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For counsellors and psychotherapists working in healthcare

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Don't blame the mother 08

Plus

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*From the **Editor***

NAOMI CAINE

The relationship between mothers and daughters can be complicated. It can also result in conflict. Is the conflict generational, as the older generation tries to assert its authority and the younger generation attempts to declare its independence? Perhaps. Could hormones create conflict, as pubescent girls and menopausal women struggle to manage hormonal changes, possibly at the same time? Perhaps. But maybe there's another way to look at the relationship dynamics between mothers and daughters.

'Clients with chronic depression can be a challenge'

Rosjke Hasseldine argues in her article on p8 that we can only really understand women's emotional lives in the wider context of their generational experience of sexism and misogyny. How are women treated in the family? What roles are they expected to play? And what is the psychological impact of the prevailing belief system?

It is a compelling argument. It's also a compassionate argument, as it neither blames nor pathologises women for their emotional struggles.

Clients with chronic depression (dysthymia) can be a challenge, because they often don't believe they can get better. It's hard work for the therapist, who can start to lose confidence in the efficacy of the therapy, and so feel as hopeless or worthless as the client. And that's why the article by Andrew Bates on p14 is a must-read.

Andrew explains how interpersonal psychotherapy can prove effective with dysthymic clients. It's a short-term, active therapy, which emphasises the difference between 'state' and 'trait', so encouraging the client to think of their depression as an illness and therefore treatable.

The article takes us step by step, session by session, through the treatment model. It therefore instils confidence and optimism in the reader, much like interpersonal psychotherapy awakens trust and hopefulness in both the therapist and the client.

When Sarah Pennock first started working with clients with addiction issues, she followed a treatment model based on abstinence. But she started to notice that its effectiveness in the short term wasn't matched by its success in the long term. Clients would often relapse and so return to an abstinence programme in an almost never-ending, dispiriting cycle.

As Sarah explains on p20, it was only when she combined the addiction model with an attachment model that she could explore with her clients the root causes of their dependency, helping them towards a sustained recovery.

Sarah offers a case study, which not only charts her client's journey of self-discovery, but also her own. It is an honest and moving portrait of the relationship between theory and practice, as well as the relationship between therapist and client.

The pandemic has made its mark on our work. In particular, it has made many of us think about how we maintain the boundary between client and therapist, when we are collectively living through coronavirus. On p26, Andrew Keefe writes about his own lockdown life – and what he has learnt about safe and effective practice.

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In touch *with your BACP*

Most members earn £30,000 or less from counselling work

Around three-quarters (75.4%) of our members earn an annual income of £30,000 or less from their counselling work. And only 36.4% could earn a living from their counselling work, according to our latest workforce mapping survey.

The average number of paid, client contact hours a week was 11.6, with the highest number in university or higher education, employee assistance programmes or the workplace, NHS IAPT and secondary schools. Members working in the third sector had some of the lowest numbers of paid hours.

Only

36.4%

could earn a living from their counselling work

The average number of unpaid or voluntary client contact hours a week was 2.3, although 63.1% reported working zero unpaid hours. Unpaid hours were highest among students and trainees, those in the third sector and coaches. More than half (56.8%) of third-sector practitioners worked some unpaid hours and only a quarter (27.6%) agreed they could earn a living from their counselling work.

A high proportion of respondents (44.7%) did not want any additional, paid work. Of those who did, 53.4% wanted between 5% and 25% more work and around a third (36.3%) wanted 50% or more additional hours.

Respondents from mixed or multiple and white ethnic groups had the highest average number of paid hours. Those from black and mixed ethnic groups reported earning a lower average annual income than other ethnic groups.

People aged 35 to 44, 45 to 54 and 55 to 64 received the highest number of paid hours, and earned a slightly higher annual income than younger and older age groups. Respondents aged 75 and over worked the highest number of unpaid hours.

Respondents who considered themselves to be disabled worked a slightly lower number of paid hours than those who were not disabled, although the number of unpaid hours did not vary. They were also more likely to be earning no income or an income of £20,000 or less. However, there were fewer differences in higher salary brackets.

Males and people who self-described their gender had a higher number of paid hours than females or non-binary respondents. There were minimal differences in unpaid hours. Men were more likely to be earning a higher annual income than women.

Gay men and gay women or lesbians worked a slightly higher number of paid hours, on average, compared with people who were bi, heterosexual or who self-described. There were few differences in annual income overall.

Almost 10% (9.3%) offered therapeutic work in languages other than English, including British Sign Language. Of these, 33.1% reported they worked in the third sector.

We would like to thank everyone who has taken part in our workforce mapping survey. Your feedback helps us to develop and improve our knowledge of your current working practices.

The survey also supports our policy and advocacy work, by enabling us to identify gaps in provision and make a stronger case for support with policymakers and commissioners.

Response to regulation of healthcare professions

We have responded to the latest Department of Health and Social Care consultation into the regulation of healthcare professions across the UK.

The consultation asked for views on:

- the criteria used to decide whether a profession should be regulated
- whether there are regulated professions in these sectors that no longer need statutory regulation
- whether there are unregulated professions that do need statutory regulation.

The Government stated in its consultation document that it doesn't have any plans to bring any extra professions into statutory regulation, apart from physician associates and anaesthesia associates. Health Minister Edward Argar also confirmed there were '...no current plans to regulate psychotherapists, counsellors or other therapist roles', in response to a question from Labour MP Lloyd Russell-Moyle.

BACP is committed to working within a regulatory framework that delivers the high professional standards and level of public protection that's expected of our members.

Our view is that if the Government were to explore the possibility of statutory regulation of counsellors and psychotherapists, it would need to be in collaboration with all the relevant professional bodies – and proposals would need to be proportionate to risk. We'd consult all our members if changes were proposed.

BACP creates paid jobs for therapists

We're working to stimulate paid employment opportunities for our members, talking to key stakeholders, including politicians and decision makers from across the nations, to help them understand the positive changes that counselling can make to people's lives.

Last year, at the height of the COVID-19 pandemic, we worked closely with The Care Workers' Charity to help develop its Mental Health Support Programme. The service provides up to 10 therapy sessions with a qualified BACP-registered therapist, through our organisational member, Red Umbrella, a specialist mental health organisation delivering counselling and training. The service continues to work with vulnerable care workers and has provided hundreds of hours of paid employment for our members.

We campaign for greater availability of evidence-based counselling and psychotherapy for the public, which is free at the point of need. We also call for an increased choice of the interventions offered, reduced waiting times and improved availability and access to services for all groups within society.

We engage with strategic stakeholders to showcase the valuable contribution that counsellors and psychotherapists, and counselling and psychotherapy, can make to the health of the nation. We also demonstrate that our members constitute an often undervalued and underutilised workforce that should be playing a more central role in healthcare services.

Call for the Government to deliver critical investment in therapy

BACP has called on the Government and policymakers in London to invest in counselling and psychotherapy, to help tackle the chronic, wide-ranging and long-lasting mental health issues of COVID-19.

At our roundtable discussion, Building Back Better Mental Health in London, we told the Minister and Shadow Minister for Mental Health that our highly skilled and qualified members are ready now to support communities in the capital in their recovery from the pandemic.

Our Chair, Natalie Bailey, said: 'Counselling and psychotherapy are part of the solution to a major issue. They are critical to the recovery from the pandemic. And we have 61,000 members who can contribute to that solution.'

Chief Executive Dr Hadyn Williams also challenged plans by both the Government and the Opposition to create new roles, when we already have a highly skilled, trained and available workforce.

Calling for more paid opportunities for qualified counsellors and psychotherapists, Hadyn said: 'We'd like to see an enhancement of the role of counselling and psychotherapy within the NHS, which better uses our trained workforce. IAPT has a significant role to play but isn't the only solution.'

What's new in the CPD hub?

Luan Baines-Ball discusses why pronouns matter. Luan also shares their thoughts about whether therapists have really embraced gender diversity.

Kate Dunn and John Wilson ask whether we are paying enough attention to the psychological impact on clients and therapists of moving between online and offline spaces.

The CPD hub contains more than 300 hours of online resources, with new content added every month, including video recordings and audio files.

All resources have a CPD certificate for you to download. You can subscribe to the CPD hub for £25 a year. Please visit www.bacp.co.uk/cpd/cpd-hub for more information.

BACP publishes latest SCoPEd framework

The latest version of the Scope of Practice and Education (SCoPEd) framework has been published, a shared standards framework developed by six professional bodies, including BACP, which represent more than 75,000 counsellors and psychotherapists.

It transparently sets out the core training, practice and competence requirements for counsellors and psychotherapists working with adults.

There have been significant updates and improvements to the framework since the previous version was published in July 2020. The key changes include:

- greater emphasis on the role of the therapeutic relationship and the qualities of the therapist
- further focus on equality, diversity and inclusion, as a theme embedded and integrated throughout the framework
- additional standards relating to online and phone therapy
- more consistent use of language that is inclusive and more accessible to a wider audience
- the addition of a glossary of terms.

BACP and the other SCoPEd partners are now entering phase two of our work together, and we have jointly committed to:

- continuing to develop the framework to provide essential information to clients, patients and service users to make informed choices about the support they seek
- conducting an impact assessment of the SCoPEd framework
- creating a shared set of principles – based around fairness, inclusion and transparency – for implementing the framework
- working towards agreed shared 'column titles', which are not included in this version
- agreeing transparent and evidence-based mechanisms for members and registrants to progress between the columns of the framework as they develop their training, skills, knowledge and experience.

You can find the latest version of the SCoPEd framework at www.bacp.co.uk/news/news-from-bacp/2022/2-february-scoped-framework-published

Guidance on inappropriate behaviour

BACP has published information to support counsellors and psychotherapists who might have to deal with inappropriate behaviour. Behaviours considered to be inappropriate might include:

- stalking (repeated attempts to impose unwanted communication or contact)
- any act or threat of physical violence or property damage
- comments and jokes of a personal or sexual nature
- inappropriate touching or grabbing
- sexual propositions (written or verbal)
- exposure of genitals or masturbation (face-to-face or over the phone).

You might feel a sense of duty to help those who contact you for support, but it's important to recognise when the contact has gone beyond a level where you feel comfortable or safe. You might also be concerned with safeguarding the individual who has reached out to you. However, you need to consider your own self-care.

If you feel you're the subject of uninhibited or poorly controlled behaviour, particularly of a sexual nature, you have the right to raise your concerns. You can talk to your supervisor, who is there to help and support you – and might have personal experience or professional advice. If you're an employee, you should speak to your HR team for guidance and policies. Or, you can contact the Ethics team at www.bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub

To formally report your concerns, or for specialist advice, call your local police on the non-emergency number, 101. If you feel you're in any immediate danger, do not hesitate to call 999.

Member blogs

Matthew Cormack, a person-centred counsellor and the Mental Health and Wellbeing Officer for the Scottish Pagan Federation, explores the powerful connection between LGBTQIA+ history and art in the blog, *Therapy, Art and LGBTQIA+ History.*

In a blog, *The Healing Power of the Human and Pet Connection*, Dr Christine Rhodes explains that animals can have a positive effect on a person's growth and healing. Christine also introduces us to her 12-year-old Cairn Terrier, Jock.

Viewpoint

JUDY STAFFORD

My recent reading[1] has revealed that some clients apparently want their therapists to be more directive. I think, to a certain extent, that has always been the case. Who wouldn't want help with their dilemma?

When clients have reached a low ebb, they might hope that the counsellor will make the decisions for them, that they can simply hand their problems over to someone else. They might also be a little disappointed to discover that isn't the case. Person-centred counselling, in particular, advocates that if the counsellor encourages the client to take charge of their own decisions, then the client is more likely to own them, to become stronger and autonomous, and to self-actualise as a result.

