

# New Psychotherapist

ISSUE 68 / SPRING 2018

ISSN 2516-7162 (ONLINE)

## The fight for young minds

WHY THERAPISTS ARE  
ON THE FRONTLINE

### Inside

#### INTERVIEW

Susie Orbach on  
fame, feminism and  
the future of therapy

#### SPOTLIGHT

Helping clients cope  
with miscarriage

#### ON SCREEN

Does TV drama get  
psychotherapy right?

Plus 

Special Report  
CAN THE TALKING  
CURE STOP SEX  
OFFENDING?

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# New Psychotherapist

The magazine of the  
UK Council for Psychotherapy

■ **Editorial address:** UK Council for Psychotherapy, America House, 2 America Square, London EC3N 2LU

■ **Published by:** James Pembroke Media, 90 Walcot Street, Bath BA1 5BG

■ **Editor:** Flic Everett, ukcp@jamespembrokemedia.co.uk

■ **Issue 68 Consulting Editors:** Sarah Niblock, Sandra Scott, Mary MacCallum Sullivan, Rachel Pollard, Juliet Grayson

■ **Head of design:** Simon Goddard

■ **Senior project manager:** Lizzie Hufton, lizzie.hufton@jamespembrokemedia.co.uk

■ **Advertising:** Jack Watts, jack.watts@jamespembrokemedia.co.uk, 0203 859 7099

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# Welcome

ISSUE 68 / SPRING 2018



#### FLIC EVERETT

Flic Everett has been a journalist and editor for 25 years. She has written for *The Times*, *The Daily Telegraph*, *The Guardian*, and many other titles, most often on relationships, personal development and family issues.

She has promoted the benefits of psychotherapy throughout her career

**W**elcome to the Spring issue of the UKCP members' magazine. As you can see, ongoing changes are being made, from the name, *New Psychotherapist*, to the design, to – most importantly – the content.

We hope this new look and direction will reflect the realities of the psychotherapeutic profession in 2018, with a fresh focus on members' concerns, client issues and CPD, along with insights into different modalities, and interviews with experienced practitioners.

We're beginning with a hugely controversial topic – the treatment and rehabilitation of people who commit sexual offences, and what it takes to work with them. This special section, produced with the organisation StopSO, goes far beyond the media's

sensationalist headlines and examines what motivates sexual offenders, their dysfunctional beliefs and, crucially, how trained psychotherapists can help to break the cycle of abuse.

Working with children, too, is in the spotlight thanks to UKCP's conference, Mind The Gap, on 28 April. Our Report into the growing need for psychotherapy for children looks at current policy and explores how we could improve provision, an increasingly urgent task.

There's also more uplifting news, with a look at community housing as one approach to improving mental health, and an in-depth interview with Susie Orbach, on how therapy – and public attitudes – have changed since she started out. And on a lighter note, UKCP member Hilda Burke's new column takes a look at how therapy is portrayed in the media.

Ultimately, *New Psychotherapist* aims to bridge the gaps between the profession, policymakers and clients, by airing your concerns, sharing your ideas and bringing psychotherapy ever further into the mainstream; no longer seen as merely an option, but as a necessity for a fully functioning society.

I welcome your views and ideas, and if you'd like to be featured in Spotlight, have a burning opinion on an aspect of the profession and its current challenges, or would simply like to share some news in Bulletin, please do get in touch.

Enjoy the issue.

FLIC EVERETT  
Editor

#### Get in contact

We welcome members' views on our profession and this magazine.

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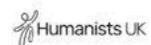
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\* Subject to validation

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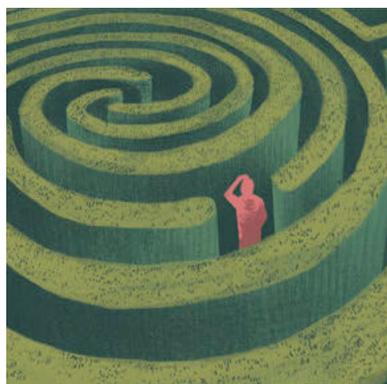
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Renowned psychotherapist Susie Orbach on the rising tide of mental health issues, #MeToo and what really happens in her consulting room

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The organisation StopSO is dedicated to working with both people who commit sexual offences, and survivors. Our in-depth report looks at all aspects of this controversial work, from managing shame to legal issues and overcoming judgment to outcomes



**22** Why vulnerable clients need a different approach

## On the Cover

The youth mental health crisis and how therapy can help to fix it

Turn to page 16



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# Bulletin

ISSUE 68 / SPRING 2018

*News, insight, reviews and reports from the latest conferences — here's what's happening in the profession*



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## NEWS

### A new beginning

**Martin Pollecoff**, Chair of UKCP, and Professor **Sarah Niblock**, CEO of UKCP, introduce your new member magazine

**A**t UKCP, we're delighted to bring you this fresh new design and ambitious vision for our member magazine.

Through *New Psychotherapist*, UKCP will drive greater social engagement with our psychotherapies to create a better future for individuals, couples, families, groups, businesses and wider society.

That's why our next edition will be sent to every MP and relevant policymakers in the UK, putting the value and potential of our psychotherapies at the heart of social, political and economic agendas.

We will work across the organisation with partners in government, civil society and the private sector, and with people and communities to support shifts in public policy, fuel social engagement and increase private and public resources for psychotherapies.

Ultimately, we need to engage millions of people to demand change in the diagnosis and treatment of mental health issues, to bring the highest quality psychotherapies to all who need them.

## TRUSTED SOURCE

We want UKCP to be the ultimate, most trusted destination for the public, policymakers, practitioners and business leaders looking for the most credible information on solving the mental health crisis, as well as releasing untapped potential to ensure the UK's future success.

*New Psychotherapist* presents the latest developments and thought leadership in the field, an authoritative but accessible voice to improve knowledge and understanding of our highest quality practices. We very much hope you enjoy reading this transitional, member-only issue and we look forward to your feedback.

▶ **Let us know what you think. Email:** [communications@ukcp.org.uk](mailto:communications@ukcp.org.uk)



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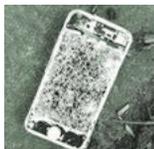
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### Kids in crisis

Underfunding, neglect and social media: why the kids aren't alright  
Pages 16-21

## NEWS

# Dog days

**T**herapy dogs are increasingly being used alongside traditional psychotherapy to support survivors of traumatic events, such as the Florida Parkland school shooting, and people with depression and anxiety. New research suggests that time spent with therapy dogs has measurably beneficial effects for stressed university students. The University of British Columbia (UBC) surveyed 246 students before and after a drop-in dog therapy session, with up to 12 different dogs. They filled in questionnaires immediately

afterwards, and a day later. A dramatic reduction in stress was reported, though the effects were marginally lessened by time. 'We found that, even 10 hours later, students still reported slightly less negative emotion, feeling more supported, and less stressed, compared to students who did not take part in the therapy,' said Stanley Coren, co-author of the study.

Do you use animals as part of your therapy practice? Write in and let us know.

► [doi.org/10.1002/smi.2804](https://doi.org/10.1002/smi.2804)

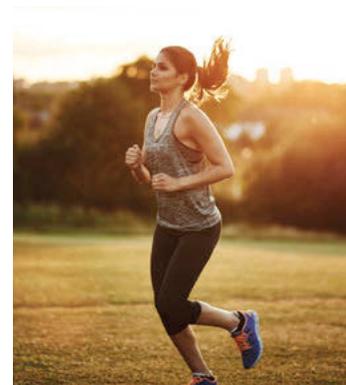


Photo: Getty Images

## NEWS

### M.E. FINDINGS UNCERTAIN

A medical trial which concluded that psychotherapy and exercise helped patients with M.E. was unreliable, according to a new study. The PACE trial, funded by the Medical Research Council, investigated the most effective treatments for sufferers of myalgic encephalomyelitis (chronic fatigue syndrome). Results published in 2011 claimed Graded Exercise Therapy and CBT were 'moderately effective' and worked for more than 20% of patients. However, there was a backlash of criticism from patients and M.E. organisations over how conclusions were reached, and unpublished data has been re-analysed as a result. The new findings from the University of Wellington, NZ, published in the journal *BMC Psychology*, now show that CBT and GET are 'not effective ways of treating a serious neuroimmune disease'.

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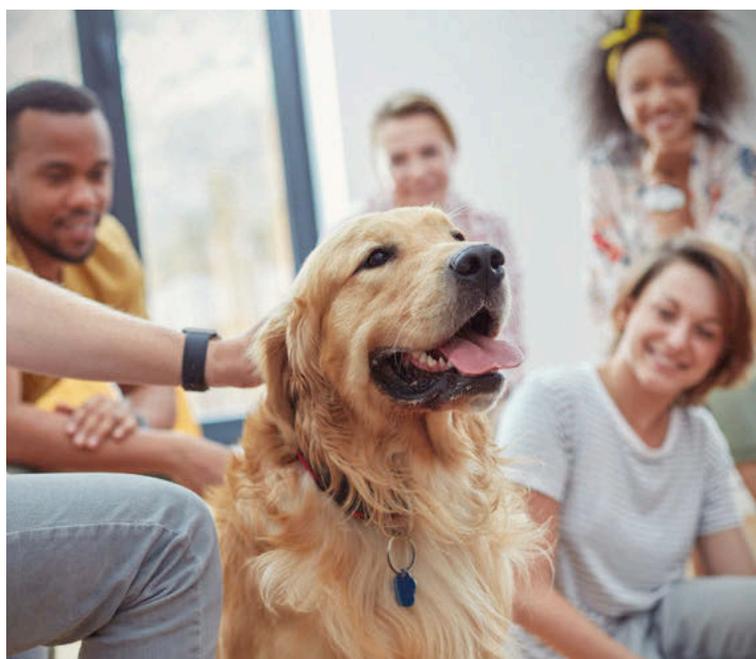


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**'Even 10 hours later, students still reported slightly less negative emotion'**



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**‘We convinced the board to host the 10th instalment in Freud’s home city’**

**CONVENTION**

**Planning ahead**

**F**or those with a five-year career plan, make a note – in 2023, The 10th World Congress for Psychotherapy returns to Vienna from 25-29 July. More than 4,000 researchers and scientists will congregate at Sigmund Freud University to discuss developments in psychotherapy. ‘Working closely with the Vienna Convention Bureau, we were able to convince the council’s board to host the 10th instalment of the conference at my university in Freud’s home city,’ says Professor

Alfred Pritz, President of the World Council and rector of the Sigmund Freud University in Vienna. The congress will even feature ‘Freudian walks’ through the city, during which the latest findings will be discussed. Save the date...



Photo: Getty Images

**NEWS**

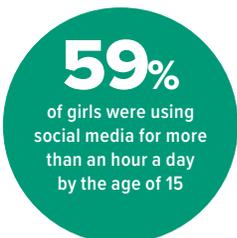
**SELFIE CULTURE? ‘EPIC FAIL’**

New research published in the journal *BMC Public Health* has found that social media use affects adolescent boys and girls differently. Research from the University of Essex and UCL uncovered a connection between time on social media aged 10

and a drop in wellbeing aged 10-15. Girls used social media more than boys – at 13, half of girls were using it for over an hour daily, compared to a third of boys. But by 15, the usage had risen to 59% using for over an hour daily (girls)

and 46% (boys). ‘Our findings suggest that it is important to monitor early interactions with social media, particularly in girls, as this could have an impact on wellbeing later in adolescence,’ said study author Dr Cara Booker.

**ABOVE:** Research suggests that time spent on social media is affecting adolescents’ wellbeing





### On-screen analysis

How realistic is therapy on TV? This issue: Dr Reisman in *Big Little Lies*  
Page 50

## CONFERENCE

# Challenging the medical model

Speakers highlight the impact of environmental, social and physical factors on mental health

**R**ichard Bentall, researcher and Professor of Clinical Psychology at Sheffield University, stressed the importance of trauma therapy at the Annual CPJA Conference. Addressing the meeting of psychoanalytic/psychodynamic psychotherapists, he observed that the more severe the trauma, the greater the likelihood of mental illness.

Challenging the traditional view of psychiatry that mental illness is a brain disorder, he emphasised the importance of social, environmental and psychological factors. Research shows there is no specific gene that causes mental disorder. He also highlighted flaws in the research cited by proponents of the medical model of psychiatry.

He listed precipitating factors for mental ill health including migration, childhood poverty, abuse and trauma, urban living, bullying, inequality and poor parental communication, and added that research has shown specific associations between certain kinds of adversity – symptoms that had been explored in the Adult Psychiatric Morbidity Survey, which looked at paranoid symptoms and auditory/visual hallucinations (Bentall *et al* 2007). People who experienced rape or childhood sexual abuse and trauma tended to develop hallucinations, whereas those experiencing institutional care, such as prisoners, tended to exhibit paranoia. ‘The evidence is rock solid for environmental factors,’ he concluded. ‘If you want to make the world a

mentally healthy place, you’ve got to change the world.’

Dr Douglas, a leading member of Critical Psychiatry, psychologist and psychiatrist, outlined the history of mental illness, emphasising that reducing mental problems to brain disorders had led to abuses of patient rights. Bio-medical interventions had been counterproductive and he argued Randomised Controlled Trials failed to address their own inbuilt biases and ignored negative outcomes.

He described the government’s IAPT programme as the ‘political explanation of psychological quackery’ and called for wider measures within the research – currently, it shows that 50 per cent of IAPT clients do not get better and relapse rates in short-term therapy are high.

Both speakers called for a collaboration between psychotherapists and clinical psychologists to challenge this dominant medical-model schema.

*Rhoda Dorndorf*

### Details

- **What was it:** Cure or Contain? Challenging the medical model
- **Where was it:** The Council for Psychoanalysis and Jungian Analysis annual conference, London
- **When was it:** 14 October 2017

## RESEARCH

### E AND SYMPATHY?

MDMA-assisted psychotherapy is undergoing final clinical trials as a treatment for PTSD. If the findings are positive, it could become a prescription medication in the US within three years. However, the trials, reported in the *Journal of Psychopharmacology*, have been funded privately and as yet, there is no information on how psychotherapists might incorporate the drug into a treatment plan, or whether the UK would also adopt this controversial approach.





**Home truths**

The housing scheme that offers a refuge to people in distress

Pages 24-27

**BELOW:** The exhibition champions female creatives



Photo: Lucy Jones

**CONFERENCE**

# Claiming Research as a Clinical Resource

Three keynote speakers explore the value of research for therapeutic work

**T**he aim of this event was to allow clinicians and researchers to explore the value of research for therapeutic work. Three keynote speakers offered presentations on different perspectives: Dr Jonathan Wyatt introduced the value of qualitative methods that put the researcher’s experience at the centre of research; Professor Gillian Hardy spoke on the variety of research relevant to clinicians and gave examples from her work, of both quantitative and qualitative studies, emphasising the importance of teamwork; and Professor John Nuttall spoke on the tension between qualitative and quantitative approaches and outlined strategies for overcoming these.

The final presentation was from Professor Sarah Niblock, CEO, who opened the conference and then

offered a session on making research available in the media.

