up front

When we sit down with clients we are hoping that we can provide something that will help them find their way to a better place in their lives. Change is such an important part of life and yet we tend to take a step back from it and at times can see change as totally threatening. A strange mix! Somehow our clients – and perhaps we too – have acquired the idea that change is frightening or at best endurable. Those who fully embrace change are not so often seen among our clients.

This isn't new knowledge, but it was brought home to me how important it is to find a way to accept that change isn't always dreadful, at least not in the long term. There was a meeting of the AIP Executive in which this edition of *The Independent Practitioner* was discussed. We chose to honour someone who brought change to the lives of a great many people, enabling them to move on with their lives after enormous change had occurred.

Pat Justice was among the early counsellors who set up the then BAC and had a hand in the creation of Divisions. Those were times of great change and she found herself more than equal to the challenge. Her outlook was elegantly simple. Her way of life brought her into contact with a lot of challenges, working with very traumatised victims of all kinds. These people needed change somehow, to find their way to a new and better place within themselves, and Pat was the person who knew more than most how to bring that about.

We have dedicated a part of this journal to our memories of Pat, who died earlier this year. The Executive have worked through changes brought about by Pat's illnesses and ultimately death, her family are still doing so, as are her friends, spread around the globe and all with a story to tell.

Regulation will bring change and I hear people talking about how frightening that change already is to them. In reality it means that counselling is alive and well; that there are enough people touched by it to seek government approval for regulating it.

Like us, like Pat's family, it is something we need to work towards and to work for whatever change will bring us. If you have worries or concerns about regulation and how it will affect you as an independent practitioner, please send them to Margaret Akmakjian-Pitz, our journal editor. All questions are valid, and will be given space for debate. We don't offer answers, but we can find out more, and alert those at BACP currently working on regulation to things specific to our Division.

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 July 2009.

Letters

Dear Editor,

I just wanted to register my concern about the tone and content of the article I have just read in *The Independent Practitioner* ('The open secret', spring 2009).

I am an independent practitioner myself, having worked in private practice for many years. To summarise, I found Emily Brown's labelling of the person having the affair as the 'infidel' somewhat judgmental and perhaps rather revealing about her, since the primary use of the term is for someone who believes something different from the speaker!

The whole article seems to be based on the premise that having relationships, in this case sexual in nature, outside of one's marriage is wrong, and needs intervention and 'treatment' to put the individual and the marriage back on the 'right tracks'. I wonder whether Emily herself is explicit with her clients about what she thinks and feels about the right and wrong way to behave in committed relationships, as part of her initial session with her clients. I hope she is, so that they have an opportunity to find somebody else to work with if they so choose.

Obviously, the reasons people have relationships outside their main relationship can be very complex, and people might at points benefit from exploring some of these complexities in a therapeutic setting, but surely most usefully with a therapist who is open to a much wider definition than Emily seems to have, of what is and isn't an acceptable way to lead one's life. And as for the therapist 'colluding with the infidel', surely it is for the client in question to decide for themselves whether or not they want to reveal another relationship to their spouse. This is surely not for the therapist to decide. Clearly, if a therapist is uncomfortable with a client's agenda for any reason, then the most honest thing to do is to discuss it in supervision and not pretend to the client that they are at ease, since I cannot see how they can be offering the best service to the individual/couple in question if they are not. Indeed, it appears that this is what Emily does, but my concern would be how she does this and what her clients are left with when she stops working with them. Do they feel judged by her? Frankly, I cannot see how they wouldn't. Clearly there is no point pretending that, as therapists, we enter into relationships with our clients free of our own belief systems and free of judgment. But surely it is for each of us to scrutinise our own thinking and feeling, and examine our own triggers, rather than impose them on our clients, who rightly expect more of us.

I would imagine you included this article in your journal to provoke discussion and I sincerely hope that it does that.

Yours sincerely,
Cordelia Galgut

Editor's response: *All articles published in* The Independent Practitioner *reflect the author's viewpoint, rather than any official AIP stance. Provoking discussion was not my primary motive. This article was originally published in a California therapy journal and I thought it would be interesting to see how our profession operates in the US. I apologise for not making that clear. I am always pleased when anything in this journal evokes a reaction, and I thank you for your thoughtful response. MAP*

Dear Editor,

I am a member of AIP and see some interesting material in *The Independent Practitioner*, for example the recent issue on supervision. Unfortunately I can't read it as I have a visual disability.

I get *Therapy Today* on audio, and can use tape, CD or daisy book format, but appreciate that this may not be possible for a smaller journal.

I have received assistance from Access to Work and have equipment which enables me to read transmitted documents on JAWS or print them out in larger print provided that the documents are not PDF. Would this prove to be an alternative?

Many thanks,
Marion Brion

Editor's response: *After consultation with the publications department at BACP, I have arranged to send a final draft in Word as at least a temporary solution. BACP's equality and diversity officer, Ian Thompson, is currently looking into visual impairment provision so that a more permanent solution, offering a more complete journal, may be found. MAP*

Dear Editor,

Many, many thanks to Morag Wolverhampton Fabriano for her courageous article on borderline personality disorder (*The Independent Practitioner*, spring 2009). I suspect I'm one of many who also secretly wear that 'badge', and possibly with a bit more self-acceptance from now on.

Now I'm hoping there is someone out there who will write a similarly inspiring article called 'Once a bulimic, always a bulimic'.

Name withheld

How I work: multi-aspect therapy in general practice

Edwin Alan Salter shares his philosophy and style of practice

The interests and difficulties of independent practice are two sides of a coin. Those who arrive at my door are unlikely to represent the generality of distress. Nowadays I have few simple cases, for these have usually been helped in the sessions available from person-centred counsellors attached to medical practitioners, or perhaps by psychiatric nurses with a cognitive-behavioural base. Almost everyone I see has tried pharmaceutical prescriptions and most have failed with psychological therapy.

The sheer assortment of problems is sometimes frustrating. How nice it would be to have a sustained series of phobias or obsessions: lessons could be more clearly learned and applied, perhaps developments worth communicating achieved. As it is, I am forever exploring, tackling each individual and issue afresh. This article sets out some of the guiding principles necessary to function purposefully.

Beginnings

Because my own training has spread over various methodologies, I often draw on several of these to deal with problems from different perspectives. Depression, for example, may be associated with current events, poor physical activity, lack of social reinforcement, unresolved past issues, inadequate coping and planning skills, recurrent negative thoughts or distorting cognitive strategies. Any of these elements (and others, not to mention physiological/genetic factors) will suggest its own therapeutic response.

There is always the need to consider the balance of past and present factors (not least those apparent in behaviour in the first few minutes of the unfamiliar situation of arrival) in deciding a therapeutic approach. Often I take a family history and summarise it in a geneogram: much may become clear about the likely source of difficulties. With many problems this diagram is a useful aid to explanation when appropriate, for understanding reduces guilt and anger and facilitates action.

Sometimes an early decision has to be made between giving adequate practical help and a thoroughgoing treatment. Older people, for example, have less elasticity and less time, and may well be more vulnerable to the hurts of a past re-examined. Others, impatient or intolerant, can perhaps only be helped enough to keep going by a plainly relevant method. And all endings, like beginnings, need to be calculated, for there is no perfection to be achieved, only, perhaps with too much time, either dependency or error.

Roles

Faced with an assortment of problems, theories and techniques, some rationalising principles are necessary. A multi-aspect approach – as distinct from simply being eclectic – cannot be managed if every process requires total reinvention, though small discoveries are likely.

It is important to reserve the role possibilities of the therapist. For example, to begin with a somewhat distanced listening style leaves open its development toward an analytic attention and does nothing to prevent the emergence of an authoritative stance, a cooperative style or indeed a range of alternatives from the companionable to the devious or radical. Most of us will have a preferred role or pattern for ourselves: practitioners cannot help evidencing a chronological age, sex and some social identifiers, and perhaps these matter more than we like to think.

Some people have definite preconceptions about a therapeutic relationship (occasionally even hoping for a therapist who declares the same problem or at least has – rather incompetently it might be thought – much suffering to reveal). For me a transition from the expert to the cooperative often suits, but recent cases have included one starting off with a large dose of energetic expressive activity and a different long case finishing almost as a reflective companion in a philosophical dialogue. Having been a teacher I also find that role comfortable and it is often an acceptable conclusion when reviewing and explaining preventative self-help. Need and sequence guide the choice of role.

Therapies

Starting in 'failed cases' plainly urges the adoption of something new to give fresh hope and avoid an approach already impaired. So the history, including learning with due respect from the previous process, should precede declaring a stance. As work progresses there is in all cases a

continuing requirement for sequencing that is, and appears to be, purposeful.

