Welcome...

...to the first issue of Contemporary Psychotherapy - an e-journal for psychotherapists of all modalities. Contemporary Psychotherapy is a new space in which to explore therapeutic topics: a forum for debate where we can all clarify existing knowledge and create new ideas for our own learning and in the interests of our clients. The journal has been in preparation for almost a year. During this time we have been working to create a journal with a unique character which will offer our readers interesting articles and reviews, stylish design and artistic photographs. We hope you like our approach.

These are interesting, albeit anxious times. No one yet knows how our work, our profession, our clients and we ourselves will be affected by forthcoming regulation or the worldwide economic crisis. Increasing our awareness of our changing socio-political environment and stimulating us to respond by further developing the therapeutic craft is one of the aims of Contemporary Psychotherapy.

Inside you will find a number of leading therapists’ views on the future of psychotherapy and a suggestion that the thinking of Nikolai Berdyaev, a Russian ‘post-atheist’ philosopher, could enhance our understanding of the therapeutic process. We hear from Canada how GPs there determine which therapy to suggest to patients, get a sense of NHS liaison psychiatrists’ attitudes towards psychosomatic disorders and psychotherapy and discuss the provision of counselling for people in exile. And there is more, including film and book reviews.

The journal is in PDF format, so it can be downloaded or read on screen. This offers considerable flexibility enabling you to print in black and white or in color, in its entirety or by article …and it’s free!

We invite you to tell us what you think of Contemporary Psychotherapy; we are keen to learn from you and we would welcome your letters and comments - as well as your articles and creative images. Best wishes

Werner Kierski
Editor-in-Chief
Important changes taking place in the UK psychotherapy world raise the question: what might the future look like? Although, as with any future, the future of psychotherapy in the UK cannot be known, these very changes can give us an idea of the direction in which we are headed.

We are referring to the forthcoming government regulation of the profession and the funding of a massive Cognitive Behavioural Therapy (CBT) programme throughout the country. In addition, both for students and qualified therapists, the requirement for academic rigour in psychotherapy training and research, will become ever more important.

With these thoughts in mind Contemporary Psychotherapy asked a number of key psychotherapists - Emmy van Deurzen, Holly Connolly, Alan Frankland and Dr Elizabeth Campbell - for their predictions.

All agreed that the forthcoming regulation is potentially positive, and should lead to clearer structures and high professional standards. However concerns were also raised, one of which was that attempts would be made to squeeze all therapies under one umbrella. The government may also be seduced, it was feared, into focusing only on so-called “evidence-based” modalities at the expense of those for which the “evidence” has yet to be formalised. As Professor Mick Cooper recently pointed out, it is the relationship that is the crucial element of effective psychotherapy but relationship-based modalities are not currently perceived to be “evidence-based.”
All those interviewed recognised CBT as a valuable therapeutic method, but warned that it is over-rated and tends to be used as a ‘one size fits all’ tool. There were also concerns that the NHS, trying to deliver CBT cheaply, will fail to treat mental health problems appropriately and effectively; some therefore considered that the private sector may become an important influence in maintaining a necessary therapeutic diversity.

**Threat to some therapeutic models**

It was not totally clear to the interviewees how the many modalities will be affected by the changes, however therapists and trainers have been asked to communicate with each other across modalities to agree the best training and supervision in order to meet the challenges. But let the experts speak for themselves:

**Question:** At the moment some strong influences may alter the field of psychotherapy and counselling in the UK. These include: the government initiative to regulate the profession, the growing influence of CBT and increased access to therapy funding. Taking everything into account what do you personally think will influence the field?

**Elizabeth Campbell:** The government in future may not recognise some theoretical models and regulation will ask for evidence-based models. The government did not follow suggestions to have different regulatory bodies for different types of psychologies and psychotherapies; it will all be under one roof. There will also be, in future, European regulation of psychotherapy. The European Association for Psychotherapy is lobbying for this. At the moment the UK is behind everyone in Europe in the field of regulation.

**Alan Frankland:** I think it is very hard to say, and I do not have the confidence in making predictions that I had a few years back when I wrote a chapter on The Future for Counselling Psychology (in *Handbook of Counselling Psychology*, Woolfe, Dryden and Strawbridge, 2003). There is a clear intention by the government to provide some kind of psychological therapy for more people, but I do not think that this will be delivered by people who we would currently regard as psychotherapeutically competent; the ‘low intensity therapies’ will, I think, be delivered by minimally trained (or retrained) operatives and by machines and even the higher intensity stuff will, I think, often be delivered on the cheap. This is because there will not be enough money allocated to fund the thing properly, but NHS leaders will still be keen to 'show' that they are meeting targets for delivering services.