Two workshops also offered sessions on research methodology, including analysis and research in progress, and for reporting studies completed by UKCP members. The Practitioner Research Network presented the findings and process of the Moments of Meeting project, reporting the value of learning about research and benefits for clinical practice.

This successful day, attended by more than 100 people, was supported by Regent’s University and Balens Insurance; the organisers would like to thank them both.

**Details**

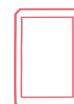
- **What was it:** ‘Claiming Research as a Clinical Resource’, Biennial Research Faculty Conference
- **Where was it:** Regent’s College, London
- **When was it:** 30 September 2017

**NEWS**

**IMAGES OF THE ID**

A new exhibition showcases the work of young female photographers from around the world, and focuses on women suffering from eating disorders, trauma and other mental health issues. *Girl Behind the Lens: Stories of Mental Health and Empowerment* is at The Horse Hospital, London, from 27 April, in support of WomanToWoman, a social enterprise. The images have all been created by women with experience of mental illness. Prints will be on sale to help fund a women’s eating disorder peer support group and a women’s refugee group run by a trained, multi-lingual psychotherapist. For more information, visit: [womantowomanproject.com/mental-health-photography-recovery](http://womantowomanproject.com/mental-health-photography-recovery)

**‘Three keynote speakers offered presentations on different perspectives’**



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**Speaking her mind**  
 Susie Orbach on why the need for therapy is greater than ever  
 Pages 28-31

NEWS

## A new approach for black teens?

**T**herapists working with black adolescents may need a new approach, according to research from Rutgers University-Camden in the US. Depression is a growing issue for young people of colour. The study, *Psychometric Properties of the CES-D Among Black Adolescents in Public Housing*, newly published in the November 2017 issue of the *Journal of the Society for Social Work and Research*, found that this group tends to express its feelings by



Photo: Lilly Roadstones

complaining about conflict with other people and by experiencing pain. Black youths have a higher suicide rate than white peers (the likelihood is six times greater) and researcher Wenhua Lu, an assistant professor of childhood studies at Rutgers University-Camden, says, 'When assessing and treating black adolescents' depression, clinicians need to pay particular attention to complaints about interpersonal struggles and physical discomfort. Treatments such as interpersonal psychotherapy may work better for this population.'

► [www.journals.uchicago.edu/doi/abs/10.1086/694791](http://www.journals.uchicago.edu/doi/abs/10.1086/694791)

**ABOVE:** Depression is a growing issue for black adolescents

## 'Clinicians need to pay particular attention to complaints about interpersonal struggles'

RESEARCH

### Office meltdown

UKCP's recent research has revealed a worrying picture of British working life, with anxiety and depression rising by almost a third since 2013. Mental health issues are most prevalent among part-time workers (33.6%), who are often on zero-hours contracts, low pay and juggling childcare. An upcoming issue of *New Psychotherapist* will look at the problems in more detail, with a focus on how therapy can help in the workplace.

NEWS

### GRIEF CAMPS FOR KIDS?

Grief camps for bereaved children is an idea gaining traction in the US. The Seasons Hospice Foundation in Michigan hosts the three-day Camp Kangaroo, teaching children about emotions, loss and coping mechanisms via therapists. Although there are charities dedicated to helping bereaved children in the UK, as yet, dedicated camps have not been launched, though US results show they can offer significant support if delivered by qualified therapists.

# Reviews

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

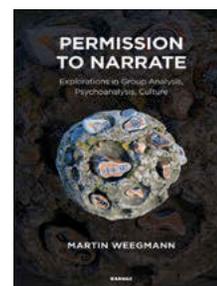
## Permission to Narrate: Explorations in Group Analysis, Psychoanalysis, Culture

**T**he power of words – how individuals and groups find expression, articulation and redress through language and narrative – is explored in this set of essays by Martin Weegmann.

His deep concern is with questions of language, position and articulation; he speaks of psychotherapy as being ‘a form of permission to narrate as the space within which those dominated by their problems... might come to tell and experience their lives differently’. The

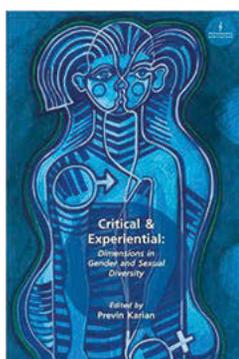
range of ideas presented is diverse and broad, from the cultural significance of monsters, the rhetoric of revolutions and narratives of recovery in AA, to astute observation and challenge of long-held psychoanalytic beliefs.

He offers thought-provoking insights in reviewing his own professional journey and pertinent clinical vignettes bring his ideas to life. He bravely shares his own psychoanalytic journey with humour and candour, looking at how ‘fascination’ might work, for example, at an individual and group level. He ends with discussion of how psychoanalytic organisations may come to function as retreats, reassuring themselves inwardly, but potentially immunising themselves from interdisciplinary developments as well as a changing social world.



### Details

- **Reviewed by:** Linda Vickers, Psychotherapist at Glasgow School of Art Counselling Service, and in private practice
- **Author:** Martin Weegmann
- **Publisher:** Karnac Books
- **Price:** £19.99
- **ISBN:** 9781782203629



### Details

- **Reviewed by:** Angie Fee PhD, Psychotherapist / Supervisor / Trainer in Sexualities & Genders
- **Edited by:** Previn Karian
- **Publisher:** Resonance Publications
- **Price:** £38.50
- **ISBN:** 978-0-9957625-0-3

## Critical & Experiential: Dimensions in Gender and Sexual Diversity

**T**he book opens with a bold introduction, clarifying the editor’s disappointment in mainstream psychologies, and paving the way for pioneering and subversive narratives around gender and sexual diversity (GSD).

The writing highlights the gaps in counselling and therapy training, wherein the binary categorisation of sexuality and gender simplifies and reduces complex issues such as identity and desire

to psychological or biological models. These necessary chapters are a challenge to the powerful and privileged position heteronormativity holds in social institutions, such as education, medicine, psychological theories and therapies, and family and relationship structures.

I liked the resistance against any particular ‘flow’ of debate, forcing the reader to think more carefully about what they are reading, unaided by logical structure.

I also enjoyed the idea of critical thinking being applied to the lived experience, taking it out of the realms of academia and pedagogy.

Stories of identity and desire are embedded in cultural discourse. This book tells new stories, illustrating how the regulatory nature of heterosexual discourse organises desires into binary categories that fail to account for the complexity and fluidity that underpin people’s lives.

# Feedback

*We want to hear your stories, news and views, so please get in touch*

**RIGHT:** Clients' demands are becoming ever more complex



Photo: Getty Images



## JOIN THE UKCP MEMBERS' FORUM!

**Have your say, influence policy and be part of our community**

The Members' Forum is a debating chamber where any member may have their voice heard by UKCP's Board of Trustees. Its purpose is to facilitate better communication between different parts of UKCP, regardless of location, psychotherapeutic approach, or their activities or services within UKCP.

### THE FORUM IS DESIGNED TO:

- promote and foster participation and dialogue across our organisation
- allow discussion of the issues relevant to the direction, ethos and strategy of UKCP
- encourage and support good practice and innovative thinking at the leading edge of psychotherapy and psychotherapeutic counselling.
- act in an advisory capacity to the Board of Trustees. It can submit questions or recommendations and may, if necessary, call for an election to remove elected trustees, the Chair or Vice-chair of UKCP.

Any UKCP member may attend meetings but only elected/nominated members have a vote. Each UK nation or region has two representatives. The Members' Forum is convened and chaired by a moderator who has a non-voting place on our Board of Trustees, ensuring they are able to represent and communicate the views of the Forum directly to the Board.

### Upcoming meetings:

- 30 June, Cardiff
- 9 September, London

If you'd like to attend, please email [alex.crawford@ukcp.org.uk](mailto:alex.crawford@ukcp.org.uk)

## Language lessons

**A**s a systemic family psychotherapist who has worked in adult mental health in the NHS for 22 years, I have seen the progressive weakening and disappearance of psychotherapy from services.

The general language of mental health services, both among professionals and in the offer to clients, is more and more exclusively the language of clinical psychology. While the skills and competence that clinical psychology brings to the NHS

are invaluable, I am concerned that psychotherapy is beginning to be considered not too useful in the NHS because of the need to offer a fast, simply packaged solution to complex and chronic problems.

This trend is clearly not responding to the complexity that clients bring to mental health services; their demands/requests would be better met by a rich, multiple, differentiated offer of interventions.

*Francesca Curti Gialdino*

## Video support

**T**hank you for your helpful bulletin from the Complaints and Conduct Committee.

I found it immediately useful and applicable and it's helping me to rethink and review

my current practice protocols.

I love the fact that it's in video format. It's so good to see and hear you, and it makes me feel part of a community. I have saved the link and I hope I will be able to

continue to access it from time to time.

As a member, I wanted you to know that I really appreciate this kind of information, which supports me directly in my work.

*Patricia Taddei*

### Have your say

Tell us what you think of this issue. Email

[communications@ukcp.org.uk](mailto:communications@ukcp.org.uk)

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**Date: Thursday 29 November 2018, Central London.**

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**Date: Starts 14 September 2018, Central Oxford.**

▶ **The Space Between: Trauma, Growth and Transformation**

An exciting five day residential offering a unique opportunity to join a community of practitioners interested in deepening their work with trauma. Bringing together elements of theory, practice development and personal process, we will build a ground of support for growth and transformation.

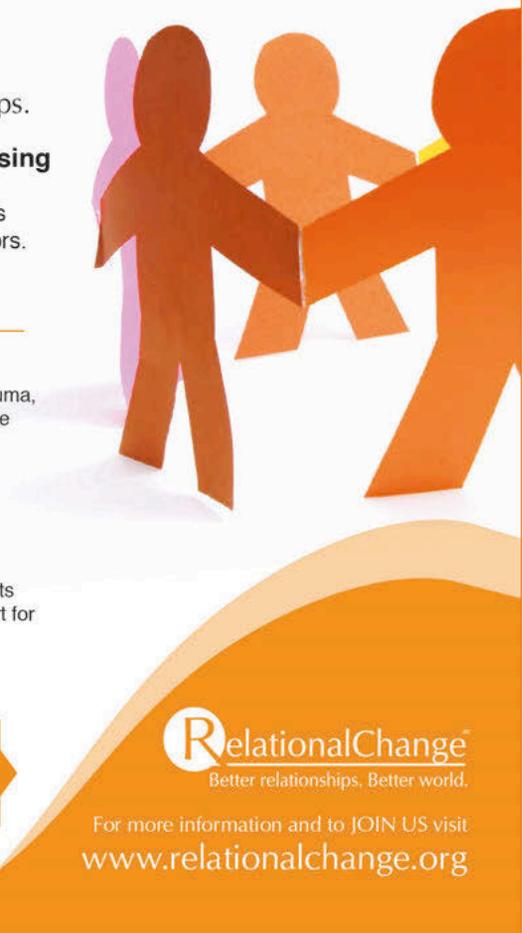
**Date: 1 – 5 October 2018, Oxfordshire.**

▶ **Supervision Certificate/Diploma:**

**A Relational Change Process**

This Certificate/Diploma course is suitable for therapists, counsellors and coaches wishing to supervise others. The course will be based on our model of a deeply relational and contextual approach to supervision and supervisory practice.

**Date: Starts 31 January 2019, Kingston-upon-Thames. Surrey.**



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	Leamington Spa ISAT Diploma Cohort 10	Module 1 26 to 29 November Module 2 7 to 10 January (2019) Module 3 4 to 7 March (2019)
CPD Days	Location	Dates
Understanding & Recognising Sex Addiction	Leamington Spa	Tuesday 24 April    Tuesday 23 October
	London	Saturday 19 May    Saturday 3 November
Working with Partners	Leamington Spa	Tuesday 22 May    Tuesday 6 November
	London	Saturday 9 June    Saturday 1 December
Working with Couples	Leamington Spa	Tuesday 3 July    Tuesday 20 November
	London	Saturday 14 July    Saturday 8 December

For more information, please visit [www.thelaurelcentre.co.uk](http://www.thelaurelcentre.co.uk)



London: 020 7965 7302 · Leamington Spa: 01926 339 594





# THE KIDS ARE ALRIGHT... AREN'T THEY?

CHILD AND ADOLESCENT MENTAL HEALTH PROVISION IS FINALLY GETTING SOME SUPPORT, BUT WILL IT MAKE A DIFFERENCE TO CHILDREN IN NEED – AND WHAT DOES IT MEAN FOR THERAPISTS? AHEAD OF UKCP'S CONFERENCE ON CHILDREN'S MENTAL HEALTH, **RADHIKA HOLMSTRÖM** INVESTIGATES

16

**T**he truth is, unless we are going to be able to use at least some funding to do work which has a depth of complexity and profundity – which is really traditional psychotherapy in flexibly applied, contextual forms – it is going to bounce off the surface for many children,' says Stephen Blunden.

Blunden chairs the UKCP's College of Child and Adolescent Psychotherapies and is one of the main movers behind the UKCP 'Minding the Gap in Children's Mental Health' conference on 28 April 2018. The conference will bring together professionals 'to discuss the role of innovative and applied psychotherapeutic approaches in meeting the current national scale of unmet need in child and adolescent mental health'. It comes at a time when there are moves to tackle that need – but the question is whether the planned provision will offer enough,

either in quality or quantity, to make any real difference.

## CRISIS POINT

The staggering size of the problem is not in doubt. According to the charity YoungMinds, one in four children and young people in England shows some level of mental ill health, while one in 10 children and one in five young adults has a diagnosable mental health disorder. The Office for National Statistics figures for 2004 (the most recent available) cited in the new Green Paper from the Departments of Health and Social Care, and Education, Transforming Children and Young People's Mental Health Provision, estimate 850,000 children and young people in the UK have a diagnosable mental health problem. And despite the wide consensus that early intervention can make a huge difference, many are offered inadequate provision, or none at all.

For the past three years, the Government has been trying to tackle this issue. In March 2015, Norman Lamb MP (the then Minister of State for Care and Support) launched Future in Mind: Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing, and the government committed an extra £1.25 billion to Child and Adolescent Mental Health Services (CAMHS) funding over the next five years. However, a vast proportion of the children who need services are still not accessing them. A report for the Children's Commissioner in 2016 found that 'large numbers' of children and young people are still put on long waiting lists, or fall through the system because they miss appointments and then have to start again – and that's if they're not turned away in the first place. A number of children and young people don't qualify for the support available, either because they have not



**IN 2015, THE  
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MENTAL HEALTH  
SERVICES**



experienced symptoms for long enough, because the services do not deal with their condition or because their condition is not considered severe enough.

In any case, the context is of repeated cuts and constantly changing parameters, which means that any new resources are far too frequently not 'extras'. To compound the problem, an analysis from YoungMinds published at the end of 2017 found that a disturbingly high proportion of CCGs in England were using the extra CAMHS funding for other areas of spending.