Sometimes all the signs and symptoms seem to function confusedly in relation to the main difficulty, but eventually patterns emerge. For example, bedtime worrying may lead to late sleep, to diminished energy, to coping failures, to self-blame or avoidance by others, to a low self-concept or fearfulness, thence to a globally poor mood and to worrying: how useful if this can be interrupted at what is a possible first stage. Some methodologies define a sequence (antecedent-behaviour-consequence or whatever) to guide intervention. A vicious circle may have to be examined to find a point of attack, perhaps intrinsically easier or susceptible to a method of choice (and what is believed in may do best). A very non-verbal person may simply feel inadequate and unhelped within the kind of discourse often adopted by therapists (in a case rather similar to the worry example, being kept busy was more fruitful than thinking about thoughts). Hypnosis may be sought as a lazy way out but if requested from conviction is worth considering when applicable (as in its traditional 'ego-strengthening' use).

Combining therapies requires care. One clue comes from our ability to perceive or do two things simultaneously if they are sufficiently distinct. The same modality confuses – two aural inputs or two awkward motor outputs for example – whereas knitting and chatting are fine. Some activities are more easily bracketed off phenomenologically, and again, there is a clue in the way people can handle some brief interactions without revealing (or experiencing) a chronic condition.

If the activity is not construed as engaging obviously with the problem, it may be so much the better, as the expectations of difficulty and distress are not provoked: similarly with a task that can be routinised and carried out in a merely workmanlike manner. A simple example would be a movement prescription for short bursts of energetic activity to assist with mild depression: recently a teenager generally withdrawing from schoolwork and relationships got a useful initial lift in this way. If the treatment emphasises subjective rumination (or free association) and the recall of experience, it may be possible to interweave transformed alternatives (perhaps derived from neuro-linguistic programming – NLP) without too much disruption. For example, re-visualising more remotely, without colour or from another viewpoint will diminish impact; re-hearing in a way that reveals more about the original speaker will shift attention from a damaging message to its origin in another's damage.

Change

The essence of therapy is change, and the interlinking of aspects can help with this mobility. It is sometimes a useful liberation as a therapist to adopt (particularly in supervision) the 'aspect seeing' and imagination of aesthetics. Perhaps figure and ground should reverse; for example not going out is actually about staying in, or interpretive concepts; for example restraint and protection, are fittingly exchanged. The 'as if' of story telling or metaphor can open up alternative views. In a female-dominated family the young daughter had a baby, the household then with three marginal husbands (one deceased) – some dark tales of magical thinking finally gave insight.

Occasionally change seems very slow and one waits a long time. External circumstances may impose a period of near stasis with a good deal of effort needed simply to remain in place. Particularly welcome signs of change are insights reported by the subject, whether about self or others in relevant contexts. A jealous/envious woman has taken a year to begin to see how others are limited/suffering and so to feel less resentful/angry; and she begins to comment on herself.

A sometimes necessary question is 'What has to happen to enable change?' If there is still no answer then any change that is available should be embraced. If new relationships with the opposite sex seem unattainable, how can relationships of any kind be built and enriched? It may seem meaningless (and so be regarded as unacceptable) to wear a different colour every day, vary the routes of journeys, add one social contact however slight each week, or give up watching the late TV news. But even irrelevant changes can have consequences – the unfamiliar increases arousal and brings new interpersonal events.

Achieving any change builds confidence and a sense of control. And it implies that the sought change is also possible. To stop doing something may need a reframing tactic – a partner's social behaviour is not to be reacted to as embarrassing but can be seen as charming or bold. Or it may be necessary to build up a general competence for stopping by practice, initially with easy targets. Nowadays, with those who come because of unwanted habits, I also sometimes fly such a kite as a preliminary test for resistance.

Changes in the wider world shift all our perspectives. The beliefs and concerns of individuals, the likely harms that they suffer, and the theories and treatments available alter. The history of therapy is enmeshed with such larger events and paradigms.

Dimensions

The therapies do not arrange themselves conveniently in a single order that might guide sequencing, though they differ in their emphasis on origins and manifestations. Assigning cause to an event in early life (whether analytically, by age regression, family work or however) can be satisfying and helpful, but by itself is not curative. Equally, extinguishing a behaviour (whether by flooding, relaxation counter-conditioning, suggestion or whatever) may be more permanent and generally beneficial if it is given a context.

Although qualitatively distinct,

therapies can be ranked on various dimensions – expertise is more evident in transactional analysis than person-centred, challenge more explicit in rational-emotive than cognitive, and so on – and subjects vary in their sensitivity to such dimensions. Personal constructs appeal to careful and rational minds, drama therapies to those needing expressive force. Sometimes an admixture of tough-tender, directed-expressive, active-reflective or other polarity is more effective. Clearly this is akin to the study of personality dimensions, and it is useful as a practitioner to bear in mind one's own range on such measures (the three, four, five... N axes of alternative accounts) as well as estimating that of the subject.

Therapeutic time is conventionally measured by fixed intervals – the hour, the week – and may be divided into formal stages such as investigation, treatment, ending, follow up. But the essential dynamics of time are phenomenological, tied to the experience of the subject. Relative to my time sense, some are bothered because 'It isn't getting anywhere' fast enough while others seem happy to stay with interminable retelling.

The primary concerns of the practitioner are perhaps the nature of the task, the consequent choice of method, and the organisation of the work through time. Problems are sometimes clear and limited (or the therapist chooses to see it that way) – a phobia or a life management issue – but they too may transform and evolve. Does loneliness connect with personal confidence or conversational skills, and whence might arrogance or a lack of questions derive? What is presented as an eating issue might be almost anything (and how curious that something as clinically defined as anorexia remains therapeutically opaque). Occasionally there is deception, as though (within my experience) one could deal well with distress in a general way while the subject's concern is actually with thefts at work or a sexual desire.

Problems, like methods, have no unifying dimensions, though they can of course be assigned degrees of severity, persistence... even perhaps mapped and located in terms of cognitive, emotional, and social components.

The concerns of the subject may be seen primarily in relationship terms – with oneself and one's trouble (how this is construed depends on theory), with family and the immediate world, and with the therapist. It may be that such relationship axes partly constitute or illuminate the problem or treatment, for example if, respectively, there is focus on past actions, on systems, or on transference.

This is, of course, all simplification, but better some model than no order at all. The three-dimensional box of relationships (the subject's view of self, world, therapist – three Rs) might be imagined as progressing with changing colours through a three-dimensional space of therapy (the three Ts of task, treatment and time in the therapist's view). To pursue this image (if bearable), all would hopefully end with a lovely clear 3R cube nestled at the zero points of the 3T experience. To emphasise the simplification, it should be added that the viewpoints may be exchanged – a kind of meta-aspect seeing. Empathy requires the practitioner to be at home within (and sense the vulnerability of) the 3R relationships, and with understanding the subject will become aware of and involved in the more objective 3T progress of therapy.

Overview

Central guiding principles are necessary if a multi-aspect approach is to be manageable and to be distinguished from the chaotic or merely opportunistic. Initially, aspects spring from carefully considering the presenting problem. The whole treatment may be thought of as proceeding through a multidimensional space that is both objective and experiential. Therapist and subject have complementary but shareable viewpoints.

Multi-aspect therapy can be achieved by suitable knowledge and skill, at the simplest by matching problem features with recommended treatments in a systematic order. This does not translate as merely treating symptoms: the problem with its own internal priorities has to be understood to be properly resolved. The task can also be approached with an aesthetic attitude, requiring sensibility and imagination as well as critical analysis to guide the work to a successful conclusion. The outcome will be unique in a modest way, but thoughtful attention enables such interesting, sometimes complex, journeys to be undertaken with hope and sensible purpose.

This article (as I reconsider it) seems to have highlighted variety, but unity is above all essential for the whole to make sense. The balance between technical and 'meaningful design' cues depends on personal style – and this affects both the therapist's effort and the subsequent placing of the therapy within the life experience of the subject. ■

Dr Edwin Alan Salter worked in performing arts before travelling through education to psychology and therapy. He is based in King's Lynn (kl.humanfactors@virgin.net).

