UKCP
UK Council for Psychotherapy

# New Psychotherapist

ISSUE 76 / WINTER 2021

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**New Psychotherapist**
The magazine of the
UK Council for Psychotherapy

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# Welcome

ISSUE 76 / WINTER 2021

**ANNA SCOTT**
Anna Scott has been a journalist and editor for 20 years, writing about health, education and management issues. She also works part time with primary school-aged children, and has a keen interest in psychotherapy, along with psychology, completing a Bachelor of Science in Psychology in her spare time

**As a psychotherapist working in a diabetes clinic within an acute NHS trust, Kate Hardenberg knows first-hand the challenges of working in the health service – from finding a job as a psychotherapist in the first place, to accessing funding and proving the efficacy of psychotherapy to colleagues and patients.**

In this context, she has conducted research which shows that – far from the common perception that psychotherapy is expensive and unproven in its effectiveness – for every £1 her hospital spends on psychotherapeutic care, it saves £29 in costs (*page 22*).

Other psychotherapists who work in the NHS, or with charitable and public-sector organisations, are able to show the impact their work has on people who would otherwise not be able to access psychotherapy. They are working in multi-professional teams, helping to address not just physical and psychological health difficulties, but issues related to housing, employment, education and more.

The people they help range from children with serious physical illnesses (*Kate Waters at Great Ormond Street, page 34*), to parents and infants who are struggling with attachment (*Yvonne Osafo at West London Action for Children and Croydon Parent Infant Partnership, page 26*), and people with addictions (*Andy Ryan at Changing Lives, page 30*). Many would not be able to access psychotherapy any other way.

But these examples are not typical – provision of psychotherapy within the NHS across the UK is patchy, at best. There is little patient choice of talking therapies and there are too few opportunities for psychotherapists to work in NHS services. This not only limits the choice of working context for psychotherapists, it also denies a choice to NHS service users in many parts of the country who cannot access the talking therapies they need.

Increasing access to psychotherapy for all will be crucial as we begin to understand the impact of the pandemic on mental health in greater detail – specifically that mental health issues have got worse for certain groups, including children, people from ethnic minorities and people from low-income households.

The pandemic has also had an impact on how many of us are dreaming and Melinda Powell explains how dreams can provide a kind of 'nocturnal therapy' (*page 46*). Elsewhere this issue, Sarah Niblock outlines how UKCP members have experienced the delivery of psychotherapy via telephone or online (*page 38*). Enjoy reading.

Anna

**ANNA SCOTT**
**Editor**

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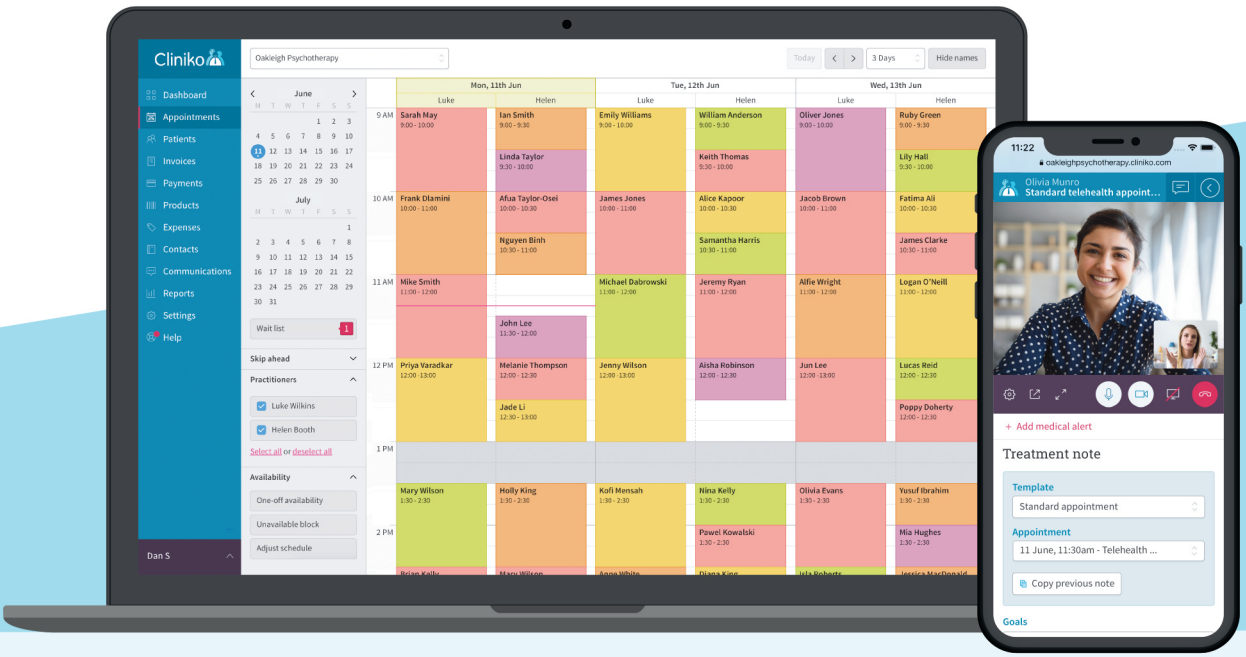


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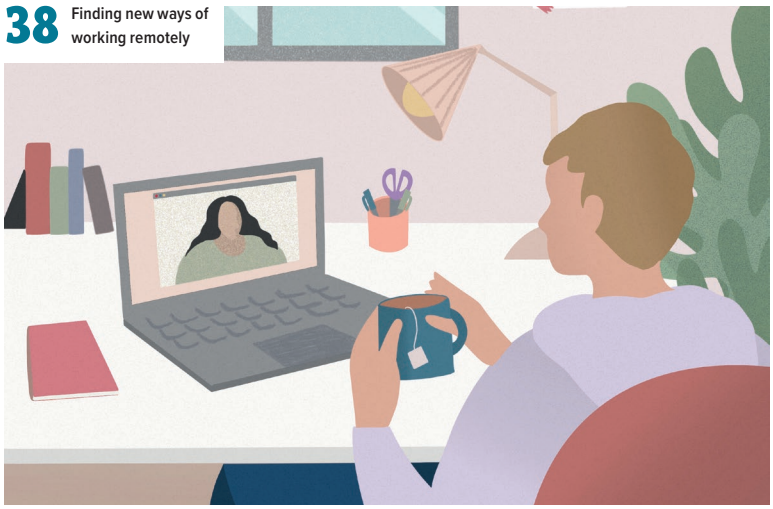

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This issue, we celebrate the work of psychotherapists within the NHS


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Bulletin

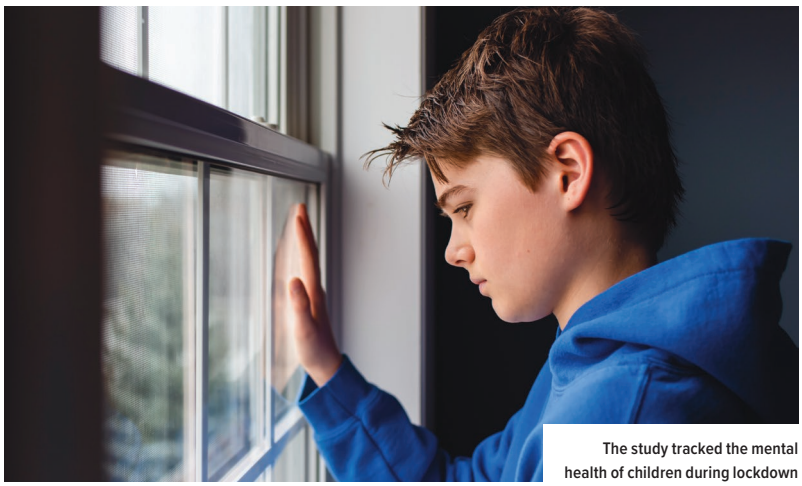
ISSUE 76 / WINTER 2021

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

RESEARCH

# Children in low-income households have poorer mental health outcomes

Poor mental health outcomes for children living in poverty have been demonstrated by two new pieces of research



The study tracked the mental health of children during lockdown

The links between poverty and children's mental health have been demonstrated by two large-scale research studies, as UKCP calls for a review of the government's mental health plans for children.

The Co-SPACE study, in which the University of Oxford has been tracking parents' and children's mental health during lockdown, found that children living in low-income households were two-and-a-half times more likely to have greater emotional and attentional difficulties after one month than those in higher income households.

In addition, parents and carers from low-income households reported that their children, aged between four and 16, had higher levels of unhappiness and worry, were more clingy and experienced more physical symptoms associated with worry than those in wealthier households. Behavioural difficulties for primary school-aged children from low-income households were also more common.

UKCP's policy and public affairs manager Adam Jones said any behavioural issues at school arising from these circumstances must not simply be met with exclusions. 'It is essential that there is support in place to address these issues. The government's existing plans for children's mental health support do not go far enough,' he said.

Research ongoing since before the lockdown – the Millennium Cohort Study of 8,500 children born in the UK at the turn of the century – has also found a link between a family's assets and their children's mental health.

The research team at the UCL Centre for Longitudinal Studies analysed data based on parents' current income, taken when children were age 11, as well as their average income, taken over the preceding ten-year period. They also examined links with children's outcomes, using parents' reports of children's mental and physical health, and results from cognitive tests, all taken at age 11.

The researchers found that it was, in fact, only housing wealth that was associated with children's mental health. 'As housing wealth inequalities increase, it is possible the divergence in children's emotional and behavioural problems could be intensified,' said Dr Ludovica Gambaro, co-author of the study, published in *Child Development*. *See also feature, page 18.*

▶ **'Rapid Systematic Review: The impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19' is published in the *Journal of the American Academy of Child and Adolescent Psychiatry*. tinyurl.com/rapidsystematicreview**

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**Sleep on it**
Exploring the therapeutic benefits of dreams
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COMMUNITIES

# MENTAL HEALTH SUPPORT 'NEEDED FOR CHILDREN LIVING OUTSIDE CITIES AND TOWNS'

## Those living in remote communities risk feelings of isolation

Children living in remote rural and coastal communities in the UK are at risk of missing out on mental health support because of poor digital connectivity, limited public transport and a lack of safe spaces, a report has found.

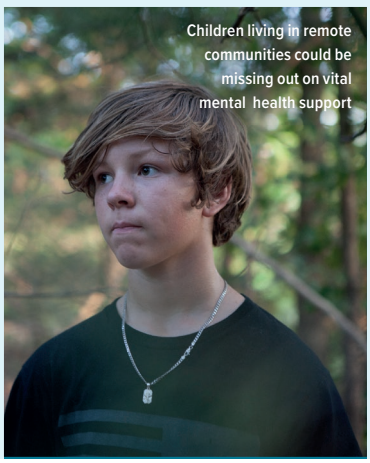
In particular, those aged between eight and 13 years living in poverty and marginalised communities, with a disability, or those whose gender or sexual identity is different from most of their peers, face disadvantages in rural areas, according to 'The space between us', published by the Centre for Mental Health.

Rural poverty is less visible than in urban areas, but can leave children especially isolated and excluded, and rural areas are often poorly served by specialist mental health services, the report, funded by BBC Children in Need, found.

'We need to take action now to ensure no child's mental health is put at risk because of where they live,' said Centre for Mental Health deputy chief executive Andy Bell. 'This means investing in rural and coastal areas, from parks, schools and community centres to mental health services, and reaching out especially to children facing the biggest disadvantages in life.'

UKCP psychotherapeutic counsellor, Natalija Stevens, who operates in rural Norfolk, added that a shortage of available therapists in rural areas compounds this issue. 'There have been emails circulating from one local therapist to another trying to find a specialist for someone looking for therapy for their child,' she said. 'Currently there are two centres I can suggest for eight to 13 year olds [to receive therapy], which are both an hour's commute in a car from the village I live in.'

One reason for this shortage is the unavailability of specialised training for therapists, and people having to travel long distances for training. 'Long-distance training is not just associated with greater financial costs – such as paying for accommodation – but also loneliness and the wellbeing of those training,' she added. 'When I started training, some of the people on my course were taking an hour or more to drive to Norwich, with no public transport available, and if they wanted to specialise in therapy for children they would need to add at least another hour-and-a-half's travelling to reach another city.'



Children living in remote communities could be missing out on vital mental health support

RESOURCES

## CALL FOR COUNSELLORS IN SCHOOLS IN ENGLAND

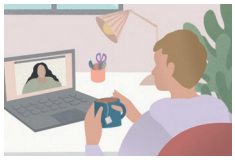
Fewer than half of state schools in England can offer their pupils onsite counselling in the wake of the pandemic, a recent report has found.

In its report 'The New Normal: The Future of Education after COVID-19', think tank the Institute for Public Policy Research found that 48% of nearly 7,000 teachers surveyed after the first wave of the pandemic said their schools offered onsite counselling to students. The think tank said the government should introduce a national entitlement to key support services, such as onsite counselling, in schools after the pandemic.

UKCP organisational member the Institute for Arts and Therapy in Education has, along with the Centre for Child Mental Health and Trauma Informed Schools UK, provided trauma and mental health training to 311 schools and community organisations across Cornwall, after becoming the workforce training provider for a Big Lottery funded project with Cornwall Council and HeadStart Kernow in 2017. Nearly 1,000 practitioners have accessed a ten-day diploma and two-day training and a further 3,500 have accessed whole staff training. The programme will run until June 2021.

Dr Margot Sunderland, co-founding director of IATE, said: 'There are one million children in the UK with a mental health problem. All the research on adverse childhood experiences (ACEs) shows that having one emotionally available adult (EAA) before the age of 18 can interrupt the trajectory from ACEs to long-term mental and physical ill-health. We have found that teaching counselling and active listening skills to selective emotionally aware school-staff can provide so many more children with an EAA.'

Harry Quilter Pinner, lead author of the report, added: 'Many schools are unable to provide the support young people need to thrive. Without urgent government action to ensure every school can provide vital services such as counselling and after-school clubs, there is a profound risk that the legacy of the pandemic will be even bigger educational and health inequalities.'



**Smooth transitions**
How members have adjusted to working remotely during the pandemic
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COMMUNITIES

# Investment in mental health 'urgently' needed for COVID-19 recovery

Increased funding for mental health services must be a priority, according to new reports

More funding in mental health services is needed

Mental health provision in NHS, community and voluntary sector settings must be prioritised as part of any COVID-19 recovery plan, according to UKCP, as councils in England warn that failing to invest in mental health immediately will undermine the country's recovery.

'The long-term mental health consequences of the pandemic are plain to see, but there has so far been little indication that the government has got to grips with the scale of response required,' said UKCP's policy and public affairs manager, Adam Jones. 'Furthermore, the level of demand can only be met if the psychotherapy and counselling workforce is successfully deployed in the NHS, community and voluntary settings. That's why UKCP is calling not only for more funding, but for the government to work with us to address the structural barriers to psychotherapists working in publicly funded settings.' (*See feature, page 14.*)

His comments came as the Local Government Authority called for funding for councils to spend with local partners on meeting communities' mental wellbeing needs, which, it states, will play a crucial role in every aspect of recovery planning.

