly spiders. ■

The open secret

Emily M Brown, author of *Patterns of infidelity and their treatment*, takes an in-depth look at the dynamics of extra-marital affairs

A secret affair is almost an oxymoron, like an unmoving earthquake – no matter how much effort is expended on keeping it hidden, its impact severely shakes, and sometimes devastates, the comfortable certainties of marriage. Presumably 'unknown' to the spouse, the affair nonetheless has enormous power to create feelings of shame, tension, distrust, fear, suspicion and self-doubt in both parties; feelings that seep like a dark taint into the entire fabric of family life. A hidden affair is not just a betrayal, but a time bomb that can destroy the structure of belief, faith and integrity that is at the core of our sense of security with those closest to us.

The secret affair fundamentally alters the quality of married life. Not only is the affair hidden, but the process of secrecy results in a web of lies necessary to hide the original secret. The infidel has to sift through the ordinary details of daily existence before speaking. He or she has to think about where time is spent when not at home; films seen and restaurants visited that may be unknown to the spouse; exposure to new opinions about art, politics and clothing styles that might reveal another life. When one spouse is having an affair, the other spouse becomes the outsider, the one not in on the secret, the de facto third party. The spouse often lives in a miasma of half-truth and doubt, a world in which nothing about the relationship to the infidel seems clear and straightforward. Knowing something is amiss, but not knowing exactly what, the spouse wonders 'what is wrong with me?' and tries hard to 'fix things', redoubling his or her efforts to become a better husband or wife.

But the attempt doesn't make any dent in the thick wall that separates the couple, so the spouse becomes even more anxious, resentful and suspicious, while the infidel continues to blandly or irritably deny any problem, becoming even more unavailable. At the same time, the infidel often lives in guilty fear of being found out, frightened both of hurting the spouse and of the retaliation that revealing the secret might unleash. In any case, however much the infidel tries to seal off the affair in the realm of the strictly private, it inevitably invades the nooks and crannies of a couple's relationship.

The colluding partners

Paradoxically, there are probably no truly secret affairs – most spouses probably know on some level, though they may not be able to bear acknowledging what is obvious to friends, family and even the children. In probably two-thirds of the couples I see, the spouse knows more or less consciously about the affair, but pretends not to know. Both partners engage in a kind of mutual deception to avoid the terror of having to confront each other. Among some middle-aged couples, for example, the infidel, usually, though by no means always, a man, has maintained what almost amounts to a second, concurrent marriage for five, 10 or more years. Sometimes in these quasi-marriages, the infidel carries on a parallel social life in the company of the lover – entertaining or going out to dinner with other couples. The 'at-home' spouse prefers to consign the affair to a limbo of semi-conscious awareness, because she is terrified that forcing the issue might threaten the marriage, however unsatisfying, and cost her the only security and identity she knows – that of being the recognised wife, keeper of the household and beneficiary of the financial perks. When these couples come to therapy, usually the infidel wants help in leaving the marriage, while the spouse wants to hang on at all costs. Often these marriages are beyond resuscitation, eroded by many years of emotional distance, suppressed anger and disappointment preceding the affair.

The prognosis is much more hopeful for marriages of younger, conflict-avoidant couples. In these marriages, usually between people in their 20s and 30s who have been married six to 10 years, both spouses want the marriage to work and try very hard to please each other, but are frightened of expressing differences and terrified of showing anger. Eventually, resentments pile up without being resolved, and the more desperate of the two begins an affair

Editor's note: The terms 'spouse' and 'marriage' are used throughout, but the issues remain the same for all those in committed partnerships and relationships.

in an unconscious or semi-conscious attempt to get the spouse's attention. In these cases, the affair is a serious threat to the marriage only if the underlying message is ignored – the infidel's unacknowledged feelings of anger or abandonment, for example. The danger is that the spouse may either rush off to a divorce lawyer, or, after the initial shock, prematurely forgive the infidel and allow the marriage to revert quickly to a state of artificial placidity – until the infidel goes on to have another affair. In neither case do the partners learn how to handle the ordinary push and pull of marriage, and even if they remain together, the chances for building a good relationship grow increasingly dim.

Whatever the circumstances, however it occurs and whatever knowledge the spouse may or may not have, the real secret of an affair is *not* the affair itself, but the even deeper secrets about the marriage that neither spouse can face or deal with. The affair is often a screen, a distraction that obscures the anger and sadness between the partners, the disappointments each feels about the relationship, the gaps between what each needs and what each is getting from the other. If the spouses come from families characterised by avoidance, emotional withdrawal and secrecy, or by conflict that overrides all else, odds are that they, too, will choose indirect and unconscious ways of expressing dissatisfactions.

Most affairs have little to do with sex and a lot to do with keeping anger, fear, depression and emptiness at bay, which often means keeping dangerous and disruptive feelings about the spouse from full consciousness. There is no such thing as a 'meaningless' affair; every infidelity, whether a passionate involvement or an overnight fling, is an encoded message spelling out the dynamics of a failing marriage, a detailed commentary on the way the infidel and the spouse related to their families of origin, the way they see themselves and the way they are with each other. Understanding these issues is critical to understanding the marriage and to helping the spouses rebuild a better relationship – or end it – based on the knowledge gained in this crisis. Obviously, the couple cannot know the meaning of the affair if it is never discussed, if one spouse remains forever in willed, but doubtful, ignorance.

The colluding therapist

If the record of most traditional marital therapies were any guide, you would never know how critical and revealing infidelity is for understanding the dynamics of a troubled marriage. In spite of the value therapists give to honesty and integrity, they have too often colluded with infidels who hide the truth and spouses who don't want to hear it. Frequently, therapists justify their hesitation to bring the affair into the open as a high-minded respect for confidentiality and ethical neutrality, claming, for example, that it is the client's 'right' to reveal or not reveal the affair, and that it would be overly 'directive' to push for disclosure.

But the therapist is hardly neutral if he or she enters into an implicit bargain with the infidel to keep the secret from the spouse, thus replicating the triangle between husband, wife and lover. Some therapists will see the couple without addressing the affair, as long as the infidelity has been terminated, on the principle that it is no longer relevant to the ongoing dynamics of the marriage. But the message of this position is akin to *'it is no longer happening, therefore it is as if it never happened, therefore it has no bearing on the marriage and needn't be mentioned'*. Again, not only does this position create a dishonest alliance with the infidel against the spouse, but it obliterates a very rich source of information about what is deeply wrong with the marriage.

Infidelity is experienced by most spouses as a terrible betrayal, and the disclosure of an affair will certainly be a wrenching, often traumatic

PHOTONONSTOP/ALAMY

"The real secret of an affair is *not* the affair itself, but the even deeper secrets about the marriage that neither spouse can face or deal with"

turning point in the marriage, which may not survive the revelation. Many family and marital therapists who oversubscribe to a professional and personal mandate to 'save' marriages are afraid to confront affairs for this reason – the truth will cause the marriage to dissolve, exactly what the couple is ostensibly in therapy to avoid. Therapists who take on the responsibility for 'saving' marriages often seem to care more about their clients' marriage than their clients do; indeed they seem to care more about the clients' *marriage* than they do about the *clients*. In reality, they are afraid of pain – their own as well as their clients'. They agonise over whether they should surface the affair at all, whether it might not be better to concentrate on communication patterns, or family of origin or anything at all except the shattering fact of the ultimate betrayal. It's not uncommon for therapists to feel angry at the infidel for creating this dilemma and then to feel guilty about feeling angry.

Infidelity can elicit tremendous rage and grief, and a sense of hopelessness about one's marriage and one's self that are often quite daunting even to experienced clinicians. Therapists, after all, want to relieve pain and suffering, not cause it, and revealing an affair is almost bound to make people feel worse, not better, at least in the short run. Many therapists grew up in alcoholic, depressed, abusive or otherwise dysfunctional families in which they were the peacemakers, the negotiators, the caretaker children who 'rescued' their parents, looked after their siblings and tried to smooth over the discord at home. This legacy lives on in their tendency to protect and soothe their clients rather than confront them, even when the pain of confrontation is the first step in genuine therapeutic growth.

Therapists are also frightened of precipitating terrible, life-threatening situations – suicide or even murder, for example. Indeed, it is distinctly *not* a good idea to reveal an affair when one of the spouses may become physically violent, though the therapist needs to know what the client means by saying 'He'll get violent if he finds out'. For some, this means, 'he'll yell' – not a sufficient impediment to disclosure – while for others, it means, 'he will break my arm and may even kill me' – which certainly is. While spouses who have never lost control are unlikely to do so even when faced with a partner's infidelity, any history of physical violence should rule out disclosure.

It is equally unwise to reveal an affair in the midst of legal divorce proceedings between the couple. 'Out-the-door' affairs occurring just before the end of a marriage are intended to obscure the anger and pain and to transfer blame for the divorce to the third party. This type of infidelity can easily be used vindictively as a potent legal weapon in custody battles and financial settlements. If the spouse suspects an affair and wants to know, however, the therapist should not be party to hiding reality. Nonetheless, if the spouse does not know and is not asking, the focus is more appropriately on the other secret: the infidel's decision to end the marriage on practical issues rather than on infidelity, revelation of which at this point can so easily be used to wreak legal havoc.

Finally, a therapist should not bring up an affair without being available to follow through on the aftermath, to guide the couple through the period of shock, anger and guilt, and help them either improve their marriage or separate as constructively as possible. This is not short-term work. If your role is limited, for example to three sessions as part of an employee-assistance programme, or you are the therapist for a child in the family, you will not be available to help reconstruct the shaky structure that disclosure has made of the marriage. Sometimes, all you can do is suggest couples counselling without revealing to the spouse what you suspect. And yet, if the issue is an acting out child, revealing the affair and the related marital and family issues may be critical to the treatment.

The facilitating therapist

How does a therapist 'discover' an affair, if both spouses are mum? Often, the infidel pulls the therapist aside after a joint session and reveals the truth. But even when this does not happen, the therapist picks up the same cues that the infidel is giving the spouse. We hear that the partner is coming home late several nights a week, that he has suddenly become preoccupied with physical fitness or bought a new, fashionable wardrobe, that she has become irritable and testy around the house and secretive about what she does when she's not with her husband.

More telling, though, is the sense of a missing piece in the therapy, of a confusing fog surrounding the problem. The therapist gets an intuitive feeling in the therapy of something not quite right, something being withheld, an elusive quality. The nature of the issue seems to shift from session to session.

In one couple, for example, 'Phil', the husband, had a litany of relatively trivial complaints, which he delivered in a low key, slightly querulous monotone – his wife, 'Rita', spent too much money, she never had a babysitter lined up when they wanted to go out, she wouldn't phone to tell him when she would be home late. He was like a mole burrowing underground, looking for a problem he couldn't quite identify. In the meantime, his wife had few complaints of her own, but seemed very willing to change in herself what he didn't like; she responded to him with slightly dissonant niceness and cooperation – an 'anything-you-want-dear' quality that smacked of appeasement. Usually, when one spouse seems to be scrambling around trying to pin down the problem while the other seems both less mystified and more helpful, I suspect an affair, and in this case, I thought the wife was the infidel.