### LOOKING TO THE FUTURE

The new Green Paper proposes funding for every school and college for a designated senior lead for mental health; new (funded) mental health support teams, supervised by 'NHS children and young people's mental health staff' and managed jointly by schools/colleges and the NHS, to provide interventions for students with mild to moderate needs and support 'the promotion of good mental health and

wellbeing'; and trials of a four-week waiting time for specialist services. It also proposes whole-school approaches and mental health awareness training, as well as making 'mental wellbeing' part of the curriculum.

But will this well-meant approach fulfil its intentions? In its response, UKCP welcomes this focus on young people's mental health, but points out that the underfunding and withdrawal of support services goes back a long way. It is also concerned that the therapy provision proposed is not highly skilled or qualified enough. In particular, it does not mention psychotherapists (although NICE guidelines now recommend psychodynamic psychotherapy for treating moderate to severe depression in children and young people). UKCP suggests that, as a minimum, each school team should include a UKCP qualified child psychotherapist or family therapist 'who has the skills and experience to deal with the full range of presentations they may face'. And indeed, the response points out, a qualified workforce of psychotherapists already exists ready to be put into place.

'I work with children who, in many instances, come out of psychiatric care, and I'm struck by the number of colleagues

who talk about children in schools who are every bit as disturbed,' says Blunden. And while many students are not at what he calls 'the heavy end', he feels they too deserve a full suite of expertise to support them. 'Schools need someone with the capacity to assess who needs in-depth work and who needs to be listened to a little bit.'

Adding in that expertise also benefits the whole-school approaches and general awareness of mental health issues that the Green Paper advocates, adds Jill McWilliam, Chair of the UKCP Faculty for the Psychological Health of Children. 'It's useful for teachers to know how to operate and to have the language but it's also useful, if they can't do the 'next bit', to have someone in school who can. If we can talk to the teacher confidentially and appropriately, we have something that works in the class. And if the class has some language for talking about that, that's good too.' McWilliam also points out that in addition to trained child psychotherapists, there is a 'small tribe' of educational psychotherapists with their own specialist skills.

### FROM TALK TO POLICY

The 'Minding the Gap in children's mental health' conference will – among other



### Comment

#### Sarah Mann Shaw Drama therapist and UKCP psychotherapist

**Sarah is an HCPC-registered drama therapist, UKCP child and adolescent psychotherapist, UKCP integrative psychotherapist and supervisor. She is based in Nottingham and works with the full age range; her youngest client is five.**

'Over the past six years or so, the issues with which children and young people have been referred to me in private practice have been much more serious. We are seeing very stressed children, children with really poor impulse control, eating issues, evidence of obsessive behaviours – lots of complex issues. These are children in crisis, and I just wonder what it's going to take before we start thinking about it properly, in a more integrated manner.

'Many of them would have had some kind of statutory provision before. But in our area it's nigh-on impossible to get access to CAMHS. A lot of therapists who work in schools are in training or placement therapists, so sometimes the complexity of presentation is beyond their competency. Children are referred to CAMHS who refer them back to the school counsellors and therapists, who are getting overwhelmed. Parents get so frustrated they make the decision to go private.

'In my own practice, I try to create teams, working with the parents/carers and going into a child's school to talk about how the child presents and how the school can respond – but that is at the parents' initiative and it's quite expensive; a lot of families

simply cannot have access to that. Sometimes schools have used pupil referral money in the past for school work, but that isn't happening any more. We've had occasions when parents have self-funded sessions and a report that they can take to CAMHS for ongoing provision, but that is rare and it is very, very expensive and doesn't set up the support the entire family needs.

'I don't know what training courses are planned to enable school staff to be mental health specialists in schools, but there doesn't seem to be talk about the psychotherapists and creative arts therapy already there. And if existing funding for teams is being cut, it seems to me to be a contradiction in terms. The more I think about it the more concerned I am and the angrier I feel.'

### What do you think?

Share your thoughts and opinions by emailing:

[communications@ukcp.org.uk](mailto:communications@ukcp.org.uk)

things – open up the debate to more people in the psychotherapy field. 'We wanted to bring together therapists from different modalities and encourage child psychotherapists to look at what each other is doing, almost as a masterclass,' McWilliam explains.

A key speaker will be Kathy Evans, Chief Executive of Children England. Evans will be talking about the policy context and she is also working with UKCP to develop a broader policy strategy. 'There needs to be a stronger voice for child psychotherapy in the emerging debate about child mental health,' she agrees. 'There's little attention, certainly in the public policy environment, on when and where relationship-based therapeutic work is appropriate.'

There are already some clear ideas about overall policy. 'We would like recognition of the different levels, and a range of applied methods, where schools are able to make use of educational psychotherapy, art therapy, music therapy, group work, one-to-one... it's not one size fits all,' says McWilliam. She's also keen to stress the

fact that mental health issues don't operate in a vacuum, and that policy and practice must take account of other things that affect young people. 'Housing, education, health and social care; at operational level – joining those things up in schools would make a huge difference to young people who are struggling.'

Evans's brief for the conference is to help UKCP members draw out from their practice what needs to be said and advocated for in policy terms. 'I'll be the person with the least expertise in psychotherapy in the room,' she says cheerfully. 'I have expertise in child policy. There are an array of questions in my mind: recruitment and training? Where and how should psychotherapy be available? What about the care system? What about the asylum and immigration system? How far do psychotherapists want to be identified as part of the health system? My role at the conference is to be led by the participants in drawing out and framing those issues.'

### BREAKING THE TABOO

Despite all the rhetoric about tackling the crisis, psychotherapy remains 'the last taboo' in policy terms, McWilliam feels.

'One of the difficulties we have is the fixation with 'quick fixes' and another is economics – it's expensive even though it's cost-effective. And last, there's the fact that many people don't want to think about psychotherapy in the first place. It throws up too many issues for them on a personal level. It would be very easy to dumb down the role of psychotherapy but we have a responsibility for opening up the debate.'

'Governments think prevention will save money. It won't; it'll uncover a much greater range of need,' Blunden adds. 'It has repeatedly been shown that you need to put in a whole range of resources – and for significantly disturbed children that needs to be experienced professional psychotherapeutic help, building some kind of capacity to relate to others safely. Fiddling around at the edges with small amounts of money is going to achieve very little. You have to put the whole suite of resources into it to respond to the whole range of needs.'

'It's just too important not to retain in-depth psychotherapeutic work,' McWilliam concludes. 'It's heart-rending walking down the street and seeing people who, if they'd been offered this, might have had a very different life.' ●



### Conference overview

#### Have your say

**Minding the Gap in Children's Mental Health will include:**

#### ■ Hearing and feeling the child's individual narrative in the context of an integrated systemic therapy treatment: a whole systems approach to healing trauma/hurt minds

With a detailed focus on a therapeutic interaction between an iST Child Psychotherapeutic Counsellor and a child, participants will hear/experience the intricate nature of the work with traumatised children. They then look through the wider lens of the adult group, whole community and the organisation as a whole to view the therapeutic approach that contributes to 'holding and containment' within the context of the whole systems approach.

#### ■ What happens at the point of NOT understanding

Many children experience intense feelings of being stupid in the current data-driven learning environment. This session is a whole-class approach where we explore these intense feelings and focus on supporting children's ability to move from shame-filled defensive behaviours to being open and responsible.

#### ■ Therapeutic story groups

This workshop will explain what a therapeutic story group is and how the model has been applied with Looked After Children and within school-based intervention. Participants will experience how social and emotional development is

promoted through safe group structures and the making of a shared, illustrated story over several weeks. We will also look at how a resilience evaluation tool has been effective in recording improvements in and out of the classroom.

#### ■ Family Group: multi-family therapy in schools

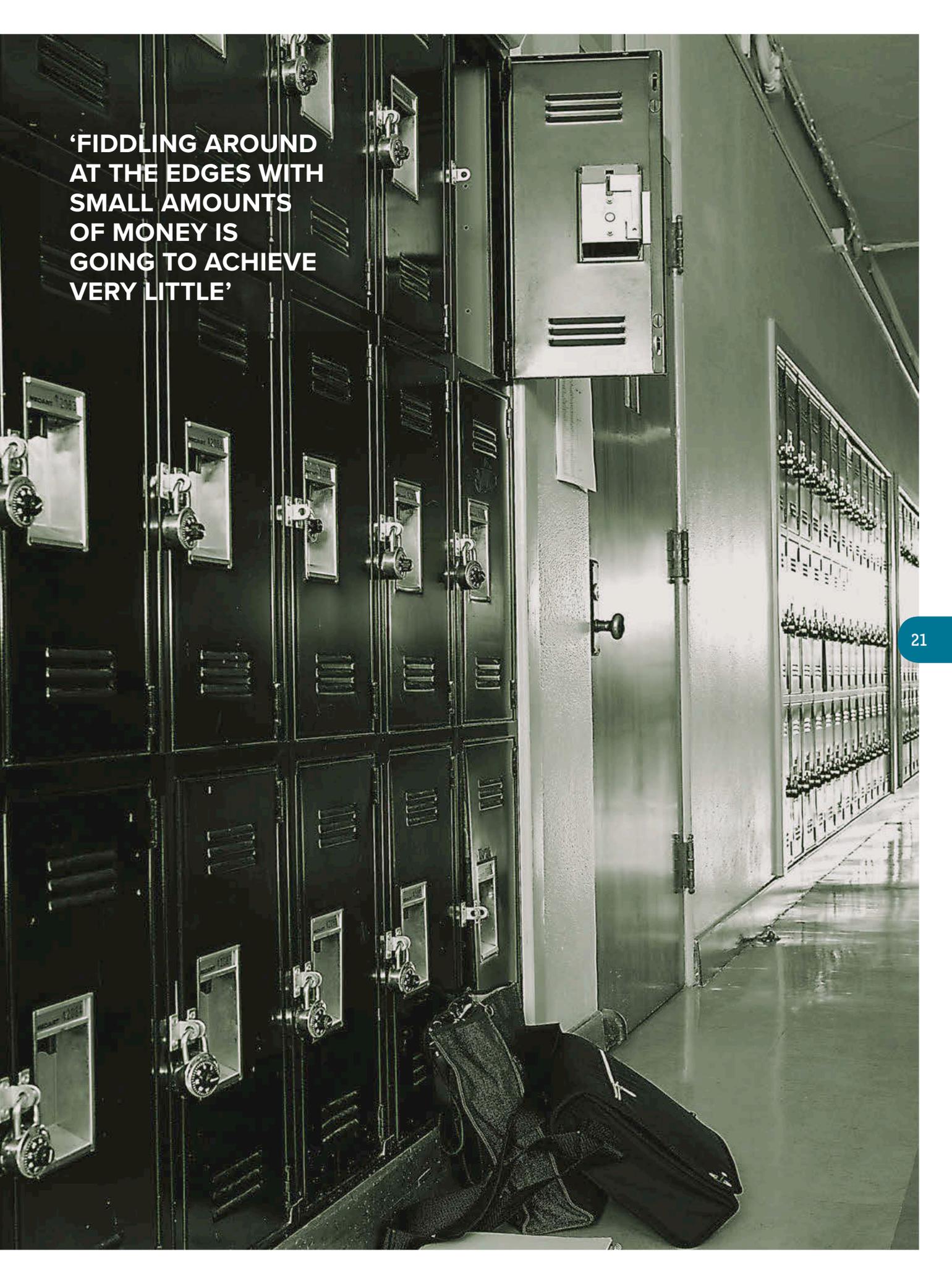
The School & Family Works (SFW) runs Family Groups in nine London schools, supporting families facing significant challenges, where children are unable to make good use of opportunities at school. Weekly, up to eight parents and children work together in each Family Group, in three-hour sessions facilitated by a therapist and a senior member of school staff.



#### Save the date

Minding the gap takes place on 28 April, at Holborn Bars, London. See [psychotherapy.org.uk/events](http://psychotherapy.org.uk/events) for further information and tickets

**'FIDDLING AROUND  
AT THE EDGES WITH  
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VERY LITTLE'**





# ‘Specialist psychotherapy is vital for women with complex needs’

INTEGRATIVE PSYCHOTHERAPIST ERENE HADJIIOANNOU BELIEVES A NEW APPROACH IS NEEDED TO HELP SOME FEMALE CLIENTS



**ERENE HADJIIOANNOU**

Clinical diploma in integrative psychodynamic counselling, and MSc in integrative psychotherapy

Between 2014 and 2018 Erene created and delivered two specialist third-sector psychotherapy services in women-only spaces within Leeds: Together Women Project, and Support After Rape & Sexual Violence Leeds

**A**s a psychotherapist, I believe the therapeutic endeavour is of little value if it cannot be applied outside the consulting room. My clinical experience with female offenders and survivors of sexual violence includes an active engagement with the reality of their lives, to maximise the effectiveness of psychotherapy.

We assume women are able to find a specialist women-only therapy service, and access it when they are ready to engage. But this process is hindered by what we can offer: usually time-limited psychotherapy following a long wait. The impact this delay has is devastating. We know the demand for psychotherapy outweighs provision, and the difficulty of working within time-limited funding periods.

Sometimes we cannot offer therapy because a client's needs exceed what can ethically be provided. We know that clients will have to navigate the mental health system, wait, and potentially deteriorate. That is, if there are any suitable services for them to access. This context is sometimes the main challenge in providing the work, not the work itself. But I believe that there is a strong argument in favour of specialist psychotherapy for women with complex needs, despite the obstacles.

The service provided at the Together Women Project was delivered by me on an unpaid basis. As I could only sustain this for two years, the service began and ended with me. Working from a volunteer model devalues the

client's presenting issues as well as our profession. The best we can offer should not be a service that may suddenly become unavailable. Therefore, ring-fenced funding is key, especially as statutory services refer into the third sector for specialist work.

For female clients who cannot afford private psychotherapy, there are additional barriers that affect engagement such as: the unavailability of free childcare, low income, and limited women-only spaces for gendered issues. Being at continued risk of harm from others and to themselves intensifies this, and rarely creates a straightforward therapeutic process.

Female survivors often describe being turned away from services at the point of disclosing sexual violence, or being unable to engage because they were allocated to a male practitioner. If they have reported the crime to the police, there is often little understanding about how therapy can help or hinder the criminal justice process. With female offenders I have encountered, physical violence in relationships sometimes goes both ways as a form of communication, in addition to the more



### References and reading

- (1) World Health Organization. (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. (1992). Geneva: WHO.
- (2) *Prison: The Facts*. Bromley Briefings Summer 2017. (2017). The Prison Reform Trust.
- (3) *An Overview Of Sexual Offending In England & Wales*. (2013). Ministry of Justice, Office for National Statistics, and Home Office.
- (4) Masterson, J. (2004). *A Therapist's Guide To The Personality Disorders*. Arizona: Zeig, Tucker & Theisen Publishers.
- (5) [www.rapecrisis.org.uk/statistics.php](http://www.rapecrisis.org.uk/statistics.php)

dominant male-to-female sexual violence within that relationship.

The lives of these women are marked by fear and violence, often leading to traumatically re-living the past – distressing memories, flashbacks, and hyper-vigilance (1). With 48 per cent of female offenders re-convicted within one year of leaving prison (2), and 90 per cent of sexual violence occurring from a known person (3), their worlds become very small.