Relevant articles by the author

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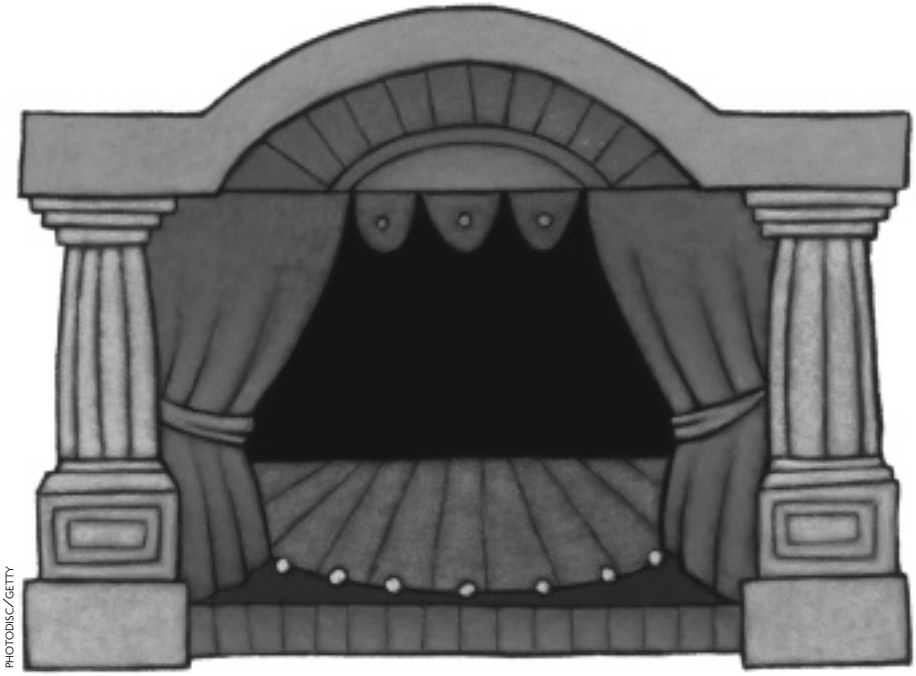

PHOTODISC/GETTY

The struggle for authenticity in the second act

Greg Madison confronts his 'black speck'

To fully wake up to living demands something other than clinical technique, self-help protocols and therapeutic homework. It requires the inspiration of art. All great art worthy of that description calls us to see the world and ourselves more clearly. The biblio-therapeutic impact of the work of JM Barrie rests in its ability to unnerve the sleepy trance of life and to resuscitate the struggle back to authentic living.

James Matthew Barrie (1860-1937) was for some years *the* pre-eminent playwright of the English-speaking world. His new productions opened with sold-out performances in London's West End and across the world. He was also in great demand as an after-dinner speaker to the great and the good. Today, apart from his most popular play, *Peter Pan*, Barrie's name has slipped from the footlights into obscurity and along with him, a precious developmental view of human existence.

In the late 1980s I spent a year studying Barrie's plays and his philosophy, under the tutelage of psychology professor Paul Swartz at university in Canada. Paul and I teetered uncomfortably at the edge of respectable academic psychology as the discipline began its demise into a narrow scientific view of human existence. While Paul's interests were perhaps better accommodated within a psychologically sophisticated English department, mine crossed into existential philosophy and psychotherapy in an attempt to comprehend my own emerging biography. Out of that year of scholarship we published a paper of our work together, *The view from betwixt and between: JM Barrie and humankind*[1]. Now, over 20 years later, I view that year of study and Barrie's warnings from the perspective of middle age and the awareness that somewhere along the line I abandoned 'myself' and aligned my unfolding future with the life less noble.

Barrie believed that life is not unlike a three-act play, but with a second act that seems to be missing. The first act lays out a trajectory of possibility that, if followed, would allow us to grow into the person we were 'meant to be'. The final act offers us an opportunity to wake up and realise that at some point in the midst of life we lost our way. In fact the second act of life is the longest and it is during this part of the play that the struggle for life occurs, largely unbeknownst to us. Barrie desperately wants to warn us about the second act, when we fall asleep for years. During the long sleep of the second act of life a 'black speck' grows within and in the fullness of time it pushes us out and assumes our place in the world. An imposter takes over the entrancing life we were meant to lead and carries us into the shadows of the murky world of wrong-headed ambition and artifice.

In an address to the young graduates of Edinburgh University, Barrie warns about getting lost in the treacherous character of that middle act: 'You may sometimes roam round the earthly tenement that once contained you, trying to get back. Perhaps you will get back. That sometimes happens... All I can assure you is that in that second act, now about to begin, something will get in which is either to make or destroy you'[2].

To maintain the 'entrancing life' is a struggle – we have to fight for it. It requires the courage to attain a sort of 'self-mastery'. Barrie himself had wanted to be an explorer, but instead his 'familiar' took him and he became a writer. As a writer, Barrie presents themes of immense psychological value, including the idea of the lost second act, the presence of a 'familiar' or interloper who takes our place, and the possibility (unlikely for most of us) of grasping a 'second chance'.

If we can muster the courage, some of us are offered second chances to return to the 'authentic' person we set out to be. Barrie repeatedly puts his philosophy into the voice of his main characters, here in the protagonist of *Dear Brutus*: 'There is something we are born with, not Fate or accident, which are outside

us, but something in ourselves that really plays the dickens with us and makes us go on doing the same sort of fool things, however many chances we get.' Can we cut this thing out? 'It depends, I expect, on how long we have pampered him. We can at least control him if we try hard enough. But I have for the moment an abominably clear perception that the likes of me never really tries'.[3]

According to Barrie, we can shape ourselves if we have the courage to control our human frailties, such as jealousy, worldly ambition, ignorance, contempt, resentment, arrogance, a thirst for power. But the black speck 'gets nearly everybody in the end if they don't look out. We all seem to be touched by it, and are perhaps sent into the world to decide for ourselves whether we are worth saving. Above all things, don't defer finding out what your particular speck is – for they vary very much – before it spreads.'[4]

The speck is with us from the beginning, the familiar enters in the second act, both work to disable our realisation of the entrancing life. The speck could be thought of as 'the base element that indulgence cultures into a surrogate self. We may understand the familiar as in turn advancing the spread of the speck, supplying the medium through which our particular liability metastasises into the whole of our living. It is the speck acting through the familiar that corrupts our second chances into waste and repetition.'[1]

Barrie was especially clear about the place that career plays in a human life. In contemporary society career and ambition are synonymous with life itself, devaluing anything that cannot be listed on a CV. Yet Barrie proclaims, 'we have all become too self-conscious about the little parts we play – they are little parts even in our own little lives'[2]. The entrancing life and worldly success seldom coincide. Professions are shallow endeavours compared to the depth of the greatest moments in life, when we battle for our very souls.

We can recognise, even from today's increasingly superficial vantage point, that Barrie was describing to us how the crux of existence is increasingly shunted to the shadows, replaced by consumerist greed and the race to get ahead. For some of us, like the immortal Peter in *Peter Pan*, there is no second chance: '... the window was closed, and there were iron bars on it, and peering inside he saw his mother sleeping peacefully with her arm around another little boy ... in vain he beat his little limbs against the iron bars'[5]. But those bars were up for life; there was no return. Peter, like many of us, was lost for ever.

The second acts of Barrie's plays are often set in a magical timeless place, like the islands of *Peter Pan, The Admirable Crichton*, and *Mary Rose*, or the enchanted wood of *Dear Brutus*. These are places of destiny, where each character faces a situation so extreme that we can see into their true nature. 'Mistakes are repeated, illusions shattered, and a glimpse inward made available. This glimpse sows the possibility of a second chance.'[1] But for some of us the battle with the familiar enemy is stacked so heavily against us that to struggle courageously and lose is not entirely to fail. Regardless of the outcome, to struggle is itself a noble act.

Courage and the speck lie side by side. Whether we nurture the virtue or the vice is a choice for which we alone are responsible. If we open the door to the vice, something sneaks in 'like a thief in the night' whereupon it waits quietly until we become used to it. Eventually we realise that little by little it has supplanted us and taken our place on the stage. When I think back to that year of study with Paul I *know* that the man I am now is not the one I was heading to be. At some point the course of that young man lost its navigation and if I were to follow back the line from the present it would not connect to him, but to some small black speck that grew into the imposter that has taken my place. We need to be constantly attuned to the great moment when we hear the faint call to turn from the inauthentic and all the glitz and glamour that the mundane world can muster. For me the speck was fed by the fear of a future designed solely by myself. A year after my Barrie studies, I sat writing the comprehensive exam that would facilitate my formal entrance into a graduate programme that I no longer believed in. With a little more courage I might have maintained my commitment to myself and to the inscrutable entrancing life that beckoned. Where would that have led me? Perhaps for you there was also a moment where out of greed, expectation or lack of courage, you veered from the enigmatic path and promise of what life could have been.