After enough sessions to achieve rapport with both spouses, when I think there is an un-revealed affair, I meet with each partner

individually. While I talk to the spouse about whatever seems relevant – family-of-origin issues, for example, or his or her feelings about the marriage – I confront the suspected infidel about the affair. Rather than ask whether he or she is having an affair (which provides an easy format for answering 'no' and cutting off any further discussion) I begin the session without much preamble by saying firmly but not accusingly, 'I think you are having an affair'. Then I say nothing, and refuse to be drawn into verbal fencing – I do not respond seriously, for example, to derailing questions like, 'Why do you think that?' If the infidel changes the subject I make the same statement again, and wait. Besides trying to distract the therapist, the infidel will either admit the affair, admit a different secret or deny the affair and terminate therapy after that session. Anything but a genuine, believable, 'no' means yes.

After greeting Rita, as soon as she sat down I said, 'Rita, I think you are having an affair'. She looked at me, took a long, deep breath, looked away and then at me again and said 'Yeah.' We talked about it – who it was with, how long it had been going on – and as soon as I had the major details, I began in that same session to discuss how and when she was going to tell her husband.

There are times when an infidel continues to stonewall – refusing to admit the affair or even to discuss it – and in those cases, the therapist, in my opinion, has no choice but to discontinue therapy with the couple; to continue working with them would constitute a betrayal of the other spouse. I refer them out to individual therapy with different therapists. If the spouse wonders why I am stopping, I may say I do not think they are ready for couples work or may suggest asking the partner. It is important to resist the temptation to say anything else, without either exposing the secrecy or implicitly helping the infidel to continue hiding it.

Once the affair has been admitted, I do not insist that the infidel end it before telling the spouse or as a condition of continuing therapy. The decision and responsibility for ending an affair belongs with the infidel and the couple, not the therapist, whose mandate is solely to bring it out in the open and work with it in the context of therapy. Further, the therapist who becomes preoccupied with ending the affair may well get stuck for weeks with an infidel indefinitely postponing making up his or her mind, while in the meantime avoiding telling the spouse anything.

> 'The goal of therapy is creating an honest forum in which the couple can discuss what is happening between them'

Obviously, whether the affair ends or not will be critical to the marriage, but at this point the goal of therapy is creating an honest forum in which the couple can discuss what is happening between them. The more time the therapist spends trying to convince the infidel to end the affair the more deeply mired he or she becomes in the system of secrecy that excludes the spouse, and the less likely it is that the partners will ever confront each other. The therapist inadvertently becomes not a marital therapist, but a confidant of the infidel.

The exposure

Rita's response to my pressure to tell her husband was typical. At first panic and then deep ambivalence. 'Oh my God, I absolutely can't tell him. He'll go absolutely nuts!' she said. 'He always said that the one thing he couldn't deal with was cheating.' The infidels in conflict-avoidance marriages often feel deeply frightened of the spouse's reaction, very guilty about what they are doing and depressed about the prospects for the marriage. At the same time, they still care about the spouse, and often want honesty at least as much as they fear it. I help the infidel explore both sides of the ambivalence, playing out the consequences of either telling one spouse or not telling, and the pros/cons and costs of each. I ask the infidel what is the worst and what is the best likely outcome of telling and what is the best and worst of *not* telling.

Rita, like other infidels, went back and forth – 'If I tell, he'll divorce me, take the kids and the house: I'll lose everything.' If, on the other hand, she *didn't* tell, she said, maybe he would never find out, and the affair, which wasn't so important to her, would eventually end and everything would just be okay. 'But what if he finds out anyway?' I asked. Panic, again. 'My God, I would really lose everything!' At first Rita was so frightened of Phil's reaction that she could not bring herself even to speculate on what positive effects there might be to telling.

'What if he never does find out?' I asked. 'How will it affect you a year from now? Five years?' Implied in the question is, 'What else will you have to keep secret in order to hide this secret?' Rita thought for a long moment, and then mumbled that if she *did* tell him, maybe, just maybe, they could begin to really talk things over. In fact, Rita began to see that the worst and the best outcome of not telling might be the same: a continuation of a bleak marital stalemate and the inability ever to build an honest, trustworthy marriage.

This process, from confrontation through preparing the infidel to tell the spouse, usually takes about two to three sessions. Any longer than that and the individual sessions take on the attributes of an affair. But

usually, once infidels have admitted an affair to the therapist, and have begun to consider the possibility of telling the spouse, they become overwhelmed with suspense and anxiety until the secret is actually told and they know how it turns out.

Once they have decided on telling, we need to rehearse what they are actually going to say, and prepare for what is likely to be the most exhausting and painful session of therapy. Because the infidel feels so vulnerable, he or she usually chooses to tell the spouse during a joint session, counting on the therapist's presence to moderate the emotional volatility of the occasion. During the rehearsal state, the unedited first draft of the infidel's disclosure speech is often very accusatory, aimed at shifting the blame away from him or herself and onto the spouse: 'You were so cold and nasty and never around when I needed you, and so I had an affair.' Gradually, the infidel comes up with a simple, straightforward statement, preceded neither by attacks nor apologies, to be delivered at the beginning of the joint session.

The revelation

At the joint session, the therapist first greets the couple, then waits for the infidel to begin. If the spouse, who suspects something big and unpleasant is looming, begins talking nervously to delay the bombshell, I suggest quietly that there are other issues to discuss at present, and then I say nothing, allowing the infidel to make the announcement. Typically, the infidel turns to the spouse and says something like, 'I need to tell you that I've been having an affair.' This may be the first time the spouse has actually experienced what the knowledge of the affair really feels like. It has been one thing to suspect infidelity, and quite another to face the reality. So the response is usually a mixture of shock and recognition, then relief, rage, desolation, sorrow. The spouse needs attention from the therapist during this session and the space to express his or her shock and pain. Following the shock whether now or by the next session, there may be yelling, screaming, and bursts of tears, threats to leave the marriage, to sue the infidel, to destroy him or her.

At this point, the infidel is no longer on centre stage, feels helpless and has little to say except to apologise repeatedly, voice guilt and self-recrimination, and ask for forgiveness. The therapist needs to be very available to the spouse during this disclosure session, even quietening the infidel's anxious attempts to apologise, to let the spouse express his or her pain. When Rita stammered to Phil that she was sorry, that she hadn't meant to hurt him, that she hadn't known what she was doing, that she hoped he would forgive her, I quietly said it was too early for him to think about forgiving her now, and redirected my attention to Phil, who seemed to be struggling between furious anger and the need to burst into tears. Still not able to express the complex mix of shock, sadness and fury, he just repeatedly muttered, 'So that's what this is all about. So that's it.'

For the rest of the session I simply restrained Rita's nervous stream of apology while I sat with Phil, letting him know I understood how much this must have hurt him. At the end of the session, I suggested that the couple might want to keep some space between them during the week and not do much talking until they came again. This gave them some structured breathing room, a small release from the sense of chaos and urgency to take some major, life-changing step immediately.

Whatever pain the infidel feels, it will not be enough to satisfy the spouse, who is inclined to obsessively demand ever more contrition, suffering and apologies, more details, more abject requests for forgiveness – an appetite the infidel tries fruitlessly to appease. 'How could you do this to me?' the spouse yells. 'And then you lied about it! If you think you're going to get away with this, you just wait! I want you to hurt as much as I hurt.' The obsessive spouse frantically and relentlessly focuses on his or her own victimisation and the infidel's evil intent, looks incessantly for more evidence of wrongdoing, searching through the infidel's clothes and briefcase, phoning the infidel 10 times a day, dogging his or her steps, tirelessly demanding details about the affair: who, where, when, how many times, what it was like and who else knows?

The unrecognised undercurrent of this obsession is a refusal by the spouse to accept his or her own responsibility for creating, with the infidel, enough space in the marriage for a third party. And although the space could have been filled in other ways, the infidel chose to fill it with an affair. If marital therapy is not to sink like lead, the therapist must immediately begin addressing and bring the obsession under control, adamantly refusing to get caught up in questions of right and wrong, innocence and guilt. Indeed, obsession and apology are complementary places for the couple to hide; the cyclical pattern of complaint and *mea culpa* is yet another avoidance mechanism, allowing the couple to focus on the drama of the affair, and evading as before any work on the underlying issues in the marriage.

The aftermath

While I continue to let the spouse know that I hear and understand his or her pain and anger, I gently cut through the obsession and direct the spouse to focus on his or her own feelings – the anger and grief that he or she would rather cover over with paroxysms of self-righteous accusation, which mask the pain of rejection. I also refocus the couple's attention away from the affair and onto the mutual problems that undermined the marriage in the first place – pointing out that both of them have, for years, probably had a hard time expressing anger, for example, or that it is obvious that they haven't really been able to talk to each other for a long time. Sometimes, I implicitly disqualify the

affair as the major issue by saying to the obsessive spouse, 'You're having an affair with his affair. Is that what you want to do? Thereby suggesting that her preoccupation actually validates the affair. Once the obsession has settled, and the couple has begun to think about a joint definition of their problem that incorporates both of them, the affair begins to lose its demonic quality and the infidel no longer seems like the author of all sin. At this point, the infidel has to end the affair definitively if he or she has not done so already. The spouse needs to know ahead of time when this final contact will occur, what will be said, and afterwards requires a blow-by-blow description of the event. Revealing the affair and all the details of its ending establishes a climate of honesty and openness in which a general marital pattern of self-disclosure – the real basis for intimacy – can happen.

At this point, couples who want to stay together face the long haul of marital therapy – one or two years, probably. They have to learn what they want both from their own lives and from their marriage, and how to balance closeness and distance. The therapist should explore with them their families of origin; frequently, these couples grew up in families that were secretive and emotionally stilted, or in which anger and conflict were ever-present or relentlessly suppressed. Simply hearing about each other's families in couples counselling can teach both spouses something about how the childhood of the other shaped his or her present behaviour; this is a powerful force for instilling greater awareness and empathy in each for the partner.

Not until the spouses understand their personal and marital issues and have worked to rebuild trust is it time to consider whether to continue the marriage or not – whether the benefits outweigh the deficiencies, whether the relationship fits the needs of each. The crisis precipitated by disclosing the secret affair is not necessarily the prelude to a 'happily ever after' ending for the marriage. Either spouse may decide to end the marriage when the partner seems neither interested in changing the relationship nor willing to take any responsibility for marital problems that preceded the affair. There are also couples who find the therapy much harder work than they had bargained for; unwilling to address real issues, they cancel appointments, drop in and out of therapy and fail to follow through on assignments. They may well repeat the same experience, and the marriage will end with the new affair, or they will stay married but the infidel will continue to have affairs.