Working successfully with female offenders, I framed core difficulties from an integrative perspective. These included affect dysregulation, disempowerment, violation and mistrust in relational contact, and are experienced by clients between different facets of their internal self and external society. Viewing offending behaviour as an extension of self and self-experience is vital to working effectively.

The offer of psychotherapy is not always taken up easily. Within the Together Women Project, provision of each appointment was clinically informed, allowing for flexibility in responding to individual ways of relating. This was crucial as every woman I worked with had a diagnosis, or traits, of Borderline

Personality Disorder. Within psychotherapy I am aware of the space I occupy in a client's world, both in actuality and in the transference. I reflect on what aspects of society enter the room with us. For female offenders, one of my aims was to avoid collusion with the idea that engaging with psychotherapy was a purely rehabilitative intervention. Working from the principle of 'who are you, and what do you need?' enhanced autonomy.

Consistent engagement was important with a client who had committed a violent crime against an ex-partner. We focused on alleviating the traumatic impact of domestic violence, and understanding her personality. Containing her projections using techniques such as the Masterson principle of confrontation (4), we made progress but she did not attend our last appointment.

In non-attendance cases, I consider psychosocial factors must be playing a part in their realities. The meta-communication of absence is a way to further understand complex needs. I sought to make contact even if clients couldn't, via a phone call or a letter, more than doubling attendance rates.

Survivors of sexual violence have had

something done to them, so psychotherapy shouldn't replicate that. It's difficult to facilitate the idea that women can master their lives and bodies when this has been disproved in their experience, either through rape, or by a lack of accessible help. Collaboratively managing somatic symptoms is often the start of feeling empowered.

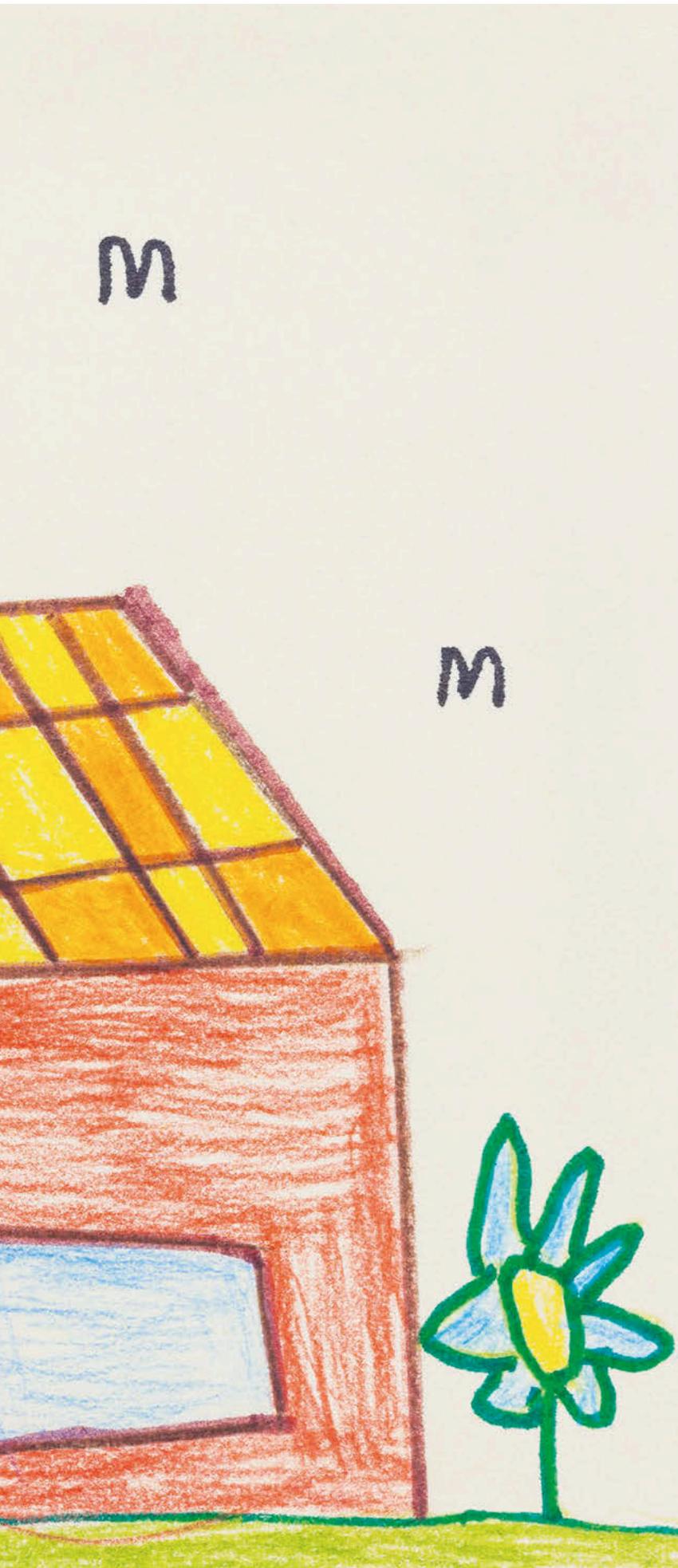
Re-framing how we think and talk about sexual violence assists in understanding it from a gendered perspective without falling into the sexism trap. Society telling women to 'be careful' misplaces the responsibility onto survivors, is damaging to men, excludes those who don't identify within gender binaries, and misrepresents sexual violence as a purely heteronormative issue. An awareness of modern feminist discourse, and of government policies on matters such as sex and relationship education, can help. This is vital as 33 per cent of survivors requesting specialist support are aged under 25 (5) and, in my experience, are more likely to self-identify as 'feminists' and use language such as 'consent' to process what happened.

I am certainly not the only psychotherapist to encounter all this. A collective ethical responsibility is obvious, and we should stand alongside our clients, as much outside the consulting room as within it. ●



**PAUL GORDON**

has been involved in the Philadelphia Association houses for many years and is the author of *An Uneasy Dwelling: the story of the Philadelphia Association community houses*, published by PCCS Books



# A HOUSE FOR HEALING

COMMUNITY HOUSES CAN PROVIDE A SAFE SPACE, GIVING YOUNG PEOPLE A CHANCE TO CONNECT WITH THERAPY IN A SUPPORTIVE ENVIRONMENT, SAYS **PAUL GORDON**



**I**magine you're at the end of your tether, on the edge of a breakdown. Or you've become weary of the years of being medicated, with ever-changing diagnoses. Or you feel you have to get away from the world – for a time at least. Where will you find a refuge?

As a very young man, Duncan had made at least two serious attempts at killing himself; it seemed only a matter of time before he succeeded. Rashid was caught in the 'revolving door syndrome': he would have a breakdown, end up in hospital and return 'home' to a lonely bedsit, usually heavily medicated, before another breakdown. Susan was eating just enough to keep out of hospital, 'simply surviving, not living'.

Three stories, three people among the hundreds who have found a place of healing in one of the Philadelphia Association's community houses.

What they found there was a welcome, a hospitality. No one panicked when they talked of their suicidal wishes, or of hearing voices, or related their histories of abuse or neglect; no one told them they were being self-indulgent. No one was thrown by the endless diagnostic labels with which some people present themselves – schizophrenic, paranoid, or increasingly common, Borderline Personality Disorder – labels that are, at best, unhelpful, at worst, invalidating.

No one presented them with care plans, or timetables of activities, or encouraged them to learn new 'social skills'. Instead, they found a fairly ordinary house, different from other shared houses only in that people were there to try to make some sense of their difficulties and, hopefully, come to terms with them, to find new ways of relating to others and to themselves, new ways of being in the world.

Since they were set up in the 1960s, by RD Laing and his colleagues, our houses have tried to provide places of genuine refuge, where the distressed and dislocated are given time and a space to find their own way, in

**‘The sense of not being pushed made a difference to residents. The gift of time is one of the most important things that we give to people who are suffering’**

The Philadelphia Association's community houses are cost effective – residents pay an affordable rent, coverable by housing benefit

the company of others who know from their own experience what they are going through.

People use the houses in very different ways – some retreat, staying in their rooms as much as possible. Others make great efforts to establish some community life, making meals, organising chore-rotas, suggesting outings, and so on. But no one can escape what has brought them there.

### STAYING THE COURSE

Time and again, we hear people say the house was at times awful, hellish even. Everyone wants to leave, at some point. And yet people do stay and face their demons, both in their own therapy and in the regular meetings that are the hub of the house's life, as well as in the ordinary life of the house.

Of course, the houses don't work for everyone. Many people are interested, come to visit, but cannot take the crucial step to move in. Others do move in only to leave soon afterwards, disappointed that the fantasy community they imagined just isn't there for them, or that it's all too much work – which, of course, it is. Some people find it hard to believe they are acceptable and do whatever they can to prove themselves right, testing everyone's patience, tolerance and understanding. But those who can make the leap of faith and move in and, more importantly, stick with it, benefit hugely. Those of us involved in the houses have seen people whose lives were saved, many more whose lives were significantly altered.

Time is central to what our houses are about. We have never imposed limits on how long people stay.



It would be absurd to say to someone in severe distress or seriously dislocated, 'You can make this place your home but you must leave within six months.' People who do not feel at ease in themselves or in the world, can take this sort of time just to begin to feel at home.

This fact, that there are no shortcuts, is something our culture – with its deadlines, time limits and targets – finds almost impossible to accept. Yet, time and again, we hear former residents say that it was this sense of not being pushed, of not being treated, that made a difference to them. The gift of time is one of the most important things that we give to people who are suffering.



### Quick guide

## The Philadelphia Association

The organisation has been helping people in distress since 1965

Since creating a therapeutic community at Kingsley Hall in 1965, the Philadelphia Association has run more than 20 community houses which have offered asylum and hospitality to people in distress. This work continues at two houses in North London.

They are places where people can address their difficulties in a situation of shared everyday living.

Residents have their own rooms, with an open invitation

to make themselves at home. People may come with a variety of diagnoses but what matters is a desire to change and give meaning to the experiences that have led to their distress.

Each community has several meetings each week with its two house therapists. Residents are also encouraged to be in individual therapy.

Many residents find that in time they are able to reduce or end medication and regular contact with psychiatric services. How long people stay depends

on individual circumstances. The insight that residents gain during their time at the houses helps them lead more fulfilling lives afterwards.

► *It costs around £20,000 a year to run each house. Administrative costs are kept to a minimum and all our therapists work part time. Donations are urgently needed. Please call 0300 123 1708, or email [office@philadelphia-association.org.uk](mailto:office@philadelphia-association.org.uk)*

Duncan was one of those whose life was saved by being in the house. Rashid had no more hospital admissions, and eventually came off medication. Obviously, this is better for the individual concerned, but it also saves a huge amount of public money. Our residents pay a genuinely affordable rent, coverable by housing benefit. Compare this with an estimated cost of £2,000-3,000 to keep someone in a psychiatric hospital for a week, or £600-800 for conventional supported housing. Not to mention the cost of drugs...

But the benefits are not just financial. The people who have come through our houses have been able to make real relationships, often for the first time in their lives. They have been able to find meaningful work or study. Instead of just surviving, as Susan said she was, they have been able to start living.

Talk of community is everywhere and it is cheap. Our houses continue to affirm the true meaning of community, something always in the making. For it is through being with others that people may find a more meaningful place in the world, hope where before they felt only despair.

The world has changed fundamentally in so many ways in the 40 years since the first Philadelphia Association communities. Yet we continue to hold to the idea that mental disturbance, emotional distress, psychological suffering – call it what you will – can, in time and with patience, be made sense of and, more important, worked through.

Let one of our former residents, Susan, have the last word. 'In the house, for the first time in my life, I found a place that felt like home and a group of people with whom I belonged.' ●

► *Find out more below and on the Association's website, [philadelphia-association.com](http://philadelphia-association.com)*



# ‘Attitudes to therapy have changed dramatically’

*By Andreina Cordani*

PROBABLY THE UK'S BEST-KNOWN PSYCHOTHERAPIST, **SUSIE ORBACH** USES HER PUBLIC PLATFORM TO SHED LIGHT ON MENTAL HEALTH ISSUES





## SUSIE ORBACH

Psychotherapist,  
psychoanalyst, writer  
and social critic

Susie Orbach set up the Women's Therapy Centre, offering psychotherapy by women for women, in 1976. Her first book, *Fat is a Feminist Issue* (1978), analysed the psychology of dieting and over-eating. She has been a consultant for The World Bank, the NHS and Unilever and is also a member of the steering group for the Campaign for Body Confidence



**F**our decades after the publication of *Fat is a Feminist Issue* kick-started new thinking on women and body image, psychotherapist Susie Orbach is still campaigning. As well as adding her voice to the #MeToo movement, she writes regularly about body image, feminism and the campaign for equality. But her other mission is to demystify the process of therapy, making it more accessible for all.

Her latest book, *In Therapy: The Unfolding Story*, accompanies the BBC Radio 4 series and offers a peek into the consulting room with fictional analysands played by actors, improvising their story as the session goes on. She argues that the need for therapy has never been greater, and that to tackle the rising tide of mental health issues in the UK, the different strands of the profession need to work together.

**Your book is about the experience of analysis, but is it useful to therapists too?**

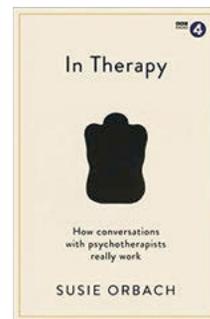
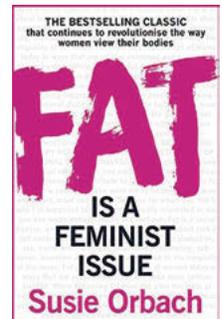
I hope so! A lot of people have told me that it's gratifying to have permission to consider what you're thinking during a session and to learn what another therapist is actually thinking. We work in relative isolation and even when you go to a supervision, people are busy projecting their own opinions onto you, so it's rare to get information on how a particular therapist thinks about the dilemmas she's being presented with, how they're affecting her, what kind of emotional struggle she's going through.

**Why did you use actors improvising stories rather than anonymised case studies?**

For as long as I've been working, I've been searching for ways to show the public what goes on in the consulting room. I wrote a book called *The Impossibility of Sex* in which I imagined characters but eventually I thought, 'this isn't good enough'. You can't use real people and getting actors to read a script doesn't show the drama, tension and boringness... everything that actually goes on in a session. The only way to do that was to put myself in a scary position in which I'm confronted by characters I don't know anything about, just as I would be in real life.

I didn't develop the storylines for the radio programme – I'd say something like 'give me a 60-year-old trade unionist...' or 'give me a young woman who doesn't exactly know who she is...' but that's as far as my role went. The producers would sometimes ask me about plausibility. I have a lot of friends who are fiction writers, and anything they can make up is actually far less extraordinary than real life.

**RIGHT:** Orbach's best-selling debut helped to take thinking on female body image in a new direction **BELOW:** Her latest work goes behind the scenes in the consulting room



**In your real practice, do you find that your media profile affects clients' attitudes to you?**

Not to sound showy-off, but I've never really not been well known, so I couldn't say! When we started the Women's Therapy Centre it had a high profile from the beginning and then I wrote a best-selling book. Some clients seek me out because they've read my books or heard me on the radio but most just think they're coming to see this nice lady in Hampstead.