**'The long-term mental health consequences of the pandemic are plain to see'**

'Our place: local authorities and the public's mental health', written with the Centre for Mental Health, shows how collaboration between councils, the NHS and community groups can form part of a wide range of approaches and strategies in tackling the determinants of mental ill-health.

UKCP systemic psychotherapist John Woolner welcomed the report's focus on 'moving away from the narrow lens of a medical model'. 'This mirrors the relational nature of systemic psychotherapy, which moves comfortably between internal systems of attachment and trauma, to the wider focus of how our lives, relationships and mental health are shaped by global events and powerful discourses in relation to such things as gender, age, race, religion and sexuality,' he added.

### FIFTH OF POPULATION COULD NEED MENTAL HEALTH SUPPORT FOLLOWING PANDEMIC

A model devised by the NHS and Centre for Mental Health has forecast that up to 10 million people will either need new or additional mental health support as a direct consequence of the pandemic.

The Forecast Modelling toolkit, devised for local areas to calculate a forecast of additional demand for these services, also shows that 1.5 million of those with mental health difficulties will be children and young people under 18. According to UKCP, 'meeting this need will require the work of all the psychological professions, including greater use of psychotherapists and counsellors in the NHS.'

▶ *For further information, visit centreformentalhealth.org.uk/forecast-modelling-toolkit*

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**What is the impact on us when we can't talk about our gendered sense of self?**

This conference will bring together clinicians from diverse backgrounds to explore the ways in which our early attachments may contribute to how we develop our sense of a gendered self and how we come to experience our bodies sexually. Our speakers will be bringing multiple perspectives to this conference – and in particular, perspectives from attachment theory, feminism and transgender theory. The aim of this conference is to explore and develop our understanding of the many ways in which we come to experience our bodies and how we choose to identify ourselves.

### SPEAKERS

**Meg-John Barker (they/them)**

**Igi Moon (they/them)**

**Susie Orbach (she/her)**

***Further speakers to be announced.***

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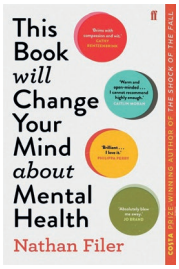
# Reviews

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

## This Book Will Change Your Mind About Mental Health




It's an old cliché to say a book had you hooked from the first line – but when that line is 'I remember the first time that I forcibly medicated a person against his will', are you surprised?

Filer is a fine writer; this book is in a conversational style, but without compromising on rigour. He deals with difficult issues deftly, with even-handedness and a huge dose of humanity. He takes in all the key waypoints regarding mental health, how we conceive it and how we deal with it, making this a brilliant primer for anyone thinking of studying mental health.

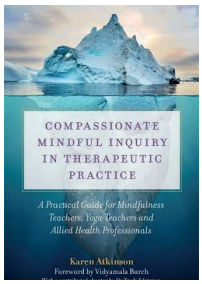
But there's also plenty for those already in the field, not least the most concise primer on medications I've yet read and a fascinating section on the hierarchy of perception. Filer uses the controversial diagnosis of 'schizophrenia' as the core of his book, from which all discussions branch. These always begin with the brilliantly told story of an individual affected by 'schizophrenia', which really captures the often gradual onset of 'illness' and the mix of social factors, emotional need and an undeniable internal logic that generates the sufferer's delusions.

We come away with a sense of how blurred the lines are between psychosis and reality, questioning assumptions around diagnosis and treatment, hit hard by the sufferers' stories – and the effect on those who love them. Some stories are devastating.

### Details

- **Reviewed by:** Nick Campion, integrative psychotherapist
- **Author:** Nathan Filer
- **Publisher:** Faber & Faber
- **Price:** £9.99
- **ISBN:** 9780571345977






## Compassionate Mindful Inquiry in Therapeutic Practice: A Practical Guide for Mindfulness Teachers, Yoga Teachers and Allied Health Professionals

### Details

- **Reviewed by:** Fe Robinson, UKCP psychotherapist (including EMDR and couples work) and clinical supervisor
- **Author:** Karen Atkinson
- **Publisher:** Singing Dragon, an imprint of Jessica Kingsley Publishers
- **Price:** £17.99
- **ISBN:** 9781787751750

**As both a psychotherapist and teacher of mindfulness practices, I was drawn to this book. Atkinson explores the relationship between compassion and mindfulness, presenting a model of Compassionate Mindful Inquiry that resonates with the therapeutic process. She presents the core stages as paying attention, reflective dialogue and linking, and develops this model using examples from her years teaching mindfulness and yoga.**

**Atkinson goes on to provide a method for creating a space within which clients can be mindful, and establish wise action (compassion) arising from this. The book includes an insightful and easy-to-understand chapter by Dr Trudi Edginton exploring the neuroscience of mindfulness and compassion; for me this was the most useful element of the text.**

**The book is practical throughout, offering example questions to stimulate inquiry, as well as exploring how practitioners can be at their most authentic and embodied through their own mindfulness practice. It's focused on teaching mindfulness in groups; and speaks to a broad therapeutic audience, rather than a psychotherapeutic one specifically. Any therapist who is interested to learn about mindfulness and compassion, and how they can be integrated into therapeutic work, will find this a useful read.**

# Understanding, Nurturing and Working Effectively with Vulnerable Children In Schools: 'Why Can't You Hear Me'

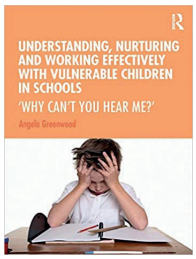
In this book, Angela Greenwood manages to bridge the sometimes difficult divide between the therapeutic and educational setting. The volume is aimed at anyone working in the educational setting – teachers, teaching assistants, counsellors and others, however, even as someone not involved with that setting, I found myself immersed in her words.

Greenwood's approach is rooted in attachment theory and developmental needs. Her holistic approach focuses on working not only with children, but also with parents and whole family systems, as well as teachers and the rest of school staff.

As you read you can feel the experience from the pages. This book provides plenty of practical suggestions and examples to transfer theoretical understanding into practice within the school setting. The author offers the concept of Nurture Base, a space ideally present in every school.

Perhaps for readers not familiar with the UK educational system in detail it would be useful to have a brief overview of what is available in terms of support. But there is a wealth of resources on how to support children struggling with separation, transition and change, endings, working with metaphor and play, and containment, as well as working with parents or looked after children, that is impressive.

Greenwood offers practical options for practitioners working in schools or hoping to set up psychological support in their school, or to set up their own version of the Nurture Base. In this book we experience the kind of holding, security and nurture we would like to see in schools, whether for our younger selves, or for our children.




### Details

- **Reviewed by:** Pavla Radostova, psychotherapist and presenter
- **Author:** Angela Greenwood
- **Publisher:** Routledge
- **Price:** £22.67
- **ISBN:** 9780367025441



## PODCASTS WE'RE LISTENING TO

### THE NAKED PROFESSORS

One in eight men in the UK suffer from a mental health disorder. Suicide remains the biggest cause of death for men under 35 and nearly 40% of men say they have noticed a negative effect on their mental health since lockdown, according to the Samaritans. But, says Men's Health Forum, men are also much less likely to seek support and access psychological therapies than women.

It is this reluctance which the podcast *The Naked Professors* aims to address, by offering relatable discussion about mindset and personal growth. Host Ben Bidwell is neither a professor, nor naked; rather, the show's name is a nod to Bidwell's mission to 'strip off emotionally' (he also gained notoriety for his nude Instagram images, documenting his journey to becoming a life coach).

Bidwell wants to represent a form of masculinity that is comfortable talking about male vulnerabilities. He does this by interviewing guests about their mental health, some of whom are described as 'perceived heroes'. If you are looking for a careful unpicking of the dissonances in our psychological notions of gender, you are unlikely to find it here. It rarely gets beyond the familiar podcast premise of providing shared truths to help normalise the more unmentionable aspects of human experience. But it is a light-touch conversation starter on interesting questions about how we raise boys, what healthy masculinity looks like and how men can find spaces to speak more honestly about their fears.

### Details

- **Reviewed by:** Kirsten Bickford, psychodynamic therapist
- **Creator:** Matt Johnson and Ben Bidwell
- **Available:** play.acast.com/s/thenakedprofessors

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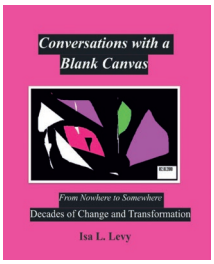
# Conversations with a Blank Canvas:
## From Nowhere to Somewhere Decades of Change and Transformation

In this memoir, author, arts psychotherapist and UKCP member Isa L Levy shares an honest and thought-provoking self-assessment of her life journey. Psychologically it is reflective in ways which invite the reader to engage more consciously with their own journeys.

It follows a chronology of eight decades in Levy's life, revealing her growth and evolution. The dominant metaphor is that of engaging with a blank canvas before one begins to paint and it includes the themes of evolving from the 'black and white' feelings of depression and loneliness to reaching a more meaningful 'colourful' life through psychotherapy, creative expression and spiritual rejuvenation. Over the decades Levy reveals how she journeyed from a false self to a more authentic self, showing her psychological, artistic and spiritual processes through images, poetry and words, as she evolves to reach a state of 'belonging'.

As well as photographs relating to her life and relationships, Levy has included colour plates of her vivid paintings in the book. She is an accomplished artist, who completed a master's in arts and psychotherapy in her early sixties. In her seventh decade, Isa has a whole new career as an arts psychotherapist. In her eighth decade she returns to the stage in a musical production based on Susie Orbach's book *Fat is a Feminist Issue*.

Ultimately, *Conversations with a Blank Canvas* is a story about change, in which Levy offers insight into her own healing process so that others may embrace theirs.




### Details

- **Reviewed by:** Pat Devereaux, freelance journalist
- **Author:** Isa L Levy
- **Publisher:** Independently published
- **Price:** £20.00
- **ISBN** 9798652896898



## PODCASTS WE'RE LISTENING TO

### MENTALLY YOURS

Mentally Yours isn't just one of Anne Uumellmahaye's wedding vows to Dr Michael Hfuhruhurr in the Steve Martin classic *The Man With Two Brains*, it's a Mind Media Awards-nominated podcast. Yvette Castor and Ellen Scott, both journalists for the newspaper *Metro*, have combined their extensive and versatile experience (a lot of which already centres on mental health matters) to 'chat to a mystery guest each week and discuss all the weird stuff going on in our minds'.

Both Castor and Scott have an easy rapport with their guests and topics run the gamut of mental health issues, including imposter syndrome, unconscious bias, how to sleep well, trauma, alcoholism and, most intriguing to me, the art of rest. In this episode, broadcaster, author and academic Claudia Hammond joins the team to shine some much-needed light on what I think a lot of us don't take as seriously as we could.

'The Art of Rest' provides succour to the relentless commodification of time. As mental health professionals we are ethically bound to self-care and sending the message to the wider world that we can all try to be gentler with ourselves and simply 'be' rather than strive 'to be' anything else is a deeply supportive message. Here is a podcast for these difficult times. Put your feet up and have a listen. The time is (mentally) yours.

### Details

- **Reviewed by:** Mark Hammond, psychotherapist
- **Creator:** Yvette Castor and Ellen Scott
- **Available:** metro.co.uk/tag/mentally-yours-podcast/

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**Dr Jonathan Pointer, Clinical Psychologist & Integrative Psychotherapist, www.therapysancturary.com**

"An excellent course confirming that I will pursue this approach in private practice. Excellent teaching style, building positive learning experience each day. It was great to put theory I learnt years ago into practice!"
**Dr Caroline Linton, Psychiatrist and Hypnotherapist**

"It is really important for my work as a psychologist, to be able to utilise hypnotherapy as an evidence-based therapy. I've already got a knowledge of CBT, I've found it absolutely amazing to be able to integrate that with hypnotherapy."
**Amanda Wood, Chartered Counselling Psychologist**

"Excellent course – fast, furious and completely effective."
**Joyce McNeil, Chartered Psychologist and Integrative Counsellor**

"I was reassured by the evidence-based approach and concept of skills training. The course is very honest and open about a complex subject. I have heard of many of these techniques before but I now understand how to apply them."
**Beth Scofield, GP**

"My experience of learning on this course has been more than life-changing - it opened up a whole new world for me! Also it provided a good mix of theoretical background, hands-on practice and self-experience. I loved the diversity of participants and learning from highly professional, experienced teachers."
**Dr Dorothee Amelung, Organisational Psychologist**
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"Very professional and helpful for a novice starting their own practice. Detailed and practical."
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# A MEANINGFUL CHOICE OF THERAPY

ACCESS TO A RANGE OF NHS TALKING THERAPIES, ESPECIALLY PSYCHOTHERAPY, IS LIMITED ACROSS THE UK. YET A FULLY TRAINED PSYCHOTHERAPEUTIC WORKFORCE HAS DEMONSTRATED ITS VALUE DURING THE PANDEMIC. **HAZEL DAVIS** REPORTS



**It's hardly newsworthy that the UK is facing a mental health crisis. Almost one in five adults (19.2%) were experiencing some form of depression during lockdown in June 2020[1]. Before the pandemic, an estimated one in six people in England alone reported experiencing a common mental health problem in any given week[2]. Yet one in ten people wait more than six weeks for talking therapy within the NHS via IAPT (Improving Access to Psychological Therapies) services, usually CBT[3].**

Provision of psychotherapy within the NHS across the UK is patchy at best, and is seen as an expensive and long-term commitment, which isn't necessarily the case. 'There's a real lack of choice for people seeking support,' says Adam Jones, UKCP's policy and public affairs manager. 'Seeking help is a big step for many people to take and it can be very disheartening – and sometimes damaging – if your first experience of mental health support doesn't meet your needs. That's why we're calling for a better range of interventions to be made available, so people across the UK have access to what's right for them.'

When Sara Jones tried to access psychotherapy in Manchester earlier this year, her experience was far from ideal. 'I had a bit of a breakdown and ended up in A&E,' she explains. 'I was sent home with a number that promised 24-hour support. I rang them and they proceeded to tell me their rules. I could call as often as I liked but calls are capped to 20 minutes. After ten or so minutes explaining this they asked why I had called. I started to open up. Suddenly I was told, "Your 20 minutes are up, goodbye" – literally mid-sentence. Opening up about your mental health is hard enough. To be then cruelly cut off and dismissed is downright damaging, in my opinion.'