**Effective developments in psychotherapy only outside NHS**

Outside the NHS, however, I think we shall continue to develop and that well trained therapists and counsellors (with high level qualification to Masters and Doctoral levels) will refine ways of helping and of providing services which can be shown to be effective when properly delivered over a reasonable (but not necessarily very long) period of time. My guess is that we shall see more practitioners integrating insights from what we would currently see as clinical neuropsychology, cognitive and CBT approaches and (just as strongly represented) phenomenological and relational approaches. I think the style of working will be relational in tone, because complex work cannot be over -
schematised into simple procedural paradigms, but I have no doubt that the content of the encounters will include cognitive strategies and ways of working related to the relatively new findings about infant (and later) changes in brain activities associated with relational and other experience that is currently coming to the fore.

**Emmy van Deurzen:** In the UK, registration with the HPC will definitely happen. This will create a clearer structure for the different sectors of the profession and will also have advantages in terms of professionalism: no VAT to pay, government recognition, etc. Though people are afraid of this now, it will actually be an advantage in many ways. The government investment in short-term therapy (IAPT) is also a good thing. Having more short-term interventions available will make more people aware of the need for longer-term work as well.

**Question:** What are the main factors, in your estimation, that influence the possible changes you just described?

**Alan Frankland:** I think the thrust of developments in the NHS will (often) be related to the bottom line, i.e. financial considerations - trying to appear to be providing a widely available and classy service on the cheap. I fear that counselling psychologists and some psychotherapists in NHS employment will be dragged along the same route towards becoming distant service co-ordinators and supervisors for under-trained operatives whose intentions will be good, but whose skills (and hence satisfactions) will often be low. I think that practice in relation to people with mental health issues is slipping away from either psychotherapeutic or medical models of treatment/therapy and back to a risk-aversive warehousing model, dominated by ideas of containment.

**Emmy van Deurzen:** Collaboration of psychotherapists, psychologists, counsellors and psychiatrists would be an important factor in this. We also need a longer period of time to bed down these changes and make them work for the profession.

**Question:** If you are thinking of several factors that influence the future of psychotherapy, which one of these do you feel is the most important? And why?

**Emmy van Deurzen:** Integration of different methods is a very important new development, which will increase over the years to come. There is a convergence of different methods and absorption of rival approaches by each method. This will lead to interesting new ways of working.
Holly Connolly: In 5 to 10 years it looks likely that there will be more public confidence in counselling owing to its increased availability and forthcoming regulation introducing strict standards of practice. Lord Layard’s report does seem to endorse the value of mental health, which looks likely to boost public belief in counselling. Although many therapists may currently feel obliged to learn about CBT methods, I wonder whether learning to use CBT will loosen some practitioner’s theoretical models – both enhancing their own practice and enabling them to contribute creative possibilities to CBT. In the future more commitment to meet the more rigorous standards will be needed from trainees; some students may fall by the wayside. We will probably continue to have alternative-minded rebels who find ways to practice their own thing, possibly changing the name of what they do.

Question: How do you think the diverse landscape of the many theoretical modalities might be affected? Will there be an increase, decrease or no change in the number of modalities?

Elizabeth Campbell: What is slightly alarming is the stronghold of CBT and how this affects funds for training. We thrive on diversity not just one approach. Therefore, a lot of psychological therapy courses teach at least 2 models, such as systemic, psychodynamic or interpersonal psychotherapy (IPT).

Holly Connolly: Some styles of practice may not be recognised owing to the promotion of CBT. Whilst CBT has a proven track record, it also has significant limitations and is not a cure for all. The values framework within which therapists operate is as important as the therapeutic process itself. It seems the government could be promoting a mechanistic approach to psychotherapy, neglecting to recognise the significance of the framework. That’s why at the University of Chichester we are incorporating in our training familiarity with CBT methods within a Humanistic framework, which we believe is of great benefit to clients.

Alan Frankland: I think we are already seeing the effects of the government fantasy that CBT is a cheap cure-all, but they are not as negative as some would have feared. The therapeutic community (counsellors, psychotherapists, counselling and psychotherapeutic psychologists and some psychiatrists) has already seen through the rhetoric, but people know which side their bread is buttered. Thus we are seeing courses springing up offering a CBT model for Person-Centred therapists etc. This is paralleled by a conceptual move from within CBT as well. As more practitioners realise there is greater subtlety in the human condition and human troubles, so they are evolving the model. I meet more therapists, for example, who call themselves cognitive rather than CBT, who are moving to a schema focus, who are integrating mindfulness, although that is also being degraded, not to say bastardised in many cases to a mechanistic procedure taught to, almost done to, others rather than practised with them. The situation is complex and I do not think it’s all bad by any means, but we do have to remain vigilant about quality. Too much that is labelled as CBT in NHS settings is simple.
psycho-education and sometimes not much more than psychologised bossiness! We have to try to ensure that the whole thing is not dumbed-down and that humane and relational values are at the heart of policies aimed to help troubled people, otherwise real opportunities will be lost and huge amounts of money wasted.