**Your marriage to author Jeanette Winterson has been in the news, does this mean LGBT+ people seek you out more?**

I don't think so. Even earlier on in my work, women would come in couples because they felt that I understood particular aspects of women's connection to each other. At first there was some curiosity because I was with a man for so long and then I was with a woman [Orbach was married to psychotherapist Joseph Schwartz for more than 30 years – Winterson describes her as 'post-heterosexual'], but the landscape has changed now. We still have internalised homophobia, just as we still have internalised racism and misogyny, but we're pretty vigilant about working on it.

**How has the public attitude to therapy changed since you started practising?**

Dramatically. Back then it was all hidden behind closed doors – one of the things we tried to do at the Women's Therapy Centre was to open things up and make it something you could talk about – which was just unheard of at the time. Now it's no longer considered an elitist practice and whenever there is a public incident, if something difficult or traumatising happens, we often hear about counsellors being on the scene.

‘Therapists can see the **issues in society** that are causing the rise in anxiety and depression – **increasing poverty, increasing bullying, the attack on Muslims and stoking of public rage** all have a deleterious effect on mental health. **The challenge for us** is that unlike any other profession, our confidentiality rules mean we can’t really report on this in **an entirely honest way**. A doctor can at least say ‘the patient survived’ – we’re not even supposed to have the patient’



**Have your say**  
Tell us what you think  
of this issue. Email  
[communications@ukcp.org.uk](mailto:communications@ukcp.org.uk)

**Do you think mental health is now considered of equal importance to physical health?**

There is a lot of rhetoric giving it parity but whether it's anything more than lip service is an entirely different question! There are problems in terms of public provision. Sessions might take place on the phone (which can be right for some people but not everyone) and it might be done by someone working from a manual rather than a highly trained individual. You wouldn't find untrained surgeons, so why is therapy different?

**What do you think needs to improve?**

What's needed is a proper assessment, where you actually engage with the individual and allow them to think through what would be appropriate for them. For some it may be short-term therapy, for others it would be longer term or a support group with a therapeutic feel to it. There needs to be more access to open-ended therapy – at the moment you might just get six sessions then have to go back on the waiting list. Every week I get so many emails from people looking for help – they should be able to access it via their GP and at the moment they can't. Also there's appalling pay – a lot of places rely on volunteer work which is a disgrace.

**What are the challenges for mental health in the future?**

Therapists can see the issues in society that are causing the rise in anxiety and depression – increasing poverty, increasing bullying, the attack on Muslims and stoking of public rage all have a deleterious effect on mental health. The challenge for us is that unlike any other profession, our confidentiality rules mean we can't really report on this in an entirely honest way. A doctor can at least say 'the patient survived' – we're not even supposed to have the patient. We need to work on how we bring what we learn in the consulting room to policymakers and public space without compromising those rules.

We also haven't worked out how to co-operate across the various groups. Psychotherapists, counsellors, psychoanalysts – we're all trying to do pretty much the same thing and yet we don't speak across the profession well enough. If we spoke together it would strengthen our voice. People are trying to co-operate but we're not there yet.

**Are you seeing positive changes in the women's movement?**

I'm doing a talk on #MeToo next week in New York and I realised that back in 1984 I was a member of a group called Women Against Sexual Harassment, offering women psychological help with these exact problems. Change takes a very long time, whether you're talking work-life balance, parental leave, sexuality or internalised racism. It didn't help that the social movement was beaten back when Thatcher came to power. But on International Women's Day this year, my friends and I met up and agreed that – hallelujah! – this is the year in which feminism is back on the agenda ●

► *In Therapy* is available on the BBC iPlayer:  
[www.bbc.co.uk/programmes/b071c4cy](http://www.bbc.co.uk/programmes/b071c4cy)

**Timeline**

**A LIFE IN THERAPY**

**From female body image and the social pressures on women to a behind-the-scenes look at what goes on in the consulting room**

- 1976 Co-founds the Women's Therapy Centre with Luise Eichenbaum. This pioneering practice focused on women's issues and making therapy more accessible.
- 1978 *Fat Is A Feminist Issue* argues that women's eating issues are a social problem reflecting female roles, pressures and restrictions.
- 1983 Publishes *Understanding Women*, co-authored with Eichenbaum, focusing on women's psychology and introducing the concept of the 'little girl inside'.
- 1996 A troubled-looking Princess Diana is pictured leaving Orbach's premises.
- 2005 Her book *The Impossibility of Sex* attempts to lift the lid on what happens in therapy using a fictionalised Orbach-like therapist and fictitious clients.
- 2010 Becomes a member of the steering group for the Campaign for Body Confidence, co-founded by MPs Lynne Featherstone and Jo Swinson.
- 2015 Orbach marries her long-term partner, author Jeanette Winterson.
- 2016 The radio series and book *In Therapy* sheds more light on what goes on in a consulting room.
- 2018 Orbach continues to practise, based in North London.



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# WORKING WITH SEX OFFENDERS

THIS SPECIAL SECTION, PRODUCED WITH THE ORGANISATION STOPSO, LOOKS AT THE ISSUES RAISED BY WORKING WITH BOTH SEX OFFENDERS AND SURVIVORS

## SEX OFFENDING – AND HOW TO STOP IT

**Juliet Grayson** explains why prevention is better than cure – every time



**JULIET GRAYSON**

UKCP registered psychotherapist, Chair and co-founder of StopSO, The Specialist Treatment Organisation for Perpetrators and Survivors of Sexual Offences

**H**ave you ever had a client who, after a few sessions, revealed that they had been viewing child abuse images? Even for the most experienced therapists, it's difficult to know how to react when a client confesses to a crime – particularly one that has historically had so little discussion when it comes to the right therapeutic approach, treatment and possible outcome. That's why StopSO, The Specialist Treatment Organisation for Perpetrators and Survivors of Sexual Offences, has dedicated a conference, *Tackling Sexual Abuse in the 21st Century*, in London on 2 May to the vital topic of sexual offending (find out more at [stopso.org.uk/conference](http://stopso.org.uk/conference)).

With the vast boom in illegal online pornography, increasingly, therapists are facing this challenging scenario. Some may not feel able to work with the issues themselves but need advice on referrals. Others cite the importance of working with this client group, and are keen to equip themselves with the specialist skills required to do so. Sadly, working with sex offenders is no longer a niche area.

In 2016-2017, there were 64,667 police-recorded sexual offences against children across the UK.

'We are dealing, unequivocally, with the tip of the iceberg,' Chief Constable Simon Bailey, the National Police Chiefs' Council Lead for Child Protection, told BBC2's *Panorama* (*When Kids Abuse Kids*), 'and we know that only one in eight reports are actually coming through to the police.'

By this reckoning, the true scale of child sexual abuse is likely to be around 517,336 sexual offences against UK children every year – or a staggering 9,949 a week, almost one new child being sexually abused every minute of the day.

My own interest in this controversial issue began when a non-offending paedophile contacted me to ask for help. I asked colleagues Glyn Hudson-Allez, a forensic psychologist, and Ruth Hallam-Jones, a UKCP registered psychosexual therapist, 'What help is there for people concerned they might touch a child, who haven't been arrested?'

Both had been working with active and potential sex offenders for decades yet the startling answer was, 'None'.

### WINDOWS OF OPPORTUNITY

'If they are an internet offender looking at child abuse images, they can attend a group programme through the Lucy Faithfull Foundation (LFF), but only if they have been arrested, charged or convicted,' says Glyn. 'For those who have fantasies about children but have not yet touched one, there is the LFF StopItNow! helpline. Beyond that there's no therapeutic help.'

For people who have voyeuristic urges, exhibitionists or those who offend against adults, there is no support available until they have been imprisoned, Ruth went on – 'and even if they get convicted, they are often released before attending a Sex Offenders' Treatment Programme. Many go back into the community without any help.'

Shortly after this dispiriting conversation, a group of therapists got



Photos: Simone Padovani/Awakening/Getty Images

## ‘What help is there for people concerned they might touch a child, who haven’t been arrested?’

together to brainstorm. Many of us knew people who had struggled with sexually inappropriate behaviour, and had tried to find help to remain law-abiding. We shared stories of non-offending paedophiles seeking therapeutic help and not finding it, or being shamed by horrified therapists. In some cases, these clients had vowed never to look for help again.

We recognised that one significant way to reduce child and adult sexual abuse was to ensure that perpetrators who want to stop can directly access help. That’s when we decided to create a UK-wide network of therapists open to working with people who commit sexual offences of all types: from troubling thoughts to acting out, and in 2011, The Specialist Treatment Organisation for the Prevention of Sexual Offending was born.

Understanding the roots of sexual offending is key to developing the right approaches. It’s generally agreed that its genesis often lies in childhood trauma and attachment injuries, such as a parent dying, alcoholic parents, neglect, violence, bullying, or sexual abuse, and most sex offenders know they are different when they are still young. Eleven per cent know by the time they are 10, and a further 40 per cent realise between the ages of 11 and 16. By 25, a huge 72 per cent of sex offenders know they have inappropriate sexual thoughts or behaviour, yet most do not offend until their early thirties. This offers a crucial window of opportunity for

education and therapeutic interventions targeting young adults.

### A NEW APPROACH

We need a culture change in therapy, to make it acceptable to acknowledge a sexually inappropriate attraction and safe enough for people of any age to ask for help. One factor that could build trust is our use of language. Most of us mistakenly refer to ‘paedophiles’ when discussing child molesters. The definition of a paedophile is someone who has a primary or exclusive sexual interest towards prepubescent children (generally 11 and under) – but there are many non-offending paedophiles who never act illegally. There are also those who commit contact offences with a child, but their primary sexual interest is in adults.

Researcher James Cantor says, ‘Paedophilia is a sexual orientation. It is something that we are essentially born with, and it’s as core to our being as any other sexual orientation.’ His research with prisoners shows that paedophiles tend to be up to 15 IQ points lower than average, 2.5cm shorter than the norm and three times more likely to be left handed. These characteristics are generally determined during the second trimester of pregnancy – suggesting that for some, paedophilia could be determined at the same time, and possible causes may include maternal stress or malnourishment. And though some people are born with paedophilia, for others

it is brought on by childhood trauma or a blow to the head.

Most therapists know the devastating consequences of sexual abuse on all levels: physical, mental, emotional, and spiritual. But given that it costs approximately £65,000 to put someone in prison for a year (including court costs and police time), offering therapy in the community provides a very cost-effective solution. Let’s imagine the government funded StopSO’s staffing and administrative fees and provided sufficient funds for subsidised therapy. If just one person in 150 that asks StopSO for help receives effective therapy, and as a result does not commit a crime, then StopSO is cost effective. If just 10 per cent of (potential) perpetrators that have asked StopSO for help are no longer imprisoned, StopSO therapists save the taxpayer almost £8 million.

In many instances, therapy can make all the difference. By treating the early trauma, and working on strategies to help clients stay law abiding, we can change their lives. ●

► **StopSO has no government funding and needs £250,000 a year (less than the cost of jailing four people for a year). To donate, please visit [stopso.org.uk](http://stopso.org.uk)**

■ **Notes:** On 18 March 2018 (National Child Sexual Exploitation Awareness Day), StopSO announced that whilst its main work will remain with perpetrators of sexual abuse, it will expand its services to include offering therapy to those people who have been sexually abused, hence the new name, The Specialist Treatment Organisation for Perpetrators and Survivors of Sexual Offences. StopSO would like to give special thanks to Sarah Bird for editing the articles in this section.

## COULD YOU WORK WITH SEX OFFENDERS?

**Dr Terri Van Leeson** explains what it's really like to work with sex offenders and why more therapists are needed in this vital and rewarding area



**DR TERRI VAN LEESON**

is a forensic psychologist who has worked extensively with life sentenced and sex offender clients. She previously worked in the Dangerous and Severe Personality Disorder Service for the NHS in the category A Prison Estate

**T**hroughout my 15 years working with convicted sex offenders as a forensic psychologist, one issue continued to strike me. Many of the men had tried to get help for their problems before they offended, but to no avail. This left many feeling isolated and confused – and worse, they went on to offend.

Clearly, we were missing vital opportunities to avert potential catastrophic damage to children. I wondered, 'How can I use my skills differently, to head off crime before it even occurs?' That's why I now also work with StopSO, the national charitable organisation which offers an innovative way of preventing child sexual abuse.

### A CHALLENGING MOVE

I sometimes found those first years of my work with sexual offenders against children difficult. It was emotionally challenging, particularly when I also had a young child of my own.

However, with good clinical supervision and space to process when I was triggered, I gradually became more adept at bolstering my resilience, becoming a more effective practitioner. I learnt to be congruent, accepting and empathic towards clients. They need that more than anything else – so many experience high levels of shame, one of the most debilitating and dehumanising emotions – don't underestimate how much might be in the room. You must be able to deal with both the client's shame and your own disgust, which may be triggered regarding the offence, or the client's sexual thoughts.

It is essential to put preconceived ideas aside, and realise that some of the client's upbringing and sexualised experiences, including their trauma, may be very significant events. Many of my clients have been systematically sexually and violently abused, so understandably, they have grown up with a distorted experience and beliefs about the function of sex, children and boundaries. It can be difficult to explore their idea of children as sexually knowing and robust, a world view so different from our social, moral and ethical norms. However, unless we provide that supportive therapeutic space for them to examine their assumptions safely, those ideas will remain fixed.

### THE CLIENT CONTRACT

The issue of contracting has presented challenges. Apart from the usual topics of payment, sessions and

cancellation arrangements, many of my clients refuse to sign anything. They're worried that the minute they open up, I'm going to tell the police – although in fact there is no need to do so unless a client is actively offending. At times, I have worked with clients without any written contract, to ensure they keep coming. It goes against teaching, but in some cases, working at this highly responsive level has been essential to facilitate client engagement.

Actively managing dynamic risk with clients who have a clear sexual attraction to children is a process you need to deal with openly, and one that can change quickly. I am honest with my clients, telling them what I will report to the authorities. But I am also clear that I won't overreact. StopSO has a supervision network to call on if this work falls beyond the scope of your usual supervisor.

Whilst I safety-plan with a client if they feel at risk of offending, there are other clients who label themselves as 'virtuous paedophiles' or 'minor-attracted persons' who have never offended and have no desire to do so. This is most common with very young men, but the risk of harm to others, particularly children, differs. Each intervention must be bespoke, targeted to meet changing needs and risks, in addition to longer-term goals.



### Work with us

If you'd like to become a StopSO therapist contact [info@stopso.org.uk](mailto:info@stopso.org.uk) or sign up for training at [stopso.org.uk/foundtrain](http://stopso.org.uk/foundtrain)



### Case study

#### UNHEALTHY THOUGHTS

When a client is asking for help to manage intrusive, unhealthy sexual thoughts, I start with immediate coping skills, offering psycho-education about their urges, distraction techniques and mindfulness. I also take them through the process in a session so they have a visceral experience of it before they leave the room.