Conclusion

Finally, some couples come for therapy with different agendas; the spouse wants to save the marriage, but the infidel wants out. In these cases, the 'secret' is not necessarily the affair – usually the spouse knows – but the infidel's own plans to decamp. The therapeutic focus in these cases is getting the hidden agenda on the table and then helping the spouse come to terms with it. In these situations therapists who postpone surfacing the infidel's true intent, or who attempt last-gasp marital counselling are not addressing reality. Just as the spouse needs to know about an affair, he or she must be made aware when the real intention of his or her partner is to leave.

Whether the marriage ends or whether it continues, important lessons can be learned from the affair and the successful outcome of therapy is the ability of the couple – separated, divorced or still together – to reach the point where they can forgive each other. Couples who decide to stay married work on understanding what the affair means and why it happened, and develop a new pattern of open, honest and complete communication. They have courted each other anew, the old marriage no longer exists, and they have come to recognise and accept the role each played in bringing about the marital crisis. They are ready to forgive the other because each knows he or she also requires forgiveness. Understanding their mutual 'betrayal; of each other makes forgiveness possible. At this point, I invite each spouse to formulate a request for forgiveness from the other. Usually, the infidel requests forgiveness for the affair, while the spouse asks to be forgiven for his or her own role in the crisis; for neglecting the partner, for being secretive or angry, or whatever it was that helped set the stage for an affair. Suggesting that both partners request forgiveness from each other is not to implicitly absolve the infidel of the betrayal or suggest that the affair has not been a devastating blow to the spouse. Nonetheless, neither spouse – whether the couple stays married or separates – is served by a therapeutic stance that automatically condemns the infidel as the 'sinner' while protecting the spouse as the 'innocent victim'. As should be clear by now, this kind of therapeutic moralism about infidelity just reinforces the rigid marital stalemate that the couple brought to therapy in the first place. Both spouses must recognise and accept responsibility for the breakdown in their marriage, both have contributed to it, both have a good deal to regret and a good deal to forgive.

The affair has shaken the marital house to its foundations, but for that very reason, it is often the most powerfully transforming crisis a couple can undergo. Even if the revelation proves to be the *coup de grace* for the marriage, it is an opportunity for growth and greater integrity for each partner independently. But as long as the secret affair remains a secret, these possibilities are foreclosed. Like an elephant in the drawing room, a secret affair in marriage does not leave much space for anything else. ■

Emily M Brown, LCSW, is the author of Patterns of infidelity and their treatment *(Brunner-Mazel). This article first appeared in* The Networker *May/June 1993.*

Self-injury: self-expression inside out

Self-injury and self-harm can be distressing for caring professionals, yet provide relief from intolerable distress, writes **Wedge**. When you see clients who habitually hurt themselves, what can you do to help?

Professionals who work with people who self-injure can often feel helpless and frustrated by the self-destructive and self-sabotaging impulses of their clients. Self-injury and self-harm can elicit a great many emotional reactions from teachers, parents, partners, colleagues and healthcare professionals, and with no clear route regarding treatment and support for self-harm, potential helpers can feel unsupported, neglected and hopeless.

There is hope, however, both for people who self-injure and those who may be in a position to provide care and treatment. I have battled with self-injurious behaviour most of my life, and I have been working with professionals and other people who hurt themselves since 2002 to raise awareness about self-injury and self-harm from a service user's perspective.

I have been fortunate to receive help from doctors with experience in the field of self-injury and self-harm, though at times I have felt abused by healthcare workers. I have reflected and meditated on my own self-injury, and have an understanding of where it all stems from and what it does for me. I have also learned a great deal from the thousands of people who have told me their stories through our voluntary organisation, FirstSigns (formerly LifeSIGNS).

Coming to a partial understanding of self-injury has taken me many years, and I am thrilled to find that more and more professionals are taking a keen interest with a view to offering practical help to people who self-injure.

What is self-injury?

At FirstSigns, we define self-injury as a coping mechanism (see box, below) – something a person learns to rely on to help them deal with intolerable distress. We do not focus on the self-injurious behaviour or method of wounding, but rather consider the emotional drivers behind the behaviour and the emotional state that self-injury brings about.

Self-injury and self-harm: definitions

■ Self-injury is a coping mechanism. An individual harms their physical self to deal with emotional pain or to break feelings of numbness by arousing sensation.

■ Self-harm is an umbrella term, an overarching definition that includes eating disorders, food-related issues, drug and alcohol misuse, risk-taking behaviours and self-injury.

■ A professional should never assume they know what other people mean when they say 'self-injury' or 'self-harm' – nobody can know what methods or feelings a client may be referring to with these two almost interchangeable words.

STOCK ILLUSTRATION/GETTY

We have learned that a great many different behaviours that cause pain or damage to a person in an immediate sense come under the heading 'self-injury', and we know that self-injury is a very personal behaviour and that people come to it in their own, indirect ways. We have also learned that there are some activities and behaviours that are better described under the umbrella term, 'self-harm' (see box, right). The reason for the distinction is that the media throw around the term 'self-harm', and yet people mean a great many different things by this.

Not just a girl thing

The media tend to focus on young girls who cut themselves. Women's magazines and teen magazines for girls reflect their audiences, so naturally stay focused on girls who self-injure. By contrast, men's magazines hardly touch the subject – perhaps a reflection of the fact that men do not want to talk about things they perceive as weakness.

When I started looking for information about self-injury in 2000, I searched the web and found some informative sites, run by girls, for girls. As far as I could tell, they were all American. I soon decided that as a male in the UK, I could provide a perspective, so I started writing and web publishing. Since founding LifeSIGNS (aka FirstSigns), I have been in contact with many men and women who want to see the media redress the imbalance in reporting.

Self-injury is definitely not a girl thing in our experience. FirstSigns has always suspected that a bias in published research may be responsible for the apparent predominance of females who self-injure, and a report by MJ Marchetto[1] suggests that this is indeed the case:

'No gender differences were observed among skin-cutters, most of whom reported experiences of trauma. BPD [borderline personality disorder] was recorded for a minority of those skin-cutters without a history of trauma... although these results provide further confirmation of a potential association between prior trauma and repetitive skin-cutting, they rigorously challenge the validity of reported gender differences for this behaviour. Further, this study has identified that repetitive skin-cutting can arise independently of BPD and prior trauma.'

For further information about male self-injury see: www.men.firstsigns.org.uk.

Professionals working with clients who self-injure should endeavour to drop any preconceived ideas about gender differences and accept that, whatever the (obviously incomplete) statistics tell them, self-injury can affect boys, girls, men and women from all backgrounds and of all ages. The statistics on self-injury are obviously incomplete for several reasons. First, they tend to be collated from A&E departments, where 'self-injury' has often been included in 'suicidal behaviour' tick-boxes. Second, research that directly polls people misses men because there is no agreed definition of 'self-injury', and also because men are unlikely to discuss weakness no matter how anonymous the questionnaire. Third, the vast majority of people who hurt themselves do not seek help either from A&E departments or their GP, so it is impossible to have reliable, relevant statistics when self-injury is as hidden as it is.

Self-injury is the hidden affliction; it is a difficult subject, and even harder to talk about from a personal point of view. People who self-injure worry about other people's reactions, including the reactions of healthcare professionals. Will they be thought

Self-harming behaviours

Self-harm:

- Food related:
  - controlled/restricted eating
  - overeating
  - bulimia
  - anorexia
- Drug and alcohol misuse:
  - alcoholism
  - binge drinking
  - smoking
  - drug addiction; chronic or acute drug misuse
- Risk-taking:
  - sexual
  - physically dangerous
  - illegal/anti-authority

Self-injury:

- Cutting
- Burning
- Chemical
- Branding
- Scalding
- Hair pulling
- Banging/bruising, including bone breaking
- Pricking
- Scratching
- Picking
- Biting
- Ingesting, including chronic self-medicating, overdosing (which may be chronic or acute), self-poisoning, swallowing objects

> The majority of people who self-injure tell me that it helps them to cope with overwhelming levels of distress and get on with what they have to do

of as weak? Will they be considered stupid? Attention seekers? Acting out? Childish? A waste of time? Only through understanding and by providing accessible routes into care can professionals begin to reach people who would otherwise never talk about their self-injurious impulses.

Not so irrational

At first glance it may be hard to see how hurting oneself can make one feel better. Is there a 'high'? Some kind of 'rush'? On the surface, it is hard to see what is good about self-injury, especially when the person hurting themselves is ashamed of their action, and/or feels terrible at the distress they may be causing their worried partner or parents.

Talking with a client who relies on self-injury as a coping mechanism may not enlighten a professional, since not everyone can explain what self-injury does for them. It is hard to find the right words; few people are fantastic at talking about their emotions, and fewer still have the emotional vocabulary to discuss their distress and self-injury. It is therefore easier to divine the purpose of self-injury from observation rather than feelings.

Our observations at FirstSigns are that self-injury may have different functions, depending on the situation:

- intrapersonal communication/ self-expression
- making intangible emotions tangible
- release and relief from intolerable distress
- calming the mind, removing repetitive thoughts
- calming the body, physiological reduction in tension
- giving a sense of control over one's emotions and environment
- communication to other people
- demonstrating a need for help
- manipulating other (powerful) people.

With regard to the last point, we should bear in mind that any channel of communication can be used to manipulate people. It is not uncommon for vulnerable people to feel powerless, and within healthcare systems it is quite possible for a client to feel as though the support is being 'done to them' rather than provided for them, so it is little wonder that some people feel compelled to play power games.

The majority of people who self-injure tell me that it helps them to cope with overwhelming levels of distress and get on with what they have to do. The release and relief from emotional turbulence is therefore the primary function of self-injury. When a person is upset, breaking down, panicking, or falling into despair, they can rely on self-injury as a way to sublimate or bypass these debilitating feelings. Self-injury therefore provides some control of emotions that would otherwise cripple and arrest a person.

Self-injury is not 'acting out' or 'attention seeking', though it may sometimes be considered to be 'attention needing'. If a person feels unheard or invalidated in their home, school or work environments and they rely on self-injury to help them cope with their distress, then by showing their injuries they may perhaps be able to make other people 'see' what they have been unable or unwilling to 'hear'.

So there is method in the madness, and in reality self-injury is a valid coping mechanism because it works. Stressed and vulnerable people are making a logical choice; they are aiming to care for themselves as best as they can, considering their often limited options.

Hard to stop

Because self-injury is experienced as a coping mechanism, it is a mistake for carers or professionals to push for a cessation of the self-harming behaviour. Those who are trapped in a cycle of self-injury or self-harm feel under a great deal of pressure to 'stop'. They know it is not 'normal' to hurt themselves, and because they worry a lot about how people perceive them, they will go to lengths to hide their self-injury and keep their emotional difficulties to themselves. Even those of us who can talk about self-injury do not want to become a burden to our friends and carers, so we play down our distress. The pressure to quit is intense, and people frequently go through a Herculean struggle to resist the impulse to self-injure, often for the sake of others.