## GEOGRAPHICAL VARIATIONS

Access to psychotherapy in the NHS can vary radically from region to region, from nation to nation, and between urban and rural locations within the UK. For example, self-referral for talking therapy is not routinely available on the NHS in Scotland. 'Most of the so-called "psychotherapy" services available through the NHS are usually very limited and very selective,' says Galashiels-based psychotherapist Courtenay Young. 'There is almost no counselling now available through the NHS as there has been a long-term policy to phase it out as an available treatment,' he adds.



Though some of the counselling services in the voluntary sector are partially funded from within the NHS Trust budgets, Young says, 'This type of funding is generally quite limited, either geographically (to a particular area or NHS Trust), or to a certain fixed number of sessions, and they are liable either not to be increased in line with inflation, or to be wound down over a few years and then eventually cut.'

**21% of psychotherapists currently work in NHS-funded settings – 87% in paid roles and 12% in unpaid support roles[4]**

Nicola Airey, higher assistant psychologist at NAViGO Health and Social Care CIC, a not-for-profit social enterprise that emerged from the NHS to run all local mental health and associated services in North East Lincolnshire, says there is an essence of rigidity in talking therapy provision. 'Patients become hardened to services when they go through the "revolving door" [people with mental health issues who get better, then relapse, and are in and out of therapy or hospital] – and understandably so.

'Individual differences need to be recognised and acknowledged, and therapy adapted to meet them. People's lives can change while they're sat waiting for therapy. For some, their issues may resolve, but for others the outcomes are catastrophic. It's disenchanting and can often lead to hardening toward services when they finally reach the therapy chair,' she adds.

**19.2% (almost one in five adults) were experiencing some form of depression during lockdown in June 2020[1]**

## WHAT IT COULD LOOK LIKE

According to UKCP's survey of its 10,000 members in January 2020, 21% of psychotherapists currently work in

**Complex needs**

## Talking Therapies Taskforce

The Talking Therapies Taskforce (TTTF), of which UKCP is a part, aims to develop a national infrastructure for psychological therapies for people with complex mental health needs.

For the last year the focus has been on a collaboration with Devon Partnership NHS Trust and West London NHS Trust and the Centre for Mental Health, looking at the health economic evaluation of the cost of highly complex relational disturbance in public-sector health and social care services. 'There's evidence that those particular Trusts have a high volume of this type of intensive user, who can often end up as long-term inpatients in physical care settings, costing Trusts thousands of pounds each year,' says Adam Jones. 'This money would be far better spent if it were redirected to specialist psychotherapy services that can better meet the needs of this patient group.'

The other members of the TTTF are the Association for Psychoanalytic Psychotherapy in the NHS, the British Association for Counselling and Psychotherapy, the British Psychoanalytic Council, the Psychotherapy Faculty at the Royal College of Psychiatrists and the Society for Psychotherapy Research.

NHS-funded settings – 87% in paid roles and 12% in unpaid support roles (the remaining 1% preferred not to say). In addition, 74% of the paid NHS work is the result of direct employment by the NHS, and 87% of UKCP members working in the NHS are paid at Band 7 or higher. Forty-five per cent of psychotherapists show an interest in working for the NHS[4].

There are some powerful examples of psychotherapists working alongside other mental health and healthcare professionals in the NHS, such as the psychotherapy service within the neurology department of the Royal Hallamshire Hospital (*see panel, facing page*). Crucial work is undertaken across NHS hospitals – including helping children experiencing serious physical illness (*see feature, page 34*) or adults with diabetes (*see feature, page 22*) – and with primary care organisations in the NHS or other public sector and voluntary bodies, such as helping people with addictions (*see feature, page 30*) and mothers and infants that need infant psychotherapy (*see feature, page 26*). This work has a demonstrable impact on not only mental health outcomes for patients, but also cost savings for both the health service itself and across wider public-sector bodies, including local authorities, social services and the criminal justice system.

'It makes financial as well as health sense to increase access to talking therapy,' says UKCP chief executive Professor Sarah Niblock. 'While it will entail some upfront investment, the medium- to long-term savings will be very worthwhile. Firstly, it will reduce the acute financial toll and lost productivity caused by mental ill-health in the workplace; secondly, it will reduce the pressure on addiction services, the social care bill, and lessen the likelihood of people falling foul of the criminal justice system. Thirdly – and perhaps most importantly in the current context – psychotherapy unlocks potential and builds resilience for our handling of future emergencies.'

Adam Jones says that better connections between NHS training pathways and existing psychotherapy training are needed. 'We are lobbying Health Education England (HEE) to provide more funding specifically for psychotherapists and counsellors so they can take up trainee posts and work in paid roles regardless of whether they have completed the top-up trainings required to work in NHS settings.

'We also have a job to do to ensure that UKCP trainings are linked with paid NHS training placements where possible. This would have the dual benefit of reducing costs for trainees and giving therapists the experience of working under NHS structures right at the start of their careers.'

Integrative psychotherapist Dr Christian Buckland, who has held positions in the NHS and works alongside consultant psychiatrists and clinical and counselling psychologists, believes that psychotherapists need to adapt or expand their training to align skills more closely with the needs of the NHS. 'Whether or not we agree with the medical model used within mental health services in the UK, its usage is prevalent, and psychiatric language

**87% of UKCP members working in the NHS are paid at Band 7 or higher[4]**

**100,000** There are more than 100,000 highly trained psychotherapists and psychotherapeutic counsellors at the forefront of the mental health sector, supporting hundreds of thousands of the UK's most vulnerable people[5]

remains the dominant discourse,' he says. 'Therefore, if we want to have more psychotherapists working within the NHS it is important for our training to acknowledge this, and know how to work with this model, while also knowing other ways of working.'

## A READY WORKFORCE

'However,' adds Buckland, 'when the lockdown was introduced in March 2020, psychotherapists had to adapt quickly in order to continue to support those who needed our services. We did it, and the speed at which we adapted to a new way of working is something we should be extremely proud of.'

According to UKCP's survey, 40% of members donated their expertise by spending some time working on pro-bono contracts and supporting the NHS and voluntary sector. This figure has dramatically increased since the outbreak of COVID-19. 'Psychotherapists are one of the groups of hidden key workers in this crisis,' says Sarah Niblock. 'While we applaud all our members who have been able to volunteer their time and skills to support others, we will continue through our policy and campaigns work to protect our members' livelihoods and secure the recognition and paid opportunities our members need in order to provide crucial support in an accessible and sustainable way.'

The UKCP is among a number of organisations, including the British Association for Counselling and Psychotherapy (BACP) and the British Psychoanalytic Council (BPC), which wrote to the Secretary of State for Health and Social Care, Matt Hancock, in spring 2020. They highlighted the more than 100,000 highly trained psychotherapists and psychotherapeutic counsellors at the forefront of the mental health sector, supporting hundreds of thousands of the UK's most vulnerable people, and who are ready to work in the NHS, to help to alleviate the great many pressures it faces in relation to the provision of mental health services[5].

The letter calls on the government to make a commitment to provide a genuine choice of talking therapies through primary and secondary care NHS services across the whole of the UK. And among the UKCP's other policy objectives is a call for longer term talking therapies to be offered to people with complex mental health problems with the aim of eradicating the so-called 'revolving door' of people with serious mental health issues, and for funded trainee places in IAPT (Improving Access to Psychological Therapies) for non-CBT practitioners.

Sarah Niblock points out that UKCP is working hard to secure more funded training and work opportunities within the NHS and to increase public awareness and understanding of the value of psychotherapy. 'We are calling on the national government, local government, MPs and the NHS to take action now to provide a genuine choice of talking therapies through primary and secondary care NHS services across the four nations.' ●

**What do you think?**
Share your thoughts and opinions by emailing: **editor@ukcp.org.uk**

**Good practice**

### Royal Hallamshire Neurology Psychotherapy Service

The Neurology Psychotherapy Service at the Royal Hallamshire Hospital in Sheffield is an example of good practice in psychotherapy in the NHS. For patients experiencing extreme physical symptoms, seizures and paralysis, for whom the causes are psychologically driven, the service has a seven-strong team of experts in CBT, gestalt therapy, lifespan integration, integrative, intensive short-term dynamic psychotherapy and acceptance and commitment therapy. 'Our goal is to improve quality of life,' says neurology psychotherapy manager Aimee Morgan-Boon. 'We offer four to 20 hour-long sessions and we see 3,000-4,000 patients a year, with a waiting list of 12 to 18 months. This is likely to increase if people already disposed to psychological challenges have a difficult COVID-19 experience.'

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# A MATTER OF SOCIAL JUSTICE

THE PEOPLE WORST AFFECTED BY COVID-19 AND MENTAL HEALTH ISSUES ARE OFTEN THE LEAST ABLE TO ACCESS HIGH-QUALITY THERAPY. **HAZEL DAVIS** INVESTIGATES THE IMPACT THIS WILL HAVE

**So often mental health is seen through the prism of poverty; many indicators of poverty are indicators of mental ill health. Levels of anxiety and depression remain highest among people with a lower income[1]. Emotional and attention difficulties are two-and-a-half times higher in children from lower income households[2].**

But these aren't the only indicators of poor mental health. Anxiety and depression levels remained high among young people, those with a diagnosed mental illness, people living with children and those living in urban areas, even after some lockdown measures were eased in June 2020[3]. The mental health of women has been particularly badly affected since lockdown[4], and people from ethnic minority backgrounds have had lower levels of happiness and life satisfaction – 23% reported being lonely during lockdown, compared with 17% from white backgrounds[5].

Yet the effects of the pandemic have been indiscriminate across the population as a whole. As well as the threat to physical health from COVID-19, pandemics are not dissimilar to natural disasters in terms of the way they affect individuals' mental health. People who have not previously suffered will be experiencing mental health difficulties for the very first time. The damage is also long term: research from the SARS and MERS epidemics has shown that the effects on mental health are felt a long time afterwards[6].

'Research data shows that, increasingly, people

## ‘It has become even harder to get access to mental health support’

from all walks of life are experiencing worsening mental health,’ says UKCP’s chief executive Sarah Niblock. ‘Taking into account the recession, the acute uncertainty over our health, our livelihoods, Brexit and the environmental crisis, I am worried that families and communities will become even more fragmented and split and there will be an overall health impact. Loneliness, for example, is as serious a physical health threat as it is mental – akin to smoking 15 cigarettes per day.

‘The pandemic and the climate emergency will have an unimaginable psychological toll on the emotional and mental wellbeing of our entire species,’ she adds. ‘In the wake of the pandemic, we know that it has become even harder to get access to mental health support. How the UK government responds to the scale of this challenge will have dramatic repercussions for all our mental wellbeing and our recovery economically.’

### A LONG-TERM PROBLEM

But accessing treatment via the NHS for mental health difficulties is particularly difficult and, same as it ever was, the ones who are most adversely affected are the ones who can’t get the treatment. ‘The driving force behind UKCP’s campaign to push for more psychotherapy in the NHS is a simple question of social justice,’ says Adam Jones, UKCP’s policy and public affairs manager. ‘We’re tired of the fact that the brilliant work of our members is so often available only to people who can afford to pay for therapy privately.’

Psychotherapy can help alleviate many issues, from addiction to enabling people to overcome mental illness and return to work. But without better provision, many elements of social injustice, such as poverty, crime and poor physical health, will continue to worsen. In its 2017 report, ‘Dying From Inequality’, Samaritans found that socioeconomic factors including poor living conditions, unemployment and debt contributed to higher suicide figures, with men feeling more susceptible to the negative effects of recession than women[7]. Those who are unemployed are two to three times more likely to die by suicide than those who are in employment. Low educational levels and not owning a home also increase the risk of suicide.

‘We know that people who are socioeconomically disadvantaged are less likely to request help for any emotional or mental health issue than those less disadvantaged,’ says integrative psychotherapist Dr Christian Buckland, who works alongside other mental health professionals, such as consultant psychiatrists, counselling and clinical psychologists. ‘These findings also indicate those from socioeconomically disadvantaged backgrounds are not as likely to receive a referral to specialist services from GPs in relation to self-harm than those in less-deprived areas.’

### PRIVILEGES

So where are people accessing help for mental health difficulties? Charity Mind found that since April, 27% of nearly 9,000 people they surveyed who had been able to receive therapy, accessed mental health support through a private provider, 16% got help through charities, and 49% received support through the NHS[8].

‘We’re concerned that the government will continue to rely on the voluntary sector to pick up additional demand post COVID-19,’ Niblock says. ‘That would be unacceptable to a patient needing physical treatment, so it beggars belief that it is seen as acceptable for mental health treatment.’

For those people hardest hit with mental health difficulties, the lack of access to appropriate talking therapy through the NHS can be devastating. For example, the NHS needs to be better prepared for the inevitable influx of minority groups that are going to come through its doors seeking help for mental health, according to integrative counsellor and psychotherapist Dwight Turner.

‘Lockdown has shown up degrees of privilege and highlighted how disproportionately affected by this illness minorities have been across the western world,’ he says. ‘Often on the frontline, they’re the ones on the receiving end of the traumatic impact of what’s going on, not to mention racism and prejudice. With local lockdowns it’s often been the minorities who have been considered at fault. We’ve seen an awful lot of stereotyping and prejudice and the wooliness around the rules has made divisions even worse, with people being pitted against each other.’

Just over 22% of mental health staff in the NHS have a minority ethnic background[9]. Yet systemic racism is all-pervasive and self-perpetuating, even among well-meaning people. ‘The classic example is a workshop on race where a person of colour might be expected to speak for everyone of colour,’ he adds.

### URGENT INVESTMENT NEEDED

And psychotherapists can play a major role in ensuring the voices of their patients and clients are heard. ‘We are the ones on the frontline hearing the levels of despair,’ says Buckland, ‘and I am anticipating the suffering will significantly increase over the next year, whether this is additional distress from the loss of loved ones from a pandemic, result of redundancy and job loss, loneliness and isolation, humiliation and shame from loss of job or exclusion from communities, exacerbation of existing mental health issues, illness from medical conditions that have been left undiagnosed, operations postponed, breakdowns in relationships due to the divide in opinion relating to race, pandemic restrictions or the erosion of civil liberties.’

## ‘People who are disadvantaged are less likely to request help’

## ‘We have to invest in protecting people’s mental and emotional wellness’

There are real worries among specific groups. ‘My concern is the level of suicide may have already significantly increased this year and will continue to do so as the economic and health effects and responses to the pandemic are felt for the years to come,’ adds Buckland. ‘We are told that the lockdown has significantly impacted those who have previously had issues with alcohol, eating disorder charities have stated a significant rise in calls to their helplines during the lockdown.’

Addressing these issues is crucial, not just in response to the pandemic, but in having a hugely beneficial effect on society. As most therapists and patients know, if one person has psychotherapy, the effects are felt by partners, children, families, colleagues and even communities. ‘If we want a resilient, agile society where people can thrive, where children’s life chances are massively improved (given that the seeds of 75% of adult mental health issues are planted in childhood), then we have to invest in protecting people’s emotional and mental wellness,’ Sarah Niblock says. ‘We know that too many people are arriving at the therapist’s door as a last resort after other methods to address their issues – such as short-term interventions and medication – have failed.’