Perhaps the 'second chance' is really not to squander the first and only chance, to immediately engage the foe and its socially condoned harpies. Self-mastery is a constant struggle, beginning when we begin and ending when the verdict is inscribed on tablets of stone.

As a psychotherapist I not only see Barrie's vision played out in my own life, I also see it clearly illustrated in the deeper layers of the stories I hear each day in my consulting room. There is a shared humanity in the struggle to live an everyday life that is worthy of the human soul. Some clients search in vain to identify where their black speck came from. What happened in the first act that caused the second act to veer off into a life half lived? But redemption does not come from trying to personalise a universal. We all have a speck; it is part of our human inheritance. Perhaps for some, therapy itself offers a place, like Barrie's island or wood, where the struggle can recommence today. Where together we wage a pitched battle with whatever black specks we are sensitive to, requiring the courage to embark on the adventures that await, or turn away into obsession, addiction or, worse, 'success'.

Many of these terms, such as 'authenticity', 'self-mastery', 'soul' or even 'self' can be quibbled with. Yet for many of my clients and for

myself there is an evocative recognition in Barrie's warnings. In a profession that has arguably become too focused on symptomatic alleviation, technical intervention and 'outcomes', Barrie reminds us that it is still legitimate to talk about life itself, and the valiant struggle for self-creation. And what of each of us – did we follow the virtue or the vice along our journey to become psychotherapists? In various ways maybe we also have become too obsessed with the little parts we each play in a profession eager for social legitimacy. Perhaps it is also valid to consider that the profession itself has its own 'black speck' that has now grown into a 'familiar', and that as psychotherapists we are struggling to regain not only our own place on the stage, but essential aspects of what this profession, also, was meant to become. ■

Dr Greg Madison is a registered psychotherapist (UKCP) and chartered counselling psychologist (BPS) working in Brighton and London. He lectures on focusing therapy and existential therapy and has special interests in cross-cultural relocations and the deeper meanings of 'home' and 'belonging'.

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BACP Fellow Patricia

Friends and colleagues offer mem

From Tessa Adams

I first met Pat when she applied to do the MA in Applied Psychoanalytic Theory at Goldsmiths' College. As part of the course she contributed her professional understanding and demonstrated that she could become a valuable part of our team. In this light she was employed to lead our Introductory Counselling Course and was deeply valued by the students she trained.

Later I came to know of Pat's work through supervising her clinical case load. What always impressed me was Pat's concern for her clients and her ability to hold difficult situations with sensitivity and patience. She was insightful and able to assist her clients to find a deeper understanding of their aims and ambitions in life. She was a therapist who loved her work and who had a level of concern that brought individuals out of despair into their own creative awareness.

She will be missed for both her professional contribution and her affection for all of us who came to know her as a dedicated caring person.

From Susie Holden Smith

Pat and I met when we studied for an MA at Goldsmiths in 1995. She lived in Docklands and had been active in counselling survivors of the Docklands bombing. The experience spurred her passion for working with PTSD. Before becoming a counsellor she had run clubs and holidays for learning disabled children, and in this we found common ground. I, too, had worked in this area, but had adopted two boys with different problems. Pat's hands-on experience understanding the pain and pressure on families living with learning disability contributed to her direct understanding of my concerns. I am very grateful for her true friendship. Pat and her then husband, Nick, travelled the world, living among the natives. As a result of this she had an unconditional affinity to many different cultures. They took their young children Emma, Andre and Netta to places most of us would only dream of visiting. Pushing prams through the sand, scuba diving in the Red Sea and walking barefoot in the Australian bush, Pat's enthusiasm and detachment from her own body meant she hardly felt any pain or anxiety, or if she did she never showed it.

Pat did not take life too seriously. My memory of our graduation was throwing off our mortar boards in the toilet and singing ABBA songs. (She was the dark one.) By chatting too much in the hotel bedroom we narrowly missed her picking up her BACP fellowship at the annual conference. However, we ran like the wind (not so easy for Pat in her snakeskin high heels) and she gave a spontaneous speech straight from the heart about her work with tsunami victims in Thailand. The publishers I sat with were impressed at how she bought the evening to a lively close.

During her latter years Pat lived in a converted church in the Roman Road. There she entertained regularly and opened her door to any passing neighbour. Her Christian faith grew and she became friends with the vicar of St Paul's Church and helped to support the local community.

Pat and I talked a great deal about life and death. After an accident in Thailand two years ago where she had been forced to drive her car into a dam, submerging herself underwater and resulting in several breakages and a head wound, she wrote the following poem:

Justice, 1945-2009

ories and tributes

Kingfishers flying in the sky
From whence they come I know not I
Sit upon their wings forthwith
I fly like magic in the air
They take me to places I never dared
I'm in the heavens like a cloud
I drift and float I'm not allowed
'Tis in my mind, all my senses in my head
My body morphed into a creature instead
A loving being of the universe
An underwater fairy
That bubble beneath my heart sincere
Life is wonderful, life is great
Live it to the full before you reach that final gate.

Visiting Pat in hospital during her last days was a very special time. Her love of life meant that each day she took time to appreciate the young nurses who cared for her. Pat, forever the clotheshorse, never stopped wearing her beautiful, huge turquoise ring and earrings. My daughter Jessica, who adored her, painted her long nails purple. Her blue eyes never lost their sparkle and showed up even more with her newly grown-through short hair. Pat's three beloved children Emma, Andre and Netta arranged for a record player to play old 70s vinyls and the hospital room became a place of celebration of her life. Sergeant Pepper and the Rolling Stones lightened up the room and we all stayed on a high note.

Pat's passion for leopard-skin prints and turquoise accessories may have been interpreted as flamboyant, but beneath the wayward image beat a warm heart that reached out to many people.

She was a sixties flower child, who never lost the 'love one another – peace' slogan as a template for her life.

From Tony Hutchinson
I have many fond memories of Pat. She was a larger-than-life personality who revelled in the glare of publicity and could captivate most she met and infuriate others. She was always committed to what she did with a passion that was overwhelming and ultimately had a heart big enough to love the world.

From David Poole
I didn't really know Pat but my fleeting impressions of her are the sense of a warm, vibrant woman, always ready to encourage or contribute in a workshop setting, and a person whose openness would stimulate openness in others. Strangely, I think the most haunting memory is not something she said, but wrote. This was the account of being in the car, where she almost drowned – which was a very intense account – and probably deserved wider circulation. I think her determination shone through that, in every way. I've no doubt she'll be much missed.

From Justine Oldfield Rowell
I happened to sit next to the rather flamboyant and striking member of the (then) PRG committee in the hotel foyer on the morning of the first PRG conference I attended. It was all new to me and it must have shown, as I was then given my first experience of Pat the Passionate. I also experienced a warm and bubbly personality. I confessed to the fear I had of her which she found enormously strange, but it also brought us closeness on the committee.

I recall getting a text out of the blue one day that told me to buy a particular paper immediately. I went straight out and bought one. There, in the middle, was a double page

THE JUSTICE FAMILY AND SUSIE HOLDEN SMITH

spread about the terrible conditions at the Stonehenge festivities that year. Taking up nearly half the pictures and story were Pat and her husband, dressed in best hippy garb and almost covered in mud, but with faces wreathed in smiles of pure enjoyment, outside a mud-caked tent in almost ankle-deep ooze.

In contrast, although always flamboyant in dress and hair colour, Pat had a passion for the work she did best – working with the victims of trauma or lecturing or giving keynote speeches around the world. When I became Chair of (then) PRG, Pat became my enthusiastic deputy, someone who saw herself as our emissary wherever she went as she travelled to far-flung places, as well as someone who was willing to work behind the scenes to ensure conferences went smoothly and members were happy. She lived life deeply and passionately and it was thus reluctantly that she stood down as Deputy Chair, to enable her to raise money for those whose lives were broken and whose families were lost as a result of the tsunami in Thailand. With the money, she supplied endless training and support, and when the time was right, specialist trauma help. A quite special woman and one very loyal to all those she loved.