When they put into practice their new self-awareness and become confident in their own abilities, the sense of achievement they feel with their successes is character building and healing – and helps them to be able to make decisions and choices in the future.

'We have a strong commitment to listen to, learn from and work with our members'

So, would we be doing clients a disservice by being more directive? Sometimes, when a client is telling us about their difficulty, we can quite clearly see that we would take a certain approach to remedy the situation. It can be hard to set that aside and be truly empathic to the client's perspective and experience. But I think it's the client's problem and it must be the client's solution; otherwise, we become coercive rather than supportive. Humility is a huge asset, along with remembering that the client is the true expert on their life.

Of course, we can be a sounding board for the client and we can offer common-sense perspectives, which the client might be obscuring in their panic or fear. We can even role play ideas, so they can consider the likely outcome of any action they might take. But it's up to the client to choose or reject a 'solution'.

When we revisit progress, maybe in a following session, it's also important not to show any disappointment if they've decided either not to act or to do things differently. We must be continually supportive of our clients, never critical.

BACP resources

At BACP, we continue to support our members. There are several new or updated resources on online working – GPiA 047 *Working Online in the Counselling Professions,* GPiA 124 *Social Media, Digital Technology and the Counselling Professions* and GPaCP 004 *What Works in Counselling and Psychotherapy Relationships.*

We continue to campaign for the profession at all levels and are committed to raising awareness of equality, diversity and inclusion (EDI) issues, including neurodiversity and disability, counsellors' pay, supervision and our legal obligations under the Data Protection Act and the UK-GDPR.

We also have a strong commitment to listen to, learn from and work with our members via workshops, surveys, social media, communities of practice networks and events, some of which still take place online, but some of which are happening face to face. We formed the Listening Group as a response to this organisational strategy, and regularly update staff on members' responses.

Our website is due for a refurbishment, so I hope you will let us know, if you haven't already done so, what you would like us to improve or do differently. Your ideas are most welcome. If you would like further information on any of the above, do get in touch by emailing me at judy.stafford@bacp.co.uk

Highlight moments

Finally, I'd like to share with you some highlight moments that have cheered me so far this year – and I hope they will cheer you, too.

I am delighted by the tiny flowers coming through in the garden, particularly snowdrops, azaleas and primroses. I have seen a kingfisher fly at incredible speed along the river, a flash of turquoise, and then sit on a branch looking out for fish. I watched a grebe emerge from the river with a silver fish in its mouth. I also saw a heron, keeping so still and then stretching its huge wings, ready for flight. On a clear night, I admire the brilliance of the stars in the dark sky, particularly the constellation of Orion. Hearing the laughter of a young relative also brings me joy. I hope you can treasure such simple pleasures as these and bring them to mind when you need some light relief.

***Judy Stafford** works in the Healthcare, Journals and Professional Standards departments of BACP. Until recently, Judy was also a registered member of BACP and a person-centred counsellor. She is now caring for an elderly relative.*

Reference

1 Wotton M, Johnston G. Embracing challenge in therapy. Therapy Today 2021; 32(9): 36–39.

Don't *blame* the mother

The complicated relationship between mothers and daughters can only be fully understood in the wider context of women's experience of sexism and misogyny, writes ***Rosjke Hasseldine***

The mother-daughter relationship is complicated – and often characterised by conflict. The conflict is sometimes attributed to women's hormones, be it a daughter's adolescent hormones or the mother's menopausal hormones. Or, it is put down to generational divide and misunderstanding.

I have worked with women as a mother-daughter therapist for more than 25 years and, to my mind, these 'explanations' are sexist and outdated. There is now a growing understanding that mothers and daughters do not relate in a cultural vacuum, that the relationship dynamics between mothers and daughters tell the story of women's lives. As I write in *The Mother-Daughter Puzzle*: 'Women's generational experience with sexism and gender inequality is the root cause of why mothers and daughters fight, misunderstand each other, and emotionally disconnect.'[1]

'Mothers and daughters do not relate in a cultural vacuum'

Understanding the dynamics between a mother and daughter involves understanding what has happened in the daughter's life, the mother's life and the grandmother's life. It involves understanding the sociocultural environment that the daughter, mother and grandmother live or lived in, which includes their family, cultural beliefs and gender norms about femininity, motherhood and daughterhood, and how these are passed down the female line. And it involves understanding the emotional and relational impact of women's generational experience with sexism, gender inequality, misogyny and violence.

My research and clinical work with thousands of mothers and daughters from different countries and cultures led me to devise the mother-daughter attachment model (MDAM), as I believe that we have to explore the attachment with the mother in order to appreciate our female clients' lives, and the root causes of their mental and emotional issues.

The MDAM explains why mothers and daughters fight, misunderstand each other and emotionally disconnect. It also explains the psychological harm that generations of sexism and patriarchy inflict on women, girls, mothers and daughters. The MDAM allows therapists to dig below the emotional, mental and relationship issues that their female clients present in the counselling room and uncover their sociocultural causes. Or, to describe this therapeutic process another way, the MDAM helps therapists to connect the dots between the behaviour, belief system and self-belief of their female clients and how they have been treated.

It is important to note that the MDAM is non-blaming and non-pathologising. My clients have taught me that blaming mothers and daughters for causing their relationship problems does little to explain and heal their conflict. Rather, it feeds patriarchal censure of mothers for failing to live up to unachievable standards of availability and nurturing. Paula Caplan writes in *The New Don't Blame Mother* that a review of published articles in major, mental health journals showed that '...mental health professionals overwhelmingly indulged in mother-blaming. In the 125 articles, mothers were blamed for 72 different kinds of problems in their offspring'.[2]

My clients have also taught me that treating women's maladaptive reactions to sexism, blame, shame, invisibility, violence and emotional silencing, as if they stem from their own pathology, rather than society's pathological treatment of women, does little to relieve their emotional and mental struggles.

Mother-daughter attachment

To illustrate how all roads lead to the attachment dynamics between mothers and daughters, I will share my work with Sharon, whose name and identifying details have been changed. Sharon was a 25-year-old woman who was referred to me by her doctor because she was suffering from social anxiety. It had become increasingly difficult for Sharon to go out with her friends and interact with others. She was petrified of

upsetting people and being misunderstood. Sharon's doctor had prescribed medication and had suggested that she see me for assertiveness training.

Sharon lived in England and was the only daughter and eldest child in a family of three children. Her mother worked part time in a local supermarket and her father was a security guard. After graduating from university, Sharon found work in a childcare centre, which she enjoyed. She said: 'I love looking after the little ones, especially the toddlers. I love watching them learn about themselves and their environment.' Sharon had recently moved out of the family home into a shared flat with two girlfriends, which had caused some problems at home, because her mother relied on Sharon to help take care of her siblings.

I worked with Sharon on Zoom. During our first session, she told me that her doctor had advised her that she needed some assertiveness training to help her feel less anxious about speaking up with her flatmates and her parents, as well as her colleagues and the parents at the childcare centre. When I asked Sharon what she wanted, she was startled and confused by the question. Eventually she said: 'I don't know. I'm not sure. I think that I should have some assertiveness training because that's what my doctor wants me to do, and I have an appointment with her in a month's time and I want to show her that I've improved.'

'Blaming mothers and daughters does little to heal their conflict'

In my experience, assertiveness training has value, but it lacks the necessary depth to uncover why Sharon felt unable and unentitled to speak up for herself. Sharon needed to understand how the women in her generational family advocated for themselves or silenced themselves.

Sharon presented as a young woman who had learned to follow other people's commands. If she was to learn how to speak her emotional truth, she needed to understand how women's voices were treated in her family, culture and society. As I write in *The Mother-Daughter Puzzle*: 'When we delve into the often-confusing dynamics between mothers and daughters, something wonderful happens. Women learn about who they are. Women learn about why they believe what they believe and why they make the choices they make. Women learn about their female history, including how patriarchal thinking and sexist beliefs restricted their mother's and grandmother's lives, limited their powers and harmed their emotional wellbeing. We learn how women and families internalise these sexist beliefs and pass them on from mother to daughter.'[1]

When I asked Sharon how her mother requested what she needed, Sharon immediately said: 'Oh, Mum never says what she wants. She does what Dad says, and she hates it when people are upset with her.' I responded: 'So, you're a little like your mother?' Sharon looked surprised when I made this observation and, after some time, said: 'I guess so. I haven't thought about it like this. I just thought that Mum was a doormat and, to be honest, I get angry with her sometimes when she doesn't stand up to Dad and just does what she's told. But I guess I'm doing the same. I don't like to admit this, but maybe it's true.'

History mapping

As with all my clients, I mapped Sharon's mother-daughter history to discover why she had learned to believe that she should follow other people's commands. The mother-daughter history-mapping exercise is the MDAM's diagnostic tool that charts the lived experience of the three, main women in the family – the daughter, mother and grandmother – their relationship with each other and their generational experience of sexism and patriarchy.

As we mapped Sharon's, her mother's and her grandmother's age, education, jobs, the gender roles they were expected to play, how they voiced or silenced their thoughts, needs and desires, and how the men listened to and emotionally supported, stifled or neglected their wives and daughters, it became clear why Sharon was so afraid to speak up. Every female in her generational family was highlighted as silent. In Sharon's family, women were not asked what they thought, felt or needed; belief in the 'culture of female service' reigned supreme. It was as if the language that sought to understand and honour what women felt, thought and needed was missing in Sharon's generational family.

The 'culture of female service' is a term that I coined to describe the normalised, patriarchal belief system that expects women to be care-providers, not care-receivers, and mothers to selflessly look after their family. And Sharon's mother and grandmother had completely internalised this gender role stereotype. They had learned to prioritise their husband's and family's needs over their own. Sharon consequently had little understanding of what her mother and grandmother wanted for themselves or who they were as people and women, outside of their caregiving role.

When Sharon and I talked about how she didn't remember her mother ever doing anything for herself, she said: 'Selfless caregiving is like a badge of honour in my family. And now that I think of it, I had forgotten about how my

mother won't disagree with Dad. About a year ago, Dad was angry about some political thing that had happened. I can't remember exactly what had upset Dad, but what I do remember is how Mum refused to disagree with him, even though I know she did. I remember arguing with her afterwards about it and she didn't understand why I was frustrated with her for not speaking up. It happened a lot. At dinner, Dad would talk and talk, and Mum would never disagree with him. And if I did, and Dad got angry with me for disagreeing with him, Mum would get angry with me for upsetting Dad.'

Suddenly Sharon started to cry, and I could see that she had made a new connection in her mind. Through her tears, she said: 'No wonder I feel tongue-tied when I have to speak up. There is no model, no script, no entitlement in my family for women speaking up. Where could I have learned how to speak up for myself? Not from Mum and Grandma. And not from Dad, either. Mum and Grandma haven't learned to speak up for themselves. They act as if they don't have a single thought of their own. They act as if they only need what other people need.'

Sadly, Sharon's generational experience of emotional silence and of women prioritising men's thoughts and needs is still common, even after decades of feminist struggle. The language that speaks and enquires after what women feel, think and need is still missing in many families and in many societies, as the #MeToo movement has revealed. Sharon's mother-daughter history map showed how families silence women's voices by shaming and criticising women who speak up for themselves. Sharon's family described women who weren't afraid to speak their truth as 'uppity', and Sharon's mother and grandmother had been shamed into not being 'uppity'. But the price of this shaming was high. It had cost Sharon her emotional and mental wellbeing. It had cost her mother's and grandmother's relationship with themselves, and it was costing Sharon's relationship with her mother.

As Sharon started to claim her voice, her relationship with her mother became increasingly difficult. Unfortunately, Sharon's mother did not adjust well to Sharon's new-found assertiveness. It threatened what her mother had come to believe about herself as a woman, how she had learned to keep herself safe by staying quiet, by not acting like an 'uppity' woman. Sharon's new-found voice was also an uncomfortable reminder of the voice from which her mother had disconnected. The daughter's honesty might have reminded the mother of moments in the past when she might have yearned to speak up or even scream, but didn't, which can also be a source of conflict between mothers and daughters.