Some clients attend just one session. Having a psycho-educational input about sexual development and why some people become sexually aroused to children is enough to help them. Others may need fortnightly sessions over a year or more. Additionally, this type of work can involve other family members. It's not unusual for a man to turn up for his first session with his wife. The men (and occasionally women) I continue to work with are human and they are struggling to get their needs met in a healthy, adaptive way. Those who come through StopSO are openly asking for help.

#### THE THERAPEUTIC TOOLBOX

As a therapist, you will already have most of the skills to work with these clients. You may use psychoeducation, your empathy, congruence, ability to reflect, mindfulness and distress tolerance techniques. There are also specific techniques for working with men who are having unhealthy, sexually intrusive thoughts. Additionally, but only if trained, you might work with people who have sexual dysfunctions.

Further helpful knowledge includes awareness of the criminogenic aspects – deviant sexual interests, sexual preoccupation, attitudes tolerant of sexual crime, a lack of intimate relationships with adults, antisocial lifestyle, impulsivity and low self-control, employment instability, negative peer associations, substance abuse and poor problem-solving abilities. Research shows that addressing these can be the best way to prevent reoffending.

StopSO is deeply committed to offering face-to-face therapy for anyone who finds themselves sexually attracted to children but doesn't know where to turn for help. These clients are incredibly rewarding to work with – I'm making a real difference by offering focused therapy to young men who know they are sexually attracted to children and don't want to offend. Most importantly, I am making a difference by protecting current and future generations of children from being sexually abused. ●

► [Find out more: pathwayps.co.uk/associates/dr-terri-van-leeson.html](http://pathwayps.co.uk/associates/dr-terri-van-leeson.html)

#### Jimmy's story

**Dr Van Leeson's client was a scared ex-convict, in danger of reoffending. Here's how therapy changed his perspective**

**'Jimmy\* had briefly been in prison for the first time, following a sexual offence against a child. Considered 'low risk', he received no treatment and on release, worried he might offend again. He worked with me for 15 sessions and was eventually able to understand why he became sexually aroused to children.**

'Jimmy grew up in a family that fought. His parents' physical fights usually started with his father's drinking, and escalated. He remembered putting himself between them, to protect his mother. His father would lash out at him instead, hitting where it did not show, and would later beat his mother, while Jimmy lay in bed listening.

"I remember the agony of hearing that," Jimmy told me, "And I couldn't do anything to help her." Occasionally, his mother would leave, taking Jimmy to a refuge, but she always went back.

'In therapy, we worked through the impact of living with violence. We explored the way Jimmy thought about children, and I often challenged his assumptions. For example, he saw children as "adult" enough to know what sex was and able to choose to have a sexual relationship. He didn't realise that, even if a child was, as he perceived it, "flirting" with an adult, that did not mean they wanted sex. He began to appreciate that the way children explore life is to "practice" a skill, and flirting was one such skill for teenagers. Over time, he recognised

that it is the adult's responsibility to hold the boundary.

'Jimmy's therapy included developing specific skills to control his unhealthy sexual urges, such as modified covert sensitisation, a technique that directed his thinking onto a different path. We thought of the most devastating consequences if he acted on his old triggers. He saw the police arriving, his name in the headlines, the custody cell, and most importantly his adult daughter, distraught. He wrote these down, then as he thought about his old triggers, I read out the negative consequences, linking them to feeling bad, and I reminded him of the pleasure and pride he would feel at all times, and look at it regularly. He would mentally recite the negative consequences whenever he had a sexual thought about a child, to build up a profound and lasting aversion to the stimulus.

'Over time, Jimmy learned to masturbate to images of adults rather than images of children, and his repertoire of healthy sexual activity developed. Other areas of his life and lifestyle improved, because he no longer felt self-loathing or alienated from the rest of society. He started to eat healthily, chose to drink less alcohol, and began to enjoy adult friendships. His dynamic risk of harming a child in future had dramatically reduced.'

*\*not his real name*

## A REWARDING CHALLENGE?

Three forensic therapists working long-term with sex offenders explain why they believe sexual orientation can be managed, and discuss the professional qualities needed to work in this difficult but important area



**DR KERENSA  
HOCKEN**

HCPC registered and  
BPS chartered forensic  
psychologist, based in  
Nottinghamshire

### **‘Changing perceptions must be a part of government strategy’**

*Dr Kerensa Hocken*

**I trained in prisons, working in the SOTP (Sex Offender Treatment Programme), and then specialised as a treatment manager.**

There are many opinions on whether people who commit sexual offences can be cured. I dislike language that medicalises the condition, which oversimplifies the issue. It’s not an illness. Not all people who commit sexual offences are paedophiles and not all paedophiles are offenders. Research shows that over-identifying with a label is likely to increase the risk of reoffending, and that a non-offending, pro-social identity reduces shame. This must be expressed in context and with a view to attachments.

Studies show that victim empathy and breaking down denial, does not relate to reoffending. Breaking down denial is now thought to break down the functionality for wellbeing, and wellbeing is a protective factor for non-offending. Instead, we now help them to create distance from their offender identity, to build a pro-social sense of self, to reduce shame, but take responsibility for their behaviour. There is no collusion of ‘poor you’.

Therapists need core skills: the ability to be warm and supportive and also to ask difficult questions, to share direct thoughts non-judgmentally. You need to help the person self-reflect. New therapists can fall into a trap of being too challenging, and not therapeutic enough – it’s important to have a balanced view, and not to pathologise the behaviour. This work needs experienced, confident therapists. Get good supervision and CPD. Unpick your assumptions about the people you work with, work on your self-awareness. Network with people who work with this

group and read the desistance literature; this outlines the factors that influence why people desist from sexual offending.

I am careful with my use of language. My clients are ‘people with sexual convictions’, or ‘people at risk of committing sexual offences’. They are not sex offenders.

Some do reoffend and this is a complex area. For those who’ve been in jail, good supervision from the probation service, post-prison, is essential.

Internet-only offenders are different to those who act out. Some people would never know they had the capacity to be aroused by abuse images prior to the internet. For some, there is a long-standing sexual interest which is beyond just a capacity to be aroused. There is a biopsychosocial model of paedophilia that suggests a long-standing interest or orientation towards children, and it is possible to see the events in a client’s life that show growing interest. I’ve never had to report any behaviour to police, but I have worried about someone who was on the edge. Still, I don’t think we need mandatory reporting in ethical private practice. Prevention is cost effective and achievable, and changing perceptions about this must be part of the government’s strategy. The economic and social costs of the current situation are just too high, particularly the enormous costs to survivors.

It is so rewarding to see change, be it small, slow or dramatic. I try to help change behaviour and protect future victims. I often think, ‘today, I can change another life’.

► **To refer a client who has troubling thoughts, or who has committed a sexual offence, go to [stopso.org.uk](http://stopso.org.uk)**



### **StopSO Conference**

Tackling Sexual Abuse  
in 21st Century takes  
place on 2 May, London  
[stopso.org.uk/  
conference](http://stopso.org.uk/conference)



**DR GLYN HUDSON-ALLEZ**

Retired forensic psychosexual therapist, based in Wales

### **'In my experience, these clients all have childhood trauma'**

*Dr Glyn Hudson-Allez*

People believe that paedophiles can't be changed, and that if they have offended against any child, all children are at risk. That's why Social Services sometimes remove all children from a family, resulting in further trauma. Media reports and litigation fuel a reactive approach, too. Neither SOTP (Sex Offender Treatment Programme) or CBT deal with the underlying issues, and these clients are also unlikely to open up in group work, as they have spent a lifetime in secrecy.

It is a myth that all perpetrators have been sexually abused, but in my experience, they all have childhood trauma. It's also untrue that a therapist in private practice must tell the authorities if someone commits an offence – this is only the case within the NHS. Research has found that

the more images people view, the less likely they are to act out. I once worked with a potential rapist, however, whom I felt would start acting out. I talked to the police, but until an offence was committed they couldn't do anything.

It's important to learn trauma skills: to deal with the clients' early experiences. Find out how old they were when trauma happened, and how they coped, particularly events at two, puberty and adolescence.

If you betray a flicker of disapproval they will know; though it is difficult not to have feelings of judgement, particularly if you have children. Beware of collusion, but you have to trust what the client says until proved otherwise.

This work is immensely rewarding – it's a child protection issue. But it's important not to fool yourself that a client is 'sorted'; they might do it again but they, not you, are responsible for their behaviour. Have personal therapy, try to find a supervisor who knows forensic work — and don't think you can heal everyone.



**PAT HOARE**

Senior BACP accredited counsellor and supervisor, based in Devon

### **'Hold firm to the belief that change *is* possible'**

*Pat Hoare*

Thirty-five years ago, I started counselling men convicted of serious sexual offending. Initially I was tentative in my approach, but I realised it was more helpful to communicate openly and help them face the reality of their behaviour.

People believe that talking about 'it' will make it worse or invite others to 'act out' by giving it publicity. Avoidance, lack of knowledge and personal history often contribute to this belief.

I firmly believe it is possible to change patterns of entrenched behaviour. It does, of course, require investment on the part of the client in order for them to become 'safe'.

Some people are surprised that I choose to engage with these clients, in

particular pointing out the need to support the abused. My response is that I think my work with perpetrators is invaluable, and safeguards potential future victims. I have absolutely no doubt in the value of 'prevention', which this therapy is so effective in bringing about.

My advice for any therapist starting to work with this client group is to hold firm to the belief that change *is* possible, and to trust yourself. Invest fully in yourself and in training, and seek regular supervision and support.

## THE TROUBLE WITH SHAME

**Dr Andrew Smith**, who trains therapists for StopSO, on the connection between shame and sexual offending



### DR ANDREW SMITH

has been working in the area of sex offending for 13 years. He is the author of *Counselling Male Sexual Offenders: A Strengths-focused Approach* (Routledge, 2017)

**S**hame and its related forms – embarrassment, disgust and stigma – can be viewed, positively, as regulating anti-social behaviour. Shame has been utilised restoratively, through ‘re-integrative shaming’, whereby an offender meets his victim to learn about the harmful consequences of his actions. However, for this or any other form of rehabilitation to be effective, it has been argued that an offender must develop a ‘redemptive script’ of his life through therapy, where his essential ‘good self’ is developed or re-established.\*

This distinct dualism between shame and guilt can be viewed as a social construction. However, the therapeutic journey from shame to guilt can provide a conceptualised framework for working with sex offenders who experience high levels of shame, and research evidence indicates rehabilitative benefits of helping clients escape a shame-saturated identity.

### LEFT AND RIGHT BRAIN THINKING

Many sex offenders have deep-seated attachment problems and have experienced trauma and abuse. DeYoung (2015) relates chronic shame to such dysfunction and lack of adequate attunement by

care-givers. Taking a psychoanalytical and neuro-scientific perspective, Shore (2012) posits that ‘good enough’ parenting inculcates a positive ‘ego ideal’, hardwiring the message of, ‘I should give myself a bad time if I fall short, but not that bad a time’ (a functional left-brain guilt response). However, pre-rational shame impulses are predominantly located in the right brain hemisphere. If shame is linked to early developmental problems, the offender will be unable to engage with a rational consideration of guilt, until the early attachment and trauma wounds are tended to by a therapist, providing the emotional attunement and regulation missed in childhood. Once this is achieved, left-brain, strengths-based cognitive-behavioural rehabilitative goals can be worked towards, although the treatment pathway for each individual will be different. These include meeting social, emotional and sexual needs in pro-social rather than anti-social ways, enhancing emotional regulation, restructuring cognitive distortions (if motivated), raising awareness of consequences of offending (if motivated), encouraging a safe, but satisfying sexual fantasy life and safety planning.

Many sex offenders not only have to cope with subconscious, right-brain shame, but also left-brain conscious awareness of the pariah status of a sexual conviction, compounding deep-lying shame schemas. The shame of sexual offending becomes their ‘master status’ or ‘extended identity’ – the offence becomes the person.

Instinctive disgust about sexual abuse of children is magnified by the mass media search for attention-grabbing headlines, trading in good and evil archetypes within a risk-averse society that demands protection from its folk devils, independent of the objective risk of sexual reoffending.

Female sex offenders can suffer from an additional source of shame, with their sexual offending activating collective unconscious archetypes of ‘loving mother’ and ‘terrible mother’. The loving mother is idealised: the ‘terrible’ one split off, and projected onto the demonised other, rendering female sex offenders particular repositories of shame.

### SHARING THE SHAME

When working with victims of sexual abuse, the potential for ‘vicarious traumatisation’ is significant. Pearlman





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## GOOD PRACTICE

In order to work effectively with sex offenders, therapists need to have worked through their own personal shame issues, often through their own therapy. They also need to be able to acknowledge, understand and share vicarious traumatisation symptomology with a supervisor who understands this phenomenon and the particular potential shame issues attendant on working with sex offenders

For many sex offenders suffering from early attachment and trauma problems, it will be necessary to address right-brain shame issues through the healing qualities of the therapeutic relationship over time, before addressing left-brain cognitive restructuring. Throughout the process, good supervision can enable therapists to keep perspective, leading to a healthy work-life balance, and avoiding the dual therapeutic evils of over or under-emotional involvement with this group of clients. ●

and Saakvitne (1995) posit that although there is some overlap with 'burnout', vicarious traumatisation is not simply emotional exhaustion or a consequence of the gap between clinical aspirations and the reality of everyday clinical work, as in 'compassion fatigue'. Vicarious traumatisation is not connected to a specific client or relationship. It occurs cumulatively across time and place and, in addition to classic trauma, can result in disruption to the therapist's sense of identity, world view and spirituality, triggering shame about indifferent or hostile feelings towards clients.

'Vicarious traumatisation can leave the therapist serious, cynical, sad. He may develop an increased sensitivity to violence, or be prone to bouts of grief and despair... It can affect his ability to live fully, to love, to work, to play, to create' (Pearlman and Saakvitne, 1995).

Close engagement with the lives of victims, and empathising with abuse experiences, can lead to vicarious traumatisation. However, fear of getting too close to offenders' accounts of sexual abuse can result in the practitioner becoming conflicted about the overlap between empathy and collusion.

If the therapist has not worked through personal experiences of abuse and disempowerment, this may compound the sense of emotional conflict, with a potential for punitive or punishing practice to ensue, resulting in a shame reaction. Working with offenders who deny and minimise their sexual offending can mean therapists feel deskilled, leading to cynicism and moral outrage.

Such hostile feelings towards clients can undermine the therapist's ego ideal, again producing shame.

For practitioners working with sex offenders, engagement is more problematic as the perpetrator can often also be a victim of sexual abuse and other traumas.

The majority of victims of sexual abuse do not go on to sexually abuse others although the evidence from my clinical practice is that many sex offenders have suffered sexual abuse and been exposed to a set of interlinked, highly stressful, abusive life experiences, including experiencing and witnessing violence. There is also the here-and-now distress of being unable to have contact with their children, due to (usually necessary) child protection issues,

and rejection by family and friends.