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Illustrations: Detmer / Ikon

# ‘For every £1 the hospital spends on psychotherapy, it saves £29 in costs’

FOR TEN YEARS, **KATE HARDENBERG** HAS WORKED AS A SPECIALIST PSYCHOTHERAPIST IN A HOSPITAL DIABETES CLINIC. SHE EXPLAINS WHAT LIFE IS LIKE IN AN ACUTE NHS TRUST



I have type 1 diabetes and two of my childhood friends died from diabetes-related self-harm. When I was doing my psychotherapy training, I wanted to do a placement within a diabetes clinic because I knew a lot of people who struggled with the illness. But at the time, few hospitals provided psychological care around diabetes.

I asked a diabetes consultant at the Royal United Hospitals Bath NHS Foundation Trust (who was my own doctor) if they would let me, as a psychotherapy student, do a placement in the clinic. They agreed after some persuasion; but they wanted me to do it for at least two years – they didn’t want to set up a service and build demand only to lose it again. I ended up doing the placement for nearly three years and in that time the consultants managed to secure funding to continue the role.

It is always very tough to get psychotherapy funded by the NHS and when trusts receive funding it is normally for psychology. Within diabetes that funding is usually for children. I knew that Clinical Commissioning Groups (CCGs) would be mostly interested in the efficacy of the clinic, so I collated data for several years to try to prove the value of psychotherapy. I was able to demonstrate cost savings equating to every £1 the hospital spent on psychotherapy it saved £29 in costs. It has been useful for getting the CCGs to provide funding based on money savings with the most costly patients, to help people with diabetes in distress who may not incur such costs.

For example, if someone has got type 1 diabetes and is also homeless or has got mental health problems, they need a lot of help. And an overnight stay in hospital can cost about £2,000. We don’t need to do a lot of psychotherapy work with somebody to actually bring these costs down quite considerably. The NHS targets for diabetes outcomes are partly based on patients’ average blood sugar levels over three months. I can tell from the numbers that if I can work with someone psychotherapeutically for a period of time, I can bring their average blood sugar level down quite considerably.

## Hospital life

I work two-and-a-half days a week at the hospital (the rest of my time is spent in private practice), mainly with outpatients in the clinic as part of a multidisciplinary team of doctors and nurses. I work in a clinic room and patients have 50-minute sessions. My waiting list is too long (about 180 people) for patients to have a weekly session. I might check in once a month with a patient but, to an extent, I have to be flexible about it. Generally I see between eight and ten people each week.

I see anyone who has to take insulin, mainly those with type 1, but some with other types. When a patient with diabetes is admitted to hospital the team of inpatient specialist diabetes nurses, who are the first point of contact for anyone with diabetes, will be informed, and they have the specialist skills and knowledge to treat them. That team of nurses inform me so I can visit the patient too.

This allows me to build a relationship with the patients, especially if they later return to the hospital as outpatients. Some of our patients are hard to reach and won’t normally visit a doctor, so the opportunity to build this relationship is really important. For example, a homeless person admitted as an inpatient might not want to engage at all, but if I’ve said ‘hello’ to them five or six times they might start to respond and we can start to build a relationship. As

**‘The nurses and doctors I work with are really switched on to the benefits of psychotherapy’**

**Photo:** Joseph Branston

Kate Hardenberg: 'If I can work with someone psychotherapeutically for a period of time, I can bring their average blood sugar level down quite considerably'



diabetes is a long-term chronic condition, a person with diabetes usually has a long relationship with healthcare systems so even if they don't want to talk to me at first, often they will come around, especially if I have met them as an outpatient. Ultimately, I am trying to get to their relationship with themselves, and their relationship with their diabetes and management of it.

## Psychotherapeutic treatment

Diabetes is a complex illness that needs a lot of self-management – four to six injections a day, constantly monitoring blood sugar levels, understanding nutrition and physiology. People have to be very self-motivated, and many just won't be able to cope with the demands. Sociodemographics and income can come into it. Someone from a middle-class family will be able to access technology to help manage the illness much better than someone from a family with financial difficulties, for example.

When children get diagnosed in hospital, parents can react very differently right from the beginning. Some just don't really care and some are overly anxious. That will feed into how the patient will see themselves and their condition. There are so many ideas in health psychology about how the way patients cope with illness depends on people's beliefs, their family's beliefs, and society's beliefs about health and illness.

I like to ask my patients, 'If diabetes was a person, who would they be and how would you feel about them?' Everyone has a different creative take on this – 'like a boss breathing down my neck'; 'I would block them on social media and never speak to them again'; 'like an embarrassing toddler at the supermarket'. Because diabetes is a long-term condition and people need to sustain challenging self-management for an entire lifetime, the attachment model, and therefore the relationship people have with doctors and nurses, is really important.

## Other mental health professionals

I am supervised partly by a clinical psychologist. There are a few psychologists across the whole hospital but I am the only psychotherapist so far. There is also a mental health team here, funded by a different trust. Their threshold for seeing a patient can seem quite high, and I know they are overwhelmed by work. If a patient has a mental health need – for example an eating disorder – and they also have diabetes, mental health teams may not add the patient to any waiting lists until we have 'sorted the diabetes out'. If someone has complex mental health difficulties as well as diabetes there are specialist units across the UK, but they are few and far between.

What has been really positive is that the nurses and doctors I work with are really switched on to the benefits of psychotherapy and psychotherapeutic thinking as a means for helping patients with diabetes. I do supervision sessions with our diabetes nurses to encourage them to have a psychotherapeutically informed approach when they work with patients, and it has really helped. They're listening to patients' stories all the time

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***Tutor: Susie Hewitt*** ***Cost £945***
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and are so dedicated to helping them, so some extra tools are great at enhancing their skillset.

We discuss defences, the idea of optimal frustration, and empathising with patients when, from the outside, it might not be obvious why they behave in a way that may be detrimental to their health. Doctors and nurses obviously want to help their patients but the medical model is very different to a psychotherapy model. In recent years there has been a real shift in the way these medical professionals are talking to people with diabetes, mental health is much more widely thought about. Psychological support is now on the agenda for diabetes with the new CCG that has been formed here, and specialist psychotherapy has its place as well as the IAPT model.

Kate Hardenberg would like everyone with diabetes to be able to access psychotherapy

## Helping patients

I was employed because the commissioners of diabetes services could see the work that I had been doing was effective and beneficial. The psychological modality I employed was less important to them than the benefits.

However, we have just recruited a psychotherapist to work with me and as an acute, rather than mental health NHS Trust, we are not used to recruiting psychotherapists. However, one of the great things about working in the NHS is that so many opportunities come up within it. I have worked on two really interesting research projects, one about underlying mental health conditions in people who are regularly admitted in hospital with diabetic ketoacidosis (DKA), a serious complication of type 1 diabetes[1], and one looking at how children with diabetes or other long-term conditions transition from paediatrics to adult services[2]. These opportunities haven't come up in private practice in the same way.

**'One of the great things about working in the NHS is that so many opportunities come up'**

I learned very quickly that doctors respect data which is systematically peer reviewed and published and they don't if it isn't. The average doctor is not familiar with the kind of psychotherapeutic language we might engage in and we need to put it in terms they use to communicate. I also learnt that case studies were of less interest to commissioners, however great they were, because they are dealing with such huge numbers of people. As psychotherapists we have to work within that existing model. There are lots of things to adapt to in an acute hospital – like not always having proper clinic space or enough stationery for example, because medical needs should and must take priority.

The other thing about building a psychotherapy service in the NHS is that it's easier to get funding from clinical commissioners if you can demonstrate that there is demand for it – a big enough waiting list. So although it is personally difficult knowing you have 180 people waiting to see you, at least you're more likely to show the need for the service. NHS commissioning also changes over time, and varies between different areas. Sometimes they may want to get A&E admissions down. Sometimes they want length of stay reduced. It is useful to understand how these models work.

Treatment for diabetes is available and free at point of access, unlike in the USA, for example, where cost is a huge barrier to diabetes care. But many in the UK with diabetes have really poor outcomes. There are many factors involved in why they are not able to adapt well to living with a long-term, self-managed condition. We have to get to the roots of behaviour to understand this. If someone can understand themselves fully and build their self-awareness and resilience then they are going to have much more control over how they live and the decisions they make. I want there to be a service like this for people with diabetes in every hospital.

*katehardenberg.com*

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- (1) kcl.ac.uk/ioppn/depts/pm/research/diabetes-psychiatry-psychology/3-dimensions-of-care-for-diabetes
- (2) onlinelibrary.wiley.com/doi/full/10.1111/dme.13698; pubmed.ncbi.nlm.nih.gov/31116547/

# ‘We’re intervening not just for this generation, but the generations to come’

**DR YVONNE OSAFO CF** IS A PARENT-INFANT PSYCHOTHERAPIST AND CHURCHILL FELLOW FOR EARLY YEARS INTERVENTION AND PREVENTION, WORKING WITH MOTHERS, BABIES AND FAMILIES



My husband and I set up a charity for vulnerable young people when we were in our late twenties: it was an extended family for those who had left care, been in trouble with the police, or didn’t have a secure base at home. I also worked with young offenders and families where children were refusing to go to school. We began fostering vulnerable sibling groups with the idea of giving them permanence. While fostering, I realised how deep the issues were for the children, I felt that by the time they started to get help, it was too late. I got to a point where I felt like giving up.

I started to train as a child psychotherapist in 2005, to be better equipped to help my foster children. It was after qualifying and attending a seminar by Dr Stella Acquarone at the School of Infant Mental Health that I decided I wanted to focus on early intervention for children – we need to be able to help people before they give birth, ideally – and I carried on training, becoming a parent-infant psychoanalytic psychotherapist then completing a doctorate in psychoanalytic psychotherapy at the University of Essex.

Understanding how crucial the first 1,001 days of life are for children is gaining traction in public healthcare and the government has started to take notice, with the announcement in July 2020 of a review of early years’ services that aims to reduce inequalities in young children from conception to the age of two. Andrea Leadsom, who leads the government initiative, was also pioneer of the All-Party Parliamentary Group for Conception to Age Two – First 1,001 Days of life. This is an area that I am involved in and I encourage psychotherapists of different modalities to train in (*see panel, page 28*).

Early-intervention psychotherapy services for infants and their parents are crucial, not just therapeutically, but financially, in keeping the costs of social care, criminal justice and other public services down. We are intervening not only for this current generation, but for generations to come, by stopping the intergenerational transmission of trauma that leads to toxic parent-child relationships, addressing adverse childhood experiences (ACEs) at their earliest point. If we treat many of the issues that people face in their first two years of life, they will not come back to haunt them during adolescence. We can prevent a repeat of ACEs, safeguard a child for the future and prepare them to internalise healthy relationships that they in turn can share with their own babies, grandchildren and many others.

## Two different services

I work in two organisations in which there are strong and close working relationships with professionals in the NHS and other public organisations. West London Action for Children (WLAC) is a charity that has served the London Boroughs of Kensington and Chelsea and Hammersmith and Fulham for the past 104 years. I am one of ten psychotherapists working with low-income, high-risk families who are living in two of the richest areas of the country. They may have experienced trauma, their parents may have had ACEs and they will likely be living in poverty. Some are bereaved and traumatised because of the Grenfell tragedy. As early intervention lead, most of my WLAC clients are referred from the NHS hospitals in our catchment area, from the perinatal service and from social care. NHS clients come with issues such as personality disorders, depression or suicidal ideations. With social care clients, my intervention would often determine if the baby remains with the mother or is taken into care. I work with social workers, family court and other organisations to ensure that the baby is safe.

I helped to set up and pilot my second place of work, the Croydon Parent Infant Partnership, which is a partnership

**‘If we treat the issues that people face in their first two years, they will not come back to haunt them’**

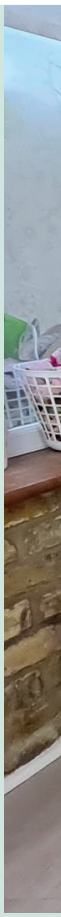

**Photo:** Joseph Branston


Osafo: 'Understanding how crucial the first 1,001 days of life are for children is gaining traction in public healthcare'



between Croydon Drop In Youth Counselling Service, the local authority and Parent-Infant Partnership UK (PIP UK). I was Clinical Lead since its inception in 2015 to December 2020. This is one of seven teams across the UK that was initially funded by PIP UK, now called the Parent-Infant Foundation. There are currently 29 specialised parent-infant relationship teams around the UK. Like the Croydon PIP and West London Action for Children, these teams are sponsored by local authorities, charities, commissioning groups, fundraising events and voluntary organisations, to help those experiencing difficulties in their early relationships with their children in the first 1,001 days of life. Though we work with a range of professionals to support mothers, infants and their wider families, 53% of referrals come from the NHS, from midwifery, health visiting and adult mental health.

In WLAC we work only with low-income, high-risk families who are unable to pay for therapy. In Croydon, there is a single point of access for people who are referred to the service, income is not relevant to who receives help and even though we might walk into a beautiful house to see a client, the issues that parents and infants are experiencing may be just as dire as for those with lower incomes.

In both organisations I work as part of a team of professionals trying to understand the needs of clients – which may include housing, education, employment, criminal justice, therapy – and how we can work together to help them. Parents can't really access psychological help if they are overwhelmed by physical needs. I may come into contact with social workers, family support workers, domestic violence support workers, solicitors, court professionals, doctors, nurses, health visitors, midwives, child protection, other mental health professionals – the list goes on. But if psychotherapeutic support is offered much earlier there would likely be less need for multi-agency interventions later. There is a single point of access for people who are referred to the service and we allocate people according to their need – key work or psychotherapy. We like there to be a network of support and working in a multidisciplinary sense.

## Working with a multidisciplinary team

Our relationships are normally very positive and non-psychotherapists are open to learning more about psychotherapeutic methods. Workforce training is important, particularly when professionals are deciding who needs to be referred to the services.

A bulk of our referrals come from peri-natal care and social care. In Croydon, one of the psychotherapists spends half a day a week in the hospital's special care baby unit. The medical staff team can consult with her, and she can speak to new parents and pick up early issues before they might develop into a referral.

There is a wide range of signs that professionals in the NHS and other organisations may pick up on and decide to refer someone to psychotherapy. It might be that a mother had a traumatic birth that has affected

Osafo is working with the Winston Churchill Memorial Trust to inspire the UK's parent-infant psychotherapists

her relationship with her infant. A mother may have developed post-natal depression or perinatal PTSD. A person may be referred to us as a preventative measure, if a baby died in a previous pregnancy, for example. We also treat mothers who have previous mental health issues, such as a personality disorder. Babies might not be feeding, sleeping well or fussing too much. They might not be giving eye contact to their mother.