At first, Sharon blamed her mother for teaching her to be afraid of her truth and for believing that she had to follow other people's commands. But, during our work together, Sharon started to see her mother with 'soft eyes', an MDAM term for empathy that reflects the understanding

that most mothers do the best they can with the resources they are given. Sharon saw how her mother had not been taught to advocate for herself and how her mother was often blamed in her family for things that were beyond her control. Sharon's mother had not been given the resources she needed to claim her voice and rights as her own person, and it was cruel to blame her for this lack.

'She needed to understand how women's voices were treated in her family'

Sharon also learned to see her father with 'soft eyes'. Though Sharon's mother and father are responsible for their own behaviour, Sharon came to see that her father, just like her mother, was a product of his gender, family background and generation. As Terrence Real describes in his book, *I Don't Want to Talk About It*,[3] Sharon's father was the result of his patriarchal environment. He, too, had been shamed into silencing and disconnecting from his emotional self. And he had been taught to believe that his masculinity hinged on being in charge and the definer of the truth. His job as a security guard only helped to reinforce this toxic, patriarchal belief system.

When we place our female clients' issues within the larger sociocultural context from which they stem, the harm that sexism and patriarchy inflict on women is brought to the surface. Understanding the attachment dynamics between mothers and daughters is central to this powerful process. Revealing these underlying attachment dynamics is key to understanding the emotional reality of women's and girls' lives, healing mother-daughter conflict and connecting the dots between how women are treated and the emotional and mental health issues that they bring to therapy.

Information about mother-daughter attachment training for counsellors and psychotherapists can be found at www.motherdaughtercoach.com

***Rosjke Hasseldine** is an MBACP accredited counsellor, who has specialised in mothers and daughters for 25 years. Rosjke is the author of* The Mother-Daughter Puzzle *and* The Silent Female Scream*, creator of the mother-daughter attachment model and founder of the training organisation, Mother-Daughter Coaching International.*

References

1 Hasseldine R. The mother-daughter puzzle. Durham: Women's Bookshelf Publishing; 2017.

2 Caplan P. The new don't blame mother. London: Routledge; 2000.

3 Real T. I don't want to talk about it. New York: Scribner; 1997.

On the couch

with Alan Phillips

What are your current roles and responsibilities?
Since taking early retirement from the NHS, I'm fortunate to be able to combine my roles as a counsellor, therapist and supervisor with the work I do in organisations as a psychosocial consultant. The work includes designing and delivering bespoke training courses and CPD programmes for healthcare professionals, as well as coaching individuals and teams. I'm also an accredited mediator and alternative dispute resolution facilitator.

Can you describe a typical working day?
There is no such thing as a typical day for me. Every week, new requests come in. Therefore, I might be working in an organisation one day and providing one-to-one counselling or supervision in my home-based practice the next. And since Zoom and remote working have become the norm, I can even combine team, organisational and one-to-one work quite easily in a single day.

What are the highs and lows of your working life?
I'm fortunate, as I rarely have lows in my working life these days. I don't advertise any of my work; it all comes in via recommendations from existing or previous clients. So, I can be highly selective about any commitments. I thoroughly enjoy working as an independent practitioner – free of managerial responsibilities, organisational bureaucracy and the politics of working life. The main low is having to chase up outstanding invoices from recalcitrant organisations!

How did you get to where you are today?
Like many counsellors, this is my second career. I came to it in my late 30s from a professional background, after a management career in higher education. In my personal life, I was heavily involved in the women's, gay and racial equality movements, and was a volunteer during the early, AIDS years, when there were no mainstream support and counselling services for victims and their families. I also studied part time as a counsellor and went on to develop my approach as an integrative, psychosocial practitioner. In addition, I have an MSc in trauma counselling and supervision. All of this came together in my work at Alder Hey hospital, at the height of the organ retention scandal in 2001. As a senior manager and head of psychosocial services, I helped implement the Excellence through Learning programme, which brought about cultural change, based on recommendations in the Redfern Report. I also designed and implemented the Family Support programme for families who were affected by organ retention. In addition, I helped to develop Alder Hey's bereavement counselling service and established the in-house staff support, counselling and development services – all of which continues to inform my current work.

How do you look after yourself?
These days, I only do things that make me happy and keep me healthy (this wasn't always the case). Predominantly, I try to maintain a good work-life balance, which includes only working for people, and spending time with people, whom I respect and who respect me.

What's the most useful thing you have learned?
Everything I do has consequences for other people, as well as myself.

If you could make one change, either in your professional or personal life, what would it be?
I'd have enough space and time to have as many animals as possible – that's part of my final retirement ambition.

Who or what is your inspiration?
Personally, my parents – especially my father, who died when I was too young and immature to show my appreciation. Professionally, the courage and integrity of liberation psychologist Ignacio Martin-Baró, who was assassinated in 1989 by the Salvadoran Government because of his work with oppressed communities and his anti-fascist writing.

What would you tell your younger self?
I'd paraphrase Freud's three conditions for mental health and wellbeing, and say – don't worry, you will develop the capacity to love and be loved; you will be fortunate to choose the work you want to do and enjoy; and you will develop the resilience to deal with 'normal unhappiness'.

What book would you recommend to other therapists?
As a psychosocial corrective to individualistic and pathologising models of human distress, counselling, psychotherapy, psychology and psychiatry, any of Michel Foucault's work dealing with the 'technologies of normalisation', such as *Abnormal: lectures at the Collège de France, 1974–1975*[1] or *The Birth of Biopolitics: lectures at the Collège de France, 1978–1979*.[2]

Do you have a favourite song?
Black Box's extended disco version of *Ride on Time*, for dancing round the kitchen when no one is looking! For the depth and breadth of human emotion, I would choose Maria Callas singing *La Mamma Morta*, from Umberto Giordano's 1896 French Revolution opera, *Andrea Chénier*.

Who is your fantasy client?
Donald Trump – the psychosocial dynamics involved in how the baby he was born became the toxic man he is, would be fascinating.

In your dreams, you are...
George Clooney, of course!

***Alan Phillips** retired as head of psychosocial services in an NHS Trust in 2016. He is now a counsellor, psychotherapist, coach and mediator in private practice. Alan is also an accredited Open Awards trainer and psychosocial consultant, designing and delivering bespoke training and supervision programmes for healthcare professionals.*

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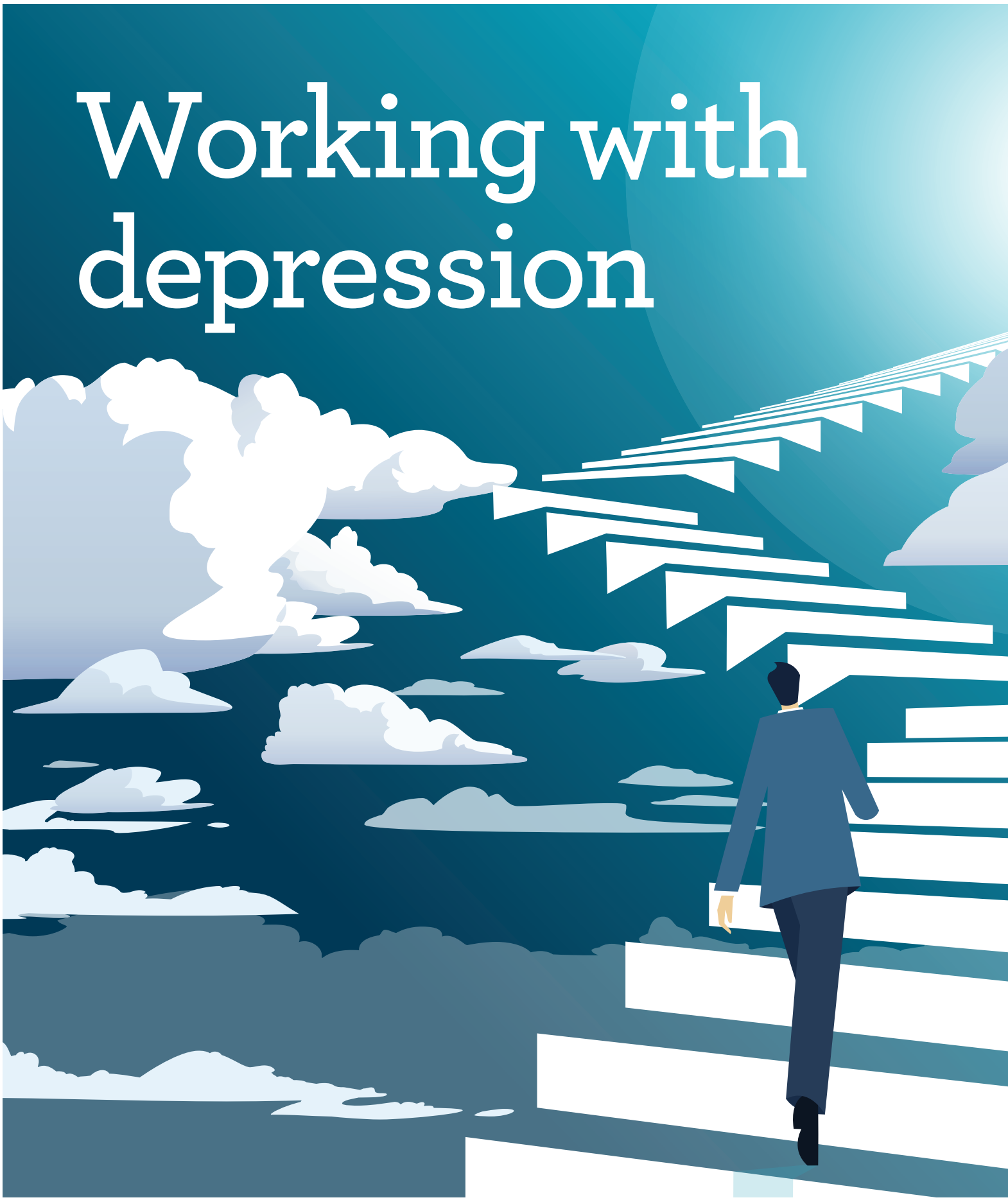
Working with depression



Chronic low mood can be difficult to treat, but interpersonal psychotherapy is recommended by NICE and widely used in IAPT services. ***Andrew Bates*** describes how it works

People who report chronic low mood or depression, sometimes known as dysthymia, can be challenging to the therapist. The depressed person might initially be met with the sympathy of others. But that sympathy might soon wear thin, to be replaced by irritation and withdrawal,[1] a process that might easily play itself out in the therapy room. The patient might also see their depression as an innate aspect of their personality, and therefore untreatable.

Interpersonal psychotherapy is recommended as a treatment for depression. In my experience, it is also effective in the treatment of dysthymia.

So, how is dysthymic disorder identified – and how is it different from a severe depressive episode without psychotic symptoms?[2] Severe depression is often easier to recognise, due to its acute nature. Dysthymic disorder tends to be less obvious. It is described as depressed mood for most of the day, more days than not, as indicated by the sufferer's subjective account or observation by others, for at least two years.[3] As with many mood disorders, comorbidities are likely to occur with dysthymia. Markowitz[4] cites severe depression, as well as anxiety disorders, substance abuse and personality disorders.

Dysthymia is a chronic condition, but the patient might well be presenting for therapy as a response to a recent life event, such as a job loss or bereavement, which has made their mood worse.