**Emmy van Deurzen:** Initially a decrease, certainly within the public sector, but ultimately an increase as the basic approaches reimbursed by the NHS will leave a lot to be desired and people will create new ones in the margins.

Existential therapy has a future as an antidote to CBT, especially because of its capacity for integration of different methods within a philosophically clear and meaningful framework and because it addresses people’s true concerns. It is also more open to cross-cultural issues than most other therapies. This will become an increasingly important issue.

**Question:** What advice do you give psychotherapists and counsellors in preparation for the next 5 to 10 years and beyond?

**Holly Connolly:** I think we all need to find ways to adapt to the forthcoming changes, be resilient, and to keep believing in our own worth as counsellors as well as our capabilities to meet any new requirements. Also, to walk the talk and keep communicating with each other. We also need to be politically aware and spotted and use opportunities to influence the growth of the profession positively in the next few years.

**Alan Frankland:** More specifically for the next five to ten years I think people entering this work will have to take their intellectual abilities and academic training seriously. I am not sure it ever was enough to be a good and warm person with a panoply of skills to be a good therapist. I am more and more sure that it won’t be in the future. Although there are some undoubted drawbacks to professionalisation and academic qualifications and it’s entirely clear that cognitive capacities, however excellent, are not enough in themselves to make a passable therapist, I think our clients deserve and the world (employers and clients) will demand that not only can we do the job in the consulting room, but that we can understand and express why we do what we do and enter into dialogue with other professionals who may not share our conceptual and value frames; I think that we should demand of ourselves a real engagement with new knowledge, with research and audit, as well as maintaining professional organisations that help us to do our jobs whilst also offering protection to the public who use our services.

**Emmy van Deurzen:** Get as much training [as possible] in a wide variety of approaches and then get a clear philosophical framework for thinking for oneself and enabling clients to do the same. Don’t panic; trust in the future of the profession which will become increasingly important as society evolves and leaves people less connected and less clear in terms of their purpose and meaning.
How do GPs in North America decide what type of psychotherapy to suggest? A Canadian GP describes how he decides.

Gerald van Gurp

CBT is a practice which focuses on the current problems and difficulties in a client’s life; instead of focusing on the causes of distress or symptoms of the past, it is used to find ways to rapidly improve the state of mind in the present time. Using his knowledge of large electronically available databases, Gerald van Gurp discusses how he arrives at the conclusion that the use of CBT to address difficult mental problems in his patients is the best and most convincing choice of those available to a GP in Montreal, Quebec, Canada.

From the point of view of the family physician, of all the therapies available to treat mental health problems and physical conditions with an important psychological component, CBT appears to be the flavor of the month, the decade, and for decades to come. The reason for this is the rightful preoccupation that doctors have with evidence-based medicine (EBM). Before advocating any new treatment, be it psychological or chemical, North American GPs and, to some extent, third party payers expect that a high standard of proof of effectiveness has been shown. Most of the time this means that at least one randomized controlled trial (RCT) has been published in a reputable, peer-reviewed journal. Increasingly, pooled data from several studies, all
demonstrating methodological rigor, in the form of a systematic review or meta-analysis, is called for. The gold standard in this regard is the work done by the Cochrane Collaboration (www.cochrane.org) which, if not familiar to the reader, is a must-browse.

In most Canadian provinces and throughout the US, general practitioners are required to keep up-to-date with a requisite number of hours annually of continuing medical education. This may entail journal reading, attendance at approved courses or hospital-based conferences. What we have been hearing from all sources for several years is that when we encounter conditions that call for psychotherapy, CBT is the way to go. We are also urged to ascertain whether the colleagues to whom we refer are trained in CBT which, according to a recent survey, was only the case for 11% of therapists in Quebec.

Who should perform CBT?

A small number of general practitioners/family doctors do so after having enrolled on courses with as little as six hours duration. A 2002 article in the British Medical Journal in which 84 North London GPs became CBT therapists after only four and a half days training suggested that such preparation was inadequate. A more recent, less rigorous Canadian study suggested that even a six hour course was to some extent useful. Clearly the jury is still out on the question of how much training is required. It’s worth noting that in both studies, Mind over Mood by Greenberger (1995) was the training text that was used.

I took the initial step of purchasing this programmed text with its companion clinician’s guide and found it concise, clear and user-friendly. On the other hand, I have not taken the next logical step of enrolling in a training session. To be available for any course of between 6-24 weekly sessions is an obstacle for many clinicians, myself included.

The question arises: Why is CBT so highly recommended by pundits and opinion-leaders of the medical community?

The short answer is that according to the methods by which that community gauges effectiveness of treatments i.e. rigorous scientific evaluation, it appears to work.