From Margaret Akmakjian-Pitz
Pat was awesome! I think the word 'charismatic' was probably coined with her in mind. Her life was cut short in terms of years, but I don't think anyone packed as much into 64 years as Pat did, and she lived every single moment of it, too. As far as she was concerned there are only two time zones – 'now' and 'not now' – and no prizes for guessing which one Pat inhabited. I've already missed her presence at AIP Executive meetings but it felt like a better world knowing that somewhere Pat was in it. It feels all wrong that she no longer shares our lives. ■

Brief psyc

There is a paucity of e

Michael Barkham. An

Brief psychotherapies have for some time been seen as the standard delivery model for a range of therapies. Indeed, the most recent edition of *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change*[1] does not include a separate chapter focusing on brief psychotherapies – it is viewed as the accepted model of therapy delivery sufficiently not to warrant this. The rise and rise of cognitive behavioural interventions, the accompanying research effort, and the increasing focus on cost issues have all served to promote the briefer therapies as a common model of service delivery.

One of the key principles – as opposed to, for example, economic drivers – for developing models of brief therapies derives from a utilitarian perspective, namely seeking the greatest good for the greatest number. This rationale makes good sense in a world in which there are finite resources, both human and financial, and where demand for the psychological therapies will always outstrip supply. Hence the aspiration to develop brief models of therapy or adapt existing ones to make them more accessible (eg self-help delivery models) would appear to be part of a plausible remedy.

However, there is a general paucity of evidence relating to decisions about treatment length. Too often, treatment length is determined and maintained by custom and practice, economic constraints, or resource allocation rather than by a clear theoretical rationale linked to the proposed mechanisms of change or, indeed, a programme of sound empirical research. Much of the research work I have been involved

hotherapies: the evidence

vidence relating to decisions about treatment length, writes
d on the issue of therapy duration v effect, the jury is still out

in over the past 20 years has, in one guise or another, considered the issue of treatment duration.

Standing back from this collective effort, two broad findings seem to emerge. The first general finding, drawn from a series of studies carried out in collaboration with David Shapiro and Gillian Hardy, is that, in contrast to the classic dose-effect relationship in which there are diminishing returns as treatment duration lengthens, results seem to suggest that the relationship between dose and response is more linear than perhaps previously thought[2].

therapy when they judge they have made a sufficient level of gain – which we have termed a 'good enough level'. Hence individuals require differing numbers of sessions and, accordingly, achieve this effect at different rates. Because people leave therapy at differing times but at a similar level of improvement, the cumulative effect is one portrayed by the traditional dose-effect model. In short, when we consider rates of change at the level of the individual client, we arrive at a somewhat different understanding of the effects of duration than portrayed by group data.

> 'Too often, treatment length is determined and maintained by custom and practice, economic constraints, or resource allocation rather than by a clear theoretical rationale linked to the proposed mechanisms of change, or, indeed, a programme of sound empirical research'

The second finding, which has emerged in collaborative work with Bill Stiles, suggests that the percentage of clients making significant improvements from therapy delivered in primary care remains broadly the same regardless of the number of sessions they receive[3]. This finding is consistent with the view that people end

What are the implications of these findings for brief therapies? Well, first they raise questions about how the traditional dose-effect model has been interpreted. And second, they suggest the need for better data on the 'natural' components and processes of therapy drawn from natural practice-based settings in order to be better informed about how we place the array of psychological therapies within given time frames. We need better evidence relating to therapists themselves and their effects, the role of common factors, and the process of change as experienced and assimilated by clients. If we have better quality evidence on these aspects of therapy, then we might gain a better understanding of how we can best define 'brief therapies'. ■

Michael Barkham is Professor of Clinical Psychology and Director of the Centre for Psychological Services Research at the University of Sheffield. He was project lead on the development of the CORE outcome measure, and has published widely on its applications in routine practice as well as on the paradigm of practice-based evidence as a complement to trials methodology.

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2 Shapiro DA, Barkham M, Stiles WB et al. Time is of the essence: The fall and rise of brief therapy research. Psychology and Psychotherapy: Theory, Research and Practice. 2003; 76:211-36.

3 Barkham M, Connell J, Stiles WB et al. Dose-effect relations and responsive regulation of treatment duration: the good enough level. Journal of Consulting and Clinical Psychology. 2006; 74:160-7.

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Still not convinced about CBT?

Below is a summary of NICE treatment recommendations for the use of psychological therapies

Guideline	Diagnostic category	Recommended treatment
CG22	**Anxiety** (including panic and generalised anxiety disorder)	CBT/medication/self-help approaches
CG72	**Attention deficit hyperactivity disorder**	Medication/CBT
CG38	**Bipolar disorder**	Medication/electroconvulsive therapy/CBT
CG53	**Chronic fatigue syndrome**	CBT/graded exercise therapy
CG42	**Dementia**	Structured group cognitive stimulation programme/aromatherapy/music therapy/CBT/reminiscence therapy
CG23	**Depression**	
	Mild	Self-help approaches/exercise/brief CBT
	Moderate/severe	CBT/interpersonal psychotherapy/couple-focused therapy/psychodynamic therapy/medication
	Chronic	CBT plus medication
CG9	**Eating disorder**	
	Anorexia nervosa	Cognitive analytic therapy/CBT/interpersonal psychotherapy/ psychodynamic therapy/family interventions
	Bulimia nervosa	Self-help approaches/medication/CBT/interpersonal psychotherapy
	Binge eating disorder	Medication/CBT/interpersonal psychotherapy/dialectical behaviour therapy
CG31	**Obsessive compulsive disorder**	CBT (group and individual)/exposure and response prevention/medication
CG26	**Post traumatic stress disorder**	CBT/eye movement desensitisation and reprocessing (EMDR) or medication
CG1	**Schizophrenia**	Medication/family interventions/CBT (counselling and supportive psychotherapy not recommended)
CG16	**Self-harm associated with borderline personality disorder**	Dialectical behaviour therapy
	Children	
CG72	**Attention deficit hyperactivity disorder**	Group-based or individual parent training/education programmes/CBT (individual or group)/medication
CG28	**Depression**	
	Mild	Supportive therapy/group CBT/guided self-help
	Moderate/severe	CBT/interpersonal psychotherapy /family therapy/child psychotherapy/medication
CG9	**Eating disorders**	
	Anorexia nervosa	Family interventions
	Bulimia nervosa	CBT
CG31	**Obsessive compulsive disorder**	CBT/exposure and response prevention/medication
CG26	**Post traumatic stress disorder**	CBT

And yet... a client said recently: ***'I want to be understood – not shown that I am 'wrong-thinking.'***

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

The website is currently running a thread asking what the major challenges you face as an independent practitioner are. Take a look – is yours listed? If not, why not add it – or comment on someone else's entry.

AIP pilot

Those of you who read our journal regularly will be aware that we have been working towards getting a project underway, to explore the clinical usefulness of CORE Net in the counselling room. (There are several 'devices' that can provide information regarding the areas of difficulty a client is experiencing, other than CORE Net of course.)

One of the benefits we hope to show, apart from the ease of use, is data that can demonstrate our ability to provide quality interventions that help clients to move forward. Because there is an initial measurement, a baseline, it is possible to show change and even aspects as a practitioner that you might be advised to put on your CPD list.

Two members have had to leave the project, due to changing circumstances. If you would be interested in taking one of these places, email me and I will explain what is involved and how to use the system – we have our own 'group' and can access the data being generated – and best of all, CORE IMS have provided everything without cost.

Justine Oldfield-Rowell
JOR@bacp.co.uk

Neuro-Linguistic Programming

A glimpse of the passion that makes the skills of NLP a wonderful addition to your professional toolbox. **Matt Hudson**, a Master NLP practitioner, shares the way NLP can be used in harmony with, as well as in isolation from, counselling and psychotherapy

You, like me, have a mind; your neurology gives you specific encoding so that you can become the organism that you are. This neurological map of the world allows you to sense things, see, hear, feel, smell, taste: these senses are 'internal' representations. In order for us to make sense of the outside world our neurological map deletes, distorts and generalises information.

For example, what do you see when you use your eyes? Electromagnetic radiation – light – hits your eyes. You can't see it for what it is so you distort it via rods and cones. That gives you the sense of 'colour'. Your two eyes give you the sense of 'depth'. You have 100,000,000 light sensitive cones but only 1,000,000 nerve impulses to your brain, so you reduce the information to a hundredth. Then it changes from electromagnetic radiation to cell activation, to a nerve impulse, to the exchange of neurotransmitters, and eventually your brain receives it and we call it sight.

So what are you really seeing as you look out at your world? Your sight operates from your beliefs and values, associations, both negative and positive, your attitude toward what you are looking at, language used, your age. All of this is going on continually so does anyone *really* see the world then? If you want to see more of this wonderful world, you must give yourself permission to read, see, hear, talk and experience more, to go beyond the boundaries that your mind has set for you.