Providing holistic therapy to sex offenders must include addressing right-brain victim issues related to attachment, trauma and shame problems, enabling the offender to eventually engage in left-brain cognitive-behavioural work, more typical of orthodox sex offender rehabilitation programmes. This requires the forming of a therapeutic alliance based on the three 'core conditions' of unconditional regard, congruence and empathy.

## COMMON FEARS

Some who have committed a sexual offence do go on to build a constructive, non-offending lifestyle, although the road is hard, and some offenders remain outside society. Ongoing therapeutic engagement with the colossal negative impact on a person's life of sexual offending can be attritional, an additional source of vicarious traumatisation.

Another source of therapist shame can be intrusive sexual thoughts about abusive material disclosed by the client. Erotic transference between therapist and client is well documented, with sexual transference and counter-transference issues fairly routinely discussed in supervision. However, experiencing voyeuristic interest in deviant sexual acts or such acts triggering arousal in the therapist can be particularly shame-inducing.

If the client sexually reoffends whilst on the practitioner's watch, catastrophic thoughts can arise in the therapist's mind about professional censure, or being named and shamed. When I train therapists for StopSO (Specialist Treatment Organisation for Perpetrators and Survivors of Sexual Offences), the most anxiety-inducing topic is, 'What would happen if a client offended?' As with any form of harm, there can never be any guarantees, even after all good practice guidelines have been followed. However, the prospect of public shame if a client commits a sexual offence against a child is perhaps greater with this client group than with any other.

For the clients I work with, the most damning conferred identity is that of 'paedo', and many professionals who work with sex offenders fear shame by association. A process of feared moral contamination and pollution can be at work, through contact with this demonised client group.

## DEEPER INTO DARKNESS: DOES VIEWING IMAGES LEAD TO CONTACT OFFENDING?

**Michael Sheath** examines the path from viewing illegal images to acting out, and finds both complexity and hope



**MICHAEL SHEATH**  
from the Lucy Faithfull

**Foundation** has been working with men who use the internet to acquire CSAM since 1995. He has undertaken published research on online groomers, and in 2013/2014 he undertook a professional certificate in counselling relating to sex addiction

It's usually moral considerations shaping any discussion of online consumers of child sexual abuse material (CSAM). Contempt is justifiably attached – they are complicit in the sexual exploitation of children – yet this understandable approach often blurs necessary considerations of direct risk. Many observers rely on 'common sense' beliefs. They assume the possibility that a man viewing sexual images of children might develop sexual fantasies which he will act out, and that men found in possession of CSAM may be already engaged in the sexual abuse of children.

Yet consensus suggests that most men newly discovered as CSAM viewers have no criminal history. Seto's (1) consideration of a wide range of studies revealed that only around 12 per cent of men convicted of viewing CSAM had prior convictions for contact offending. The most recent study, by Krone (2), suggests 86 per cent of a cohort of Australian men had no prior convictions at the time of their arrest for CSAM possession. Significantly higher rates of previous sexual misconduct have been discovered in studies using self-report, most significantly in Burke and Hernandez's 'Butner' study (3), which suggested that 84 per cent of their sample of 155 men admitted to molesting large numbers of children, although only 13 per cent had prior convictions. However, the Butner study has been criticised for methodology, and is generally seen as a 'statistical outlier' (4).

### SOCIETY'S SECRET

The obvious difficulty in retrospective studies is that the same methodologies applied to men with no convictions at all may reveal a surprising level of previous sexual misconduct. The fact that around 80 per cent of all child molestation goes unreported suggests a significant number of undiscovered child molesters must exist. It may be the case that a sample of men convicted of possessing CSAM will contain

a higher than average proportion of unrevealed child molesters: as a matter of social policy, viewers of CSAM should be rigorously assessed.

The second issue in terms of 'direction of travel' relates to recidivism. Recidivism is not, of course, a measure of reoffending; most child molestation is never reported, very little results in a conviction. Taking that into account, the revealed rate of recidivism of CSAM viewers seems very low, with Seto indicating a recidivism rate of just two per cent for contact offences and 3.4 per cent for further CSAM offences, albeit over a relatively short follow-up period of between two and six years. Krone's recent study of Australian men suggests 93.4 per cent of a cohort of 152 did not generate any new conviction for a sexual offence after a four-year follow-up. Compared to 'contact' offenders, who average a recidivism rate of 12 per cent to 13 per cent, 'viewers' appear to desist at a substantially greater rate (5).

The substantial difficulty for police and safeguarding authorities remains: how to differentiate between those who pose a direct risk of contact offending and those who, however closely connected to the sexual exploitation of children, do not.

One approach may be to consider explanations of CSAM viewing which do not rely solely on the conduct of child molesters, and which are not located only in sexual attraction and ambition towards children.

Over many years of work, I've developed a model for considering the underlying causes of CSAM viewers' conduct, using perspectives from the 'traditional' sex offender theory school, alongside the 'sex addiction' school. This model suggests a repetitive and potentially escalating series of behaviours based on viewing



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and downloading of both CSAM and 'mainstream' pornography. Our experience in running groups for viewers of CSAM suggests that few, if any, are solely viewers of CSAM, and that all of them 'graduated' to CSAM via conventional pornographic sites (see diagram, below).

Origins suggests that the roots of CSAM viewing are often located in childhood. Early exposure to pornography is common. What men 'learn' from this is important: many develop a relationship with pornography, and use it as a comfort when they feel unhappy. Others develop expectations, based on misogynistic or brutal stereotypes. Dysfunctional schema, about the acceptability of rape, the entitlement of men to 'release' and the rejection of the idea of harm caused by sexual offending, may feature. Pornography available online might amplify deviant schema, or create them.

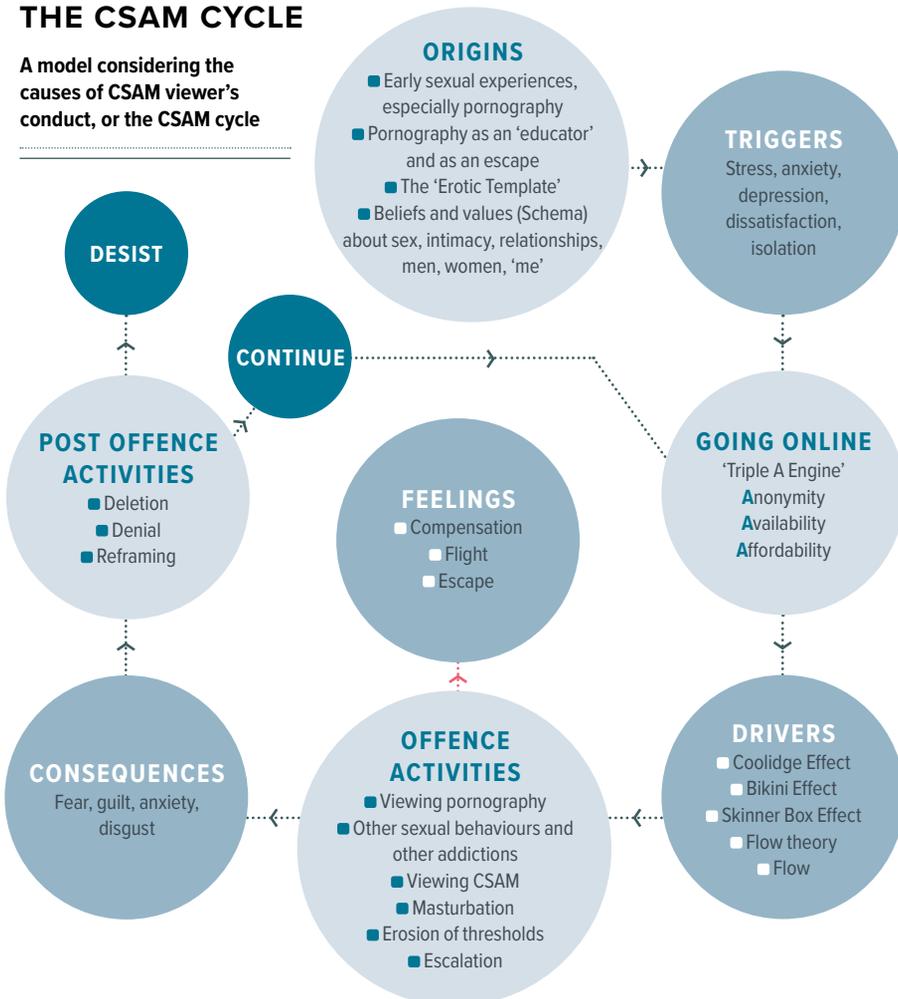
Triggers may not exist for all offenders, but they are common, and typically consist of events leading to dysphoria, whether sudden, such as debt, or chronic, e.g. a problematic marriage. Through habit, individuals often seek solace or distraction through pornography. Online sexual behaviours are amplified and made more reckless by the promise of anonymity, (which reduces shame), the availability of diverse forms of pornography, and affordability.

The drivers in the model relate to psychological forces which affect viewers of all forms of pornography. The Coolidge Effect (6) suggests that pornography's effect has diminishing returns in terms of maintaining the viewer's interest, and the constant search for novelty pulls viewers towards increasingly extreme subject matter. The Bikini Effect (7) suggests that viewers experiencing sexual arousal are

Causes of CSAM viewing

THE CSAM CYCLE

A model considering the causes of CSAM viewer's conduct, or the CSAM cycle



more likely to behave impulsively, while the Skinner Box Effect (8) suggests that viewers become bound up in collecting. Flow theory (9) suggests the viewing and collecting of pornography and CSAM allows for immersion and generates a sense of focus and attainment, albeit through illegitimate means. Thus, the process becomes an end in itself, as opposed to shaping the viewer's sexuality.

### INCREASED ISOLATION

Offence activities include searching for, collecting and viewing of CSAM, as well as other material such as fantasy stories, and online conversations. Aside from unambiguously abusive behaviours, offenders may also engage in online sexual chat with adults, webcam sex, or gambling as well as 'offline' activities – phone sex lines, drug consumption or alcoholism, frequently replacing one addiction or distraction with another. Masturbation provides reward for deviant thoughts, further disinhibition, and a drive to repeat behaviours and offences. Over time, thresholds as to the acceptability of material erode, with increasingly abusive or sadistic material being viewed: offenders may be surprised how far they are prepared to fall morally, since most will have, offline, conventional views about children and sex not matched by their online behaviour. Many will insist that what they are viewing is 'only pictures', or represents past events over which they have no control.

Feelings experienced during viewing vary. Alongside sexual arousal there are many others, including

generic excitement, escape, numbness, astonishment, and nausea. The common thread seems to be that feelings arising from viewing both pornography and CSAM tend to obliterate the feeling that existed before viewing: the 'trigger' feeling is subsumed to the feeling arising from the offence.

Consequences of offending, prior to arrest, primarily exist in the offender's mind. Many describe a range of negative emotions as soon as they disconnect from the internet, others as soon as they ejaculate. Fear of discovery or arrest may intrude; guilt, self-hatred and self-disgust are often experienced. They may, in relationship terms, move away from existing friendships and intimacies because of an inner feeling of unease and vulnerability, since having an honest relationship with someone might require them to disclose what they are doing. This retreat increases isolation, and causes further dependency on the internet.

Post-offence activities consist of practical efforts to remove traces of the online activity, but other mental processes occur as attempts to return to normality. These might include promises made to the self to desist from further viewing, or justification, that it is 'only looking', that the children involved are enjoying themselves, or that their suffering may not matter because they are unknown. If the underlying stresses at the core of the offender's behaviour are not resolved, he is very likely to continue to use CSAM. Most offenders will try and fail to desist.

The CSAM cycle, as a model of explanation, points to the urgent need for robust, research-based risk assessment of CSAM viewers, so those who pose a direct risk to children can be differentiated from those who have exploited children indirectly. No assumptions should be made about either prospective risk or retrospective behaviour. Neither group, of course, is blameless – and all need to be held to account. ●



## A CHANGE OF DIRECTION

If you're interested in working with sex offenders, **Juliet Grayson** offers advice on where to train

**W**orking with people who have committed (or might commit) a sexual offence is a specialised field. At the very least, therapists need to:

- Think about how to keep themselves safe
- Know the basics of the laws around sexual offending and the legal requirements about reporting illegal behaviour
- Develop a proportionate response to risk
- Think about the ethical issues involved in this work including reporting (and not reporting)
- Consider their own reaction to working with sex offenders, including arousal, disgust, and vicarious trauma
- Understand the dynamics of working with these clients, some of whom are experts at manipulation and grooming
- Be aware of the criminogenic and other factors that research suggests will reduce sexual reoffending
- Know what is within their competence and when to refer on
- Be aware that clients might not be direct, due to feelings of fear and/or shame. For example, a client who starts therapy for depression, and after months admits to looking at child abuse images as a way of 'calming himself down'. I recommend that all therapists have some Continuous Professional Development (CPD) for situations such as this.

### WHAT STOPSO CAN OFFER

StopSO (The Specialist Treatment Organisation for Perpetrators and Survivors of Sexual Offences) offers therapists a three-day Foundation Training course, (if preferred, therapists can just attend one or two of these days). StopSO also offers a 10-day Certificate in Therapeutic Practice with Sex Offenders, and various ad-hoc training days, good practice days, and peer supervision days.

### STOPSO FOUNDATION TRAINING (3 DAYS)

This consists of three one-day workshops accredited for CPD by the College of Sex and Relationship Therapists (COSRT):

- **Crossing the Line Day:** Provides information about the legal and ethical position when treating those at risk of committing a sexual offence, foundational knowledge on why individuals commit sexual offences, and explores the emotional demands of working with this client group, including distinguishing between duties of care.

- **Assessing Risk Day:** Provides a framework for assessing individuals accused or convicted of a sexual offence, in order to help therapists make informed decisions about whether they are competent to work with a given client, whether or not to maintain confidentiality, and helping therapists to make case formulations based on relevant risk and criminogenic factors.

- **Treatment Interventions Day:** Provides a historical perspective on treatment intervention for this client group, and explores how a range of therapeutic models and approaches can be applied to working with individuals who pose a sexual risk.