Parents, teachers and friends may feel that if the self-injury goes away, everything will be all right. However, focusing on 'stopping' self-injury, as if this is all that is wrong with a person's world, is counterproductive. Such preconceptions drive self-injury underground, and people will be unable either to be honest or to discuss their secret hurt. Counsellors and psychotherapists, who rely on the therapeutic relationship with clients, may be better placed than most to know that trust and honesty are critical to understanding and healing.

With all the will in the world, resisting the compulsion to self-injure can be impossible over the long term. In the short term, people can consider distraction techniques and alternative activities, as described below. However, in terms of helping people to break away from a chronic reliance on self-injury as a coping mechanism, it is counterproductive

for professionals to put pressure on people to 'just stop'.

Rather than talking about 'stopping', I would suggest that counsellors discuss the idea of 'moving away from self-injury and self-harm' and replacing self-injurious behaviour with other, more adaptive coping strategies. If a person has new ways of dealing with upset, stress, mental ill health and difficulties in their life, they have new choices and options regarding how to behave. If a person learns to seek health and happiness, and to be in control of their own life, they may then be able to leave self-injury behind them.

Taking care of yourself and your clients

People who work with clients who self-injure need to be prepared to give up their preconceptions and accept that self-injury has a purpose, a function, and that it is a valid way to cope for those who feel they have no other way. The work requires patience, setting aside judgment, and effective use of supervision and/or debriefing in order to help and empower clients.

Before considering how to provide new choices for people who self-injure, professionals working with such clients should reflect on how they may feel throughout the process. Self-injury is such an emotive subject that on an emotional level it will affect anyone working with people who self-injure, and they may end up feeling uncomfortable and less than confident in their treatment and support services. Ensuring that you have colleagues with whom to discuss your observations and feelings, and that you make use of supervision and/or team debriefing sessions, is very important.

When I am delivering training to carers, doctors and welfare officers, we often talk about how frustrating it is to be able to help a person for only a few weeks. We talk about feelings of inadequacy, and even anger at some clients' lack of progress. Thus I am hoping that the majority of professionals work within a close team, and that they have excellent debriefing processes whereby they have the chance to express themselves and seek counsel from others who are experienced in regard to working with clients who may self-harm.

There is also a need for professionals and professional teams to recognise that self-injury is often a long-term entrenched behaviour. There is no quick fix, drug or therapy that offers a solution for all. Moreover, people often self-injure for years before disclosing their behaviour to a professional. This professional's reaction may set the scene for any help the person may seek and receive in future. It is therefore vital that anyone working with a client who self-injures is open, non-judgmental and fairly non-directional, as any hint of exasperation or dismissiveness may switch the client off to receiving help that is offered.

It follows that anyone working with a client who self-injures should not expect a change overnight. A person does not move away from self-injury just because they have professional help and support, however excellent that support may be. Professionals should be prepared for the long haul: even with a client who responds well and acts on everything they have put before them there may be multiple relapses. A person may have an absolute understanding of their self-injury and the advice given, yet still return to self-injury when they feel crushed by life.

Professionals should not berate themselves for being just a small part of a larger chain of support. They may not see the full value of their part in therapy come to fruition, but the seeds they plant in their time working with a client can be life changing for that person later on. They should not discount their impact, even if it is a smaller contribution than they would like.

It can be helpful for professionals to talk about self-injury in a frank and practical manner with clients who self-injure. However, the focus should be on the emotional drivers behind the behaviour, rather than behaviour itself or its physical effects. 'Scar checks' are inappropriate except in the case of physicians who need to physically treat a patient. A person's emotional distress cannot be judged by their wounds. Self-injury may tell a story that is written on the body, but only the person involved can read it. Body checks invade a person's personal privacy and destroy the trust and honesty required in a therapeutic relationship.

It is also important to avoid 'no-harm contracts' or any attempt to impose one's will as a professional upon the client. A person may well be in a powerless situation at home or work, and self-injury may feel like their only way of retaining some authority over their lives – this should not be taken away. Instead, a client should be reassured that they are not being asked to 'stop', but to develop new ways of coping so that they have more choices.

To empower people they must be provided with more, not fewer, choices. The choice to self-injure is always the client's.

> 'In terms of helping people to break away from chronic reliance on self-injury as a coping mechanism, it is counterproductive for professionals to put pressure on people to 'just stop'.'

Finally, a professional working with a young client should explain their confidentiality policy in a clear and open manner, and inform the young person of exactly how the professional means to work with their parents or guardians. The parents of young clients can often need managing, and professionals should dissuade them from overreacting. Removing all the knives from the kitchen does nothing but force shame upon a child, and they will become even more secretive about their self-injury. If their bedrooms are raided and 'tools' and items (like bandages) are taken away, they may be forced to use alternative methods of self-injury they are not familiar with. Broken glass and lighter flames can be more dangerous than razor blades and safety pins.

Distraction and other alternatives

Self-injury can be seen as a compulsion, but it is not something that just 'happens to' a person and is out of their control. Self-injury is a choice; the person is choosing to cope as best they can. Although self-injury is a chronic syndrome, people can be directly helped to move away from it as a coping tool and make new and better choices. The results, which may not be dramatic, can be life changing.

The following distraction techniques may help.

The 15-minute rule

A professional can explain to a client that they have the choice to hurt themselves, and that their choice is not going to be taken away. The client needs to be encouraged to recognise their own power and then make a decision to put off the self-injury for just 15 minutes. After 15 minutes, they can choose to hurt themselves, or they can assess how their feelings are progressing and choose to wait another 15 minutes.

Surfing the urge

If a professional discusses with their client how it feels to have an emotion (like anger, love or anxiety) build and grow to intolerable levels, it can be agreed that just as a wave of emotion builds, so it declines. Accepting that emotions (of all types) develop like waves can be a powerful meditation, especially when we focus on how we may feel, say, two per cent 'better' after reflection (perhaps during the 15-minute-rule game).

State change

How we treat our body affects our thoughts and feelings; for example a person who is feeling afraid may make themselves smaller by hunching their shoulders or hiding behind their hair. By changing their physical behaviour a person may thereby be able to break free from the cycle that leads to self-injury. Standing, breathing from the diaphragm and lifting the head and eyes will change one's physical state. Washing up is another good activity when there is a need to break cyclical thoughts.

More alternatives and distraction techniques are available from www.firstsigns.org.uk/help/

However we tackle the behaviours around self-harm, we should always approach a person with compassion and respect. They are doing the best they can, and as professionals and carers we can help them to make real changes in their lives. ■

Wedge (his real name) has been writing and speaking about self-injury for many years; as an adult he sometimes, just sometimes, cuts himself. You may contact Wedge at: Wedge@firstsigns.org.uk or via: www.firstsigns.org.uk

Reference

1 Marchetto MJ. Repetitive skin-cutting: parental bonding, personality and gender. Psychology and Psychotherapy. 2006; 79:445-60.

This article was first published in the Healthcare Counselling and Psychotherapy Journal *(HCPJ Vol 9 No 1), a quarterly journal of the British Association for Counselling and Psychotherapy.*

Challenging issue

Recent media coverage of the assisted suicide controversy makes this challenge very timely and gives us much to think about. Please send your thoughts on how you might respond to the editor for possible publication in future editions of *The Independent Practitioner*. Alternatively, do you have a challenge to offer readers?

Your client discloses an act of euthanasia:

Jack has been a client in therapy for over a year. He has come with work-related stress issues and has a terminally ill mother. He disclosed, at the most recent session, that he smothered his mother in her sleep a few nights ago. You are aware that she had repeatedly asked him to help her die. He said that he could not bear to watch her suffer any longer. He says that you are the first person he has told although he wonders if the GP suspects. What ethical and practice issues might this raise for you?

News

Living with suicide

Healthtalkonline, the UK's largest online resource of patient experiences of health and illness, has launched a new section for people who have been bereaved by suicide or other sudden traumatic death. Based on interviews carried out by the DIPEx health experiences research group at the University of Oxford, and guided by an advisory panel including people who have been through this type of bereavement, counsellors, the police, coroners and health professionals, the new section has the voices of 40 people from many different backgrounds throughout the UK. *www.healthtalkonline.org 6/11/08*

Borderline personality disorder

Once a borderline, always a borderline, says **Morag Wolverhampton Fabriano**

Despite what they tell you in training, I don't mind being called 'a borderline'. I can't speak for others, of course – and in my practice I'm very careful not to label *any* clients – but I quite like it for myself. It's my badge and, bizarrely, it helps me cope. In secret – which I'll explain in due course.

I knew I was a borderline before I'd ever heard the term. And I knew I needed to do something about it, although I didn't know what. It, whatever 'it' was, was causing me too much pain.

A typical example – and a watershed event – was when I was dog-sitting for a colleague and his wife. I harboured a hope that they liked me, that I was special to them and that they trusted me to take care of their dogs and their house, so I showed up happily on the appointed day to settle myself into their spare bedroom. To my horror there were black hairs all over the pillow. I was enraged. And hurt, but mostly furious. 'OK to pick up their dog poo but not important enough to put clean sheets on the bed for, then,' I fumed to myself. Repeatedly. On and on, all night long. 'I won't even sleep in the damn bed then; I'll sleep on the floor. And I'll leave them a note telling them that and just how insulted I was at their callous disregard. And they can find some other mug to take care of their poxy house and minging dogs.' And on and on and on. These people I had thought were so wonderful were now detestable (a typical borderline 'swing') and I was devastated. I had lost them. The pain of the separation was excruciating. Had self-harm been part of my repertoire at that time, this imagined 'loss' would have caused me to do incredible damage to myself physically.

Bedding down on the floor was horribly uncomfortable, so eventually I did change the sheets and pillowcases and got into bed to continue my rant, writing and re-writing in my head the note I would leave them at the end of the week.

The following evening when I arrived – *un*happily, this time – at their house for my second night, I was mortified to find one of the dogs curled up asleep on 'my' bed and the pillow awash with the same black hairs. At the time I didn't find it funny either, and spent not a few minutes having a borderline rant at people whose dogs left hairs on beds so housesitters thought the sheets hadn't been changed and therefore felt uncared about, hurt and abandoned

> "At the time, I didn't find it funny, and spent not a few minutes having a borderline rant at people whose dogs left hairs on beds so housesitters thought the sheets hadn't been changed and therefore felt uncared about, hurt and abandoned"

PHOTODISC BLUE/GETTY

DSM-IV Diagnostic criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: do not include suicidal or self-mutilating behaviour covered in criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (eg spending, sex, substance abuse, reckless driving, binge eating). Note: do not include suicidal or self-mutilating behaviour covered in criterion 5.
5. Recurrent suicidal behaviour, gestures or threats of self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (eg intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days.
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (eg frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

beds so housesitters thought the sheets hadn't been changed and therefore felt uncared about, hurt and abandoned. Another typical borderline reaction: it's *their* fault.