So take a moment now and imagine a situation in your life that you know you continue to feel bad about. Take a few moments to notice what you see, hear, feel and experience while you play this movie inside your mind. Now consider what you had for your dinner last Wednesday. Now think about a time when you were really curious and mentally take notes on this movie, take all the information you need from your point of view. Then genuinely take all the information from the other person's side.

Now sit back as an onlooker and take notes as if you were the film director watching actors on a film set. Consider, from this position, how you can add new sound effects or lighting, basically whatever you need to turn this crummy movie into an award-winning, educational, motivational and awe-inspiring classic. Now collect all your information and try in vain to run the old movie. By moving your mind into different positions you allow your brain to experience new learning. And that's it in a nutshell – stop running bad movies and set yourself free! ■

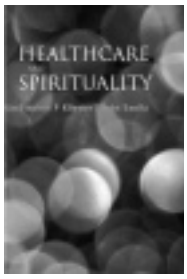
"If you want to see more of this wonderful world, you must give yourself permission to read, see, hear, talk and experience more, to go beyond the boundaries that your mind has set for you"

Matt is happy to receive questions, which he will try to answer in the next edition of this journal. Write to him care of the editor at the address on page 1.

Book reviews

Healthcare and spirituality

Stephen P Kliewer, John Saultz
Radcliffe 2006
ISBN 978-1857756227 £27.95



This book was of particular interest to me bearing in mind the current changes in the NHS – a time when counselling is being valued more and when there is empirical evidence to substantiate 'good' results. The authors give an interesting potted history of how healing was initially deeply imbedded in spirituality, but with the advent of the age of reason and scientific revolution this perspective changed. This book was written to educate medical professionals and patients to address the important issues regarding the quality and meaning of life for all of us.

Case studies illustrate how different approaches to religion can affect a patient's healing, eg a terminally ill patient who has been brought up in a fundamentalist religion and adhered to its rules, may get very angry with God for his suffering, because he has been a good person and stuck by The Rules. Whereas a person who sees God as a loving God (not punitive) and is more mainstream with his religious beliefs, can accept life as it is and not blame God.

The emphasis in the book is the need to address 'the whole person' and not just the body (or mind). Each person is unique – not just a group of symptoms. Likewise their religious persuasions are also different, eg Buddhists do not believe in an actual soul, but aim to reach Nirvana – a state of balance and self-realisation before they reincarnate.

I liked the quotes in the book, such as Albert Einstein's; 'Science without religion is lame. Religion without science is blind.' This quote embodies the need for medical scientific-based dogma to broaden out and embrace spiritual beliefs and values. It reminds me of our work as counsellors and how at present one theoretical tool which is easy to measure, is being seen as the most effective and others which are integrative and treating the whole person less so.

Many chapters end with reflective questions such as 'Is your reality consistent with your spiritual domains?' and 'What are some of the key concepts of values that comprise your spiritual beliefs?' These questions enable you to interact with the body of the book personally and facilitate self-knowledge of where you are on your spiritual journey (if you are on one).

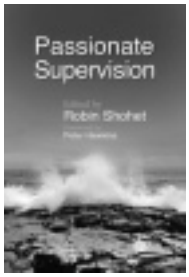
In my work as a counsellor and transpersonal psychotherapist I have found that clients gain comfort in their personal spiritual beliefs, and even if they don't believe in 'God', praying helps when they are in emotional or physical pain.

The book is written in a clear, informal style. The authors use explanation and analysis to present a subject or to clarify an idea. The appendices give brief explanations of counselling skills, meditative exercises involving the creative imagination and a spiritual involvement and belief scales which measure core beliefs. *Healthcare and spirituality* is educational and inspirational, and would be suitable for a range of healthcare professionals.

Susie Holden Smith is a counsellor/ psychotherapist with the NHS, in education and private practice

Passionate supervision

Robin Shohet (ed)
Foreword by Peter Hawkins
Jessica Kingsley Publishers 2008
ISBN 978-184310556 5 £14.99



If you are seeking a book full of academic and research theories, models and quotations, if you wish to answer specific questions or view 'Super Vision' as purely an ethical requirement done by a supervisor who evaluates the supervisee, then you would do well to turn to codes of ethics and practice or elsewhere. If, on the other hand, you are looking for something more exhilarating, are seeking to improve your practice through a deeper level of reflection or are aware of feeling defensive or fearful of taking issues to supervision (in its many forms), then this inspirational, readable and well-structured, down-to-earth book is for you.

Offering a realistic and honest insight into the personal experiences of a wide range of authors from within the helping professions, each experienced in their own field, the book is packed with warmth, mindfulness and humanity. As with most books relating to the topic of supervision, the developing trend towards workplace supervision is acknowledged. However, more than making our own processes available and transparent, Peter Hawkins in the foreword explains how 'passionate supervision' goes beyond being fully present. Developing a spirit of inquiry, free from preconceptions, fixed opinions and fears, the reader is encouraged to engage more fully in their supervisory relationships bringing love, spirit and soul, embracing a passion through

openness and generosity to share experiences. Robin Shohet introduces each chapter asking the author what they most wish the reader to take away from their writing; and concluding the book by giving examples and challenging us to explore our own belief systems and avoidance. Facing these fears or defences which can pose as anxiety, anger, shame, preoccupation with safety, rigid adherence to beliefs, rules and procedures, passionate supervision provides a loving space where they can be dissolved into consciousness providing healing for supervisee, supervisor and client alike.

This is the kind of book where you can delve in and out and take what you need at the time, comparing your experiences with those of the authors, finding commonalities and parallel processes. However, I am aware that there are those who might review the book cynically, viewing it as rather 'humanistic' and 'idealised' rather than relating to the editor's intention of 'connecting the dots in your minds and hearts, allowing them to trigger your own internal supervisor'.

Marguerite Daniel MBACP, private counselling practitioner in Clevedon, N Somerset

Beck's cognitive therapy

Frank Wills
Routledge 2009
ISBN 978-0415439527 £9.99

This book sets out to provide a concise account of Beck's work against a background of his personal and professional history. It is divided into two parts. There are 15 short chapters that examine Beck's contribution to explaining psychopathology, and then 15 more looking at Beck's suggestions for the best methods of treatment. Within each chapter the author also attempts to view each topic in the light of current research and of other relevant theoretical or pragmatic positions. He attempts a lot in a mere 166 pages.

I enjoyed this book. The author communicates well, and the combination of the lightness of his style, and the corset imposed by the series editor, mean that the chapters deliver substance without crushing with impenetrable weight. I found the first half of the book to be the most rewarding. Wills gives a clear account of Beck's contribution to the evolution of CBT theory. Throughout this section there is a definite sense of an empirical pragmatist at work, slowly moving away from psychoanalysis, using patient statements to build hypotheses, then testing these hypotheses and refining theory, starting with depression and moving into other areas of psychopathology. Among other things Wills explains the use of imagery, the development of the different levels and types of cognition, the role played by emotion (the 'Royal Road to cognition') and the interaction with behaviour.

The second part of the book outlines the classic CBT 'treatments' – case formulation, homework assignments, thought records, structured and goal-oriented activities to challenge and rebuild thinking and behaviour. The importance of the collaborative relationship is discussed at length. The strength of this section is that the author does provide snippets of recent research that either validate or question particular approaches, although the practical implementation of the strategies is barely touched on.

Another strength of the book is the sense that judgments are informed by the realism of a practising therapist. For example, in the chapter on formulation as a means of developing focus for therapeutic work, Wills spells out the need for great sensitivity to the client's particular situation in order to avoid robotic implementation of theory ('CBT by numbers').

Although I enjoyed the book I have a few reservations about it. First, in some ways, I was surprised by the lack of the specifically distinctive material for Beck. If Aaron Beck is the gentle angel of cognitive therapy, Albert Ellis is the rough diamond. Of course, such descriptions are unhelpful caricatures, but as I read this book I found that, for me, Ellis was always lurking in the background, and I could hear attendees on training courses asking: 'Apart from differences in personality, what are the theoretical and practical differences between Beck and Ellis?' We occasionally have a specific answer – in chapter 7, for example, where the differences between Beck's 'dysfunctional thinking' and Ellis's 'irrational beliefs' are discussed. We also learn the reasons Beck was less profligate with time and depth than his erstwhile psychoanalytic colleagues. However, for a lot of the time Beck's distinctiveness has to be implied. However ably Beck is described, the backcloth needs more substance for his distinctiveness (the title) to be more fully appreciated.