In what follows I’ll share with you the current consensus of medical opinion on the role of CBT in the management of frequently seen psychiatric ailments as well as a few physical conditions, but before doing so, it would be useful to describe a randomized controlled trial, the cornerstone of evidence-based medicine. An RCT in which I was involved in 2002 examined depressed patients visiting offices of general practitioners in Montreal. The main objective was to ascertain whether patients with major depression recruited from a primary care setting improved more during a three-month treatment period with St John’s Wort or with the antidepressant sertraline (Zoloft). Half of the 87 participants received one of the treatments which were carefully masked to be indistinguishable to patients and doctors, and their allocation was random.
One such study may not be considered enough to justify a strong message to practicing clinicians. In fact at around the same time that our study was published, a larger, American trial in a tertiary care setting, involving patients who were more severely depressed, drew a conclusion different from our own. Hence we needed to look at the results of as many RCTs as possible in the form of a systematic review or meta-analysis, the speciality of the Cochrane Collaboration. This has been done in the case of St. John's Wort for depression.

The more psychotherapeutically minded GPs may carry out their own research of the appropriate treatments for patients presenting mental health problems.

My own research (using the online libraries of RCTs, systematic reviews of Cochrane, past issues of the very practical and much read American Family Physician and the data bank of the continuing medical education site, Info-POEMS [problem-oriented evidence that matters] found the evidence-base for effective use of CBT.

Entering the following keywords, ‘cognitive behavioral therapy’, psychological therapy(ies), as well as the names of a number of conditions into the online databases, the argument for the referral to CBT was strong. In the following list, I outline the evidence that I found for referring for CBT.

**Post Traumatic Stress Disorder (PTSD)** - A 2005 Cochrane review looked at 29 studies of psychological treatment of post-traumatic stress disorder. Trauma-focused CBT and stress management appeared to be effective as did eye movement desensitization and reprocessing (EMDR). Other therapies (supportive, non-directive counselling, psychodynamic therapy and hypnotherapy) were found not to be superior to waitlist/usual care (the control group). In reference to ‘other therapies’, the review stated that there was evidence of a greater drop-out rate in psychological treatment groups and unexplained heterogeneity observed in the comparisons; it recommended caution in interpreting the results of the review.

**Generalized anxiety disorder (GAD)** - Twenty-five RCTs with 1060 subjects contributed data to a systematic review concluding that CBT was more effective than treatment as usual/waitlist. A few of the studies compared CBT with supportive therapy but heterogeneity and small numbers precluded drawing any firm conclusions.

**Panic Disorder** - An article on the treatment of panic disorders in the American Family Physician (AFP) looked at multiple evidence-based reviews. Strong evidence supported the effectiveness of CBT alone or in
Combination with anti-depressants. At 3-4 months 73% of CBT treated-patients were panic-free compared to 27% of controls with 46% remaining symptom-free at two years. Longer-term studies suggested that CBT alone was better than anti-depressants which, when continued for more than six months did not reduce relapse rates.

Social Phobia - CBT lasting from 16-24 sessions, whether in individual or group format was found to be particularly effective for treating social phobia when compared to supportive care. Authors of a review in AFP also noted a lower relapse rate compared to treatment with anti-depressants after discontinuation of therapy. As in any condition in which pills and talking therapy both work, patients’ preferences are paramount.

Obsessive-compulsive disorder (OCD) - A Cochrane review examined eleven studies comparing a control to cognitive behavioral therapy and concluded that any variant thereof was effective.

Adjustment reaction - No meta-analysis was found but one RCT compared problem-focused CBT with ‘supportive’ counseling for 57 patients with cancer and an abnormal adjustment reaction. The authors concluded that the CBT group had a greater improvement in anxiety, adjustment to cancer and use of coping strategies than patients receiving supportive counselling. The effects were measured after eight weeks of treatment and were still apparent at four months.

Major depression - Authors in AFP cite numerous RCTs and meta-analyses showing CBT effectively treats unipolar major depression, possibly more so in mild-to-moderate cases. They clarify additionally that it is as effective as an interpersonal or a brief psychodynamic approach.

Depression in childhood and adolescence - Similar conclusions were drawn about childhood and adolescent depression. CBT is the first choice in mild-to-moderate cases while anti-depressants are considered for patients with more severe disease.

Chronic Fatigue Syndrome (CFS) - According to a Cochrane review which included 164 subjects in three trials, the physical functioning of adults with severe CFS benefitted from CBT when compared to orthodox medical management or relaxation therapy. There was no statistical difference, however, for patients with milder forms of the condition typically seen by GPs.

Fibromyalgia - A meta-analysis of studies looking at treatment for the fibromyalgia syndrome concluded that together with pills and exercise, CBT can play a useful therapeutic role.

Obesity - The obesity epidemic in North America should be attacked using an approach that includes stimulus control and cognitive re-structuring (under the rubric of CBT) and, according to authors of a systematic review in AFP, stress management and social support.

Eating Disorders - The same appears to apply to binge-eating and bulimia although it is much less successful in the case of anorexia nervosa.