It was the next day before it dawned on me that as I had not written the friendship-severing letter, this now-restored-to-wonderful couple need never know about my borderline rage attack. This realisation was, I think, the beginning of my working out a system for dealing privately, and therefore more effectively, with such pain-filled episodes.

I'm always taken aback when my colleagues make dismissive comments about borderlines. Don't they know what pain such clients feel? Yes, the pain is often self-inflicted but it's a very real pain all the same. The pain of being separated, abandoned, the vital connection broken. Don't they remember that anger is likely to be a secondary emotion, flooding in to cover up the even more intolerable feelings of hurt, fear or shame? They could be so much more helpful – and feel better about themselves as counsellors – if they could reframe unpleasant behaviours that upset professional carers as having meaning for the troubled clients, in terms of their early experiences. Those of us with personality disorders are people who do not know how to elicit care effectively from others. I hope they all read John Rowan's account of his difficulties in working with a particular client (*The Independent Practitioner*, Winter 2008). That, along with Helen Pattinson's *Idiot's guide to counselling me* in the same issue, made me think about writing this article; another view – from the other side, so to speak – but even more important, offering an account of what has helped me to cope, and what I teach my own clients who suffer from such painful feelings.

It has taken a while, a long and painful while, but what works for me is to first acknowledge to myself that I am indeed a borderline disordered personality. *Yet no one else need know if I follow my 'system'.* It's a very simple system, but it won't work without the awareness and acknowledgement of what I am. Hence my willing acceptance of the diagnosis: my badge, as it were.

The next step is much harder. It requires me to acknowledge *immediately* that I might be having a 'borderline attack' when something happens that upsets me, even when I am *100 per cent sure* that my reaction is justified and not one bit of an over-reaction. This has taken some practice, but I've become pretty good at taking my hurt away to examine in my own good time, reassuring myself that if it turns out to be genuine I can make my statement tomorrow, or the next day, or whenever. It's just that *now* is not a good time. Experience has shown me that well over half the time I *have* over-reacted, but on the occasions when I haven't, the delay in reacting has allowed me to respond calmly and reasonably, in a very adult fashion – which has invariably led to an all-round satisfactory outcome. And best of all, there is no ugly breach to heal. I haven't 'lost' a friend or relative, I haven't made a fool of myself, I haven't accused people of deliberately setting out to hurt me, and I haven't revealed what a childish tantrum-thrower I can be. Only I need know that about me.

Which is why I'm writing this article anonymously. Except that anonymity – non-existence – is so painful for me as a borderline that I've invented a gloriously flamboyant name for my writing self. Sometimes I entertain small but happy fantasies about Morag W-F becoming an acknowledged and sought-after expert on BPD. It helps me get to sleep. ■

Editor's note: *Offered for review (see page 25) is a reader on personality disorders that emphasises Morag's point of view of such disorders as the painful result of not getting appropriate attachment needs met in early childhood, and promotes more empathy for sufferers.*

Online counselling: another string to your bow?

Gill Jones explains what it is and answers some commonly asked questions

As a reader of *The Independent Practitioner* I was concerned to see no mention of ACTO (Association for Counselling and Therapy Online) in the recent list of abbreviations, and I am grateful to Margaret Akmakjian-Pitz for encouraging me to write something about online counselling. The UK is facing a recession and many independent counsellors may already be experiencing a slow-down in their client referrals, and wondering about alternative sources of income. I hope this article will answer some of your questions and point to some of the opportunities. Inside this article I have posed questions that have been asked by colleagues who are not working online. Online counselling (variously called e-counselling, e-therapy, cyber counselling etc) refers to a formally agreed counselling relationship that is conducted over the internet using text. (I will leave video/audio/picture/virtual reality and other ways of offering counselling over the internet for another time.)

Online counselling and psychotherapy has been around for several years (I have been working online since 2001) but UK therapists seem curiously reluctant to embrace it. Indeed, it has its critics. A number of therapists still do not see how counselling via the internet can possibly work, and their questions suggest there is disbelief that relationships can be made via the internet.

How can you truly understand your client if you can't see their facial expression, body language or hear the changes in their tone of voice? How can you possibly build a working alliance let alone a therapeutic relationship with someone through a computer? Is it safe? Is it effective?
Maybe there is also a feeling that 'proper counsellors' don't work in this way.

Let us remember how Freud conducted many of his cases. Some of his clients lived a long way away and he treated them by exchanging letters. Is email contact so very different? Many of you will be familiar with email and will quite likely already have had email contact with clients for session scheduling or sending homework instructions or other written information. Some of you may have maintained a counselling relationship using email (eg with a face-to-face client whose work necessitated regular travel). Did you have problems writing such emails? Is conducting an entire relationship with someone whom you never meet face to face going to pose more challenges? My answer to this last question is yes, it probably is going to be more challenging (just as any new skill is a challenge) but it is possible and can have advantages both for you and your clients.

How do you schedule online counselling appointments?
Online counselling takes place either asynchronously/not in real time (eg email) or synchronously/in real time (eg live/chat session). Asynchronous online counselling uses an exchange of emails written at different times to suit the individual. A live online counselling session takes place when you and your client have made a prior arrangement to be at your computers at the same time and are both using the same (agreed) chat programme. What each of you types into your computer appears simultaneously on both your screens. Many online counsellors use a mixture of email and live sessions with their online clients.

How does an online counsellor know how their client is feeling/behaving just from their writing?
As an experienced online counsellor you will have found ways of assessing your client's state of mind from their writing. You will be alert to variations in writing style, pacing, vocabulary – even silences. What the client responds to or ignores in a counsellor's enquiries can also be helpful to the work. In their reply, an online counsellor will create Rogers' conditions of warmth, empathy and unconditional positive regard through their writing, in order to build an online working alliance with the client. Psychological connectedness is abundantly present in online counselling as the written word focuses the content of a session both for counsellor and client so the online counsellor does not particularly need to promote or maintain it.

IMAGESTATE/ALAMY

Where can you learn these online counselling skills?
There are a number of specialist training courses in the UK for counsellors who are planning to work online: the main ones (which are all conducted over the internet) are listed at the end of this article.

What are the advantages of online counselling?
Online counsellors do not have to leave the house. They can write emails when it suits them (early mornings are a popular time) and can fit their online work around other daily tasks and routines. Similarly, online clients do not have to go anywhere to access their counselling and can arrange a session to suit themselves. They can write to you in the middle of the night if they wish, knowing you will respond at an agreed time. This flexibility makes it ideal for young mums caring for small children, anyone who has to make complicated arrangements to attend a counselling session, and for those who work shifts or who, for any other reason, find attending regular sessions difficult. It is also useful for those who are hard of hearing or who have speech problems such as stuttering, as working with text allows them to articulate their issues with fluency and to be immediately heard and understood.

What other advantages are there for the online client?
For some clients, the anonymity of the internet is helpful. Some online clients have said that things which can be hard to talk about, such as sexual abuse, can be discussed more easily with an online counsellor because they feel relatively anonymous and 'safer' from their counsellor's reaction. Some online counsellors who might have to work hard to achieve equality in a face-to-face relationship – perhaps because of their counselling setting or the way they talk – find that equality is already established and none of these audio/visual hurdles need to be navigated when they work online.

What about the disadvantages. How do clients know they are contacting a 'proper counsellor'?
Well, there is nothing to stop anyone setting themselves up as an online counsellor with a website and fake credentials (or as a face-to-face counsellor, for that matter). For this reason, a group of UK online counsellors, the majority of whom are BACP accredited, set up the Association for Counselling and Therapy Online (ACTO) to inform and educate the public about online counselling and to provide mutual help and support for its members (many online counsellors work from home and contact with others in the online world is important). All members' qualifications are checked and a client who wants to verify the credentials of a potential online counsellor in the UK can ask if they are a member of ACTO. BACP guidelines for online counselling recommend that online counselling

Association for Counselling and Therapy Online http://acto-uk.org

ACTO, the Association for Counselling and Therapy Online, was set up in 2006 as an umbrella organisation for counsellors, psychotherapists and psychologists who did their basic training in the UK and who work online. BACP did not feel there were sufficient numbers to set up a division for online counsellors but it was felt that those of us who do work in this way needed a 'home'. Working online can feel very isolating without ready access to colleagues who work in the same way, especially for people in private practice.

The International Society for Mental Health Online (ISMHO) has been in existence for much longer but is very US-centric and we felt a British-based association was needed for those who work within the UK therapeutic tradition.

For a very modest membership fee ACTO offers access to a discussion forum where members can share experiences and information and learn from one another. There is a newsletter that contains not only information about what has been happening within the organisation but also details of current and future developments in online therapy. There is also an online peer supervision group that is much appreciated by those who take part in it.

Recently added services include offering one-off supervision to anyone who would like an alternative opinion on a counselling situation or to those whose regular supervisors are temporarily unavailable; and an online bookshop with a link to amazon.co.uk.

Our members tell us how much they enjoy being part of our friendly and dynamic group. The forums may be especially helpful to those who are just beginning to work online, or who do not undertake a great deal of online work, as they can seek advice or information from those who do it all the time.

The ACTO website is at: http://acto-uk.org. Please feel free to pay us a visit and see what's on offer!

is suitable for experienced rather than beginner counsellors and that training for such work is desirable.

Is online counselling effective?
Some informal research was carried out in 2002 by the Clinical Study Group of the International Society for Mental Health Online, which showed that help via the internet can be extremely effective. The study can be found on the society's website (www.ismho.org/clinical_case_study.asp). More research studies are being conducted into online counselling, many of them using UK online counsellors as research subjects.

If you want to find out more about online counselling, consider attending the first ever conference |to address this subject, to be held at Leicester University on 25 April 2009. Called 'Online counselling and therapy in action' (OCTIA), its aim is to present a picture of what is happening in the online counselling world. If you are curious, watch for advertisements in the February and March issues of *therapy today* or visit the conference website at: www.octia.org.uk.

If you are still sceptical about working online, you could try a session as an online client. The ACTO website contains a directory of therapists, who would be delighted to offer a single (paid) online counselling session to someone wondering if working online as a counsellor is for them. ■

Gill Jones MA, MBACP is a senior accredited counsellor, founding chair of ACTO (2006/8), and course director at Counselling Online Ltd. Gill is a co-author of Online counselling: a handbook for practitioners *(Palgrave, 2008). Email: gill@gjcounselling.co.uk.*

UK organisations offering specialist training for online counsellors
■ Counselling Online Ltd: www.onlinetrainingforcounsellors.co.uk/
■ Online Counsellors: www.onlinecounsellors.co.uk
■ OCST: www.ocst.co.uk

For your toolbox:
10 steps to happiness

If happiness is born out of optimism, here are the 10 most important steps to get you started, gathered from some of the great optimists in the world. Adapted from an article by Max Kirsten, published in *The Times*

1 Treat yourself kindly. Accept occasional negative feelings as normal and that if you let them, they will pass.

2 Listen carefully to your self-talk. When you can catch yourself in full negative mode – blaming yourself, blaming others, exaggerating situations or panicking – observe these negative thoughts and the thoughts and feelings they give rise to.