My second reservation concerns not the book's execution, but its conception. I do hope I am wrong, but I found myself wondering if this was a book in search of a target audience. I could not quite work out who it was aimed at. The cover claims that it will appeal to both newcomers and experienced practitioners wanting a succinct guide. Readers generally interested in Beck will want far more on his life and background. Equally, hardcore CBT therapists may be disappointed by its introductory nature. However, those undergoing initial training in CBT will need a much more developed and practical approach – the book Wills co-authored with Diana Sanders (*Cognitive therapy: transforming the image*, Sage 2004) would better suit their needs.

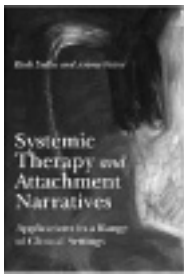
What the book does well is give a brief introduction to Beck's development, his originality, his rigour, his pragmatism, and his relaxed attitude about the ownership of 'his' model. Therapists who have some experience of using CBT, and who wish to have their understanding

of one of the founders of their espoused model strengthened, will probably find this an informative and enjoyable read. Equally, therapists from other backgrounds who are not looking for a CBT manual but who wish to be more informed about the work of one of the three most cited authors in the counselling and psychotherapy literature, will find this concise book very helpful.

James Rye is a director of Connections Counselling Ltd (www.connections-c.co.uk) and works as a psychotherapist, counsellor, supervisor, and trainer.

Systemic therapy and attachment narratives applications in a range of clinical settings

R Dallos R, A Vetere
Routledge 2009
ISBN 978-0415416580 £19.99



I was rather taken aback when I began this book. Where are the little boxes, giving an overview of the most important points, the pictures and the questions for discussion at the end of each chapter? This is not a reader-friendly book.

It is also a difficult book for those who, like me, are new to family therapy. This is supposedly a companion book for Dallos' earlier book. Not having read the earlier book, I cannot comment, but this volume is so thoroughly comprehensive that a companion book seems superfluous.

The thrust of the book is that dealing with our own and others' feelings is dependent (until therapy) on early attachment patterns. Allowing clients to tell their stories lets these patterns emerge, so that dysfunctional patterns can then be worked with in a behavioural manner. The authors join systemic theory with attachment theory with narrative theory. Thus a new theory, attachment narrative therapy (ANT), comes out of their work.

Having introduced their model, the authors move on to look at life cycles, explaining that the ways in which people learn to deal with transitions at the beginning of their lives may be played out in subsequent families. The next chapters explain the use of the theory in a variety of settings: couples' work, emotions, trauma and traumatic events, grief and attachment, alcohol and eating addictions. There is a chapter called 'regulating emotions', which seems to offer a behavioural approach for dealing with feelings. The penultimate chapter, 'Formats for exploration', gives – at last – some practical ways of using the model.

The authors are psychologists who specialise in family therapy, and who have developed an interest in relationships, which might explain the rather dry and academic writing. There is almost a total lack of humour, though I did enjoy the analysis of TV's SuperNanny's use of the 'naughty step'. I also enjoyed the case studies and would have liked more of these. I was interested to see that this model only works with families or couples with some capacity for empathy, and that this is assessed early on. I would have liked to have read more about the assessment methods.

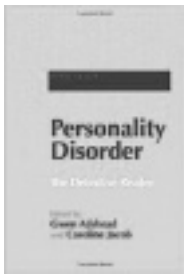
Throughout, the authors are at pains to demonstrate their cultural sensitivities and to point out that their model works cross culturally. I was not entirely convinced by this, but I appreciated that they had thought about the cultural implications of their way of working.

In conclusion, this an interesting, book even for those not directly involved in family therapy, or those who do not wish to work in a way that is primarily behavioural. Most of our clients, after all, will be familiar with living in a family, or an approximation of that, and many of the issues brought up here will be applicable to individual and couples' work as well as family therapy. Once I had resigned myself to the fact that this would be a difficult read, I found plenty to interest me.

Heather Dale, senior lecturer, Huddersfield University; senior accredited counsellor

Personality disorder: the definitive reader

Gwen Adshead, Caroline Jacob (eds)
Jessica Kingsley Publishers 2009
ISBN 978-1843106401 £22.99



The 14 papers collected in this volume primarily address working with personality disorders in a team context, such as a ward setting, with other mental health professionals. (There are fascinating examples of the splitting and projection that can occur among team members, caught in the countertransference common with these patients.) This might suggest there is little here for the independent practitioner; in fact I found a wealth of insight in these pages that could be applied equally to working independently.

The book has three parts. Part I, 'Theory, aetilogy and psychopathology', features two papers outlining research into the causes of personality disorders. While interesting, this section for me was the weakest of the book. The papers in question date from 1964 and 1974, and I suspect more recent research might offer a different picture. The 1964 paper, for example, reports a high correlation between illegitimacy and later development of personality disorders; given that being the child of unmarried parents is now common,

and does not carry its past stigma, one wonders whether these findings would be replicated in contemporary research.

Part II, 'Clinical implications', contains fascinating papers, particularly focusing on transference and countertransference issues, from Winnicott's classic 1947 paper 'Hate in the countertransference' as well as more recent papers from the late nineties. I found Kingsley Norton's paper, 'In the prison of severe personality disorder,' particularly useful in explaining how such clients' interpersonal struggles create barriers of misunderstanding in the therapeutic relationship: the therapist is in danger of equating challenging behaviour with 'no progress' on the one hand, and mistaking compliant behaviour for genuine progress on the other.

Part III focuses on 'Treatment and management', and offers some solid, practical advice. I am sure this section will prove an invaluable resource for me, one I will return to many times. One paper, 'Ten traps for therapists in the treatment of trauma survivors', has broader application beyond the treatment of those with personality disorders. I could recognise the traps listed from my own experiences with trauma survivors, and the paper offers useful advice on how best to avoid these pitfalls.

The book purports to represent a range of theoretical orientations in its papers, though in practice the emphasis seems to be psychodynamic, with some attachment theory included. This was not a problem for me, but I imagine some readers might wish for alternative views. The back cover claims the book includes new papers, though the most recent paper dates from eight years ago. For me, these are small quibbles: overall, I found this book an engrossing and informative read, and it has earned itself a permanent place on my reference shelf.

James Phillips, MBACP, counsellor and psychotherapist. www.jptherapy.com

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.

Rational ethics in practice. Narratives from counselling and psychotherapy Edited by Lynne Gabriel and Roger Casemore. Routledge.

Depression. Cognitive behaviour therapy with children and young people Chrissie Verduyn, Julia Rogers and Alison Wood. Routledge.

Free yourself from anxiety. A self-help guide to overcoming anxiety disorders Emma Fletcher and Martha Langley. ihowtobooks.

BACP Awards scheme

The 2009 BACP Counselling & Psychotherapy Awards scheme, which recognises, rewards and celebrates innovation and excellence in the field of talking therapies, is open for submissions until Tuesday 30 June.

The awards not only provide a unique opportunity to showcase your own counselling and psychotherapy service or research project, but also to bring the work of others to the attention of the wider professional community.

Celebrating work that has challenged thinking, stimulated debate or encouraged the adoption of new techniques within or around the profession is the Innovation in Counselling and Psychotherapy Award. It also recognises work that has raised awareness of the benefits of counselling and psychotherapy or promoted mental wellbeing nationally or internationally.

The Excellence in Counselling and Psychotherapy Practice Award rewards counselling projects or initiatives that have shown commitment to increasing access to counselling, and which demonstrate the significant role it plays in improving quality of life within a community, group of individuals or organisation.

Rewarding excellence in counselling and psychotherapy research is the Award for an Outstanding Research Project. In addition to enhancing awareness of the evidence basis for counselling and psychotherapy, this award also aims to encourage and inspire future generations of researchers.

Finally, the CPR New Researcher Prize, presented in Association with *CPR* (*Counselling and Psychotherapy Research* journal) and Taylor & Francis, aims to promote the work of new researchers, rewarding the best research submission relevant to counselling and psychotherapy practice at any level.

The awards will be presented as part of BACP's annual conference evening programme on Friday 9 October 2009 at the Newcastle Civic Centre,

For further information and application forms please email Claire Sharpe at claire.sharpe@bacp.co.uk

News

GPS and eating disorders
GPs are failing to help people with eating disorders such as anorexia and bulimia, according to a report from the eating disorders charity Beat. The survey of 1,500 people found that fewer than one in six sufferers (15 per cent) felt their GP understood their disorder or knew how to help them, and some believed their GP did not take them seriously. The report comes after figures released recently showed a rise in the number of young girls admitted to hospital with anorexia. Over the past decade, the number of admissions among girls aged 16 and under in England jumped 80 per cent, from 256 in 1996/97 to 462 in 2006/07.