The above list does not pretend to be an exhaustive literature review, but rather intends to give a sense of what North American Cognitive Behavioural Therapy (CBT) in North America
American GPs are hearing. Another question arises; what about the many other types of therapy offered to a needy general public? In some cases patients that I see have been in therapy for many years and have only a vague notion of what adjective would characterize the approach used by their therapist. Here in Montreal, so many styles of therapy are available that it is truly confusing for all concerned. I suspect that very few are evidence-based and, given the need for sound evidence, this is a concern for many doctors. Perhaps some or even most of these therapies have been studied to some extent, but the resulting research publications were insufficiently scientific to reach the high-end literature that is used to establish guidelines.

I should mention that psychologists who have university affiliations frequently make CBT an important part of their psychotherapeutic armamentarium and let this be known to members of my profession, an important source of their referrals. As a final note I should qualify my comments by pointing out that I’m fairly peripheral to the world of psychotherapy; I currently work in an emergency department, a palliative home care program and a community-based group practice. My early research interests other than St John’s Wort included arrow injuries and childhood osteomyelitis in Papua New Guinea. On the other hand, all general practitioners/family physicians are regularly called upon to find appropriate resources for patients that we see and this, of course, includes psychotherapists.

References:

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Sometimes we are haunted by a terrible dream. We see the time of super-machines dawning with which man could govern the world... had he not disappeared...

N. Berdyaev

The Matrix is all around you

The Matrix (1999)

The psychological theories underpinning different modalities of psychotherapeutic practice are all shaped by a fundamental tension inherent in the discourse of psychology as a whole. Psychology is at one and the same time a scientific and a hermeneutic discipline. The nature of the theoretical framework underpinning therapeutic practices of different modalities will depend on its location along this spectrum. On one end of the spectrum cognitive-behavioural approaches veer towards a complete exclusion of the hermeneutic dimension, and on the other end, for example, developments within post-Jungian theorizing such as James Hillman’s archetypal psychology veer towards a complete exclusion of the scientific in favour of the hermeneutic. Moving further on this side of the spectrum the colourful variety of humanistic and transpersonal psychologies are seen by some as falling off the cliff into boundless subjectivism.

But, however much the proponents of a scientific psychology based on quantifiable, measurable research data may be inclined to scoff at the woolliness of those who favour hermeneutics, in the end

Georg Nicolaus
psychotherapists will always have to deal with real people. The total exclusion of the hermeneutic dimension arguably leads to a virtually complete incomprehension for this existential dimension, which is fundamental to the phenomenology of our experience. At the very least, as Martin, Sugarman and Thompson argue in their book, *Psychology and the Question of Agency* (2003), we have to include some notion of agency in our theoretical models because, after all, “those clients and communities who request the professional services of psychologists make their request for assistance mostly in agentic form” (Martin, Sugarman, Thompson 2003: 5).

**A fresh view on the concept of agency**

In view of current cultural dynamics, fresh attention to the concept of agency and of the person seems warranted to me: “Some envision a time when our languages and cultural practices will dissolve into a universal, more sophisticated and scientifically more correct way of speaking about experiences and actions in ways that have little place for agency or associated ideas”. A blatant example of this prevalent tendency is J. Pollock who argues in his book, *How to build a Person*, as follows: “My claim is that constructing a person is the same thing as constructing an accurate computer model of human rational architecture” (Pollock 1989: 112).

Both scientifically-minded theorists, and post-modern theorists who have had a significant impact on recent psychotherapeutic and psychoanalytic thought, dream of the final ‘death of the subject’. Post-modernism is supposed to offer us a critical toolkit to tackle scientism, logocentrism, racism, sexism, the marginalization of minorities and to sensitize us to the contextuality of our experience and the pluralist, multicultural universe out there. Some even believe that it might enable us “through re-examination or deconstruction of psychotherapy’s definitions and assumptions, to return to a notion of ‘soul’, as an alternative to a prevalent scientific or medical conception of the mind” (Loewenthal, Snell 2003: 73). These are positive achievements that I certainly don’t want to dismiss.

Deconstruction of various forms of cultural myopia can only be healthy. But the post-modern procedure goes further, too far for my taste: operation successful, patient dead.

It may be time to look beyond post-modernism, without thereby reversing its achievements. The psychoanalyst Don Fredrickson has perceptively pointed out the shortcomings of post-modernism: “Seen from a postmodern perspective, it would seem that we now have an intersubjective psychoanalysis without a subject, an interpersonal psychoanalysis without a person, and even a psychotherapy without a psyche. In the process, postmodern theorists have substituted new forms of determinism for the psychic determinism of classical psychoanalysis that they so fundamentally reject. Indeed, postmodernism has called into question the entire project of self-knowledge. Yet if there is no subject, no person and no psyche, who are clinicians supposed to be analyzing?” (in *Fire*, 2003: 204) He proposes that we might profitably explore the ideas of a little known group of Russian personalist philosophers (for example, S. Bulgakov, P. Florensky, M. Bhaktin, V. Solovyev, Vysheslavtsev and N. Berdiaev) for some much-needed re-orientation.