Or it could be that there are issues in a family – past domestic violence, addiction or abuse. Social services may refer pregnant women who have had other children removed, and desperately want to keep the child they are pregnant with, but need help to provide a safe, caring environment.

## The therapy

When people are referred to us we consider the risk factors involved – family history etc. We hold a consultation with the family to ensure they know why they have been referred and to get an idea of their background. If two parents or caregivers are involved we want to hear both sides. The key part is that we are working with both parents and caregivers and child together. A key skill that we use to assess the parent-infant relationship is Infant Observation, after the Esther Bick (1964) method[1]. In our training we observe a mother and baby from birth to age two years to learn what a healthy relationship looks like, so that we can easily identify any deviations from the norm. We call these unhealthy patterns of relationship 'ghosts in the nursery' (Fraiberg, 1975)[2]. Sometimes you can see the 'ghosts in the nursery' straight away. We may have six, 12 or 20 sessions of therapy planned, or we may just consider the therapy to be short term or long term. Normally we like to start off with weekly sessions then, as things start to resolve, we begin to wean clients off a bit – moving to fortnightly and monthly sessions until we work towards an ending.

We prefer that women come in pregnancy because we have found that if therapy starts before the baby comes it is likely to have a better outcome. A big part of the work is encouraging the mother to bond with the baby in the womb, explaining the importance of skin-to-skin contact and looking at the baby when it's born. If parents come with older children we can also trace when a pattern of behaviour started and try to consider why.

A lot of the work we do is about giving the baby a voice that the parent might otherwise not have thought about. During the first 1,001 days of life, babies are unable to talk about their feelings and needs, but communicate these in different ways. We help parents and other carers to understand the baby's cues, to imagine what the baby might be trying to say through their behaviour and to respond appropriately. Crucially, we need to build trust, to work in the moment and use psychoeducation and understanding of neuroscience to demonstrate to mothers how to be with their babies. But I look at this work not only in the moment – I am looking at the generations to come. ●

***yvonneosafopsychotherapist.com***
***wcmt.org.uk/users/yvonneosafo2016***

**Skills**

### A highly trained profession

If the government's initiative to invest in early years is to be successful, we will need to have ready a strong workforce of highly skilled parent-infant psychotherapists who are able to work with the delicate early relationship. I chair UKCP's Infant Parent Psychotherapy Working Group, which falls under the College for Children and Young People, and is developing standards of training in infant-parent psychotherapy for psychotherapists who wish to be upskilled in this area.

One of my personal goals for the next few years is to set up parent-infant training to enable psychotherapists from various modalities to gain the skills they need to join such a workforce. I took my idea to the Winston Churchill Memorial Trust and they sponsored me to travel for two months to Scandinavia and the USA to learn from best practice in parent-infant psychotherapy in order to return to inspire a UK workforce.

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- (2) Fraiberg, S. (1975). 'Ghosts in the Nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships', *Journal of American Academy of Child Psychiatry*, 14(3): 387-421.

# Professor Dr Franz Ruppert
# Latest two books...

Developer of
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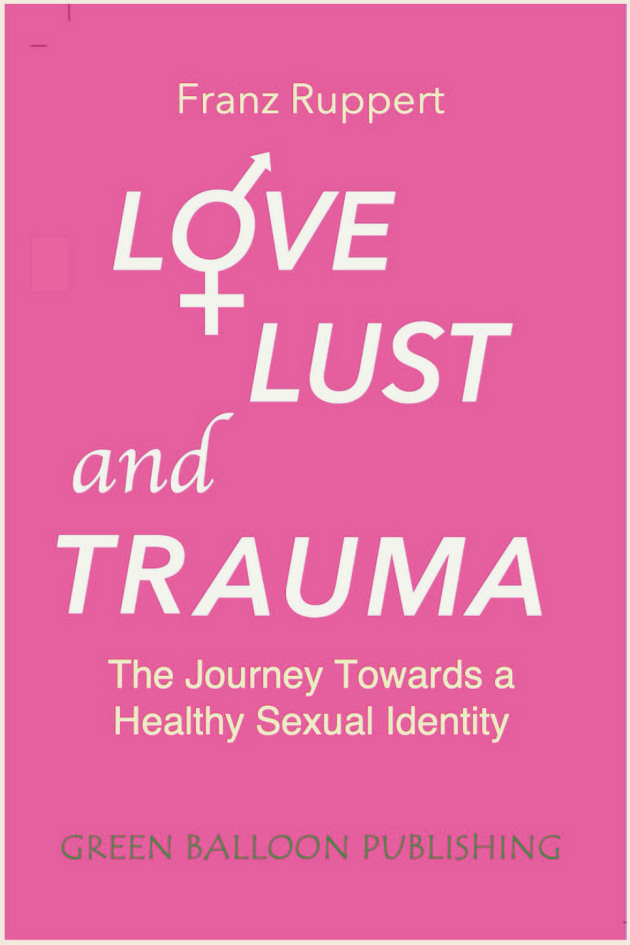
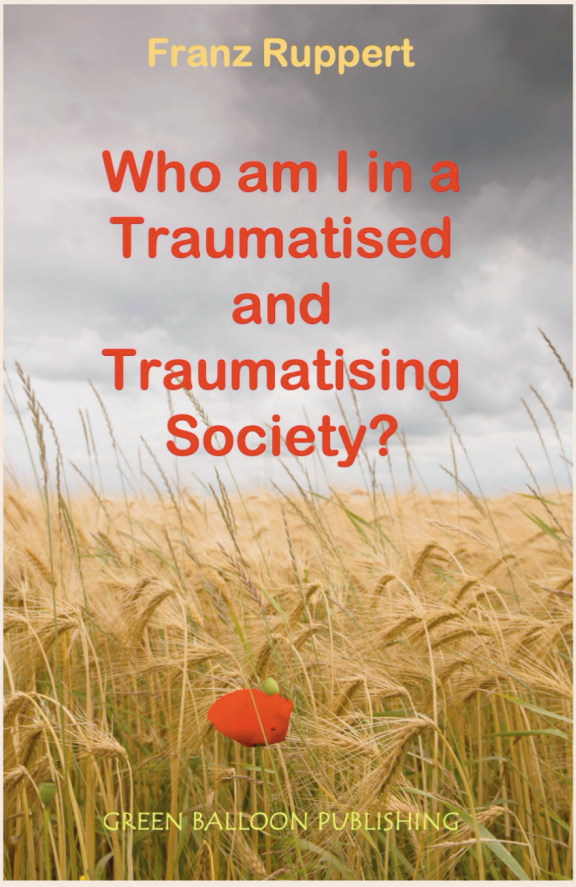
A new perspective on understanding and working with psychological and emotional trauma




## Love Lust & Trauma

completes Ruppert's theory of the Traumabiography, covering the topic of sexual trauma. In this book he updates his thinking on early traumas (Trauma of Identity and Trauma of Love), and gives a detailed account of healthy human sexuality and its shadow: sexual trauma in childhood and adulthood.




## Who am I in a Traumatised and Traumatising Society?

In this book Ruppert looks at the impact of personal trauma on society, and how society functions to continually traumatise and retraumatise. The solution that he comes to is that we can only really change anything in society and our world if we address our own personal trauma. There is no other topic more important and historically more avoided.

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# ‘This is joint work, and integration between many services is needed’

**ANDY RYAN** IS AN INTEGRATIVE PSYCHOTHERAPIST HEADING UP THE RECOVERY AND ADDICTIONS ARM OF A CHARITY THAT WORKS IN TANDEM WITH OTHER PUBLIC SERVICES



Drug and alcohol treatment services don’t tend to attract much empathy from people. Many think addiction is a choice or an ‘easy way out’ and there is much to be done to remove the stigma and attempt to understand how and why people end up misusing and become dependent on substances. But we have come a long way in the last 20 years in trying to understand addiction in relation to trauma and as an adaptation for people, rather than as a set of symptoms.

As a charity with the aim of tackling social exclusion in all its forms, Changing Lives provides recovery and addiction services (which I lead), alongside housing and rough sleeping support, women’s services (including domestic violence refuges and support for those in contact with the criminal justice system) and employment and education. My service covers anything from prescribing needs to supervised consumption to psychosocial and therapeutic treatment.

We have five ‘quasi-residential programmes’ running across Yorkshire and the North East of England. Individuals attend a centre for 12 weeks, from 9am to 5pm, five days a week, for the therapeutic group work and one-to-one therapy that comprise the Oaktrees model – an abstinence programme based on the 12 Steps. The programme of support relies on the idea of a therapeutic community, bringing people together and helping them to reintegrate into society and access different social networks. Oaktrees is similar to a residential rehab programme, but carried out within people’s own communities.

Referrals come from a range of places. People can call and ask for help; social workers refer individuals – and we’d rather people have the chance to address their addiction than have their children removed from their care; local hospitals refer people with drug and alcohol addictions who are being discharged; and the criminal justice system refers cases from court and prison.

## Multidisciplinary teams

One great thing about locally commissioned services and working alongside the local authority, public health and criminal justice teams is that we can be responsive to more immediate needs because different areas may experience problems with different substances and different demographics.

For instance, if an area has a high correlation between drug use and crime, the Office of the Police and Crime Commissioner may put money into the local authority’s budgets specifically to tackle the problems arising from the interlinked issues. The same applies to Clinical Commissioning Groups putting money into local initiatives in order to tackle healthcare issues specific to particular localities.

Over the last five to ten years, everyone has pushed the idea that there’s no ‘wrong door’ for people to knock on. A local authority-commissioned service for drug and alcohol treatment should allow people who live in that area to be able to access the service no matter what. Local authorities are also beginning to understand the need for contracts to extend beyond five years in order to allow enough time to embed a service effectively.

We have key performance indicators set by the public health team and based on data from the National Drug Treatment Monitoring System (which Public Health England runs to gather information on people receiving drug

**‘These partnerships with other agencies and professionals are not without challenges’**

Photo: Joseph Branston

Ryan: 'There is much to be done to remove the stigma and attempt to understand how and why people end up misusing and becoming dependent on substances'



treatment services across the country) or other locally pertinent data, and meet quarterly, along with CCGs and Primary Care Trusts, to assess progress of the service. With the contract we are also part of the Multi Agency Risk Assessment Conference (MARAC) and the Multi Agency Tasking and Coordination (MATAC) within the criminal justice system and often have links with integrated care systems, Clinical Practice Groups and GPs. For example, we need to let GPs know if we start prescribing methadone to people since it is the role of local pharmacies to dispense medication to our clients.

## 'Fixing' symptoms

These essential partnerships with other agencies and professionals are not without challenges. One of the difficulties is that lots of the conversations, dialogues and the service itself are centred on the symptoms of addiction. When I speak to hospital doctors they are naturally interested in blood-born viruses, liver disease or reducing the impact on A&E, for example. But as a psychotherapist of a decade sitting around those tables, I find myself thinking, 'The only way you will reduce liver disease is to understand why someone is drinking, not by telling them to stop drinking.'

Even when people do manage to get referred to Improving Access to Psychological Therapies (IAPT) , the six-plus sessions are centrally focused on fixing something in a person. Age-old ideas about mental health, that we don't necessarily agree with, still dominate in the NHS. The ideas that therapists should get to the bottom of whether addiction is caused by poor mental health or vice versa, and that therapists cannot work with clients while they are still using, mean we sometimes bump heads within system pathways. We also need to be mindful of the fact that this is joint work, and integration between many services is needed.

But we're living in difficult times for most services. It's well documented that over the last three or four years there have been huge reductions in drug and alcohol treatment, but demand isn't really getting any lower. The idea of a therapeutic alliance for drug and alcohol services is very difficult when the frequency of medical and mental health appointments has been stretched so far. The current pressures counter the research that we have developed over many decades that shows how frequency of support has a direct correlation with how effective it can be in helping build a secure therapeutic base to create a space for change.

## An ideal world

Every local authority should be able to do this kind of work, and everyone is doing their best, but the system is creating splits for people. Someone may be accessing a wellness centre, housing support and drug and alcohol

services, but because the system isn't joined up they are going through the trauma of having to tell their story over and again. Or a person accessing multiple services might start using again and go off the radar as they experience things not working for them. A high proportion of drug-related deaths in England are of people who are not currently accessing their local treatment service for help.

The private therapy model of one hour of therapy every week wouldn't help manage all of the complexities of people who have addictions, experience domestic violence or sexual exploitation, and have historic trauma, for example. Nor would it necessarily help someone who, having slept rough for their entire life, then struggles once they are housed. However, the therapeutic knowhow, theory and experience of many therapists needs to be integrated into a truly new model and approach to helping people who experience many complex issues in their lives. The standard of training I received while becoming accredited through UKCP has added to the personal insight I have been able to offer and I believe that the only way we can change is through this rich collective mix of diverse experience and knowledge.

In an ideal world, local authorities would co-commission services which would be provided under one contract with many providers in a kind of alliance. People accessing support would have one centralised key worker and frequent, intensive therapeutic support. Caseloads would drop to a reasonable size by design so that people can receive focused psychotherapeutic support and help reintegrating into society. But this comes with a price tag.

I have heard people explain at conferences that they had to survive childhood to get through to adulthood. Services weren't readily accessible, and when they did get professional help, people wanted to get them a house, or to hospital or even a dentist. Nobody wanted to talk about how bad it had been for them. Fully integrated services would have an awareness of developmental trauma at all life stages, but also be designed with the recognition of how people have had to adapt to the things that have influenced their lives.

Ryan says psychotherapy helps to break intergenerational cycles of addiction

## 'We need to create a space for people to talk and understand how they have adapted'

We need to create a space for people to talk and understand how they have adapted. A trauma-informed, adaptation-aware drug and alcohol dependency service in its truest form wouldn't even focus that much on drugs and alcohol. Instead, it would focus on how people have adapted, what using means to them, what they are seeking in their relationship with substances and how it has blocked them from healthier life choices and fulfilling their potential.

### A 'domino' effect

I have lived experience of needing and using drug and alcohol treatment services: nowhere to live, multiple hospital entries, huge problems with drugs and alcohol, and many mental health evaluations. Now I have got two children who have never seen me in addiction; I am breaking the intergenerational cycle, with lots of support. If we help people to make sustainable changes, understand themselves, regulate their own emotions without the use of substances and become the healthy people they want to be, that has a domino effect on communities and future generations.

Psychotherapy can create the space to tell stories, make meaning and help people to make sense and move on from the interlinked experiences that can result in addiction. In turn, this can help people move away from social isolation, health consequences and anti-social behaviour, avoid prison sentences or homelessness, and the next generation of children won't have to tell the story of the parent, grandparent, family member or friend they lost to addiction. ●

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# ‘Having a physical illness or health condition has a psychological component too’

**KATE WATERS** IS A SYSTEMIC AND FAMILY THERAPIST AT GREAT ORMOND STREET HOSPITAL IN LONDON, PRIMARILY WORKING WITH YOUNG PEOPLE WITH NEUROMUSCULAR CONDITIONS



I mostly work with children and young people with a wide variety of neuromuscular conditions, the most common being Duchenne muscular dystrophy (as well as being the one most people will have heard of). However, there are many other such conditions, some very rare.