3 Notice how this inner chatter makes you feel. Would you talk that way to someone else? Would you let someone else talk to you like that?

4 Take responsibility for your feelings. Your feelings, however they started, happen inside you and only you can decide how to react to them. This is the first principle of optimism.

5 Think about what you can do to help others, if you don't already. A nice benefit of this is that you start forgetting about yourself.

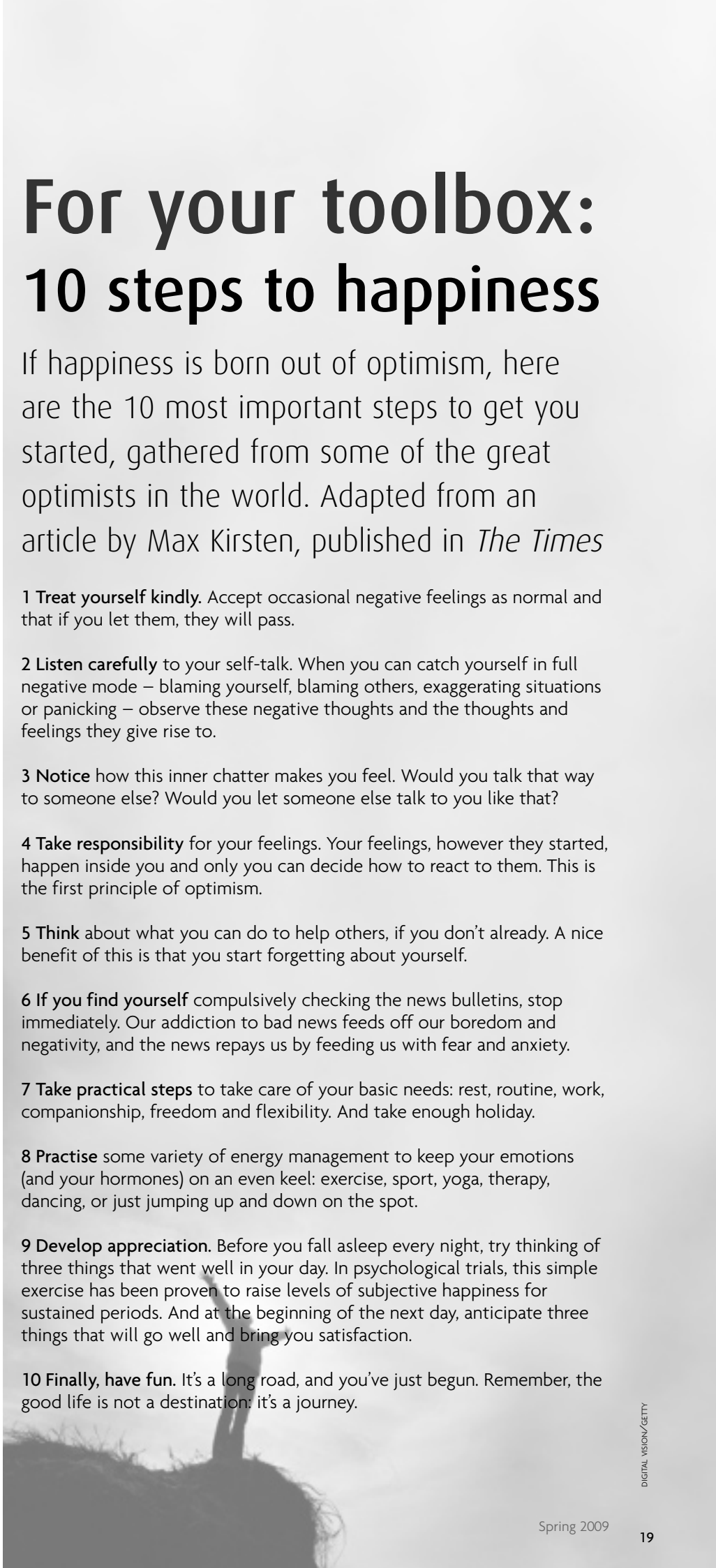
6 If you find yourself compulsively checking the news bulletins, stop immediately. Our addiction to bad news feeds off our boredom and negativity, and the news repays us by feeding us with fear and anxiety.

7 Take practical steps to take care of your basic needs: rest, routine, work, companionship, freedom and flexibility. And take enough holiday.

8 Practise some variety of energy management to keep your emotions (and your hormones) on an even keel: exercise, sport, yoga, therapy, dancing, or just jumping up and down on the spot.

9 Develop appreciation. Before you fall asleep every night, try thinking of three things that went well in your day. In psychological trials, this simple exercise has been proven to raise levels of subjective happiness for sustained periods. And at the beginning of the next day, anticipate three things that will go well and bring you satisfaction.

10 Finally, have fun. It's a long road, and you've just begun. Remember, the good life is not a destination: it's a journey.



DIGITAL VISION/GETTY

Professionalism and supervision: preparing for the future

Alun Jones shares his experience of the AIP conference last November

The day was organised with the aim of examining developments and raising the profile of the role of professional supervision as integral to counselling and psychotherapy. The conference was therefore timely in the light of forthcoming regulation and the Government's Improving Access to Psychological Therapies (IAPT) initiative. Conference hot topics therefore were concerned with the delivery of effective professional supervision, risk management, snags, dilemmas and regulatory issues concerning psychological therapies and the role professional supervision might play in ensuring good professional practice.

Professional supervision can be likened to work discussions designed to explore issues related to effective professional practice. Professional supervision is not a psychological therapy and unlike psychological therapists, supervisors will not be regulated by the Health Professions Council (HPC). However BACP considers professional supervision important in terms of fitness to practise. This conference consequently offered opportunities for healthcare professionals to become more attentive to issues related to the practice of professional supervision.

Heather Fowlie, head of the transactional analysis department at the Metanoia Institute, started the day with an amusing and highly informative keynote presentation throughout which the audience was invited to participate in various exercises designed to help think about challenges concerned with professional practice. This was a very successful and innovative approach to a keynote presentation and although an hour long, it left me wanting more from Heather.

Throughout the day various conference presenters explored different aspects of professional supervision in small group workshop format. There were four workshops available to delegates although it was only possible to attend two (I attended workshops 1 and 2).

Workshop 1
Super-vision: can you see what you need and do you need what you get?
This workshop was organised by Kathy Raffles who is an independent practitioner working in Somerset. The tasks set out for participants were to identify issues relating to supervisor qualities, and constraints and practicalities involved with providing professional supervision.

Kathy outlined the following points for the group members' consideration:
- supervisor qualities
- constraints and practicalities involved with providing professional supervision
- current professional needs
- supervisory support in relation to fitness to practise.

Kathy provided the workshop group with an insightful and novel approach to examining aspects of professional supervision. Following a number of role plays by Kathy, group members were invited to think carefully about some complex and testing human dynamics and ethical concerns associated with the delivery of professional supervision.

Kathy Raffles is a competent teacher and group facilitator. As an educator I was impressed with the teaching methodology she planned for the workshop and the clearly set-out aims and objectives. The experiential nature of the session not only provided a potent learning experience but also enabled group members to work together in an agreeable and efficient way. Because of Kathy's professional skills the group quickly settled and felt comfortable with and energised by the various exercises.

Kathy also provided group members with comprehensive and visually pleasing study aids for later reference. Included was a helpful list of questions a supervisor or supervisee might wish to ask themselves in relation to their professional practice.

Workshop 2
Fit for purpose: competencies in counselling supervision
Elspeth Schwenk, a BACP accredited independent practitioner and supervisor specialising in workplace counselling supervision, training and consultancy, facilitated this experiential workshop. Again, this was an entertaining teaching session directed by a very talented group

facilitator. Elspeth encouraged the workshop group to examine some of the developmental needs of a professional supervisor across a range of professional practice including establishing and maintaining boundaries and recognising areas of accountability in practice.

Elspeth described the aims of her workshop as encouraging group members to examine together the developmental needs of a supervisor including ethical awareness, wellbeing and ongoing professional and personal methods of support.

Much lively debate took place among group members about difficulties in achieving a work-life balance as well considering the challenges presented to supervisors by the demands placed on them to maintain an effective professional knowledge base.

Workshop 3
Risk management – avoiding the pitfalls
Steve Johnson and Philippa Weitz (representing Howden Insurance, sponsors of the conference) facilitated this workshop. They encouraged participants to explore the risks faced by counsellors and psychotherapists that form an inherent part of their professional practice. The workshop also examined the legal and ethical implications of some common oversights made by counsellors and psychotherapists. Although I was unable to attend this workshop, comments from delegates suggested that it was extremely useful to consider common pitfalls in professional life and it was presented in an innovative and interesting format.

Workshop 4
Regulation and supervision
This workshop, by Christina Docchar, project manager for supervision and continuing professional development at BACP, offered an overview of progress to date concerning the statutory regulation of the profession, including an explanation of BACP's contribution to this important area of professional practice. With forthcoming Government directives in mind, the workshop examined ways professional supervision might fit well within statutory regulation. Accordingly the workshop considered the latest professional supervision developments and how they might impact BACP as an organisation along with its members.

The final presentation of the day was by Colin Grange, a past Chair of the Employee Assistance Professionals' Association (EAPA). Colin explained the role of EAPA as it relates to independent counsellors providing healthcare to UK and international organisations.

The conference contributors were introduced by Val Potter, a past Chair of BACP and an experienced counsellor, who skilfully chaired the day's proceedings and set the tone for the scholarly gathering that followed, as well as providing a thoughtful conclusion for delegates to ponder on the journey home.

Conclusion
BACP describes AIP as 'an interesting, friendly and welcoming division of BACP that is easily accessible. We aim to provide you with a sense of professional belonging.'

In my opinion the conference organiser, Katy Hobday, succeeded in arranging a day that offered a warm and friendly environment within which to meet and exchange ideas with fellow healthcare professionals as well as explore critical issues related to effective and safe professional supervision.

As a whole, the day provided occasions for learning through experience and reflection and so mirrored the competencies required to undertake effective professional supervision. Delegates I spoke to throughout the day agreed that the conference had succeeded in meeting its aims and objectives in pleasant and comfortable surroundings.

The conference provided valuable opportunities for exploring issues relating to the role of professional supervision in counselling and psychotherapy. Although organised with independent practitioners in mind, this conference and others to follow would provide a helpful forum for all healthcare professionals interested in developing skills and competencies concerning psychological therapies. Thank you AIP and BACP!

Delegate feedback
Of the 83 people at the conference, 95 per cent of whom were counsellors/psychotherapists, 44 (53 per cent) returned completed evaluations.

The group was 19 per cent male and 81 per cent female, with 19 per cent in the 36-54 age bracket and 81 per cent 55 or older.