Beat chief executive Susan Ringwood said the rise could be down to a 'wait and see' attitude, with young girls only being admitted when they were seriously ill.
Press Association 23/2/09

Depression and returning to work
A new study from the Mental Health Foundation examines the role of depression in returning to work after a period of sickness absence across four types of chronic illnesses: depression and anxiety, back pain, heart disease and cancer. The *Returning to work* report shows that almost half (45 per cent) of those with a physical condition experienced mild to moderate depression, but were more worried about telling their employer about their mental health issues, despite the fact that depression impacted on their wellbeing and ability to function at work.
Mental Health Foundation 26/2/09

Compendium of outcome measures
The National Institute for Mental Health in England (NIMHE) has published a compendium of outcome measurement tools for use in mental health services. The document is available as hard copy on request or can be downloaded via: www.nimhe.esip.org.uk/news-and-events.html
NIMHE/CSIP 10/08

New CBT register
The British Association for Behavioural and Cognitive Psychotherapies and the Association for Rational and Emotive Behaviour Therapy have joined forces to develop a web-based register of all accredited cognitive behavioural therapy practitioners in the UK. The register includes 1,400 therapists. More information at: www.cbtregisteruk.com

'Econocide' expected to surge
American psychologists have coined the word 'econocide' to describe a wave of suicides they claim are related to the global financial crisis. More information at: http://news.bbc.co.uk/1/hi/business/7912056.stm
BBC News Online 11/3/09

Free therapy for recession victims
Fears of a depression and an anxiety epidemic caused by the recession, are forcing the government to offer psychological help to millions of people facing unemployment, debt and relationship breakdown. Sufferers will be referred to psychotherapists for expert counselling via an advice network linking Jobcentres, doctors' surgeries and a new NHS Direct hotline.
The Observer 8/3/09

bulletin board

Supervision

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.

Kent/Orpington BACP accredited supervisor, UKCP registered psychotherapeutic counsellor, offers supervision for individuals and the opportunity to join a newly formed monthly supervision group. Email Caroline Waite for more details: caroline1603@hotmail.com or tel: 0751 981 5260.

Hereford/Gloucs/Wales MBACP (Accred); supervision for individuals and group. Reduced rates for students. Contact Jane Pendlebury to discuss on: 01989 780533 janependle@gmail.com

Essex/Herts Supervision offered to trainees or experienced practitioners. Ten years' experience providing counselling/psychotherapy. Currently undertaking diploma in clinical supervision Tel: 01992 700779 or 07958 059272 info@harmonycounsellingservice.co.uk hycintht@aol.co.uk

Networking

Derby area Professional development. Peer group to meet monthly for case discussion/reading/member-led seminars, occasional speakers. If you are interested please contact Mary Cameron on 07790 397762.

King's Lynn Any colleagues within range interested in sharing a possible peer-taught day as a cheerful and inexpensive form of professional development? Contact Edwin Salter at kl.humanfactors@virgin.net

For your toolbox

The Holmes-Rahe Scale (below) was devised to measure stress levels, ranking common and not-so-common events that cause us to feel stressed. Clients are asked to tick those that apply to them and add up their score. A score of 150 is rated as more than average stress, while a score of more than 300 is 'a lot of stress'. Do you agree with these rankings?

Event	Score
Death of a spouse	100
Divorce	73
Marital separation	65
Imprisonment	63
Death of a close relative	63
Personal injury/illness	53
Marriage	50
Dismissal from work	47
Marital reconciliation	45
Retirement	45
Change in health of relative	44
Pregnancy	40
Sexual difficulties	39
New family member	39
Business readjustment	39
Financial change	38
Change in marital rows	35
Major mortgage	32
Foreclosure of mortgage/loan	30
Work responsibilities change	29
Child leaves home	29
Trouble with in-laws	29
Big personal achievement	28
Spouse starts/stops work	26
Start/stop school*	26
Living conditions change	24
Personal habits change	24
Trouble with boss	23
Work hours/conditions change	20
Moving house	20
Change school*	19
Change recreation	19
Alter church activities	19
Alter social activities	18
Small mortgage/loan	17
Alter sleeping habits	16
Change in family reunions	15
Alter eating habits	15
Holidays	13
Christmas	12
Minor law breaking	11

What else might be on this list – and how many points would you assign it?

**The word 'school' is used to indicate school, college or university.*

Proposed AIP conference 2009

20 November 2009, Woburn Place, London (tbc)

'Professionalism and regulation: making the future yours'

Statutory regulation is a subject that is currently at the forefront of the minds of most independent practitioners and the 2009 AIP conference aims to inform and prepare independent practitioners by giving the latest facts in a user-friendly manner. Delegates will be encouraged to get involved with the ongoing work and there will also be opportunities for discussion and question and answer sessions.

Sessions at the conference will include:
- Where did regulation originate?
- What are the myths about regulation?
- Where we are now in the regulation process?
- What can be learnt from the experience of other regulated therapy professions?
- Exploring the recent HPC consultation, including BACP's responses and discussing how members can contribute to the upcoming DH consultation on draft legislation.
- What do I need to do to be accepted onto the register when it opens?
- Post regulation, how will CPD be assessed and measured within the HPC?
- What other factors will shape the portfolio of work accessible to independent practitioners post regulation?

To register your interest please email enquiries@bacp.co.uk and entitle your email 'AIP 2009' or call customer services on 01455 883300.

cut out and keep

Abbreviations

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

CAC Centre for the Advancement of Counselling

CADAS Cumbria Alcohol and Drugs Advisory Service *www.cadas.co.uk*

CAF Charities Aid Foundation *www.cafonline.org*

CAFCASS Children and Family Court Advisory and Support Service *www.cafcass.gov.uk*

CAMHS Child and Adolescent Mental Health Services *www.camhs.org.uk*

CAPP Centre for Attachment Based Psychoanalytical Psychotherapy *www.psychotherapy.org.uk*

CARATs Counselling Assessment Referral Advice and Throughservice *www.hmprisonservice.gov.uk*

CAT Cognitive Analytical Therapy *www.rcpsych.ac.uk*

CBT Cognitive Behavioural Therapy *www.rcpsych.ac.uk*

CC Couple Counselling *www.relate.org.uk*

CCBP Chiron Centre for Body Psychotherapy *www.yobeely.f2s.com*

CCBT Computerised Cognitive Behavioural Therapy *www.nice.org.uk*

CCC Counselling Code of Conduct (UK) *www.bacp.co.uk*

CCPE Centre for Counselling and Psychotherapy Education *www.ccpe.org.uk*

CCT Client Centred Therapy

CCYP Counselling Children and Young People (BACP Division) *www.ccyp.co.uk*

CDC Council for Disabled Children *www.neb.org.uk/cdc*

CEBMH Centre for Evidence Based Mental Health *www.cebmh.com*

CEDEFOP European Centre for Vocational Training www.cedefop.europa.eu

CEFAHP Clinical Health Forum for all Allied Health Professionals *www.nice.org.uk*

CEHR Commission for Equality and Human Rights *www.equalityhumanrights.com*

CEMH Centre for the Economics of Mental Health *www.iop.kcl.ac.uk*

CEMVO Council of Ethnic Minority Voluntary Sector Organisations *www.cemvo.org.uk*

CFAR Centre for Freudian Analysis and Research *www.cfar.org.uk*

CHAI Commission for Healthcare Audit and Inspection *www.healthcarecommission.org*

CHI Commission for Health Improvement *www.chi.nhs.uk*

CHIPS Childline in Partnership with Schools *www.nspcc.org.uk*

CHP Certificate in Hypnotherapy and Psychotherapy

CHRE Centre for Healthcare Regulatory Excellence *www.chre.org.uk*

CHRP Council Regulating Healthcare Professionals *www.dh.gov.uk*

CIPD Chartered Institute of Personnel and Development *www.cipd.co.uk*

CIPR Critical Incident Processing and Recovery

CISD Critical Incident Stress Debriefing

CITA Council for Involuntary Tranquilliser Addiction *www.citawithdrawal.org.uk*

CORE & CORE Net Clinical Outcomes in Routine Evaluation *www.coreims.co.uk*

COSCA Counselling and Psychotherapy in Scotland *www.cosca.org.uk*

CPC Counsellors and Psychotherapists in Primary Care *www.cpc-online.co.uk*

CPCAB Counselling and Psychotherapy Central Awarding Body *www.cpcab.co.uk*

CPD Continuing Professional Development

CPE Continuing Professional Education

CPN Community Psychiatric Nurse