Neuromuscular conditions vary in their impact on the life of the individual, so some will experience relatively mild symptoms, often invisible to others, while others will experience considerable challenges to their physical health and wellbeing, including a limited lifespan. While for some people there will be a level of clarity about changes over time, for many this will include a level of uncertainty, and at times unpredictability, so for both children and their families, this presents considerable challenges to how they live their lives.

People with disabilities experience discrimination and exclusion throughout society – this is often a part of the work, trying to untangle the different levels of experience, and naming these. Systemic – and indeed all – psychotherapists have an important role in acknowledging the mental health impact of these processes, and developing and delivering therapy which is anti-discriminatory.

Photo: Joseph Branston

I have been at Great Ormond Street Hospital for more than seven years now. Coming from a (largely) Child and Adolescent Mental Health Services (CAMHS) background, this almost felt like a new career – a real privilege in many ways – albeit one where I transferred skills from previous experiences and contexts.

## Teamworking

We currently total seven systemic psychotherapists across different departments in GOSH. On one level, this is a luxury, on another we are a small part of a larger department which consists of mainly clinical psychologists, but also other mental health disciplines, who work in both mental health and with different departments across the whole hospital.

When I began working with my colleagues in the neuromuscular team, as the first clinician with a mental health hat on within the team, I was aware that I needed to demonstrate the value that systemic work brought to the team and the children and families. Equally, I needed to learn both how the hospital and the team worked – and gain a familiarity with the range of conditions and how they affect individuals and families. Needless to say, I am still learning, not least from the children and families with whom I work. In addition, I now work alongside a family therapy colleague, which is a reflection of how much the team values family and systemic work.

Having a post like mine brings a certain knowledge and understanding of the impact of psychological processes. And whilst I believe that my multidisciplinary colleagues also understand this, I also believe that we bring important experience, skills and functions to the team. Sometimes I feel that I am being something of an interpreter across different ways of thinking about the experience of a child or family in this context. That's why being able to have colleagues join me in my work, and me being able to join them in their work, is a great opportunity to expand the help that we can offer a child or young person and their family.

Equally, we have a role in supporting our colleagues in what are demanding and often emotionally challenging jobs, either informally or formally as part of staff wellbeing services. A health service which looks after its staff’s physical and emotional wellbeing is better placed to look after that of its patients.

## Working with families

I don’t see myself as always undertaking systemic psychotherapy with families. However, my practice is systemic so many people referred may want

**‘I was aware that I needed to demonstrate the value that systemic work brought to the team’**

Waters: 'I now work alongside a family therapy colleague, which is a reflection of how much the team values family and systemic work'



help with managing a behavioural problem in the child, or are struggling to come to terms with the diagnosis and/or its impact over time. Many of the children are diagnosed at a young age, and so my work may begin with parents who are struggling to manage the impact of the diagnosis, both on themselves and their wider family and networks. A number of neuromuscular conditions are the product of a gene in one or both parents (of which they are usually unaware), so there may be a level of guilt and blame over having 'given' the condition to the child. Children themselves may become used to letting their parents do the talking at clinics, and may not ask questions, even when they are given the opportunity.

Children need to be given opportunities to learn more about their condition at an age-appropriate level, but families may wish to protect the child from this knowledge. I can advise that a parent needs to ascertain what the child understands, alongside who else knows about and understands the condition (including, for example, siblings). Sometimes it helps to have colleagues join in this part of the work, for example a nurse who can talk with authority about a particular condition, and answer questions that the child has.

The transition to adolescence may also lead to psychological difficulties – in some conditions the young person will experience increased levels of disability as a result of becoming taller and heavier, with the muscles already compromised. This happens at a time when he or she would usually be gaining independence, so working with a family to both understand how this may be compromised, as well as how a family can ensure or maintain a level of independence, is important.

I have some families who I have known for a long time, and some with whom I may have infrequent contact – a number of families I may only meet once or twice. However, there is a value in me being here, and in being accessible. Part of the job is to ensure that children and families have a positive view of psychotherapeutic help, and so even if someone does not wish to engage with me, I would hope that they go away thinking that they might one day seek similar help if needed.

The families with which I and my colleagues work value this input. And the fact that it is on offer at all, also has value, I think, in validating the importance of psychotherapeutic care as part of the overall package of care. The feedback we receive, both formally and anecdotally, is largely very positive.

At a wider level, it is important that there is recognition of the fact that having a physical illness or health condition has a psychological component too, and that these two aspects of health interact with each other. As a family and systemic therapist, I am bound to think that everything is systemic! But again, the existence of these roles across different parts of the

health system serves as a reminder that what impacts upon the individual, also impacts on those around them, and that these impacts are mutual.

## Interconnected role

Systemic work sits well within multidisciplinary teams, so I may join a variety of clinics as well as undertaking joint work with colleagues from other disciplines (social workers, nurses, physiotherapists and speech and language therapists, for example). The latter offers the opportunity to both share systemic practice and develop understanding among colleagues, and for me to learn how they do their jobs. For me, this is a particularly fun aspect of the job – it is where we are both implicit and explicit about the mutual impact of physical and mental health, and can hopefully support each other in our respective roles. A child or young person may be seeing different teams across different departments and specialities, so attempting to clarify and map the overall picture can be really useful.

Across the hospital, different departments have psychosocial meetings as part of the work, and this again offers us the opportunity to share practice and ideas, as well as acknowledge the value and interconnected nature of our different roles. For example, if we had adequate accessible housing, or access to support and facilities, people with disabilities and long-term health conditions would have greater opportunities to experience a better quality of life.

Most family therapists have a prior professional qualification, so will have experience of working within health and/or social care, which helps with having an understanding of working in different roles. The increasingly complex requirements of the public sector are often a challenge, but, equally, there are immense benefits to working within teams, especially in the context of risk, and I truly appreciate being able to share this with relevant colleagues. I enjoy the experience of working in a setting which is primarily concerned with physical wellbeing. Part of the role is to find and show the myriad ways in which physical and mental health intertwine, as well as learn about and acknowledge the very real and daily challenges faced by many of the children and families with whom I work. Having the opportunity to take aspects of this experience back to my colleagues is integral to the work – trying to dismantle barriers to understanding what families and children are experiencing, whilst maintaining boundaries.

Waters is one of seven systemic psychotherapists at Great Ormond Street Hospital

**‘What impacts upon the individual, impacts on those around them, and these impacts are mutual’**

## Essential work

Very often across the UK, there is limited psychological input in physical healthcare, resulting in such services often running with long waiting lists. Also, this input may be limited in terms of the disciplines available, so primarily psychologists, some psychiatrists, occasionally mental health nurses. All of these people are vital, but so are systemic psychotherapists! We are not a luxury, and we all bring something different to the work.

We know from the evidence base on systemic interventions for adults with chronic physical illness, that these contribute to significantly better physical health in patients, and better physical and mental health in both patients and other family members[1].

We need more research in the area of working with children and adolescents, however, there is no reason to doubt that such findings would translate into this area and, for example, the evidence on working systemically with poorly controlled asthma and diabetes strongly supports this. ●

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# COMMITTED PROFESSIONALS

UKCP HAS BEEN SURVEYING MEMBERS SINCE THE BEGINNING OF LOCKDOWN ABOUT PROVIDING PSYCHOTHERAPY VIA TELEPHONE OR ONLINE. **SARAH NIBLOCK** OUTLINES WHAT WE'VE FOUND OUT



**Little did anyone imagine that in March 2020, psychotherapists would be forced by COVID-19 to abruptly adopt technologically mediated work as the 'safest' way to practise. It was for many a scramble with little choice.**

While most of the profession has counted its blessings that it could continue its urgent and vital work at a time of heightened anxiety, trauma and loss, it has not been without its challenges as well as opportunities.

Successive surveys of our members since the initial lockdown revealed how our therapists were passionately driven by their concern for their clients and service users. Fewer than 5% in private practice decided to suspend their services during restrictions. The pandemic forced the majority to migrate to the internet and telephone which, to many previously, would have felt like sacrilege.

Adjusting to the new world of 'telehealth' has been a necessary but not always easy fact of life for UKCP practitioners. Many had read, for example, Gillian Russell, in her excellent book *Screen Relations*, who wrote: 'A bed is not a couch and a car is not a consulting room'[1]. In the group therapy world, analysts argued vehemently that online groups could not be group analysis[2]. Even the very term 'remote therapy' felt antithetical to the working rapport that defines effective practice.

## CHALLENGES

Fortunately, as time has passed, some psychotherapists have found remote working not as bad as they expected and some have even started to enjoy it, as ever spurred on by clients who have expressed a preference.

One quote particularly stands out:

'There is a huge demand upon us at this time and a corresponding huge opportunity for us as therapists to provide people with a much-needed alternative way to respond to crisis. Not with anxiety and alarm, but through our own capacity to manage uncertainty and equanimity.'

While many began remote working as a 'needs must' necessity, they have looked for and found positives, speaking of breakthroughs, greater intimacy and a corresponding resilience shown by clients. They and their clients have collaborated creatively to make it work. But therapists highlight the ethical, technical, financial and modality-specific challenges. They include tiredness and transference, difficult client material and the challenges in working with particularly vulnerable clients/service users.

Many find online work exhausting by virtue of having to search harder to identify non-verbal cues. The necessary self-care comes at a cost when needing to space out or shorten sessions. Working with client after client presenting the same material is wearing, especially when it is also the practitioners' lived reality, where they may have concerns about their own health and that of loved ones. Holding their own anxiety along with their clients' is an acute experience.

**PROFESSOR SARAH NIBLOCK**
**is chief excecutive of UKCP. She has a PhD in psychoanalytic theory/female identity and is an author, journalist and broadcaster**

Working from home is also tough, whether that's down to cohabiting, cramped conditions, noisy neighbours or the pressures of homeschooling children.

### 'A COMPULSION TO HELP'

Someday, in a year or perhaps several, the pandemic will subside, and life will return to a revised version of normal. But, more than any distaste for technology, therapists are worried about what the future may hold for the public. They are daunted by the scale of current and impending mental health need in the UK. They have shared so poignantly how they are often the only point of human contact per week with vulnerable and isolated clients, and that access to wifi and a sliver of privacy is a privilege in 2020s Britain.

COVID-19 has exposed the barriers to accessing psychotherapy for particular client groups. Respondents who are working in the NHS describe the barely tolerable pressure of being on the frontline, but also the daily uncertainty of whether services will be retained. They tell us of cuts to services and bullying.

Therapists are feeling the same fears, uncertainties and grief as their clients. There's the increasing fear that COVID-19 survivors may be affected mentally and emotionally in the long term, perhaps linking to studies of the neurobiology of Parkinson's Disease and Spanish Flu. Survivor guilt is emerging as a prominent issue given the witnessing of the devastating experiences of others on a mass scale. There is concern for the impacts on frontline staff and carers who have had to make potentially life-or-death decisions.

Despite feeling exhausted by working online, with all the dropped connections and pixelated screens, UKCP therapists have not swerved from tackling traumatic material in their own homes and dissolving boundaries of space and time. Many have felt it important to be available, alongside a fierce compulsion to help.

But they have felt a loss of 'presence' in the chemistry that makes the psychotherapeutic relationship so powerful. Moving from the consulting room to the screen requires new knowledge and training. Can a highly effective therapeutic process occur without physical co-presence?

What happens to free association and the loss of room as containing space?

And they are terribly worried about the harder-to-reach clients whom, whether due to lack of privacy or simply the severity of their issues, are unable to attend remote therapy. ●

**Trauma**

## Two pandemics

One of the traumatic aspects of the pandemic at the time of writing is that we cannot clearly see the future. We are existing in the trauma, making it almost impossible to project further in time.

The pandemic has brought issues of mental health front and centre in the media – two pandemics – the virus and the associated distress, trauma and loss. There is wide acknowledgement of the emotional needs of a population dealing with a terrifying reality and an amazingly agile and committed organisation of professionals in UKCP ready to start that vital and, in too many cases, life-saving work today.

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# ‘I know from experience that psychotherapy works’

SENEDD MEMBER **HELEN MARY JONES** IS ACUTELY AWARE OF THE MANY ISSUES THAT CAN AFFECT MENTAL HEALTH, AND BELIEVES SOCIAL SOLUTIONS SHOULD PLAY A PART – ALONGSIDE MENTAL HEALTH SERVICES – IN HELPING PEOPLE



It’s nearly 22 years since the Welsh people voted for an Assembly away from Westminster to represent them, following a referendum in 1997. And in that time, both the public dialogue around mental health and the treatment available have improved, says Helen Mary Jones MS, who was elected to that historic Assembly.

‘In 1999, I don’t think I would have been telling people that on three occasions I have made use of talking therapies to deal with issues that I was facing at the time,’ she says. ‘It’s become more acceptable to talk about mental health now. There is also more recognition among GPs and others working in frontline services that mental health is their business, and there is more provision of primary services.’ But, she adds: ‘GPs are frustrated by the lack of tools available, other than very short talking therapy interventions or medication.’

Talking therapies are acknowledged now more than in previous years across Wales and the NHS, as often being a better way of addressing people’s mental health issues than medication. ‘But access is still really limited,’ Jones adds. ‘If you cannot afford to pay for private therapy, you may be fortunate to get six sessions of counselling through your GP and that will often be cognitive behavioural therapy. And I know it can be transformative for some people, but it’s not right for everyone.’

## PERCEPTIONS OF TREATMENT

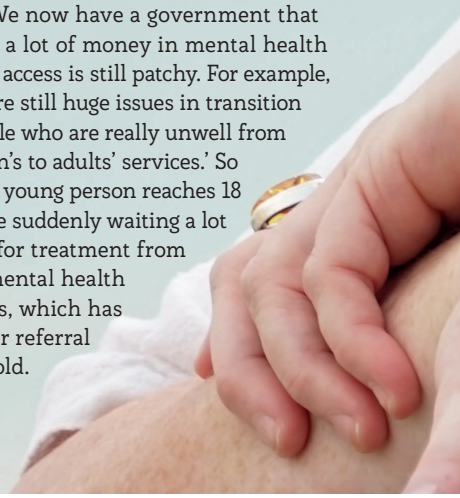
Jones points out that the clear processes, goals and peer-reviewed evidence of CBT’s success and the suggestion that it can offer a clear-cut solution to an individual’s difficulties in a given amount of time, may make it more appealing to the resource-stretched NHS. But she adds, ‘I don’t think it works for as many people as we think it works for.’ Yet when it comes to psychotherapy, perceptions of open-ended, expensive and time-consuming therapy need to be challenged, she adds.