Unsurprisingly, 62 per cent of delegates were from London or the South East; 18 per cent from the Midlands and the North West. One hundred per cent of the evaluators thought the conference was good value for money.

Average satisfaction ratings (where 1 is unsatisfactory and 5 is completely satisfactory):

Pre-conference administration	4.4
Level of service received during the conference	4.5
Food	3.6
Venue	4.2
Overall impression of the event	4.3
Speakers (content)	4.0
Speakers (presentation)	4.1

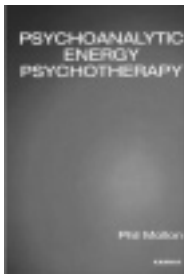
Overall, the conference was well-received by all attendees. AIP is currently in the planning stages for a 2009 conference and welcomes suggestions for content, presenters etc from all AIP members. Please contact Justine Oldfield Rowell (contact details on page 1).

Book reviews

Psychoanalytic energy psychotherapy

Phil Mollon

Karnac 2008
ISBN 978-1855755666 £29.99



Despite its rather off-putting title, this book of nearly 500 pages is relatively easy to read. It comes with the back cover endorsements of Valerie Sinason, Asha Clinton and Tapas Fleming (founder of the Tapas Acupressure Technique, TAT), and begins with a refreshing disclaimer of what psychoanalytic energy psychotherapy (PEP) does not claim to be.

I was motivated to read the book after attending Phil Mollon's workshop at the BACP conference in Telford last October. I was attracted to that by the reference to eye movement desensitisation and reprocessing (EMDR), as I have completed the three levels of training in that technique and am now a somewhat reluctant convert. 'Reluctant' because it seemed such a flash-and-dazzle technique, and I don't do f-and-d; 'convert' because I have seen for myself how well it can work in reducing the effect of severe and mild to moderate trauma. Phil Mollon himself seemed a very benign and laid-back character; it was hard to equate the man himself with the magic he was revealing, but magic it was. I can say that with a fair degree of certainty because I offered myself for the first demonstration and I know it wasn't 'rigged'. I know he 'reversed my polarities', though quite what that has done for my health and welfare is not entirely clear. But then, it was only a five-minute demonstration.

The whole premise of PEP is that talking simply isn't enough. The complex physiology of anxiety and traumatic stress reactions is often stubbornly persistent, despite therapeutic exploration in both conscious and unconscious areas of the mind. Says Mollon: 'In the case of severe trauma, talking can stir up the emotions and associated bodily disturbance without providing any resolution – sometimes leaving the clients feeling worse.'

The developing field of energy psychology offers an entirely new perspective and gamut of techniques for locating where these traumatic patterns are encoded. They are not in the mind but apparently in the energy system at the interface of psyche and soma. PEP provides a window into the deep sources and structure of emotional currents that flow through the mind.

The book begins with a rationale for PEP and continues with an explanation ('the essence'), the history, and on to the simple beginnings: tapping points and procedures, using emotional freedom technique (EFT) as a derivative of 'thought field therapy'. There are chapters on the basic procedures in an energy psychology session and while I am not saying you can do this technique by reading the book, it does give a very thorough exposition. Certainly if you have had the training then this book is a more than adequate back-up as you begin to practise yourself.

Psychological reversal and associated resistances are covered, as are muscle testing, energy toxins, working with the chakras and some thoughts on TAT. Freud, Reich and bioelectrical energy get their own (shared) chapter, followed by a chapter questioning 'is the energy concept necessary?' This chapter provides a cognitive model of EFT.

The book concludes with case studies, followed by a look at the ethical aspects of energy psychology work and the dangers of idealisation and the illusions of knowing. I found that very reassuring. Add the references and a healthy index and you can see why it runs to nearly 500 pages.

I wouldn't say it's a 'can't-put-it-down' book but it is extremely readable. For example, in the chapter on basic procedures (chapter 5) the author talks about how the multi layers of distress are revealed as the tapping (EFT) continues:

'It is as if the layers of anxieties and other forms of distress are organised in a queue, rather like napkins in a spring-loaded dispenser: as one is removed, another is immediately at its place in the front.

'Dr Callahan has a colourful metaphor for the emergence of less intense pain after the more intense has subsided as a result of TFT. He calls this the 'tooth-shoe-lump' phenomenon. One day Dr Callahan was suffering from a severe toothache. On obtaining an emergency appointment with his dentist and receiving an anaesthetic injection his tooth pain subsided. He then realised that his shoes were too tight and were causing discomfort. After removing his shoes, he noticed that the couch he was sitting on in the waiting room was lumpy and uncomfortable. This illustrates how layers of distress emerge in a kind of queue according to their levels of intensity.'

The whole book is written at this level, which brings a somewhat difficult concept well within grasp.

Margaret Akmakjian-Pitz is editor of The Independent Practitioner

The past in the present: therapy enactments and the return of trauma

David Mann, Valerie Cunningham (eds)
Routledge 2008
ISBN 987-0415433709 £19.99

In their introduction to this rich and fascinating collection of essays, the editors write of their efforts to understand the process of enactment, which they describe as 'a bridge between the patient's transference and the therapist's countertransference'.

The book invites therapists from a broad range of backgrounds to contribute their ideas on enactment and trauma; to present the theoretical understanding of the underpinning of the process of enactment and questions arising from that; and from this to discover how practitioners hold their own and their clients' psyches intact.

These are ambitious and interesting challenges that face all of us in clinical practice at some time. The authors are attempting to understand the process of enactment in the relationship between therapist and client, not simply as a theoretical position but as a practical lived experience.

The authors represent a broad range of traditions. I agree with the editors that a common theme to the writers is that the 'therapist's unconscious process leads to a break in aspects of the therapeutic frame'. This particular phrase is a very inclusive one that allows for any tradition or theoretical position to be the frame that is broken. It seems to me to speak to the heart of the book: that whichever tradition is examined, the phenomenon that we have come to know as enactment is present.

In his paper, which consists of theoretical explanation, clinical vignettes and a discussion, David Mann explains enactment as 'joint creation new to both. Each experiences it as familiar from their retrospective pasts [with] neither participant conscious of what is going on at the time.'

His points bring to mind how much is reliant on the relationship rather than on the individuals or their theoretical stance. This point is picked up by Valerie Cunningham with reference to Carl Rogers, describing enactment as 'a mutual desire to remember traumas in order to resolve the ongoing effect of them'.

She places the work on enactment in the emerging relational model of transactional analysis. She reminds us of our interconnectedness, which put me in mind of the work of humanistic psychologist Brian Bates in his exploration of ancient British shamanism.

The editors acknowledge that not all enactments are beneficial. Some affect therapy in negative and destructive ways but generally speaking, the articles focus on what is to be gained from looking at the disruptions – the place where the personal issues of the client and the therapist become unconsciously entwined.

For example, in his article, therapist Bill Cornell writes about enactment from the position of being a client. His is a sensitive account of the value of such personal disclosure by a therapist and the competing theoretical standpoints such a stance provokes. Writers such as Yalom and Casement are well known for writing about their therapeutic relationships with their clients; here Cornell combines that style with theoretical commentary about his process as a client. It is a strength of the book that it offers the practitioner an insight into a private world that cannot be seen unless offered in this way.

How successful have the editors been in their aims? Subjectively, I found the book engaging and thought provoking. I see it as a potential tool for peer supervision groups, perhaps discussing a chapter at a time. I found it an interesting if chewy read.

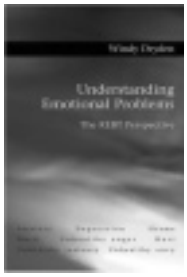
On reading the articles, I am struck again and again by the courage of the writers and their willingness to share their experiences, exposing their process: 'it is through the therapist's vulnerability that their unconscious participation can be so receptive'.

What a gift of a book. Honest, effectively theorised self-revelation, without shame or defence, by experienced practitioners; accessible chunks of narrative and chewy, interesting, joined-up theory. A good book to dip into as well as to think deeply about the interconnections between theory and practice and how that plays out in real lives in real therapeutic relationships. Not a light read but an enlightening one.

Sandy Hutchinson Nunns MBACP is a psychotherapist, counsellor and independent trainer. She offers therapeutic writing workshops and supervision for writers, counsellors and therapists. shnunns@hotmail.com.

Understanding emotional problems: the REBT perspective

Windy Dryden
Routledge 2009
ISBN 978-0415481977 £17.99



Windy Dryden has written a concise and informative book on how to understand the eight major emotional problems that clients present with, using rational emotive behaviour therapy (REBT). The core of the book tries to understand these problems/ symptoms by dissecting each disorder and breaking it down, so the therapist and the client can understand

together what is behind the symptoms and thus provide a base/foundation to move forward with an effective treatment.

Each chapter presents a new emotional problem: anxiety, depression, shame, guilt, unhealthy anger, hurt, unhealthy jealousy and unhealthy envy. The format allows the reader to compare and contrast the similarities and differences between the problems.

I found the language accessible, but as I do not work within the REBT model, I found the concept confusing at times and had to re-read parts to take in fully what the beliefs and inferences were in relation to each symptom.

This would be an excellent reference book or something to dip into when a client has any of these symptoms, as it provides a more cognitive way of looking at the reasons for the disorders.

The strengths are that it is not too academic in tone and it is straightforward. Each chapter has an overview of the basic premise of the REBT core beliefs in relation to the disorder, so that the reader is reminded gently to commit the information from the short- to the long-term memory. It works: by the end of the book I had taken on a new model of thinking, which I will integrate into my practice with clients.

The book would suit a trainee in psychotherapy/counselling or a practising therapist, but I would think the layperson would struggle with some of the concepts and ideas without any basic knowledge of therapeutic language.

The design of the book means it will remain in the specialised field of psychotherapeutic interventions rather than in the self-help section of the bookstores. This is probably wise, as the book works best in partnership with the therapist and the client, rather than a quick take-away-and-cure-myself philosophy. This is not a fast-food book for amateurs, rather a delicate and delicious appetiser that can feed the reader who wants to taste the delights of REBT, with the more main course being depression, anxiety and so on.

The book includes further reading examples for those who want to digest more on effective treatments for each disorder from the academic to the self-help aficionado.

Kate Lacy MBACP is a school counsellor and integrative therapist in private practice. www.katelacyspace2talk.co.uk

Beyond fear and control – working with young people who self-harm

Helen Spandler, Sam Warner (eds)
PCCS books 2007
ISBN 978-1898059875 £16

Rather than being targeted at a specific sector of professionals, *Beyond fear and control* is aimed at all those working with young people who self-harm.

Part One, entitled 'Working alongside young people', focuses on informal support and support within a residential community setting, and includes a chapter portraying one young girl's experiences within a hospital environment. I found the chapter on the work of a social action group to be interesting, if only because the authors grouped together people who self-harm with young people who are suicidal, when in my experience self-harm is the opposite of suicidal intent – a coping mechanism that many people have described as something that 'keeps them alive'; about 'living' rather than dying.