Dysthymic patients are more likely to conceal their difficulties, perhaps as a result of the chronicity of the condition. The chronicity often leads to adaptations, which can appear both at home and in the workplace.[4]

To compensate for their lack of self-esteem,[3] dysthymic patients often expend what little energy they have striving at work to appear outwardly 'normal'; indeed, they tend to be hard and loyal workers.[5]

Personal and social interactions can also prove difficult, due to the unpredictability and emotional risk involved.[4] Dysthymic patients often experience difficulties in asserting themselves, expressing anger and taking risks in social and intimate relationships. They can therefore experience isolation, which can contribute to the emergence of depressive symptoms.

Of course, counsellors and psychotherapists are not usually qualified medical practitioners, so are not authorised to offer a formal diagnosis. However, a therapist and their patient can agree dysthymia to be the likely difficulty, and plan treatment accordingly.

If their dysthymic symptoms have been lifelong, the patient might never have learnt interpersonal skills, such as the forming and sustaining of close and intimate relationships. They can consequently view their dysthymia as an aspect of their personality, rather than an illness. The therapist then has the daunting task of not only helping the patient to gain symptomatic relief, but also to learn the interpersonal skills they did not acquire at the appropriate time in their development.

Patients suffering from severe depression can usually recall times of remission from symptoms, when they have been able to enjoy life. Dysthymic patients do not have the luxury of such memories,[4] which makes it more of a challenge for the therapist to instil the hope and optimism in the patient that they will get better.

The therapist must therefore help the patient to distinguish between 'trait' and 'state', so the patient can more clearly see their depression as an illness. They can then better understand it and believe it to be treatable.

Before 1980, dysthymic symptoms were considered to be indicative of a depressive personality disorder. Dysthymic disorder was reclassified as a mood disorder with the publication of *DSM-3* in 1980. Previously, long-term psychodynamic psychotherapy and psychoanalysis were the talking therapies of choice, although there was little research evidence to support their efficacy.

Interpersonal psychotherapy

The origins of interpersonal psychotherapy (IPT) go back to the 1970s, when Gerald Klerman and his colleagues worked collaboratively to develop a targeted system of talking therapy to treat depression. The group was made up of psychiatrists, psychotherapists, social workers and researchers, who were interested in how the social, biological and psychological aspects of depression intersect, and how they could be used together in treatment.[6]

There is a large body of research into the effectiveness of IPT as a treatment for depression. Consequently, it is now an evidence-based intervention, recommended as a treatment for depressive disorders by NICE guidelines, and is widely used in Improving Access to Psychological Therapies (IAPT) services in the UK.

IPT is a brief, structured, present-centred therapy that is usually delivered over 16 sessions, made up of three phases: early, middle and end. It is designed to disturb or disrupt depressive symptoms and gives the patient experience of fluctuations in their depression, creating the space to bring about change.

IPT is an active therapy that requires the patient to increase their engagement with others and with pleasurable activity, in order to reduce isolation. The therapist is not a neutral party or passive observer, but an active participant in the process.[7]

An integral part of the model is the symptom review that takes place every session. The review is designed to help the patient to track their depressive symptoms and to better identify variations. The aim is to enable the patient to become the expert on their own depression and to understand that their depression is fluid, not static. For example, changes in mood, sleep, appetite and libido can all be indicators of improvement. In IAPT services, questionnaires are also used in each session to identify and track the patient's symptoms of depression and their overall functioning.

In IPT, we encourage our patients to engage with other people and pleasurable activities. So, we enquire about the patient's activities since our last session. The dysthymic patient might not have participated in an interest or hobby in many years. But the therapist should not give up. Encouraging the patient to become engaged in hobbies and activities increases their chances of making social contacts, which can open the door to the use of strategies, such as communication analysis and role play.

In session one, the tasks are to outline the IPT structure, pinpoint the patient's key difficulty, deliver psycho-education and draw up an initial therapy contract. I would also begin to help the patient identify their depressive symptoms and recognise fluctuations, so introducing the concept of their condition as an illness.

When delivering psycho-education, I normally start by asking the patient about their understanding and experience of depression. In my experience, the dysthymic patient is likely to talk about the chronicity of their depression, which they view as part of their personality. At this point, the therapist can find out how long the person thinks they have been depressed and the effects of the depression on their relationships.

If dysthymia is identified, it is helpful to put forward the 'trait' versus 'state' argument, to encourage the patient to accept that they are unwell, so they can start to experience their depressive symptoms as ego-dystonic, as opposed to innate. They can then develop mastery over their symptoms and engage with supportive others and pleasurable activities.

Initially, a dysthymic patient is unlikely to be convinced. It is, therefore, the therapist's task continually to reiterate this point throughout the therapy, in a spirit of hope and optimism. It should be clear to the patient that their mood disorder is an illness, which is treatable. The therapist can also explain that IPT has a solid evidence base for effective treatment of such conditions.

In the second session, I would take a history of the patient's episodes of depression. The history tends to be presented as a timeline, showing triggers, any previous treatment and any changes that influenced the depressive symptoms. It can be challenging, as the dysthymic patient is unlikely easily to recognise triggers or factors that change the state of their depression. It can also be useful to identify periods that were free from depression. They are likely to be few and far between, but they will support the argument that the depression is fluid and hence more treatable.

We would take an interpersonal inventory in session three, which is often a diagram, representing the people and relationships in the patient's life. It is typically presented in the form of a constellation, showing how the patient perceives their distance from those around them. The constellation helps to identify the patient's degree of isolation and possible sources of support.[7] Particular attention should be given to current, close, supportive relationships, and what the patient expects and gets from them. Unsatisfying relationships in the past and present are of interest and underlying patterns noteworthy.

The final session of the early phase of therapy (session four) is used to refine the therapeutic contract and to set goals. It can be challenging to set goals with dysthymic patients, who have little experience of anything other than their chronic state. A dysthymic patient could well find it difficult to conceptualise a goal, as it might be something they have not previously experienced – a caring and satisfying relationship, for example. The therapist and patient can agree sub goals, such as joining a club or society, where there are the opportunities to meet people, as staging posts towards a meaningful relationship. But these markers need to be concrete and achievable.

In the fourth session, a formulation is also presented to the patient, informed by what has been learnt

so far, primarily from the timeline and interpersonal inventory. The formulation is crucial in reinforcing to the dysthymic patient that they are suffering from an identifiable illness that is treatable. The use of a definition for dysthymic disorder could also prove helpful, in that the patient can better see their condition as treatable. The formulation influences the choice of focal area for the middle and end phases of the therapy.

The focal area is a pivotal feature of IPT.[7] It serves two main functions: first, it determines the current issue(s) contributing to the patient's interpersonal difficulties that caused and/or are driving their depression; second, it provides a set of treatment strategies for use in the middle and end phases of therapy. There is a choice of four focal areas: complicated bereavement, transitions, interpersonal role dispute and sensitivities.

Complicated bereavement

We talk of complicated bereavement when the patient has recently lost someone significant, but the grieving process has either not taken place or has been arrested in some way. The death of someone close can elicit great distress in the dysthymic patient, perhaps because they tend to have few, intimate relationships.[4] But it can provide the therapist with the opportunity to elicit affect and help the patient to process their loss. It could also alleviate their depressive symptoms, by allowing them to access feelings of sadness and anger, which are often difficult to express. If the patient can free up the grieving process, it could enable them to explore possibilities for initiating and developing new relationships.

Transitions

We would consider a transition to be a major change in the patient's life, such as redundancy, divorce or leaving home for university. A novel feature of IPT for dysthymia is to regard the dysthymic disorder as a transition in itself, the transition from illness to health. The patient is likely to have been depressed for a long period, often stretching into decades. The work might therefore involve helping the patient to understand what it's like to be well. The new possibilities of a life of wellness can be explored, along with the potential for new relationships, the development of new interests and a greater engagement by the patient in the world around them.

Interpersonal role dispute

People with dysthymic disorder tend to have unequal relationships of limited intimacy.[4] Feelings of unworthiness, inferiority and inadequacy can stifle their abilities to assert and express themselves, leading to the pent-up emotions that can feed their depressive symptoms. Interpersonal difficulties are common and can result in tensions or disputes, which can become 'stuck'. Work is then needed to free up the sticking points and resolve the dispute.

Dysthymic patients are more likely to settle for any relationship rather than none, often due to the sparseness of their network.[4] Therefore, therapist and patient need to explore and decide whether a relationship is genuinely satisfying. It is likely to be a challenge for both therapist and patient to define what would be

a satisfying and fulfilling relationship for the patient. But once these needs and desires are uncovered, therapist and patient can explore available options.

Dysthymic individuals often suppress anger, due to a fear of 'rocking the boat' and losing the overvalued partner or friend.[3] The patient might not even be aware that they are feeling anger, substituting it for guilt or self-criticism.[8–10] The internal rage can result in masochistic relationships, where the patient's unwillingness to set boundaries means they suffer the other person's hurtful behaviours. Helping the patient to recognise the connection between their depressive symptoms and the behaviours of others around them can herald a new understanding, clearing the way to employ new strategies within their relationships. It might be the first time they experience their own power to control events and alter their lives.

Interpersonal deficits (sensitivities)

Due to the chronicity of dysthymic disorder, patients might not have acquired the skills necessary to establish and maintain satisfying social interactions. For example, they might not have learnt how to reciprocate people's interest in them. Indeed, it's possible that these deficits predispose the patient to depression. Consequently, the sensitivities focal area is the most difficult to treat using IPT. However, the therapist can help the patient to reduce their depressive symptoms by encouraging them to increase their engagement with their network and pleasurable activities. Challenging the thoughts and feelings the patient carries about themselves can also help to modify the behaviours they use in their interactions with others.

In the middle phase, the therapist would link any symptoms and difficult interpersonal events, such as an argument, to the agreed focal area(s).[1] For example, let's say the focal area is dispute. The therapist could explore with the patient strategies for moving the dispute on. As always, it's crucial to maintain a present-centred framework, to discourage the patient's ruminations on past losses and failures. It can also help to mobilise their energy to manage their current symptoms and use their network of supporters to aid recovery.

Ending therapy

IPT, like many therapies, attaches a great deal of importance to therapeutic endings. As IPT is a time-limited therapy, it is essential to prepare the patient for when therapy ends.

Dysthymic patients tend to overvalue relationships, so it's important to allow the patient to express their feelings around ending therapy, which might include anger towards the therapist. The feelings need to be accepted and acknowledged.

It's important to show the patient how far they have come and how they are ready to transform their dependence into healthy independence. A review of the therapy is carried out, which involves the therapist and patient accounting for the progress the patient has made and what they did to reduce their depressive symptoms. The strategies and techniques the patient has learnt through IPT will help them to be their own therapist, keeping themselves well in the future.

If continuation or maintenance sessions are decided upon, the therapist needs to step back, dilute their own input and place more emphasis on the patient's new-found skills in maintaining their depression-free state.

The entire IPT treatment needs to be considered a transition in itself, from being depressed to being healthy.[4] The IPT stance that dysthymia is an illness, and that it's treatable, is paramount, as is the continual instilling of hope.

***Andrew Bates** trained as a transactional analyst and is a UKCP registered psychotherapist. He has worked in several therapeutic settings for more than 20 years and now works as a supervising interpersonal psychotherapist at Steps2Change, the Lincolnshire IAPT service.*

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Third person

VICKI PALMER

I have spent most of my 30-year counselling career trying to improve NHS mental health provision in primary care, as a result of a deep commitment to offering equal access to mental health services that are free at the point of delivery.

I have recently been reflecting on and evaluating where we have been, where we are and where we could be in the provision of good mental healthcare in the UK. I have also found myself challenged and re-energised by James Davies' book, *Sedated: how modern capitalism created our mental health crisis*.[1] The book has made me aware of recent research into the long-term effects of medication. It has also reinforced my awareness of the interconnected societal factors that are contributing to mental ill health.