‘I think there is work to be done by the psychotherapy profession in demonstrating its effectiveness and building up peer-reviewed evidence of outcomes. That’s not for my benefit – I know from my personal experience that psychotherapy works – but there are stereotypes about psychotherapeutic interventions that need challenging, and we always have to think about delivering [talking therapies] in ways that are affordable.’ UKCP has been contacting NHS workforce planners across the four nations to highlight gaps in provision that could be quickly filled by psychotherapists working in private practice or the voluntary sector, even if – like anyone moving to a new work setting – this may require a small amount of training in NHS processes.

Despite the growth in understanding of the benefits of talking therapy, medication is still used ‘too often to manage a person’s condition rather than to help them get better’, Jones says. ‘There is a place for medication – it can sometimes get somebody to the point where they are able to participate in talking therapy.’ But the resources are prioritised towards medication rather than talking therapy, she explains, and until effective and accessible talking therapies are in place we cannot take resource away from medication.

## EARLY INTERVENTIONS

Under the Mental Health (Wales) Measure 2010, NHS Wales’ Local Health Boards and local authorities have legal duties to improve the delivery of mental health services, and to provide services that focus on people’s individual needs. In practice, this includes ensuring there are more mental health services within primary care. ‘We now have a government that invests a lot of money in mental health but the access is still patchy. For example, there are still huge issues in transition of people who are really unwell from children’s to adults’ services.’ So when a young person reaches 18 they are suddenly waiting a lot longer for treatment from adult mental health services, which has a higher referral threshold.



**HELEN MARY JONES MS**
**is Senedd Assembly Member for Mid and West Wales. She is Plaid Cymru's Shadow Minister for Economy, Tackling Poverty, and Transport, and is Chair of the Senedd's Culture, Welsh Language and Communications Committee**

Paul Allsop
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## SOCIAL JUSTICE

Some of the intervention in people's lives should be social, rather than medical, Jones says. 'We have developed a tendency to medicalise unhappiness, rather than dealing with the issues that are making people unhappy. A lot of those issues are social – poor housing, in-work poverty. Instead of dealing with the fact that we should not have people living in poverty, we put a mental health label on it.'

Social justice is a particular interest of Jones, who started her career as a special school teacher, worked in a number of youth and community jobs in the 1980s and 1990s when 'there wasn't much public money around', and was involved in non-party political campaigns about issues such as women's refuges, all the time volunteering for Plaid Cymru. 'You didn't join Plaid Cymru in 1979 thinking you were going to make a career out of it. I never thought I'd live to see a successful devolution referendum.'

Prior to being elected to the Senedd, Jones stood twice for Parliament, first in 1992 when she contested the Islwyn seat of then Labour leader Neil Kinnock, and in 1997 for Montgomeryshire. For Plaid Cymru – of which she was deputy leader from 2008-2012 – Jones represented Llanelli from 1999 to 2011, returning to the National Assembly as member for Mid and West Wales in 2018. For the seven years she was out of public life, Jones was chief executive of charity Youth Cymru.

'In a previous Assembly Health Committee, I worked with a charity called Hafal, which supports mentally ill people in Wales. They've developed a recovery model which has allowed people with serious conditions to recover, they would argue, to the point where they don't need medication anymore. A huge amount of the model is focused on things like supported housing and employment.'

She's also enthused by a social prescribing model where GPs refer children experiencing emotional difficulties to Carmarthenshire Association of Children and Young People. They then support the child and their family across different areas, including housing, benefits and managing behaviour. 'The GP "prescribes" the service and the family begins an open-ended engagement with the organisation,' Jones says. 'The chief executive believes about a third of the teenagers they have seen so far would have ended up on medication without the service.'

## THE WHOLE PERSON

There is much good practice in mental health in Wales, Jones says, but delivery is an issue. 'Successive Welsh Governments have been committed to mental health treatment and access, but getting it delivered at a grassroots level needs to be prioritised.' The news that the first minister has appointed a minister – Eluned Morgan – at cabinet level with responsibility for mental health and wellbeing, is welcome and UKCP, in partnership with the Welsh Psychotherapy Institute, have already made overtures to meet the new minister to highlight barriers to people in Wales accessing high-quality psychotherapy.

Jones has concerns to raise with Morgan: 'I want her to ensure that access to the primary and secondary care face-to-face services can be restored,' she says. 'I also want to talk about longer term plans to make sure mental health isn't at the back of the line.'

For those whose mental health has been disproportionately affected by the pandemic, Jones wants to 'find out what isn't working for them and what would work for them. For example, we need to talk to people from black and minority ethnic communities who use mental health services about the support they need, instead of making assumptions. I'm also concerned that people aren't able to access therapy in their language of choice. It's got to come back to the patient, working with the whole person and then resourcing services for the long term.'

One of Plaid Cymru's pledges would be to pay the real living wage to every public-sector employee in Wales. 'If we start with everybody having a warm, dry house, for example, we'd make a huge difference, without a catastrophic cost.' This, Jones says, would free up resources for those who need different kinds of mental health support. 'And if we could use methods such as social prescribing to divert people [who don't need it] from mental health services, then we would potentially have more resources to offer more open-ended talking therapies and mental health services,' she concludes.

**Timeline**

### HELEN MARY JONES MS' CV

- **1982** – Graduated from University College Wales Aberystwyth. Began career as a special education teacher in Gwent.
- **1987** – Became organiser for ActionAid, Wales.
- **1991** – Worked at Cynon Valley Crime Prevention Bureau.
- **1993** – Spent a year working at the social justice charity, NACRO, followed by two years at Barnado's.
- **1996** – Worked as Deputy Director at the Equal Opportunities Commission, Wales.
- **1999** – Elected to the new National Assembly for Wales as AM for the constituency of Llanelli. Acted as Shadow Minister for Education and Lifelong Learning.
- **2003** – Regional Assembly Member for Mid and West Wales.
- **2007** – Assembly Member for Llanelli 2007-2011.
- **2008** – Deputy Leader, Plaid Cymru 2008-2012.
- **2011** – Appointed Chief Executive of Youth Cymru, a voluntary organisation in Wales.
- **2018** – Returned to the National Assembly as Assembly Member for Mid and West Wales.

Illustrations: Roy Scott / Ikon Images

# WAKING UP TO THE HEALTH BENEFITS OF DREAMS



MANY OF US HAVE REPORTED HAVING MORE VIVID DREAMS DURING THE PANDEMIC. **MELINDA POWELL** SUMMARISES OUR SCIENTIFIC UNDERSTANDING OF DREAMS – AND THEIR THERAPEUTIC BENEFITS

**MELINDA POWELL**

**Is a UKCP psychotherapist, author and co-founder, with Nigel Hamilton, of the Dream Research Institute (DRI) at the Centre for Counselling and Psychotherapy Education, London. The DRI promotes research into the connection between dreams and wellbeing. In *The Hidden Lives of Dreams* (2020) she looks at the importance of dreaming for mental health.**

**We spend an average of six years dreaming, yet much about the purpose and benefit of dreams remains uncharted waters. One of the first empirical studies of dreaming associated with Rapid Eye Movement (REM) sleep took place in 1953[1]. Subsequently, measurements of brain activity using the electroencephalogram (EEG) during REM provided more evidence of dreaming. But the EEG confines exploration of the nocturnal brain to electrical measurements close to its surface. The exploration of the deeper neurological substrate of dreaming remained mostly inaccessible until the mid-1990s.**

More recently, magnetic resonance imaging (MRI) has enabled three-dimensional mapping of the neurophysiology of both dreaming and dreamless states. Functional MRIs reveal not only where brain activity occurs, but also the brain processes involved in real time while the research participant is dreaming.

We now know that dreaming occurs throughout the sleep cycle, including non-REM phases, but more vivid

**'Evidence supports the claim that people benefit not only from the "nocturnal therapy" of dreams but also from working with dreams in therapy'**

and memorable dreams arise during increasingly lengthy cycles of REM sleep, totalling around two hours of REM dreaming nightly – provided that we sleep for at least seven hours.

## EVOLUTIONARY ADVANTAGE?

Key findings from empirical studies on the purpose of dreams have shown that dreaming helps promote neurological health across the lifespan of humans and other mammals. As neuroscientist Matthew Walker has observed in his 2018 book *Why We Sleep: The New Science of Sleep and Dreams*, humans spend up to three times longer each night in REM sleep than do other primates, suggesting an evolutionary advantage to our species.

Human infants spend 50% of their sleep time in REM dreaming (compared to 20% in adults), helping to consolidate the memories that underpin our sense of self. Growing research shows that dreaming facilitates perception and learning, re-enforcing memory and developing cognitive skills like decision-making[2].

There is also evidence that dreams help refine emotional intelligence through processing emotions. During REM dreaming, the emotion centres of our brains become 30% more active, and research suggests that 35% to 55% of our dream imagery is thematically related to the day's emotional content. Research on people dealing with depression resulting from the emotional trauma of divorce has shown that those who dreamt specifically of the painful process reported better clinical outcomes than those who did not[3].

In the second revised edition of *The Interpretation of Dreams* (1900), Sigmund Freud refers to dreams as a different form of thinking in sleep, and Carl Jung, in his work *Mysterium Coniunctionis* (1963), described the dreamer as taking part in their own personal drama, making dreams more meaningful.

## DREAM THERAPY

Growing evidence supports the claim that people benefit not only from the 'nocturnal therapy' of dreams but also from working with dreams in therapy. For example, research based on data from therapeutic dream groups has suggested that the insight gained from reflecting on a recent dream is felt to be greater than when reflecting on a recent event from waking life[4]. Research on the value of dreamwork with a psychotherapist has reported improvements in wellbeing and spiritual awareness[5], while research with patients in hospice care has illustrated how, at the end of our lives, we may draw comfort and self-understanding from therapeutic dreamwork[6].

In therapy, a person can be helped to make associations with their dream to better understand otherwise unconscious feelings. Additionally, they can re-enter a dream in the waking state with a therapist to explore the dream more fully. They can draw on Jung's practice of active imagination by continuing a dialogue from a dream or undertake a dream re-entry technique like the Waking Dream Process, as developed by Nigel Hamilton[7].

In *The Hidden Lives of Dreams*, I give examples of this more immersive dream therapy, such as a dream had by a woman I call Angela, who longed to 'declutter' her life to free up her unrealised creativity. In the dream, she is in a room so packed with clutter that she can hardly move. Then, she finds herself in a more spacious room with a friend. Angela wants to replicate the Sistine Chapel ceiling in this room but worries it will look too garish. Her friend assures her it would look beautiful. They look up, overjoyed to see the Sistine Chapel's vaulted ceiling in all its splendour.

Working with me on the dream, Angela saw the cluttered room as representing unhelpful patterns of thought that blocked her creativity. It felt important for her to 'look up' to gain a broader perspective on her situation. When she 'looked up' from negative thought patterns, she found the emotional energy to realise her potential.

Often, negative emotions aroused by dreams have deep connections with past emotional events that may not have been resolved. Therapeutic dreamwork can help us make these connections. For example, during the pandemic, you may have asked yourself 'Why have I been dreaming of my ex?' If so, you haven't been alone, Google searches for this question have reportedly increased by nearly 2,500% as a result of 'pandemic dreams'.

In one dream shared with me, a man visits the home where he lived with his family before his divorce. His ex-wife makes it clear he is not welcome. The house looks the same but feels out of reach. He wakes, moved by deep feelings of what might have been but could not be – a poignant loss.

With a psychotherapist, this man could, for instance, reflect on the feelings brought up by the dream – how it feels to be 'unwelcome' and how this feeling

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might apply to his life both then and now. In therapy, he could experiment with a proactive response to the situation portrayed in the dream by asserting himself positively, saying something like, 'Hey, I have a right to feel my visits to the children are welcome.' In this sense, the dream would not only mirror a psychological dynamic, but also offer a therapeutic antidote to any negative assumptions a person may be holding about themselves.

When we are under stress, our physiology gears up for a fight-or-flight response that can fuel anxious dreams. Yet, anxiety dreams can also act as a form of 'nocturnal therapy', helping to moderate our fears in waking life[8]. A broad study on the effectiveness of therapy for dealing with nightmares suggests that we can change the beliefs we hold about nightmares and our conditioned response to fear[9].

People with chronic nightmares have been shown to benefit from Imagery Rehearsal Therapy (IRT), in which the dreamer re-visions their traumatic dream, changing it and then mentally rehearsing it before sleep. A pioneering study of IRT focused on the nightmares of women who had suffered Post-Traumatic Stress Disorder following sexual abuse. Not only did their nightmare severity and frequency lessen, so did their PTSD symptoms[10].

## RE-VISIONING DREAMS

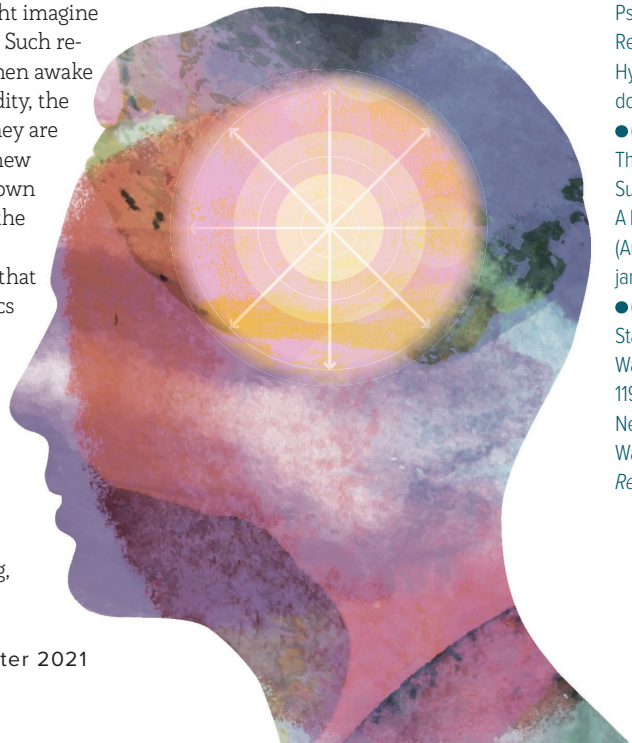
Many of us have fears in relation to the overwhelming 'tidal wave' of the pandemic. For example, people report dreaming of being overpowered by an immense wave. If you had such a dream, you might imagine riding the wave on a surfboard! Such re-visioning can be done either when awake or within a lucid dream (in lucidity, the dreamer becomes aware that they are dreaming and can decide on a new course of action). In one of my own lucid dreams, I chose to run to the tidal wave and dive through it.

In 2009, research confirmed that the lucid state has characteristics of both waking and sleeping consciousness[11]. In normal REM dreaming, brain activity associated with emotional arousal and hallucinatory imagery increases, while the activity of the frontal cortex, associated with the capacity for self-reflection and reasoning, decreases. In the lucid state, however, these areas of the brain 'wake up', revealing a gamma brainwave frequency of 40Hz – one more commonly found in highly focused waking states such as skilled meditation.