### STOPSO DEEPER TRAINING (10 DAYS)

StopSO offers the Certificate in Therapeutic Practice with Sex Offenders, accredited for CPD by COSRT. Open to those who have completed the three-day Foundation training. Covers:

- Emotional issues for practitioners
- Attachment and trauma issues
- Power and control issues and paraphilias
- Sexual assault and rape
- Working with female offenders
- Paedophiles: offending and non-offending
- Working with adolescents
- Internet offending and sexual addiction
- Working with family members
- Couple work

[stopso.org.uk/profcert](http://stopso.org.uk/profcert)

### OTHER TRAINING

- The Lucy Faithfull Foundation runs training days for professionals. [lucyfaithfull.org.uk](http://lucyfaithfull.org.uk)
- The National Organisation for the Treatment of Abusers offers workshops, (though not specifically for psychotherapists). [nota.co.uk](http://nota.co.uk)
- The NHS Portman Clinic offers two-year training leading to a qualification with the British Psychoanalytic Council and shorter courses looking at forensic issues. [tavistockandportman.nhs.uk](http://tavistockandportman.nhs.uk)
- The Institute for Sex Addiction Training provides an Accredited Diploma in Sex Addiction Counselling. [instituteforsexaddictiontraining.co.uk](http://instituteforsexaddictiontraining.co.uk)
- The Marylebone centre offers an Accredited Diploma in Sex Addiction [marylebonecentre.co.uk/professional](http://marylebonecentre.co.uk/professional) ●



**Have your say**  
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## A LEGAL MINEFIELD: WHEN SEX OFFENDING COMES TO COURT



**PETER JENKINS** is a counsellor, supervisor, trainer and researcher, with a specialist interest in legal, ethical and professional aspects of therapy. His books include *Professional Practice in Counselling and Psychotherapy: Ethics and the Law* (Sage, 2017)

**Peter Jenkins** looks at the recent rise in reporting and prosecutions of sexual offences and what that means for psychotherapists

**W**e live in a 'post-Savile era', where there is much greater awareness of sexual offending than ever before. Between 2011 and 2016 there was a 60 per cent increase in child sexual abuse cases reported to police. Police sexual abuse caseloads doubled during this period. Recent cases accounted for 80 per cent.

Social media has opened up new forms of sexual abuse, too. A survey of 50 schools reported by *The Times* in 2016 identified 1,218 pupils who had either sent or received a 'sext' since 2012. Overall, this suggests that up to 44,000 secondary school pupils were affected by sexting during the period 2012-2016. Sexting, in turn, can lead to revenge porn, or 'sextortion' (blackmail) by organised crime groups.

Growing awareness of the scale is reflected in the current Independent Inquiry into Child Sexual Abuse, and one outcome might be mandatory reporting, although abuse reporting rates in the UK are already high and this could represent a significant legal challenge to the current boundaries of therapeutic confidentiality. However, ministers have recently confirmed that a mandatory system of abuse reporting will not now be introduced for England, given that most professionals in the field do not support this measure.

### A DUTY TO REPORT?

Therapists working for the NHS or other agencies need to report child sexual abuse. Psychologists regulated by the Health and Care Professions Council also have a duty to report. However, therapists in private practice have no legal duty to report child sexual abuse, though they may do so 'in the public interest'.

There have also been major changes in how the police and the Crown Prosecution Service (CPS) respond to, investigate and prosecute reports of rape and sexual assault. The CPS has brought an added emphasis in prosecuting cases of alleged rape and sexual assault and the number of CPS specialist rape lawyers has doubled to 80 in the last year. However, the CPS and police force have been affected by public sector cuts. The number of rape claims (almost exclusively by women) recorded in England and Wales has more than doubled, from 10,000 in 2011-2012, to 24,000 in 2015-2016. Recorded rapes of children also doubled, rising from 5,878 to

11,947, during the same period. But while the number of convictions has increased, the ratio of convictions to recorded allegations has halved. More widely, the CPS reports an increase in successful prosecutions for child sex abuse offences: a conviction rate of 75 per cent.

CPS policies have been revised to enable victims of historic sexual offences to challenge a past decision not to prosecute. Prosecution efforts are now to be evidence-led, not focused on victim credibility.

Many therapists will be familiar with clients bringing a criminal prosecution for rape or sexual assault. Stress can be increased by delays, the scrutiny of witness testimony, and fear of being disbelieved.

One survey found that rape stereotypes damaging to the complainant's case were found in 26 out of 30 cases, including one under 18. This prompted a Private Member's Bill by Liz Saville-Roberts, a Plaid Cymru MP, designed to prevent the use of evidence concerning the alleged victim's past sexual history. Cross-examination of witnesses can now take place prior to the trial on video, limiting potential distress.

The CPS's practice guidance on pre-trial therapy for children and vulnerable adult witnesses also specifies that certain types of therapy be avoided, to avoid 'contaminating' their evidence. Therapy can continue prior to a criminal trial, but the CPS must be informed (with client consent). Records may be made available to both prosecution and defence.

Given the increasing attention on sexual abuse and exploitation in the media, disclosure of past abuse seems increasingly likely to figure in the work of many psychotherapists.

This raises the question of whether all therapy now needs to be considered as potentially moving onto the terrain of pre-trial therapy. Therapists working with non-recent disclosures of childhood sexual abuse can face the prospect of past notes becoming evidence in a criminal trial, sometimes many years after the completion of the therapeutic work, with therapists then being called as witnesses. ●



### Keep in touch

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**RIGHT:** Julia Bueno brings her own experience of loss to her book on dealing with miscarriage

# ‘There are no platitudes in my therapy room’

EACH ISSUE, WE FOCUS ON A UKCP MEMBER’S WORK. HERE, JULIA BUENO TALKS ABOUT HER EXPERIENCE WITH WOMEN WHO HAVE SUFFERED MISCARRIAGE

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**B**efore training as an integrative psychotherapist, Julia Bueno worked as a telephone support worker for the Miscarriage Association. She now works with women who have been through miscarriage and is writing a book on the subject, *The Brink of Being*, to be published by Virago in 2019.

Writing the book will be the first time I’ve talked about my own experiences of miscarriage. I don’t discuss my personal life in the consulting room, so it’s a leap – one I thought long and hard about.

I had a late miscarriage of twins, and the book is a weaving of personal memoir and fictionalised composite case studies. I’m exploring the less-discussed aspects of miscarriage, including the strong bonds we forge with our unborn. With early loss, onlookers struggle with the concept of a baby to mourn, but with late loss, there is a recognisable baby that a woman

labours to give birth to, and I talk about that in the context of my own story.

**My practice is very eclectic** but as I have a specialist interest, I’ve always had a proportion of women who come to me for issues around pregnancy loss and the struggle to conceive. I didn’t pick up on that work for a good few years after my loss and it’s only in the past 10 years I’ve taken it. I don’t work exclusively with it as I don’t think I could. I would find it too draining, and I enjoy working with other clients, too.

**In sessions, I am always aware that women feel responsible for miscarriage** – they will be fantastically creative in finding fault with themselves. Most women I talk to will have been given no reason for their loss and they fill the vacuum with a sense of guilt; they might be scientists and doctors, but they’ll still feel guilty for standing too close to an oven or being overworked – ‘stress’ is such a flabby term that women grab to blame themselves. Coming to therapy gives them the chance to express things they don’t like feeling, such as guilt and rage; but also envy.

**‘Most women I talk to will have been given no reason for their loss, and fill the vacuum with a sense of responsibility’**





**‘There is the power of having a safe space to tell the story of a lost baby. I help people speak out by validating their grief’**

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**It’s not really talked about openly,** but every woman I speak to looks at her pregnant friends, and thinks ‘I want what you have,’ – who wouldn’t? But they’re ashamed. And there’s also this curious grief, for the tremendous loss of something that didn’t happen; the enormity of it can surprise them when they were pregnant for just a couple of weeks. In fact, two weeks is a bloody long time to spend every waking hour mapping out a future.

**After a miscarriage, there’s a loss of innocence, too** – no pregnancy will ever feel safe again. They can lose faith in the world as a safe place, in their bodies and in their identity as a partner or a woman: all the things they took for granted.

Miscarriage can also put an enormous strain on relationships. Men don’t tend to come and talk about it in therapy; they feel a tremendous pressure to be the fixer. They can be angry too, but as we know, men are traditionally very bad at accessing help for their mental health, they feel they have to be stoic.

**There aren’t any cultural scripts for men** to talk about broodiness or birth, and I don’t think we’ve afforded men enough space around that.

**In America, there is more of a tension around the issues of abortion and miscarriage** – here in the UK, they are totally separate paradigms. People think nothing of supporting their friend who wants an abortion and the next day supporting a different grieving friend who lost a baby at six weeks – we sit much more easily with the different concepts.

**Therapeutically, normalising the emotions around loss is powerful** – helping women realise they’re not horrible or evil for feeling anger, that it’s a normal response. But it’s not just the loss itself that clients bring to therapy – miscarriage might unleash other issues particular to them, and can awaken their own experiences of being mothered; other losses and bereavements.

**There is also the power of having a safe space,** just to tell the story of a lost baby. We tell birth stories at great length, but stories of miscarriage are truncated, they’re seldom told in a linear way. I can ask the questions most people don’t ask, and help people speak out by validating their grief. There are no platitudes in my therapy room.

**In Nepal, reproductive losses are completely normalised.** If you ask a woman how many children she has she will say ‘four – two died in early pregnancy, two are living’ – and I think that’s something to aim towards. ●

► **Find out more about Julia’s work at [juliabueno.co.uk](http://juliabueno.co.uk)**

# On Screen

In the first of a new series, psychotherapist and couples counsellor **Hilda Burke** looks at the role of psychotherapists in film and TV drama

## Dr Amanda Reisman *Big Little Lies*

**T**herapists are often portrayed in film and TV but how accurate are these dramatic characterisations, and does our profession emerge well?

Of course, it isn't the responsibility of TV and film makers to portray therapists in a positive light, any more than they should teachers, doctors, priests or lawyers. The primary purpose is always to entertain. In fact it could be argued that the 'perfect' or even 'good enough' therapist with their firm boundaries and perfect awareness of counter transference vs. transference might make for quite insipid TV.

The difference between therapy and teaching or law as a profession is that most of us will have had some direct experience with the latter professions. Psychotherapy, on the other hand, is still something only relatively few of us will have experienced. And so for many, the perception they have of the profession, and its practitioners is taken from TV, film and books. In *Big Little Lies* we meet Dr Reisman first as Celeste and Perry's couples therapist.

The next time we meet her she's with Celeste in an individual therapy session. How did that happen and did Perry know about it? Couples therapists can have differing takes on seeing a couple individually but it's something I personally avoid. If Dr Reisman entered into a contract to work with both Celeste and Perry as a couples therapist but had a meeting privately with Celeste on the side, I'd consider this a breach of the original agreement.

While Perry is undoubtedly a highly violent and unstable character, the fact that he's going to couples therapy and admitting that there's violence in the relationship is a start. In reality it's rare for a violent partner to agree to therapy. By seeing Celeste separately,



**ABOVE:** Robin Weigert as psychotherapist, Dr Amanda Reisman

Photo: HBO/Kobal/Reel/Shutterstock

there's a risk of Dr Reisman excluding Perry, thereby antagonising him further. This approach might be OK if Celeste had taken the decision to move out and leave Perry, but it's clear that she's actually quite far from taking such a step.

To say Dr Reisman's approach is 'directive' is something of an understatement: she couldn't be more instructive about suggesting Celeste moves out; advising her to stock her refrigerator and pay the utilities bills in preparation. Yet I feel she's out of sync with where Celeste is at, which is the initial stage of admitting the physical abuse issue aloud. With undoubtedly good motives, Dr Reisman has stepped into the role of 'rescuing' Celeste: which, in real life, can unfortunately mean

running the risk of alienating the client and could result in therapy ending prematurely.

Certainly *Big Little Lies* triggered a valid debate over domestic violence. But in terms of how the issue was treated therapeutically on the show, I feel it was rather simplistic. I'm in the minority here: the consensus on social media being that Dr Reisman did a good job in telling Celeste what she needed to hear and psychotherapist as heroic rescuer makes for good TV, but I'm left with so many questions. What would have happened if Dr Reisman had let go of her agenda? I would have liked to see her explore why Celeste was drawn to Perry, what she experienced growing up in her family of origin that somehow paved the way for her to accept being in a long-term relationship with such a violent man? And so I'm left sitting with the unknown: a familiar therapeutic challenge!

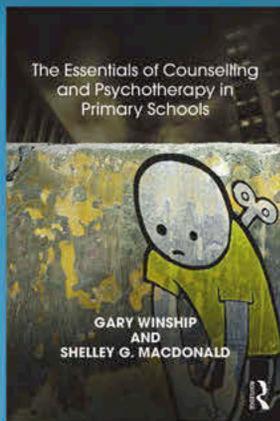
► **Next issue: *The best TV therapist ever?* *The Sopranos' Dr Melfi***

What have you seen on screen that has annoyed or inspired you? We'd love to hear your stories.

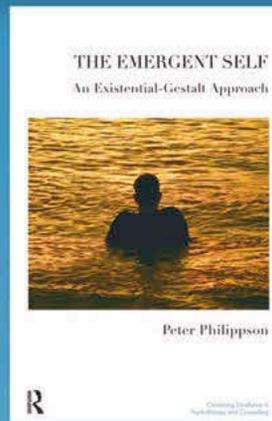
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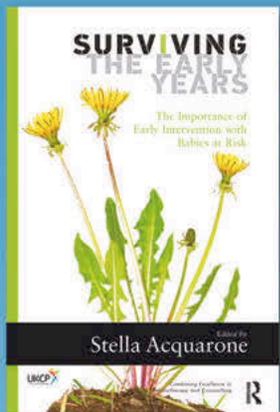
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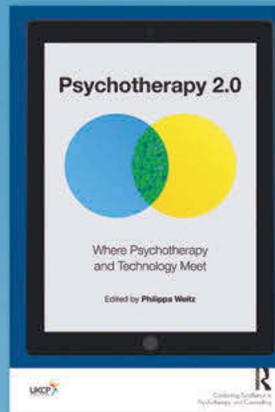
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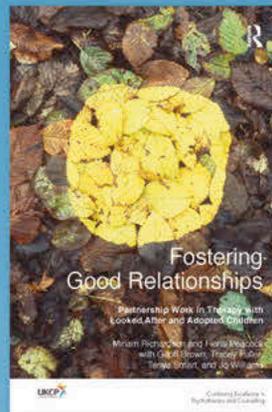
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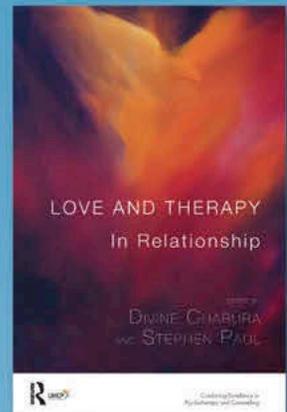
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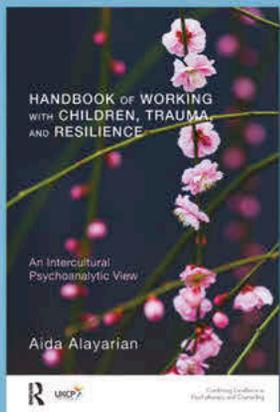
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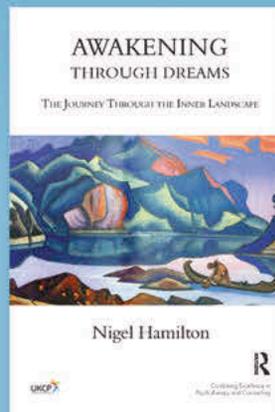
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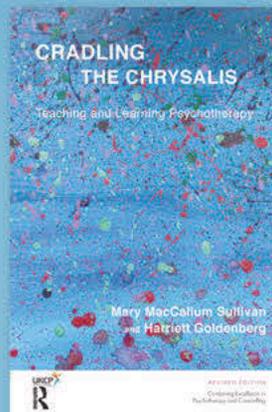
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