I believe that amongst these thinkers it is specifically Berdiaev (1874-1948) who is of great relevance here. The theorist of culture, Mikhail Epstein, pointed out that Berdiaev is one of the ancestors of a specifically Russian mode of ‘post-atheist’ philosophy. He points out that: “... three tendencies can be discerned in the misty dawn of Earth’s first post-atheist society. One is traditionalism... A second is neo-
paganism…. The third is ‘poor’ or ‘minimal’ religion...The third, Modernist, tendency, inspired by Nikolai Berdyaev, issues from the apophatic conception of pure freedom, which posits itself as anterior to God and the act of creation. It presupposes an ecumenical unification of all religions…” (Epstein 1995).

Epstein, aligning himself with this third tendency inspired by Berdyaev, seeks to develop it further into a different form of post-modernism called ‘trans-culture’.

‘Trans-culture’ transgresses boundaries and divisions. It is open both to ecological awareness and to spirituality without reducing the cultural sphere of free human creativity naturalistically or spiritualistically. Very much in line with Berdyaev’s own efforts, it seeks to create a space for free human creativity. Such a ‘trans-cultural’ approach takes up the salient motives of post-modernism while resisting the temptation to ‘kill the patient’ by falling into the trap of furthering the cause of the progressive depersonalization rampant in our current virtual society. As Marshall McLuhan already pointed out, the present rise of violence, for example, may be profitably interpreted as a result of such depersonalisation. If I feel powerless and unreal, violence may be a bid to retrieve a sense of identity.

Epstein aspires towards a perspective that is integrative without being totalitarian, multicultural without drowning in a relativism that ultimately turns out to end in depersonalization and dehumanization. The cult film The Matrix offers a potent metaphor for this depersonalization that found much resonance for very good reason. If we listen attentively as therapists to our clients the pertinence of this metaphor will become evident.

So, who was this Nikolai Berdyaev that is supposed to have things to say well worth listening to at the present time? Berdyaev was a Russian émigré who started off as a Marxist revolutionary and later, after realizing that both Marxism and capitalism were just two sides of the same coin, turned towards Christianity as the only true revolution possible. This revolution was, for Berdyaev, a ‘personalist revolution’ with the political implications of a ‘personalist socialism’. Berdyaev’s Christianity was a free, non-dogmatic, post-confessional Christianity which took much inspiration from Jacob Boehme’s theosophy. Boehme’s thought has had a broad, if often invisible influence on continental thought, ranging from Hegel and romanticism to, it might be argued, central motifs in Jung’s form of depth-psychology. A recent book by Kathryn Wood Madden, Dark Light of the Soul (2008) explores this kinship of Boehme and Jung in some detail. In a forthcoming book to be published in 2010, I seek to explore a reading of Jung’s psychology of individuation in the light of Berdyaev’s philosophy.

Berdyaev spent the second half of his life in the Paris of Sartre, Merleau-Ponty and Emmanuel Mounier and gave shape to his own form of personalist existentialism. Thus Berdyaev’s thought presents us with a fascinating coniunctio oppositorum of the conservative (Christianity) and the progressive (Marxism, sociological criticism, existentialism). But, as already indicated, Berdyaev’s thought points further into the future and offers creative new perspectives on how to move beyond post-modernism.
New perspectives for Psychotherapy

Berdyaev's existential philosophy has much to offer

His existential philosophy has much to offer for psychological theorizing. Yet, while many other existentially oriented philosophers like Buber, Sartre, Merleau-Ponty and Heidegger have been successfully introduced into the field of existential psychotherapy, Berdyaev has up until now hardly received any attention. Possibly one reason for this is that while many of the founding figures in the field of existential psychotherapy came from a predominantly Freudian background, Berdyaev's thought is more compatible with Jung's and that of transpersonal psychology in general than with Freud's.

Long before Assagioli, the founder of psychosynthesis, Berdyaev argued for a psychosynthesis to replace psychoanalysis. He offered an analysis of the structure of the unconscious similar to Assagioli's, talking of a super-conscious as well as a subconscious. That his thought can offer a contribution to the field of transpersonal psychology is acknowledged by Ken Wilber, the leading theorist in this field, who earned it some tacit academic respectability. Berdyaev was conversant with the psychological theories of Freud, Adler and Jung and with Gestalt psychology, which latter he considered to be especially compatible with a theory of the person. He shared much in common with Martin Buber's philosophy that has already found application in the dialogic approach in Gestalt psychology. Furthermore, like the other Russian personalist philosophers mentioned by Fredrickson in his paper, Berdyaev proposes an integral epistemology involving the whole person - not only the rational faculties - which “marks a transition from the interpretation of knowledge as objectification, to understanding it as participation” (Berdyaev 1976: 61); this could offer significant contributions to a new epistemology for psychotherapeutic practice. Furthermore a survey of the entire body of his writings shows many striking resonances with Jung's psychology that offer exciting new avenues for the exploration of Jung's work.