I can conceive of a time when 'dream health' initiatives promote research and public education for wellbeing. This would include recommendations for dream journaling, sharing and the inclusion of dream studies in school curricula to facilitate the development of emotional intelligence. The wider public would also be encouraged to undertake dreamwork with a qualified therapist to amplify the potential benefits of dreams, both for the alleviation of PTSD, depression and anxiety, and for positive and productive self-development.

In 2016, The Royal Society for Public Health published the leaflet, 'Waking up to the Health Benefits of Sleep', and the NHS now posts tips for 'Sleep Hygiene'. One day, these bodies may do the same for dreaming. Meanwhile, organisations like the Dream Research Institute, London, and the International Association for Dreams work to raise public awareness about dreams.

Dreams may prove fundamental to the development of consciousness. Currently, a range of methodologies – neurological and therapeutic, analytical and experiential – are contributing to a multi-dimensional approach to dreams. There was never a more crucial time than now to integrate discoveries about dreaming into therapeutic practice and daily living, for help in dealing with our personal and global concerns. ●



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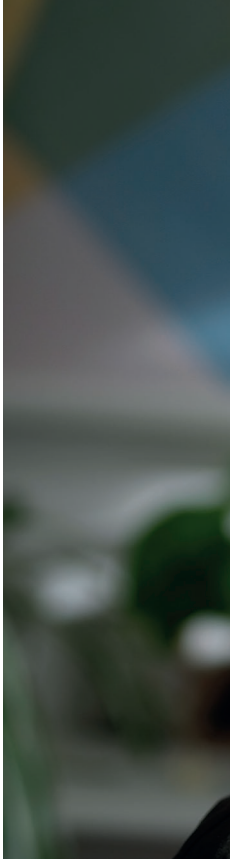


# ‘As therapists we are formed by the people we work with’

SPENDING OVER 20 YEARS WORKING WITH GROUPS ON AN IN-PATIENT MALE ACUTE PSYCHOSIS WARD HAS HELPED TO SHAPE **ED FELLOWS** AS A TRAUMA PSYCHOTHERAPIST IN THE NHS



**An art school graduate who still exhibits, Ed Fellows started his therapy career as a yoga teacher and began psychotherapeutic counselling training in 2005. Multiple qualifications followed in the intervening 15 years, with a particular focus on complex trauma and dissociation. A founding member of the Complex Trauma and Dissociation Group at the Maudsley Hospital, he’s now Senior Trauma Psychotherapist at the South London and Maudsley NHS Foundation Trust (SLaM).**

**I began working at SLaM 20 years ago in a forward-thinking, non-denominational specialist mental health chaplaincy.** Every week I walked through the double steel doors of an in-patient male acute psychosis ward to facilitate a group. I had moved from teaching yoga and meditation in a local Buddhist centre, to working in a psychiatric hospital. We offered support to people of all faiths and none, to those who wanted to feel witnessed in their experience.

**These groups were spaces to share experiences of mental health,** of the mental health system itself, and of socio-political conditions. We used talking, body awareness, movement and meditation to facilitate dialogues. I held the assumption that all experience is meaningful, even if I don’t yet understand it.

**Something meaningful would always happen.** After inviting people to join the group, I’d sit and wait, reminding myself that the only thing I could prepare for was the unexpected – someone shouting or throwing a soft drink across the room.

**We’d usually begin with a short mindfulness meditation** and then a check-in to start a conversation about how each person was feeling. Sometimes people would be quite vocal, other times their responses would be expressed through movement, by lying down, walking back and forth, or making sounds.

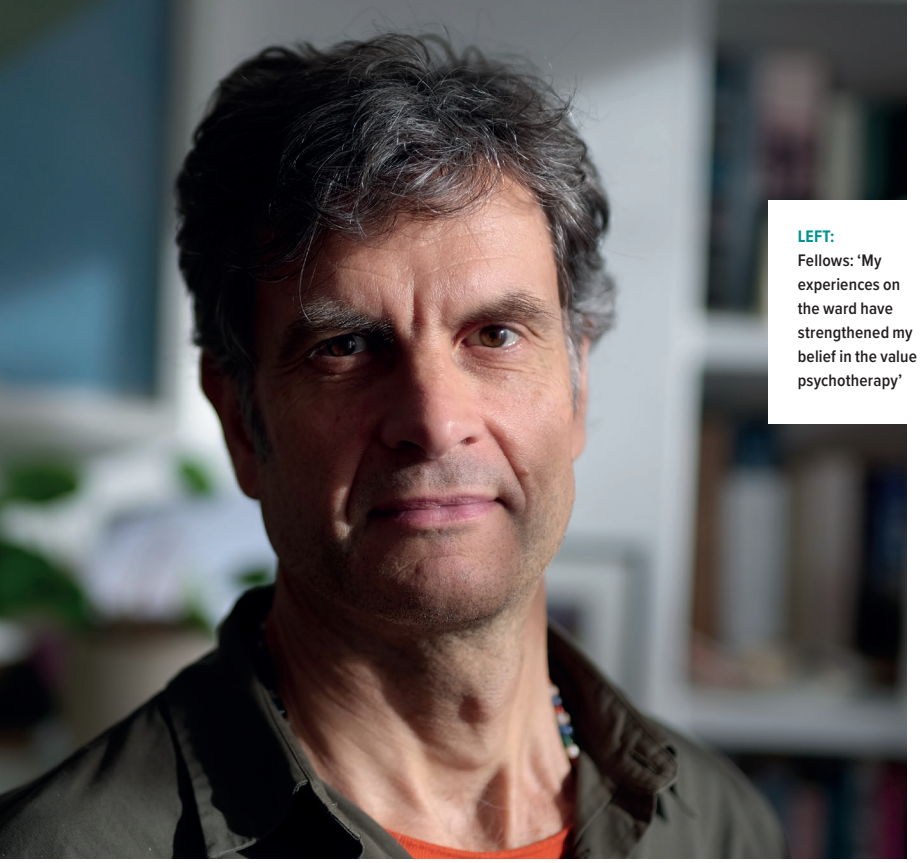
**One time, the group could hear a patient being restrained in a nearby corridor.** Tremors of memory ran through the participants’ bodies, frozen and hyperaware. We could not ignore this, so I acknowledged what we could hear, and how all of our bodies were responding. We created a space that was safe enough to acknowledge that memories were being triggered, to appreciate how the past is alive in the present.

**We were learning together how listening is a practice** that can involve the whole body, not just the intellect. It is not enough to say, ‘I am listening.’

**Once, a patient confronted me:** ‘You come in here wanting to treat us like rats in a cage.’ I was taken aback, but he had a point. I was planning a research project on the groups. His statement said so much about his experience on and off the ward. So we opened a discussion and invited others to share their experiences of feeling used.

**As I progressed through different roles (*see Timeline, facing page*),** I continued facilitating these weekly groups for 20 years. I am so grateful to all the patients who opted to spend time with me, letting me learn how to be with them. Among these patients, a disproportionate number are Black men, nearly all from the most disadvantaged backgrounds imaginable. Their lives often started with violence, marginalisation and poverty, living with the dehumanising legacy of racism.

**Black men are at least three times more likely to be admitted to psychiatric hospitals,** twice as likely to be brought in by the police, and almost



**LEFT:**
Fellows: 'My experiences on the ward have strengthened my belief in the value of psychotherapy'

30% more likely to be restrained, than the rest of the population. Their earlier experiences of powerlessness are often unwittingly re-enacted by those of us charged with responsibility.

**White people need to experience and feel the race problem.** Why would I think you can speak freely to me after decades of being silenced? Trust needs to be earned where it has been lost.

**Evelyn Waugh commented in *Decline and Fall* how going to boarding school prepared the main character well for prison.** I read this book in boarding school and could say the same about myself now working in the psychiatric system. I certainly have insight into how colonial systems can still govern our embodied emotional experience.

**My first formal psychotherapy training at Metanoia Institute was an invaluable experience** that formed a foundation for working with people who carry the legacy of trauma in a fragmented sense of self. This reflexive practice, taking care of our own pain and shame, forms the basis for being able to tolerate our prejudices in order to respectfully meet and appreciate the differences in others.

**My experiences on the ward have strengthened my belief in the value of psychotherapy.** This work gave me the confidence to set up outpatient bereavement and trauma groups in primary and secondary care, and has influenced my current work as a senior trauma psychotherapist.

**Despite the unequal power balance between psychotherapist and client,** the prohibitive costs of training and the Euro-centric orientation of most of our theories, there is hope. Embedded in our practice is self-reflection. This has never been more important and can lead to our learning to include those we exclude. We can look beyond 'mental health' to social, environmental and global health.

**We do harm when we cannot reflect on the harm we do.** Psychotherapy works with the interconnected nature of our experiences, can respectfully accommodate our differences and address power imbalances, marginalisation and exploitation.

**To suffer with someone is painful, to suffer alone is unbearable.** My work with these men has helped form the ground from which I continue to grow.

**Timeline**

## ED FELLOWS' CAREER JOURNEY

| | |
|---|---|
| 1988 | Nursed street dwellers as part of Dr Jack's Street Clinic in Kolkata, India. |
| 1996 | Ran workshops for adults with learning disabilities at Grindlay Court, Edinburgh. |
| 1998 | Began teaching yoga and mindfulness, including at SLaM wards. Continues to this day. |
| 2004 | Seven years as an Associate Fine Art Lecturer of postgrad students at Byam Shaw School of Art. |
| 2006 | Began counselling placement at Metanoia Counselling and Psychotherapy Service. |
| 2007 | Began as senior counsellor and supervisor at Elm Lodge GP Surgery – continued until 2020. |
| 2009 | Two years as visiting tutor offering Embodied Relational Gestalt at Eastleigh College, Southampton. |
| 2012 | Five years as Wellbeing Liaison Chaplain, Spiritual and Pastoral Care Service at SLaM. |
| 2015 | Senior Counsellor and Trauma Therapist at Talking Therapies at SLaM. |
| 2016 | Began current role as trainer for Relational Change Diploma in Contemporary Trauma Practice. |
| 2017 | Started as examiner at the Metanoia Institute, Gestalt Psychotherapy MSc. |
| 2020 | Started current role as Senior Trauma Psychotherapist at SLaM's IPPT. |

# On Screen

*Group analyst **Dan Neale** has analysed group dynamics in some brief clips of the BBC television comedy,* Fleabag

## Phoebe Waller-Bridge

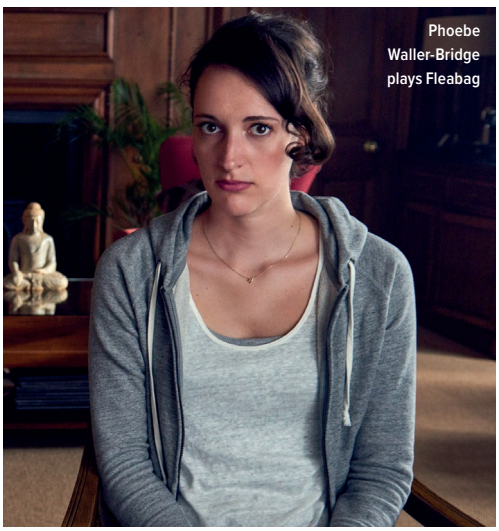
### *Fleabag*

**Analysing clips of a TV series or film can show psychodynamic processes in real time. Two scenes from BBC comedy drama *Fleabag* show how the eponymous character is scapegoated by her family.**

The first series of *Fleabag* introduced her as a confused, angry and grieving woman navigating dysfunctional relationships with her family and a number of men. That Fleabag is scapegoated by her family, and that she has a valency for this role[1], is incontrovertible from the first series. In the first episode of the second series, Fleabag is having dinner with her sister, Claire, her sister's husband, Martin, her dad and his fiancée, and the priest who is due to officiate at their wedding. Fleabag is outside smoking when her dad comes up and says, 'Darling. I – sorry, I missed your birthday.' Fleabag: 'That's OK.' Dad: 'I just. I got you – (He offers her an envelope.) In case you're struggling.' Fleabag: 'The cafe's going well, Dad. I don't –' Dad: 'Oh no just – it's just for you.' She takes the envelope. Later, her dad comments that 'you're not being "naughty".' She replies that 'it doesn't matter'.

There is a sense that Fleabag's role is to be 'naughty' – attention seeking and chatty – in contrast to Claire, and her father is reminding her of this 'group role'. The message is mixed: his wistfulness implies he wants her to be naughty. Perhaps her reply indicates that, if it did matter, she would be naughty, hinting at the functionality of her designated role.

On re-entering the restaurant, Martin says to her: 'I'm so intrigued to see how you're going to make this whole evening about yourself.' Whilst this comment has a sharper edge than her dad's, it serves a similar function: reminding her of her role. Is there also a parallel ambivalence to her dad's: does part of him want her to make herself the centre of attention?



Phoebe Waller-Bridge plays Fleabag

**'The group takes pleasure in her acting out in ways which they would personally not want to do themselves'**

Claire then says to Fleabag: 'You're being so quiet.' Fleabag: 'What do you want me to say?' Claire now plays the 'you're out of role' card to Fleabag.

Claire miscarries in the toilet. Fleabag finds her. They agree a plan to get Claire to hospital whilst protecting her secret. Back at the table, Claire abandons the agreement, and instead throws herself into forced merriment. The others are pleased.

Claire has left Fleabag stranded. The family show their pleasure at the transformation, believing it to be the effect of Fleabag's 'naughtiness' on Claire. This ambivalence is characteristic of scapegoating. Fleabag is caught in the double-bind of wanting to protect her sister, but not wanting to 'out' her. She finally accepts her 'group role'. Fleabag says: 'I've just had a... little... miscarriage.' She literally takes on Claire's problem. In doing so, she 'confirms' Martin's view of her as attention seeking, and her family's view of her promiscuity. Fleabag is not just the recipient of unwanted projections – the group also takes pleasure in her acting out in ways which they would personally not want to do themselves.

But why does the scapegoat accept the role? A generic answer is that eventually the pressure becomes too much; another is that they have a personal valency for it. A third is the threat of what may happen to them if they don't. However, what we see here, which we often see and yet often don't notice, is that the group member may accept the role out of love.


**References**

- (1) Bion, W.R. (1968). *Experiences in groups, and other papers.* London: Tavistock/ Routledge.

**Further reading**

- Gans, J. & Alonso, A. (1998). 'Difficult Patients: Their Construction in Group Therapy'. *International Journal of Group Psychotherapy.* 48. 311-26



- **Dan Neale** is the Programme Lead for training at Childhood First, and teaches at Turvey Groupwork. He can be reached at **d.l.neale.96@cantab.net**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