'I think it's time for a radical reappraisal of the evidence base for mental health'

In NHS services, we collect data to help commissioners and clients assess the effectiveness of therapy. In the services I have been closely associated with, the data consistently demonstrated a favourable outcome for 58% to 64% of clients. The data probably lulled me into thinking our service was doing well. I rarely had time to consider those who were not helped, or found time to read recent research in detail.

I was also perhaps too quick to accept the use of antidepressants as part of the solution for clients who did not find therapy helpful, as I was largely unaware of the longer-term consequences of their increased use over the past 20 years. I am not anti-medication. I am simply drawing attention to my lack of awareness of the consequences of the overuse of antidepressants.

Many in our society are quick to turn to antidepressants when they are encountering normal, human experiences of loss, grief and trauma. But I wonder whether we are sleepwalking into a short-term solution, without seeing the longer-term consequences.

I think it's important that our profession is aware of a growing evidence base, which suggests that the long-term use of antidepressants could be detrimental to mental health. In 2017, a large study, published in *Psychotherapy and Psychosomatics*,[2] looked at the progress of 3,300 patients over nine years. It showed that long-term medicated patients had significantly more severe symptoms of depression at nine years than those who received no medication or had stopped the treatment of antidepressants within 12 months. The findings of the study align with research that service users have a preference for psychological therapies over medication.[3] Interestingly, the *British Medical Journal* has also cited overuse of antidepressants as a major public health concern.[4]

Short-term use of antidepressants can be of benefit and can enable severely depressed clients to engage with talking therapies. But, as counsellors, we need to be open to talking to the GP, with our client's consent, about their medication, the timing of reducing it and the necessity for it at all.

GPs and NHS Commissioners are not usually experts in the field of mental health, so they rely on the 'gold standard' of the NICE guidelines. But the guidelines don't allow for practice-based evidence, only randomised control trials (RCTs). The study cited above, for example, could not be submitted as NICE evidence, even though it was carried out by a group of reputable researchers at a respected university, and even though it included a larger cohort of patients than most RCTs.

I think it's time for a radical reappraisal of the evidence base for mental health, to prevent us from sleepwalking into the arms of the pharmaceutical industry. We could then find additional, creative solutions that don't negate the benefits of short-term use of antidepressants for people who choose them, but that free us from their long-term use.

I am not making an anti-medication or an anti-psychiatry plea. It is a plea to all of us, as mental health professionals, to listen to the latest research and to the wishes of the individual, and then to fund and find the best approach.

Of course, it would compel us to keep our knowledge up to date, so that we could reliably inform our clients, based not on our prejudiced or sedated perceptions, but rather on research and practice-based evidence from our own and our collective database.

It would also require us to make the links between mental health and culture, poverty, employment, materialism and capitalism. We would then work in the collective interest, in a spirit of connection and collaboration, mirroring how we work with our clients in talking therapy.

***Vicki Palmer** is a BACP senior accredited counsellor, supervisor and member of the BACP Healthcare Executive. She has developed and taught on counselling and supervision diploma courses in England and Scotland and was the former CEO of Oasis-Talk CIC.*

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Attachment

and *addiction*

A shift to an attachment-focused approach has improved outcomes for clients who are struggling with addiction and dependency, as ***Sarah Pennock*** explains

After 21 years of friendship, my dearest friend collapsed from a series of heart attacks. A week later, with no evidence of brain activity, her family made the heart-wrenching decision to turn off her life support. She was 39 years old. I gained some comfort from knowing that she had been released from a lifelong battle with food; it had been her comfort, her reward, her passion, her distraction, her enemy and the place she returned to manage any and all her feelings.

Following a diagnosis of diabetes aged 14, my friend had rarely given her body the nutrition it needed. Instead, she would binge on sugar and refined carbohydrates most days, often abusing her insulin to rapidly lose weight through intentionally poor blood sugar control. By signing up to the latest diet plan, she repeatedly attempted to regain control, but consistently returned to the familiar, yet harmful, food behaviours. Our university years were marked with sudden but preventable distress, as she suffered regular, hypoglycaemic episodes, where her blood glucose level dropped dramatically, through poor management of her condition.

For much of her adult life, my friend's weight fluctuated and her diabetic body suffered. Her health, so often sacrificed for her appearance, and her food, recruited to change her mood, brought grim consequences to every layer of her life. She developed diabetic retinopathy, cataracts, deep vein thrombosis and, eventually, kidney failure. She struggled with increasing anxiety, bouts of depression and a whole spectrum of eating disorder traits. Her final year of life was largely spent in and out of hospital. Neuropathy meant minor injuries quickly progressed to more serious medical problems, her wounds failing to heal due to poor blood circulation; one very distressing admission for diabetic foot ulcers had barely avoided foot amputation. She began dialysis and waited for a kidney and pancreas transplant. When the call finally came, the organs were unsuitable. It was devastating news.

The diabetic complications couldn't be undone. I recall the moment shortly after discharge from yet another gloomy hospital visit, she repeated the doctor's morbid warning about the increased probability of her early passing, most likely before we could celebrate our 50th birthdays. I have often wondered if, in that moment, she shared my fear her life would end far sooner; in fact, she died only a few months short of her 40th birthday.

About six months after my friend passed away, following a period of personal therapy and a significant midlife appraisal, I left a 20-year career in television and decided to retrain as an addiction therapist. It felt like the right time to embark on, for me, a more meaningful vocation, one which provoked uncomfortable self-exploration, multiple turning points and deeply rewarding work.

I find myself, 10 years later, identifying as an attachment-based therapist, specialising in addiction and dependency, resulting from an integration of two, distinct models of therapy: an abstinence-based addiction model and psychotherapy informed by attachment theory. Tragically, the nutritional-based interventions alone could not save my beloved friend. As my clinical work continues to provoke memories of her struggles, I wonder if awareness of her attachment insecurity could have provided an alternative insight into her dysfunctional eating that might have extended her life.

'It felt relevant to me to make sense of Ava's historical dependency on food'

I would like to take a single case study (a female binge drinker and compulsive overeater) to describe my shift from an addiction model of treatment to an integrated, attachment-based framework for understanding and working with recovering addicts, whose dysfunctional food behaviour is maladaptive – and not dissimilar, in process or motivation, to substance misuse or alcoholism. I will share the challenges and small triumphs in helping my client surrender patterns of self-harm, while explaining why the mere avoidance of particular foods or cessation of damaging food behaviour were simply not enough to bring about lasting change. I highlight why, in my experience, the use of behavioural therapy within an addiction model of recovery has an enhanced capacity to heal and repair, when considered alongside the client's attachment functioning.

In sharing a fragment of my work with this specific clinical population, I demonstrate the link between

attachment insecurity and relapsing behaviour, and between a poor working model of self and a reluctance to pursue more constructive behavioural coping strategies. I also demonstrate why, in my experience, the client will not make the best use of therapy and a recovery community as a source of soothing and support, if they have little or no awareness of their attachment style. Additionally, I illustrate why an absence of behavioural skills training within addiction-focused, attachment-based work will limit clients' learning, restrict their capacity for positive change and therefore impede their progress towards a more secure state.

I first met 28-year-old Ava when I was working as a therapist for a 12-step, abstinence-based, outpatient addiction programme. Ava stated that her drinking and overeating were out of control and she was 'done with being fat'. She described her mood as 'sad and anxious, for as long as I can remember', with occasional panic attacks. She felt her 'long-suffering boyfriend' of eight years was a victim of 'false advertising', having met her when she was 'a young and thin trainee doctor', but who now found himself with a 'failed, obese care assistant'.

Ava was under the care of a psychiatrist and had been taking medication for depression and anxiety for four years. She had attended weekly, psychodynamic psychotherapy for the past two years and was able to offer some understanding of the impact of her childhood on her adult choices. She listed the many weight-loss plans she had tried since early adolescence, only to regain the lost pounds – and more – with each attempt. Despite significant financial and emotional investment throughout her adulthood, she had not been able to overcome the destructive behaviour around food and alcohol that now dominated her life.

'Ava would return to excessive food consumption in search of soothing'

Ava easily recalled evidence to demonstrate her difficulty moderating alcohol. There were multiple stories of regrettable and risky behaviour resulting in black-out, which had been normalised in her friendship circle, yet which consistently resulted in heightened anxiety and shame. Ava was a binge drinker, both socially and alone at home, and she did not deny her compulsion to drink and struggle to moderate alcohol. Ava was nevertheless able to surrender alcohol from day one, with only a few wobbles, which was unusual in my experience. But while counting sober days gave her a sense of shared achievement with her programme peers, it also provoked disappointment that minimal change had occurred with her food behaviour. In fact, letting go of alcohol seemed to inflame her desire to overeat. She quickly identified that alcohol was not her primary prop to manage her feelings: that badge was unquestionably awarded to food.

It felt relevant to me to make sense of Ava's historical dependency on food, but she was clear the primary goal for her treatment was behavioural change. She wanted both to lose weight and to acquire the skills to maintain a 'right-size body'. But we agreed to explore what might provoke the cravings and why none of the slimming programmes had given her the long-term weight loss for which she yearned. If recovery was simply skills training, why had Ava not managed the change to which she desperately aspired?

Ava could track her compulsive eating back to her early childhood, when her father was largely absent from the home and she was subjected to her mother's unpredictable mood swings and violent outbursts, which were later identified as symptoms of severe premenstrual tension. Her mother targeted Ava, as the 'bad, fat daughter'. Ava would fail to dodge slaps and punches, while heeding a familiar and repeated message: 'I hate you; you've ruined my life; I'm leaving.' Ava was acutely aware of her childhood anxiety and desire to cling to her mother or grandparents to get her security needs met. She remembered feeling distressed by separations from her family members and her struggle to feel soothed when reunited. Ava had many examples of her mother's misattunement, which often resulted in food-seeking behaviour to ease her anxiety and fear.

Chronic anxiety in childhood meant Ava had struggled and failed to develop an internal sense of security. She was starting to make sense of her relentless and unsatisfying search for safety in food. A mourning process needed to begin for the maternal attunement she had yearned for but never received. Each time Ava felt let down by another disappointing interaction, which led to a shameful return to overeating, I reminded her that unrealistic expectations of love or soothing from either her mother or food was an old fantasy, one that she might begin to surrender. It would be neither a quick nor a linear grieving process. Repeatedly, Ava would return to her mum and excessive food consumption in search of soothing.

In order to forgive her mother and surrender any expectations, it felt appropriate to make sense of her mother's abusive and sometimes violent behaviour in Ava's childhood. A mother's own unresolved trauma might interfere with her ability sensitively to respond to her child, affecting the development of a secure attachment and potentially contributing to the intergenerational transmission of trauma. Ava knew that being slim and in control of one's food was revered in her family; to be out of control was shameful. As an adult, Ava often reported feeling scrutinised by her mother, sensing her disapproval as she ate. Continuing to overeat was an act of rebellion, an expression of anger at her mother's judgment and attempt to control Ava's food. Overeating in her mother's presence was an indirect communication of her autonomy.

We observed a similar pattern with her boyfriend, when Ava felt dismissed. How could Ava protect herself emotionally from their hurtful judgments, not reach for excess food and still manage openness, warmth and empathy in her relationships? It was an ongoing and deeply uncomfortable piece of work for Ava to assert and maintain a separateness by expressing her feelings and needs verbally, rather than with defiant, regressive behaviour, and by recruiting internal sources of comfort that were not an assault on her body.