Part Two, on 'Abuse, oppression and self-harm', focuses on the reasons behind self-harm, with a chapter dedicated to the difficulties and added dangers faced by self-harming people who dissociate. There is a great deal of emphasis on abuse and trauma leading to self-harm, and I found this rather misleading as many young people from stable backgrounds turn to self-harm, and their needs (and distress) should not be overlooked. A chapter dedicated to borderline personality disorder raises some good points about the prejudiced treatment young people with a borderline diagnosis face. A further chapter highlights the impact of racism and the often unique problems faced by young black people who self-harm.

Part Three, entitled 'Strategies of survival', discusses the choices available both to young people and the professionals who work with them. One chapter, on self-injury and the law, reflects on how the choice to self-harm can be restricted, especially within residential settings, including prisons, where tools may be removed or banned. Another chapter, on harm minimisation, may be useful, but it focuses mainly on the experiences of one person whose self-harm is severe rather than offering much in the way of practical advice as to how harm minimisation can help all people who hurt themselves, irrespective of the severity of injury.

Beyond fear and control covers some excellent subjects. As a service user, I feel that it endeavours to cover too many themes and to reach too many people to have real depth. Nevertheless, it could well be a good introduction for counsellors and psychotherapists who want to learn more about the importance of empowering young people who self-injure.

Jules Martin is a director of FirstSigns: www.FirstSigns.org.uk. For more information on the work of FirstSigns, see the article on page 10.

This review first appeared in the January 2009 issue of HCPJ.

Books available for review

Contact the editor (details p1) if you would like to review any of the following books. Guidelines are provided and the book is then yours to keep in return for the review.

Personality disorder: the definitive reader
edited by Gwen Adshead and Caroline Jacob. Jessica Kingsley Publishers, 2008.
A comprehensive and accessible collection of 14 classic papers that address the impact of working with people with personality disorders.

Being white in the helping professions. Developing effective intercultural awareness
by Judy Ryde, foreword by Colin Lago. Jessica Kingsley Publishers, 2009.
The author challenges white helping professionals to recognise their own cultural identity and the impact it has when practising in a multicultural environment.

Systemic therapy and attachment narratives. Applications in a range of clinical settings
by Rudi Dallos and Arlene Vetere. Routledge, 2009.
Practical guidance for mental health professionals including family therapists, child, adolescent and adult psychotherapists, clinical psychologists and social workers, enabling them to apply this approach in a range of contexts.

Art therapy exercises. Inspirational and practical ideas to stimulate the imagination
by Liesl Silverstone, foreword by Brian Thorne. Jessica Kingsley Publishers, 2009.
80 tried-and-tested exercises with guidelines for applying them and advice for devising new ideas.

Beck's cognitive therapy (the CBT distinctive features series)
by Frank Wills. Routledge, 2009.
Explores the key contributions made by Aaron T Beck to the development of cognitive behaviour therapy.

Letter

Dear Editor,

As a recently joined member of AIP, I was reading your journal with interest this morning, but was disappointed when I got to page 18 (the index of abbreviations) and realised you had not included the Association for Counselling and Therapy Online (ACTO) of which I was founding chair. Although we are a small group of online practitioners (many working in independent practice) who formed in autumn 2006, we have had our website (www.acto-uk.org) for nearly two years, and are in the process of organising our first conference in April 2009.

Gill Jones, Course Director, Counselling Online Ltd

Editor's note: *We apologise for this omission and urge readers to add this organisation to the winter edition of* The Independent Practitioner. *Please also see Gill's article about her organisation on page 17.*

The list of abbreviations continues with the Bs on page 28.

Quote of the quarter

He who is outside his door has that hardest part of his journey behind him.
– Dutch proverb

Patricia Justice

It is with great sorrow that we report the death of BACP Fellow Patricia Justice on 5 February 2009. Pat was a long-time member of AIP and PRG, including several years on the executive committee and a term as deputy chair. Her dedication, humour, courage and general *joie de vivre* will be much missed by her colleagues, friends and clients. The summer issue of *The Independent Practitioner* will carry a longer tribute to Pat. If you would like to contribute your memories of Pat, please contact the editor at the address on page 1.

Spirituality and counselling in independent practice

Counsellors interested in spirituality will find much of interest at the APSCC annual conference, says **John Eatock**

Are you concerned about the issue of religion in the lives of your clients, about spirituality and its place in the health of your clients, about where ethics fits in, and about having a holistic view of health in your counselling practice? If the answer to any of the above is 'yes' then maybe you should seriously consider attending the APSCC conference this year.

The search for meaning is inevitably one of those themes (if not *the* theme) that underlies every encounter a counsellor has with a client. It is there just below the surface and yet it is not always brought out into the open. If it involves religion, the way a person behaves and their underlying ethical stance, then maybe we need to give it more attention.

What is your own spirituality about and where does it fit in to your counselling practice? Do you follow the old Freudian line and see all religion as 'projection' and avoid it like the plague? Do you struggle with a spirituality that does not involve a god; and what do you do when your client is overtly demonstrative of their spirituality? How does it all fit into your current practice?

The NHS is increasingly taking into account the place of spirituality as an integral and important part of a person's health. In 2003, NIMHE and the Mental Health Foundation published *Inspiring hope: recognising the importance of spirituality in a whole person approach to mental health*[1] and they are about to publish a new document, *Commissioning guidance on spirituality and work with faith communities*[2]. There is much else to read on spirituality and counselling but I wonder if you feel a certain lack of knowledge or skill in this regard? If so, then maybe this year for your CPD you might consider looking at the place of spirituality in your current practice.

The APSCC conference? You may not have heard of APSCC – the Association for Pastoral and Spiritual Care and Counselling. It is one of the lesser-known but fast-growing divisions of BACP and it aims to deepen the awareness of all counsellors as to the importance of issues of meaning and spirituality in clients' lives. We are currently engaged in a research scoping exercise looking at the considerable amount of work done in the last 10 years on the spirituality/psychotherapy interface, work that is often little known among counsellors. Of course, these issues are not only important for clients but for practitioners too. In a recent survey 90 per cent of BACP members said that they were interested in spirituality and that must include counsellors in private practice.

We cannot promise to give the definitive answer to this 'spirituality' issue but we can promise you a lively conference where we will open up this neglected area. There are five workshop strands:

- spirituality and assessment
- spirituality and supervision
- spirituality and pastoral care
- spirituality and ethical practice
- spirituality and training.

One of those probably concerns you, and there are some promising and interesting keynote speakers. The conference is at the very pleasant Royal Agricultural College, Cirencester, Gloucestershire on 30 June and 1 July – come to both days or just one, or arrive the night before. For more details email kathy.roe@bacp.co.uk or telephone Kathy Roe on 01455 883390. ■

John Eatock is BACP's lead advisor for counselling and psychotherapy in spiritual and pastoral care. john.eatock@bacp.co.uk

References

1 Gilbert P, Nicholls V. Inspiring hope: recognising the importance of spirituality in a whole person approach to mental health. Leeds: NIMHE/Mental Health Foundation; 2003.

2 NIMHE. Commissioning guidance on spirituality and work with faith communities. Leeds: NIMHE; forthcoming.

APSCC Conference, Cirencester: 30 June-1 July
Work in Progress Forum

We invite participants to contribute accounts of work in progress, particularly ongoing research, in a poster format with a brief (three-minute) presentation. Topics related to the conference theme **'Acknowledging the spiritual client: an ethical essential?'** are particularly welcome. If you wish to offer a contribution, please complete this form, cut it out and send it in with your booking form. For booking forms and further details please email kathy.roe@bacp.co.uk. There will only be time for five presentations so it may be necessary to decline a contribution.

I wish to offer a contribution to the conference:
Please give a brief title and description of your proposed contribution. The information will be used in publicising the forum during the conference.

.....
.....
.....
Name: .....
Address: .....
Phone: .....
Email: .....

If you require any equipment to deliver your three-minute presentation please specify here:
.....

bulletin board

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

Gloucestershire/Hereford/Gwent MBACP(Accred) counsellor and experienced supervisor. Integrative CBT. Reduced rates students/low income. Tel Doris Bottoms 01594 839317/07768 595301 enquiries@mindatrest.net.

Stockport/Greater Manchester Experienced supervisor/psychotherapist. Extensive experience of working in the statutory, voluntary and private sector. Tel Pat Megram 0161 483 3726 patricia.megram@ntlworld.com

Independent practitioners sought to pin FREE notices on *The Independent Practitioner* bulletin board. Notices should fit under the headings Networking, Placements, Research or Supervision and be no more than 30 words in length. To place a notice in the next issue email makmakjianpitz@googlemail.com before 15 April.

cut out and keep

Abbreviations

We continue – with the Bs – our quarterly column of professional abbreviations relevant to counselling and psychotherapy. Websites, where appropriate, are included for your information.

BAAF British Association for Adoption and Fostering
www.baaf.org.uk

BAAM British Association of Anger Management
www.angermanage.co.uk

BAAT British Association of Art Therapists
www.baat.org

BABCP British Association for Behavioural and Cognitive Psychotherapies
www.babcp.com

BADth British Association of Dramatherapy
www.badth.org.uk

BAOT British Association for Occupational Therapy
www.cot.co.uk

BAP British Association of Psychotherapists
www.bap-psychotherapy.org

BAPCA British Association for the Person-Centred Approach
www.bapca.org.uk

BAPPS British Association for Psychoanalytic and Psychodynamic Supervision
www.adbapps.freeserve.co.uk

BAPT British Association of Play Therapists
www.bapt.uk.com

BASRT British Association for Sexual and Relationship Therapy
www.basrt.org.uk

BASW British Association of Social Workers
www.basw.co.uk

BATHH British Association of Therapeutical Hypnotists
www.bathh.co.uk

BCMA British Complementary Medicine Association
www.bcma.co.uk

BDD Body Dsymorphic Disorder

BDI Beck Depression Inventory

BED Binge Eating Disorder

BERA British Educational Research Association
www.bera.co.uk

BFS British Fertility Society
www.britishfertilitysociety.org.uk

BHF British Heart Foundation
www.bhf.org.uk

BHMA British Holistic Medical Association
www.bhma.org

BICA British Infertility Counselling Association
www.bica.net

BID Bellevue Index of Depression

BMA British Medical Association
www.bma.org.uk

BMJ British Medical Journal
www.bmj.com

BPA British Psychodrama Association
www.psychodrama.org.uk

BPAS British Psychoanalytical Society
www.psychoanalysis.org.uk

BPC British Psychoanalytic Council
www.psychoanalytical-council.org/main

BPD Borderline Personality Disorder

BPS British Psychological Society
www.bps.org.uk

BPT Body-oriented Psychological Therapy

BRCP British Register of Complementary Practitioners
www.i-c-m.org.uk

BSA British Sociological Association
www.britsoc.co.uk