Berdyaev's notion of the person

What then, in short, is Berdyaev's notion of the person? The person for Berdyaev is not a static entity, but a dynamic process. We are ‘egos’ to begin with and are called to become persons. The person cannot be objectified. The ego or as we might also call it the ‘Cartesian subject’ on the other hand, which is itself the result of objectification as much as its sustainer, is really only the subject as biological individual, the central actor in the modern turbo-capitalist drama of rampant individualism. The person is essentially an apophatic reality, which refers us ultimately to a trans-personal unitary reality as its root-ground. The term apophatic indicates that it cannot be known rationally, but can only be actively realized in a process of subjectification, a recovery of our latent, inherent spirituality. This recovery implies an opening out both towards the world and towards the transpersonal, spiritual ground of personhood.

Concrete spirit

Spirit for Berdyaev is concrete and personal, it has nothing to do with an abstract, rationalized notion of ‘mind’. It is dynamic, free and, above all, creative. Berdyaev gives shape to an ethics of creativeness that potentially elucidates the ethical dimension of what Jungian theorists would call the process of individuation. For Berdyaev we “ought to make moral inventions with regard to the problems life sets ...[us]...For the ethics of creativeness, freedom means not the acceptance of the law but individual creation of values. Freedom is creative energy, the possibility of building up new realities...The ethics of creativeness is one of dynamics and energy” (Berdyaev 1945: 132).
The task of introducing Berdyaev’s thinking to the field of present psychological discourse is not an easy one. His thought is notoriously aphoristic in a manner somewhat reminiscent of Nietzsche. In fact, his ethic of creativity owes much to his intense dialogue with Nietzsche’s thinking, as much as maybe Jung’s psychology does and, many would say, depth psychology as a whole. This affinity and yet also disparity between Nietzsche and Berdyaev is another fact which commends him, in as much as Nietzsche more than any other philosopher is the ‘founding-father’ of post-modernism as much as of depth psychology.

I believe that an engagement with philosophers like Berdyaev is a useful exercise at the present time. Berdyaev’s notion of the personality that creatively builds up new realities is capable of accommodating the post-modern emphasis on difference (Derrida) without leading to potentially dehumanising disintegration precisely because it denotes more than an atomic individual. It denotes a differentiated microcosm, capable of accommodating otherness in its fluid, open, creative mode of being and yet is at the same time sustained in its fundamental integrity by its roots in transcendence: “The ideal of difference means to be different not only from others, but also from one’s own self, to outgrow one’s identity as a natural being and to become an integral personality that can include qualities and possibilities of other people’s experiences” (Epstein 1995: 305).

References:
In this article, Mark Nevin discusses the results of his research, carried out in 2008, into the choices made by NHS liaison psychiatrists regarding psychotherapy referrals for patients with psychosomatic illnesses. His conclusions highlight the divided nature of the UK NHS which, he suggests, compartmentalises medical and mental health and undermines the connections between mind and body. Nevin has been asked by Peter Schoenberg (author of Psychosomatics, the most current book on the subject), to present this research to the joint University College and Royal Free Hospitals monthly Psychosomatic workshop in May 2009.

Over the past two decades there have been advances within neuroscience which suggest that the dualistic concepts of ‘mind’ and ‘body’ are outdated and obsolete. Body psychotherapist, Nick Totton (2003) claims that they are being replaced by the idea of what he calls ‘Wholism’. He says there is ‘an increasing groundswell of belief in our culture that the splitting of body and mind is both nonsensical and damaging’, and that ‘Descartes was wrong’, we ‘do not exist because [we] think, but because [we are] embodied’.

Mark Nevin researches which modality NHS Liaison Psychiatrists recommend for patients with psychosomatic illness
Turp goes further and suggests that what Totton describes as a groundswell of belief is ‘something approaching a consensus’. But how does this new understanding influence our thinking about psychosomatic illness and how is it represented at an institutional level within our health service?

It has been estimated that only 15 percent of patients presenting for the first time at their GP will have symptoms that are caused by physical pathology.

Wijeratne (2007) points out that anxiety and depression are present in at least one third of patients, but they are more likely to complain of somatic symptoms like tiredness, insomnia and anorexia. He puts this down not only to a denial of psychological factors, but to the stigma of mental illness and a common belief that a physical illness will be taken more seriously by the doctor than an emotional problem. Likewise, patients experiencing panic attacks commonly present in A&E complaining of shortness of breath or chest pain due to autonomic arousal. On surgical wards, non-specific abdominal pain (NSAP- abdominal pain without any organic cause) is the most common abdominal presentation and in a year, an estimated 33,000 negative laparotomies, which many of these patients undergo, are performed at a cost of around £30 million to the health service. In the US it is estimated that excessive health care use due to somatisation costs the American health care system a staggering $100 billion annually (ibid).