The ability flexibly to regulate emotions in a context-appropriate manner is a distinct trait of secure attachment. Together, we noticed how Ava might recruit different emotional regulation strategies in different situations, such as self-blame, tolerance, criticism, rumination, obsession, shame, binge drinking or emotional eating. Of course, affect regulation and distress tolerance skills could rarely be neatly assigned to a particular point in a particular session. There was a need for flexibility and spontaneity from both myself and Ava when she began to dysregulate. To prevent her rapid slide into an unhelpful, emotionally negative place, which would inevitably result in overeating, I would appeal for a pause, to draw her towards a more cognitive state. We would frequently wonder if the detail she was so intent on sharing was serving her emotional stability or risked trapping her in unsteadying rumination. We both recognised that anything unsettling would precede overeating; hence, slowing down the session to create a break in that cycle was appealing. We recruited these opportunities to coach Ava into consciously activating her parasympathetic nervous system (the calming, restoring part), using specific skills and techniques to dissipate intense feelings, rather than automatically reaching for food to numb, escape or sedate herself until the feelings passed.

A mandatory aspect of the treatment programme was thrice weekly attendance at 12-step fellowship meetings, such as Alcoholics Anonymous and Overeaters Anonymous, where Ava was encouraged to seek support from others who were following an abstinence-based, addiction recovery programme. Evidence[1] demonstrates that this community extends therapeutic support and provides a secure base to return to each week, to identify and share recovery experiences. When planning a binge and unable to access internal resources to manage the craving, Ava was encouraged to reach out to a fellowship peer who might empathise and help her to mentalise, or remind her to recruit the calming techniques. When Ava was infused with agitation or sinking in sadness, a peer might be hopeful. When Ava felt wobbly, a peer might steady her. But, inevitably, Ava experienced days when others were unavailable, unreliable or failed to provide the stability she needed in that moment, triggering historical responses to misattunement that resulted in ambivalence about attending these meetings.

Ava had a tendency to focus on what was missing and block any nourishing interventions. It was noticeably jarring for me when, in these moments, I was unable to penetrate her wall of disillusionment and defence. It often left me feeling frustrated and inadequate. Ava's negative bias and mistrust of others threatened her connection with members of the 12-step community and therefore threatened another layer of support in her recovery journey.

In my experience, clients with traits of avoidant attachment found the 12-step meetings deeply uncomfortable, as they witnessed the emotional honesty of others. People with a more anxious style, such as Ava, demonstrated a greater desire to attend, but often reported feeling preoccupied with relationship dynamics within the community. Attachment theory[2] suggests their withdrawal from the meetings or relational anxiety is an expression of their insecure attachment. A greater understanding of Ava's attachment functioning – her

fears of either intimacy or rejection – allowed us to make sense of, anticipate and counter her emotional responses provoked by the meetings.

While attendance at the meetings was indeed provocative, the interpersonal challenges provided an abundance of opportunity to practise mentalising skills, emotion regulation skills and social skills of honest communication, tolerance and reliability. Put simply, the recovery community presented an ongoing, experiential opportunity for Ava to try out new, 'secure' ways of thinking and behaving. Our sessions gave Ava an opportunity to unpack and make sense of her responses to the meetings, while taking risks in changing her old and unhelpful, insecure coping strategies.

Following completion of my attachment-based training, I felt an increasing dissonance between the pure addiction model of the 12-step treatment centre where I was employed and my attachment-based perspective. My experience highlighted the limitations in treating addictive symptoms as one disorder. If attachment insecurity was still active and untreated, it would interfere with the successful treatment of addiction and issues of dependency.

'Attachment-based training provided the missing piece of the addiction treatment puzzle'

Without doubt, working solely within an addiction model, a task-focused, time-limited approach, had delivered results. It provided behavioural techniques to better manage affect, access to a support community and, for most, a significant shift in personal responsibility and a positive reworking of their narrative.

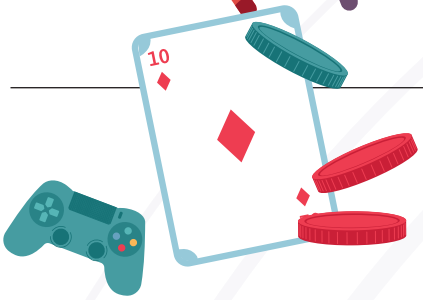
Yet in my first few years of working purely within an addiction model, I observed multiple episodes of substance and behavioural relapse. I witnessed many clients lose their sobriety or abstinence and return to the 12-step programme for a second, third or fourth treatment episode. It was, of course, distressing and disheartening for my clients. But I also felt frustrated, confused and questioning. Why was this happening, and how might I better support my clients in their bid to break their dependencies? Despite busting denial, developing motivation and teaching new skills, their reluctance to consistently recruit these skills when in need was baffling. Hearing an addicted client labelled as resistant, reluctant, defiant or a hopeless case in clinical discussions deeply frustrated me and did not make sense. Why would they seek admission to an addiction treatment programme, invest time, step away from their daily lives, then reject the step-by-step behavioural treatment being offered?

I began to question whether a therapeutic model of addiction alone could offer long-term rehabilitation, as well as short-term restoration. Attachment-based training provided the missing piece of the addiction treatment puzzle. Clients' pervasive sense of inadequacy and their shame in finding themselves an 'addict' both had to be addressed in order to positively impact behavioural change. Attachment theory[3] demonstrated how an insecurely attached person with low self-efficacy, due to their internal working model, is likely to avoid accepting challenges for fear of failure. Ava simply did not believe she was capable of succeeding, and consistently framed any perceived failures and adversities as personal shortcomings.

In my view, participating in an addiction treatment programme is only the beginning of recovery. If clients are curious and willing to engage in longer-term attachment work, they can begin to understand the root causes of their dysfunctional behaviours. Without awareness of their attachment history, a maladaptive aspect of themselves is left active, serving only to hinder their recovery process.

I yearned to offer my clients greater flexibility in the pace and length of the treatment in order to explore attachment history and attachment functioning in greater depth, with a focus on how this might influence their dependency issues and capacity to recover. So, after several years in addiction treatment centres, it felt time to step away and create a private practice in which I could integrate both models of training, specialising in addiction and dependency. I continued to work with Ava in weekly, face-to-face sessions.

Increasingly, I recruited attachment theory to assess clients, to frame their early developmental experiences, to help them make sense of their lifelong thinking and behaviour, particularly when under stress, and I used this theory to gain a fresh perspective on my relating style in the consulting room. Reviewing a client's attachment history in an extended assessment helped me to foresee the level of care an individual might demand, depending on their attachment functioning. I could therefore consider if I had the availability and emotional capacity at that point to support their needs or whether I could instead make a referral, resulting in better care for the client and a conscious maintenance of my professional resilience. It was liberating and hugely enhanced my clinical work. Attachment theory had become a theoretical anchor, a base camp for clinical exploration.



Many of us can relate to Ava, scouting unnecessary food to alter mood, to ease the impact of unwanted news, to reward, to compensate, to soothe loneliness, to rebel, to indulge with friends when creating connection. Without doubt, food indulgence was a pleasurable activity shared with my diabetic friend. It's culturally accepted to give and receive food to celebrate, to sympathise, as an expression of thoughtfulness. We all need to eat, and while for some there is a mild to moderate temptation to overindulge, for others – like my friend and Ava – a dependent relationship with food is shamefully destructive, a symptom of something far more complex than bad habits or gluttony.

Why did Ava have such a hard time following through her desire to change? I think it's because the change required far more than breaking a habit. It demanded attachment-focused work to support Ava in shifting her thinking, building self-belief, nurturing self-compassion and learning to navigate her feelings without resorting to overeating. It also required the capacity to make sense of others' behaviour (mentalisation), to challenge her expectations of others, to surrender an old coping strategy that no longer served her and – crucially – to forgive and grieve an unyielding mother, so she might no longer seek reassurance from someone who did not have the capacity to provide it. The change involved enlisting Ava's developing internal parent. It required courage to drop her guard and expose her vulnerability, when she might turn to supportive relationships rather than salty and sugary foods, when she might seek connection rather than chocolate. It required reconfiguring her 'internal working model'.[2]

For 28 years, Ava had recruited food to manage her anxiety, control her fury and soothe her sadness. Food helped minimise her social fears, temporarily escape body shame and numb her reality. Binge drinking and overeating were symptoms of Ava's insecure attachment functioning, substitutes for human support and self-care gone wrong. When her attachment needs were activated, so too was a powerful urge to eat. And in a dysfunctional way, this had helped her survive for almost three decades. For Ava, like all her programme peers, change meant loss and lamenting the old way of living. It was unsettling and slow. The behavioural change was slippery, engaging with the recovery community was fraught with uncertainty, and acting 'secure' demanded huge discomfort and risk. The result, not uncommonly, was a vacillation between dependency and recovery, an expression of ambivalence towards change and the journey towards 'earned security'.[3]

Importantly for Ava, her impulsive and compulsive eating began to lessen; her weight initially stabilised, then slowly began to diminish. Enlightened, she became more alert to self-harm, both behavioural and relational, to make better informed choices about what she needed and how she might meet those needs, both internally and externally. She began to flourish, with increasingly satisfying human connections rather than disappointing fast-food fixes.

Our work together has brought improvement in many aspects of Ava's life, but I cannot fail to share the regressions over the past three years. Unsurprisingly, some of life's stressful events (illness, job change, pregnancy, bereavement, COVID-19) activated her attachment system and old coping strategies triggered extended periods of relapse. Under difficult circumstances, Ava returned to overeating, demonstrating that change is not straightforward and feeling secure is pivotal in manoeuvring life's inevitable curve balls.

'The change required far more than breaking a habit'

For me, these past six years in private practice have brought an abundance of evidence supporting an integrated, attachment-based approach when working with addiction and dependency. Sensitivity to both my client's and my own attachment functioning has allowed me to aim therapeutic interventions at key factors that maintain the addictive behaviour and complicate the therapeutic relationship. The dual focus on behavioural change and attachment functioning has significantly improved outcomes in my clinical work. For my clients, it has brought a shift from acute, short-term treatment to sustained recovery management. It has given me an evolving confidence and belief in my ability to help liberate my clients from the despair of dysfunctional eating.

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From *Attachment, Relationships and Food: from cradle to kitchen*, 1st edition, edited by Linda Cundy and published by Routledge, 2021.

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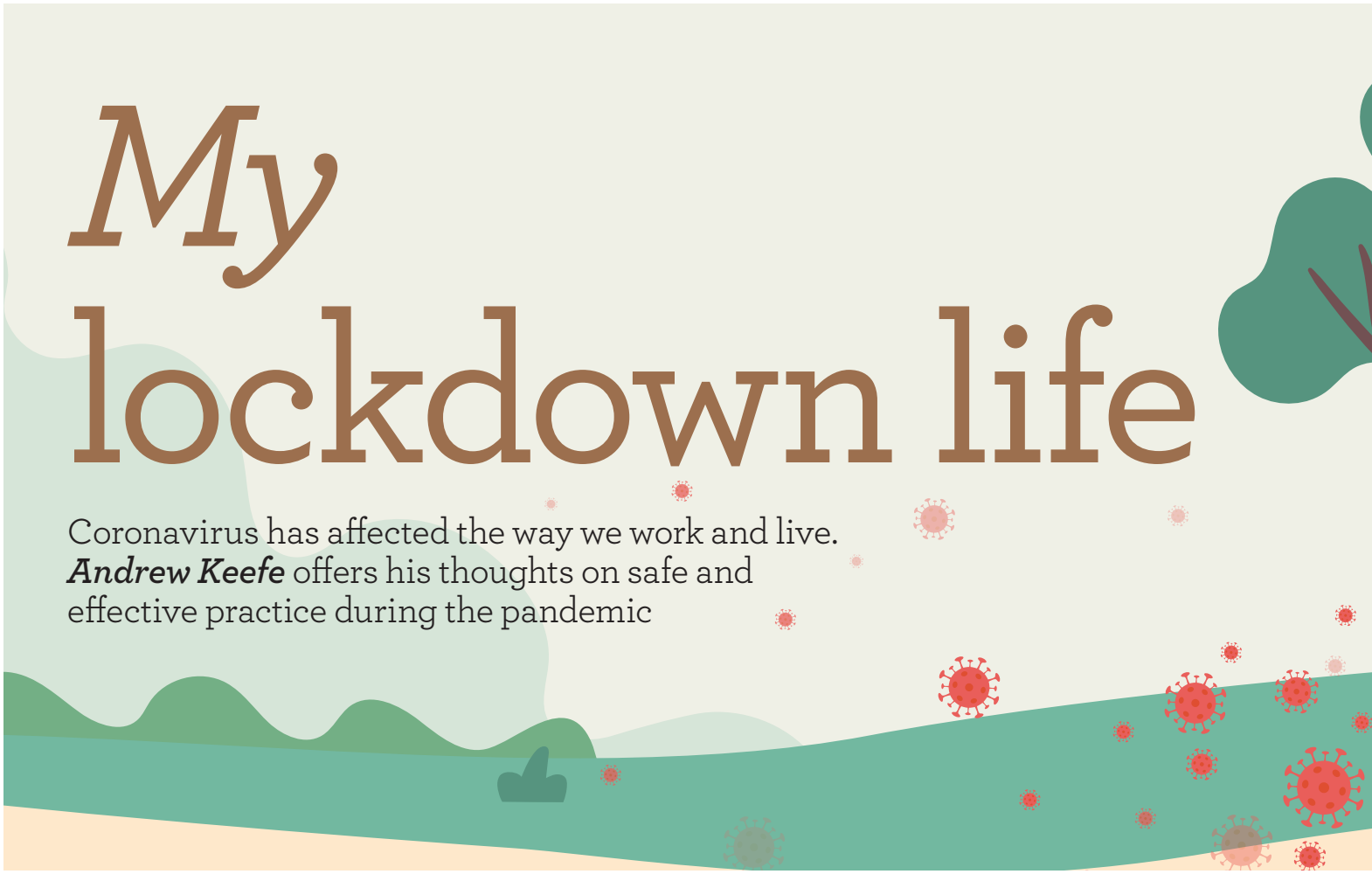
My lockdown life

Coronavirus has affected the way we work and live. ***Andrew Keefe*** offers his thoughts on safe and effective practice during the pandemic



In many ways, COVID-19 is a collective experience: therapists are living through the pandemic at the same time as their clients. We might all be affected differently by the unfolding events, and interpret their meaning according to our own internal worlds, but the events are the same. When I see the data on infections, hospitalisations and deaths, so do my current and future clients. We might also share similar experiences as a result of the pandemic – illness and bereavement, for example.

Of course, therapists often have lived experience of the issues their clients bring to therapy. But all of us going through the same stressful ordeal, at the same time and for so long – that's certainly not something I have lived through before.

In the first weeks of the pandemic, it surprised me how little clients mentioned its impact. But as weeks became months, sessions became increasingly dominated by COVID-19. Clients lost friends, family and colleagues to the deadly virus, their grief exacerbated by the restrictions on funerals and access to the dying.

Some clients with chronic anxiety at first found safety and comfort in the lockdown, though this often turned to isolation and despair over time. Others living with obsessive compulsive disorder struggled, as the barrage of messages about hand-washing increased their compulsions. The pressures of online dating were magnified by prohibitions on socialising and fears about the spread of the virus.

Many people returned to live with parents in the family homes where they had perhaps endured unhappy and unsafe childhoods, sleeping in the same bedrooms. Traumatic memories were triggered, family patterns and dynamics were repeated.

Disordered eating increased. Some clients ate for comfort; others restricted their food intake in search of some form of control. Too much alcohol was drunk, out of boredom or despair. Financial worries mounted. Routine was lost and sleeping patterns disrupted.

People living alone often found the silence and loneliness to be crushing, the lack of contact and touch almost physically painful. Flatmates and families got on each other's nerves, clashed and fought. Parents tried to juggle working from home with home schooling. Children missed their friends. The divorce rate increased.

Social distancing isolated women during pregnancy, labour and the fraught early weeks of a baby's life, increasing the risk of birth trauma and post-natal depression. All this pain was brought to therapy – and to therapists living through many of the same experiences.

I am a psychodynamic psychotherapist by training and, while I have never believed I can be an entirely blank screen, I am sparing in the personal information I give to clients. I found this position harder to maintain than usual, because of the shared experience. I had to tell clients I would be working online and they all got to see a small corner of my house.

Later, after returning to in-person work, I had to inform a number of clients that I had contracted COVID-19. They were concerned, asked how I was. I had a nasty cough for six weeks but was otherwise well. What about the clients who didn't know that I had contracted COVID-19? Should I tell them I had caught the virus but was now all clear?

Working on Zoom also allowed me to glimpse the homes of my clients. I saw them eat breakfast, met their pets. Sessions were interrupted by deliveries. We all struggled with technology, unstable Wi-Fi.

I often wondered how I would feel and respond if a client refused to take the vaccine. What ethical issues would arise in working with someone with whom I disagreed on such an issue?

The boundaries I had carefully constructed over more than 20 years of practice started to sway, ripple, bend. What was this doing to the transference relationship – the client's experience of me and my experience of them?

I needed to find ways to preserve the therapeutic frame and maintain boundaries, so there was still a safe, reliable space where clients could express themselves and be heard, accepted and helped to think. In short, so that psychotherapy could continue under these strange, new circumstances.

I have learnt to accept that there is a certain amount of information that clients will know about me, simply because we are living through the same pandemic. But how the pandemic impacts me, my personal experience of it, can remain private. There is then space for the client and therapist to wonder, to imagine what the other is like and so to encounter traces of earlier relationships. In short, for the transference to function.

I felt I had to tell clients when I tested positive, but that fell easily within my ethical responsibility to protect clients from harm. From there, it was a case of doing the simple things well – timing, reliability, empathy and warmth, all of which build the frame.

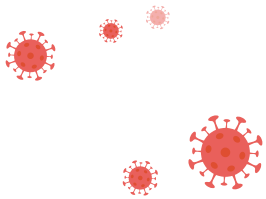
Most trauma models assume the traumatic incident or situation is in the past. The task is to work through the trauma, so it can be stored away in the brain's library, the hippocampus. The survivor can then live safely in the present, without reliving the trauma whenever they are reminded of it.

But with COVID-19, the traumatic situation continues. If someone has been traumatised by the loss of a friend, family member or colleague to the virus, they are surrounded by triggering reminders. The amygdala, the brain's alarm system, therefore thinks the trauma is happening again, causing mind and body to feel the same emotions and physical sensations.

As we know, the more traumatic experiences someone lives through, the more likely they are to develop complex, post-traumatic stress disorder (PTSD). People who were hospitalised or lost loved ones in previous waves will be feeling the impact again as they are bombarded by the news of the Omicron variant. We might not know for some time just how serious an impact this layering of trauma upon trauma has on the mental health of the population.

I have found the 'three phase' model of trauma intervention, developed by Judith Herman,[1] with its focus on an initial stage of stabilisation, to be incredibly useful. It teaches clients safety techniques, such as the safe space, grounding (focus on your feet on the floor, notice five things you can hear, see, taste, smell, touch), slow, deep, diaphragmatic breathing, all of which help clients to stay in the moment and let go of worrying thoughts about what might happen next.

I have even used a counting technique, developed by clinical psychologist



Mia Scotland. If a client is worried about the risk of dying from COVID-19, asking them to count slowly in their mind backwards from 100 to three, for instance, helps them to understand how small 3% is, where there is a 3% chance of dying should you contract the virus. Clients worried that a loved one might die have also found this to be effective.

Grounding exercises switch on the parasympathetic nervous system, calming body and brain. They also switch off the sympathetic nervous system, which the fight or flight mechanism uses to get the body ready to fight or run.

Of course, it's hard to run away from COVID-19 because it's all around us, often in the air we breathe. It's also hard to fight the virus. You can therefore be left in a constant state of alertness, with stress hormones pumping constantly round your body. Encouraging clients to move – to walk, cycle, run, swim – is a wonderful way of working with the body's self-defence system, not against it, burning off the stress hormones and returning to homeostasis, or balance.

Mindfulness, the practice of remaining in the present moment, of noticing and being able to let go of worrying or negative thoughts, has been incredibly useful in the current circumstances, when there is so much to worry about and so much time to brood. I have used and taught mindfulness even more than usual, encouraging clients to make time for it every day.

In the first lockdown, I developed my own version of the eye movement desensitisation and reprocessing (EMDR) safe space technique, which I called the 'open space'. It was created primarily for clients who were suffering from spending weeks cooped up in airless, tiny flats with no gardens, during the glorious weather of the first lockdown. The technique helped them to visualise their favourite outdoor space, tuning into what they could see, hear, smell and feel.

When I am working with trauma online, I mostly now use the butterfly hug technique. Instead of following the therapist's finger with their eyes, the client taps with their fingertips, left and right on their collarbones, to create bilateral stimulation. I have found it fairly easy to adapt and, in my experience, it has been highly effective. I have managed to work with clients in this way to reduce significant levels of trauma, without actually meeting them in person.

Of course, talking and thinking together about what is happening, what it means, how it impacts the client, how it might be thought about differently, allowing space to let off steam, working through the earlier traumas being triggered by the pandemic – all of this has helped make the experience less stressful.

Over the past two years, I have seen clients become ill, worried about them, welcomed them back to therapy and worked with them through their recovery, helping them think about the meaning of the experience and to process the emotional impact. Clients also saw me become ill, some (perhaps) worried about me, welcomed me back to work and watched me as I recovered, as my cough finally stopped.

All sorts of memories and prior experience of illness, recovery, loss and death have come up in the transference between us, and continue to do so. It all needs to be thought about and brought to light and, again, because of the shared experience, I feel pressure on the boundaries. The way through, as always, is to do the simple, basic things well: asking myself at any moment, what am I feeling and thinking? What belongs to me and what has come from the client?

As COVID-19 is a physical illness with a psychological impact, therapy clearly has an important role to play in recovery. But we also need to recognise the role of movement and exercise. The right forms of exercise, such as low-intensity cardio and strength work, help fortify the cardiovascular system, rebuild muscle mass and power, help you regain energy and also raise your mood, reduce anxiety and sharpen your thinking. Walking, then running, were crucial elements in my recovery from the illness last year, and I encourage clients to be active, too.

We are now in the third year of the pandemic. The vaccine programme in the UK is certainly helping, but new variants will continue to emerge and threaten. We really have no idea what will happen next, but two things are clear. First, there is a long way to go until the pandemic is over and the health and economy of the country have fully recovered. Second, therapists have a vital role to play in getting us through.

Therapists, in whatever setting, must think about their resilience. We need to look after ourselves so we can continue to look after clients – and what works for me is plenty of exercise, eating healthily, nurturing relationships with family, finding time to relax and enjoy life and going back into therapy. Plus, learning to admit when I'm tired and allowing myself to rest.

We also need to keep thinking about what is happening and what it means, learning about how best to respond and intervene, what has worked and what has not.

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From the frontline

DAWN ESTEFAN

COVID-19 '...is probably the biggest hit to mental health since the second world war', according to Dr Adrian James, president of the Royal College of Psychiatrists.[1] Dr James is not the first person to note the psychological impact of an infectious illness. Marcus Aurelius, the Roman emperor, observed of the plague in his memoirs at the turn of the second century: 'For the corruption of the mind is a pest far worse than any such miasma and vitiation of the air which we breathe around us.'[2]

The full and long-term effects of COVID-19 on the nation's mental health are proving difficult to determine. The 'shadow pandemic' is a term that has been used to describe the rise of mental health issues – and aptly illustrates how tricky it is to capture and assess the psychological consequences.

Mental ill health can take longer to develop and diagnose than physical ill health. Research studies struggle with accurate population representation and pre-pandemic baseline data. We are forced, it seems, to position ourselves within the discomfort of the unknown.

'The blur between online and real life is disruptive to the work in therapy'

I wonder, too, whether the pandemic has blurred the boundaries between the physical and the psychological. The need for integrated healthcare policy and services, for example, seems more important than ever before.

I have been thinking a lot about boundaries recently. Since the pandemic, therapists have been invited to question and relax the boundaries of our settings and methods. Most of us have adapted to the changes. Many clinicians, who had never previously offered online therapy, now mix online work with face-to-face sessions. Some have even shifted their private work totally online. Whatever the adaption processes, there have been challenges around our boundaries.

There are, perhaps, other ways in which the online world crosses a boundary into the 'real-life' world. I have noticed that clients are increasingly using, in their real lives and in sessions, the same language or mode of relational operating that they use online – a kind of merger between online life and reality as a way of processing, feeling and being. For example, blocking friends, family members or partners online as a way of resolving problems. It's an online defence that creates a boundary against real-life resolution. It also allows clients to avoid relational or psychological discomfort and emotional turbulence, losing the opportunity to control the narrative or explore feelings.

The same can be said for the rise of emotional release online, a kind of verbal vomiting that defends against thought or interpretation. Deaths, divorce and diagnoses are posted and left unprocessed, emotionally unregulated and unfelt by clients. They are reported in sessions in the unintegrated forms of likes, comments and emojis.

There is also 'trauma porn', the client's absorption or evacuation of pain at arm's or fingertip's length, a fascination with and incessant consumption of trauma, masked as sharing or raising awareness. Self-help gurus and trauma groups are on the rise on social media platforms, inviting people to share their trauma – and they do, perhaps forgetting the whole world is listening and watching. The result is a dehumanisation of the client and content simultaneously.

The blur between online and real life is disruptive to the work in therapy and to meaningful relationships. Our task as the therapist is to invite the disassociated material into the session, so that it can become a part of the client's real life, human and contained.

Gerd Leonhard, author of *Technology vs Humanity: the coming clash between man and machine*, once said in an interview that '...we should embrace technology but not become it'.[3] The boundary between online life and real life is complicated as we communicate more and more through screens and keyboards.

What is missing, seems to be containment, the establishment of strong boundaries, both literal and metaphorical, internal and external. We need to offer spaces where emotional experiences, thoughts and feelings can be expressed. But we also need to hold the not knowing, the uncertainty and resistance to experiencing, so it feels safe. But how do we contain what is said to be uncontainable?

***Dawn Estefan** is a registered member of BACP, psychotherapist and social commentator. She works for the NHS and in private practice.*

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Bookshelf

A Tiny Spark of Hope: healing childhood trauma in adulthood

Kim S Golding and Alexia Jones
Jessica Kingsley Publishers
978-178775431-7
£19.99

A Tiny Spark of Hope follows Alexia, who has dissociative identity disorder (DID), formally known as multiple personality disorder, as she works through three years of restorative therapy with Kim.

Both Alexia and Kim are qualified therapists, working with children and adults who have experienced trauma. Kim is a clinical psychologist, consultant and trainer; Alexia is a psychological practitioner who supports clients with a history of trauma. The book is written from the perspective of both the client and the therapist, and the chapters are organised into Kim's reflections and Alexia's reflections. It therefore offers an insight into the therapeutic process.

Kim practises dyadic development psychotherapy (DPD) – and there is a useful summary of the principles of DPD theory in the first chapter of the book. DPD gives a relational focus to the work. Kim encourages Alexia to explore her interactions with others, including the therapist, and the impact of these relationships on her everyday life.

Alexia finds in Kim someone she can trust, enabling her to express her vulnerability and work through painful emotions. Kim also finds the courage to sit alongside Alexia, without judgment. The pair consequently form an intimate bond.

Alexia struggles with conflicting feelings: she wants help but she also believes that her issues are not worthy of therapy. Kim also struggles with her need to 'mother' Alexia, to offer the strong parental figure that Alexia lacks.

I particularly enjoyed Chapter Four: 'Discovering the Russian Doll'. The image of the Russian doll suggests the various, hidden aspects of Alexia, how she buried her sadness. It also captures how Alexia was eventually able to trust her therapist and so acknowledge and reveal her feelings.

A Tiny Spark of Hope offers a moving account of the therapeutic relationship and process. Alexia bravely explores the traumatic events in her life. Kim also shows courage, as she stays by her client's side throughout her emotional and painful journey.

The book is suitable for therapists working with trauma and childhood abuse, along with anyone interested in reading a true story about how an empathic, therapeutic relationship can create a healing environment.

***Jo Sansby** is a counsellor, psychotherapist and supervisor in private practice.*

Psychiatry and Mental Health: a guide for counsellors and psychotherapists

Rachel Freeth
PCCS Books
978-191091952-1
£34.99

Psychiatry and Mental Health is a big book in more ways than one. First, it runs to almost 600 pages. Then there's the scope of the book – it covers such hefty topics as the organisation of mental health services, psychiatric diagnosis and working with clients who are experiencing psychosis.

But it's also a big book because it is unafraid to question and challenge not only our existing systems, but also the assumptions that underpin contemporary paradigms. In fact, it seems to relish the opportunity.

The chapter on the legal aspects of mental healthcare, for example, asks us to consider the fact that someone can be admitted and detained under the Mental Health Act, if they are deemed to be suffering from a mental disorder and judged to be a risk to themselves or others. In other words, they do not have the right to refuse treatment, even if they have the mental capacity to make their own decisions.

The author, Rachel Freeth, is both a qualified psychiatrist and a person-centred counsellor, which gives her an interesting perspective on mental health. Indeed, the book addresses the tensions that often exist between psychiatry and psychotherapy, between a medical model, with its emphasis on diagnosis and treatment of an 'illness', and a more holistic approach, which seeks to understand psychological distress in a wider context.

The book grapples with some knotty questions: Does the medical model lead us to pathologise emotional responses to life events? Is it the goal of mental health practitioners to relieve symptoms or to help someone make sense of their experiences – or both? How do we measure outcomes? Should we measure outcomes?

If that sounds daunting, don't be put off. The author's deft hand guides the reader assuredly through such complex considerations. The book also offers lots of 'practical' information. The chapter on psychiatric drugs, for example, explains how they work, their uses and effects, benefits and drawbacks.

It helps that the book is well structured. It's essentially a text book, but in a good way. It's divided into sections so you can easily dip in and out, which makes it a useful source of reference. I have already gone back to the chapter on eating disorders after a recent clinical encounter. The text is also broken up with suggested activities, clinical scenarios, personal anecdotes and practice points, prompting the reader to think about their own work.

The book is aimed at counsellors and psychotherapists of all therapeutic disciplines, whether trainees or experienced practitioners. And it hits the target. It will deepen your understanding and knowledge of psychiatry and mental healthcare, and how they can – and sometimes can't – work together. It also advocates self-awareness and critical thinking, which is never a bad thing for any profession, but perhaps has particular relevance and importance for the counselling professions.

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Psychoanalysis and Covidian Life: common distress, individual experience

Howard B Levine and Ana de Staal (eds)
Phoenix Publishing House
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Psychoanalysis and Covidian Life is a collection of 15 essays by psychoanalysts from around the world, grouped under headings such as 'The Setting Under Pressure' and 'Living and Thinking in Pandemic Times'. The essays all reflect on the pandemic and its impact on our internal and external landscapes.

The book opens with a look at the rise of populism in the US and elsewhere; it ends with 'Clinical Journals', which invite us into the consulting room to experience perhaps some of the first, published, COVID-charged case studies. The essays span both the broad sociopolitical landscape and the deeply personal, reflecting the universality and reach of our collective pandemic experience.

The book's first contribution is from Christopher Bollas, whose essay, 'Civilisation and the Discontented', charts the rise of populist movements around the world. He vividly describes what happens when a large group falls prey to psychotic thinking, due to the failure of traditional governing structures to contain and provide help for societal distress.

Using psychoanalytical theory, the author illuminates how governments might deny unbearable realities, such as climate change, evacuating their minds of disturbing thoughts, leaving their own and their people's engagement with reality in a diminished but more bearable state.

The result, according to Bollas, is a vacuum, a longing for a leader, a containing parent, but with less apparatus to think for ourselves. In short, it makes a population vulnerable to a populist leader, such as Trump or Bolsonaro. It also creates a mistrust of government, with potentially catastrophic consequences in a pandemic. The extensive sweep of this fascinating essay sets up the context for many of the more personal reflections that follow.

Several of the contributions consider the rapid adaptations to ways of working, enforced by the pandemic, and the strain this has placed on traditional psychoanalytical thinking, as well as on patients and practitioners.

Bernard Chervet's essay particularly resonated with me, as he describes the pressures of working under a persistent 'low-frequency', 'traumatic neurosis': a new and shared experience of an indefinable threat that pressured some interactions to become more conversational and less conducive to the development of the transference. He describes the daily psychic effort of trying to consign the experience to memory and the well understood, post-pandemic amnesia as exhausting for all.

The 'Clinical Journals' towards the end of the book are as fascinating as they are accessible. The description by Patricia Cardoso de Mello of her work with a three-year-old girl on the autistic spectrum is both moving and a testament to the power of psychoanalytical thinking to find meaning where it might seem elusive.

It is also a challenge to assumptions about the immutability of the frame. The frame, we now know, can shift, and we see the work evolve as it is carried out over a smartphone. Indeed, the frame is described as shifting more towards an internal frame that keeps safe the analyst or counsellor's ability to think symbolically. Therapy where this is in place can perhaps happen anywhere.

I think this book would be of interest to anyone working in the psychotherapeutic professions, who wishes to reflect on the multiple challenges of working and being over the past two years. It is a stimulating read for anyone who can resist the lure of amnesia now that the pandemic seems to be becoming endemic.

***Helen Lowe** is a registered member of BACP. She is a psychodynamic counsellor working with adults and young people in private practice in Buckinghamshire and at Watford Women's Centre Plus.*

BOOK REVIEWS
If you would like to write a book review, please email the editor at hcpj.editorial@bacp.co.uk.

Trigger Orientated Therapy

Integrating the reflective mind and reactive brain/body system

Following on from training over five hundred therapists across the world in the use of the Rainbow Map, Andrew Thomas has decided to share Trigger Orientated Therapy (TOT) free of charge.

This approach has been chosen in support of a diverse psychotherapy profession that is open to all regardless of financial means. Modules can be taken in any order and integrated into all mainstream modalities. Training certificates will be issued upon completion of each module.

Avoidance Theory (2hrs): The fundamental theory base on which TOT is based. This also has implications for the therapeutic relationship in terms of our understanding of mental health and the sharing of knowledge and power.

Reflective Mind and Reactive Brain Body Model (2hrs): This model has been introduced alongside the Rainbow Map and is now being integrated into work with clients across the world. It avoids the need for complex language to understand the basic function and interactions of the human system that can be readily shared with clients.

Introduction to the Rainbow Map (2hrs): Experience the Rainbow Map first hand and learn how your Reflective Mind and Reactive Brain/Body trigger.

Rainbow Map Techniques (2hrs): With thousands of clients benefitting from their therapist integrating the Rainbow Map into the way they work; new ideas and innovations have been generated since the tool was first introduced on an international basis in 2020.

Introduction to Legacy Behaviours (2hrs): Learn how the interaction of our neurobiology and our early life environment generates Legacy Behaviours that become embedded into what we come to describe as our personality.

Legacy Behaviour Techniques (2hrs): Find out how the concept of Legacy Behaviours is being integrated into work with clients.

All resources will be released free of charge in September 2022 on YouTube. Register your interest in Trigger Orientated Therapy now by visiting www.triggerorientatedtherapy.org