The doctor, driven by a need to act and a fear of ‘missing something’, is in danger of unwittingly colluding with the patient’s psychosomatic defence by the prescription of medication or referral on to specialists for further medical investigations. Referral on to psychological therapy can be extremely difficult because of the patient’s firm conviction that their suffering is purely a physical matter. The mediator between general medicine and psychological therapy is the liaison psychiatrist (LP) and an important part of the LP’s training is to develop the skills necessary to gain the patient’s trust.

In the UK there are currently 360 psychiatrists who list liaison as a speciality on the register at The Royal College of Psychiatry Faculty of Liaison Psychiatry. In my research I was interested to know how common it is for a patient presenting with somatic symptoms to be referred on to psychotherapy by LPs. I conducted a survey with 291 psychiatrists and focused on questions about CBT and psychodynamic psychotherapy referrals. I chose these two methods of psychotherapy for their obvious contrasting foci – learning through therapy as opposed to relational therapy, respectively.

The following three questions were asked and provided box ticking choices for replies:
Q1. How many times in the past 12 months have you referred a patient presenting with somatic symptoms for Psychodynamic Psychotherapy?

Q1b. I would make more referrals but I am limited by the availability of Psychodynamic Psychotherapy in my trust/area. (yes or no)

Q2. How many times in the past 12 months have you referred a patient presenting with somatic symptoms for Cognitive Behavioural Therapy (CBT)?

Q2b. I would make more referrals but I am limited by the availability of Cognitive Behavioural Therapy (CBT) in my trust/area. (yes or no)

Q3. How many times in the past 12 months have you referred a patient presenting with somatic symptoms for any other kind of psychological therapy? (please specify)

Q3b. I would make more referrals but I am limited by the availability of other kinds of psychological therapies in my trust/area. (yes or no)

From the 291 questionnaires that were sent out, 130 were returned and from these there were 109 completed questionnaires. Twenty-one of the respondents said that they were unable to participate on the basis of their change of career or retirement. Therefore this report is based on the 109 results that I received. The returned data show that, overall, LPs seem reluctant to refer patients to psychotherapy of any kind in any area in the UK, and some of the reasons for this are suggested in the comments. Of those who did refer, there was an almost seven times greater chance that they would use CBT than psychodynamic psychotherapy; the national average for referrals by liaison psychiatrists to psychodynamic psychotherapy is 1.73 per year. For CBT it is 7.67 and for other psychological therapies 3.08. A liaison psychiatrist in the UK typically refers one patient per year for psychodynamic psychotherapy, 5.2 for CBT and 1.3 for various other types of psychological therapy.

Only in London was there any difference, with a slightly greater number of referrals to psychotherapy. Nationally, fewer than half indicated that they would refer more to psychotherapy if availability were greater, but a little more than half said that they wouldn’t. For referrals to CBT, nearly 60% said they would refer more frequently if it were available and more than half said they would make more referrals overall if that was made possible by their trusts. Among other concerns was a question about adequate training for somatised symptoms and some LPs admitted to failure in their own confidence that their patients would engage in therapy.

In the third part of the survey respondents were asked to specify which kind of other psychological therapies they would consider using for referrals. The list below shows the preferences.
Figure 1.

<table>
<thead>
<tr>
<th>Types of therapy preferred if available</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling (Supportive &amp; Directional Counselling)</td>
<td>16</td>
</tr>
<tr>
<td>CAT (Cognitive Analytic Therapy)</td>
<td>9</td>
</tr>
<tr>
<td>IPT (Interpersonal Therapy)</td>
<td>7</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>7</td>
</tr>
<tr>
<td>Couple/Marital Therapy</td>
<td>6</td>
</tr>
<tr>
<td>Anxiety Management</td>
<td>5</td>
</tr>
<tr>
<td>DBT (Dialectical Behavioural Therapy)</td>
<td>4</td>
</tr>
<tr>
<td>EMDR (Eye Movement Desensitization and Reprocessing)</td>
<td>3</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>3</td>
</tr>
<tr>
<td>Health Psychology</td>
<td>3</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>3</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>3</td>
</tr>
<tr>
<td>Problem Solving Skills</td>
<td>3</td>
</tr>
<tr>
<td>Brief Psychodynamic Counselling</td>
<td>2</td>
</tr>
<tr>
<td>Bereavement Counselling</td>
<td>2</td>
</tr>
<tr>
<td>Pain Management Group, Retribution, Survivors of Sexual Abuse Group, Art Therapy, Fatigue Management Group, Anger Management, EFT (Emotional Freedom Techniques), MI (myocardial infarction lifestyle changes help following MI), Solution Focused Therapy</td>
<td>1</td>
</tr>
</tbody>
</table>

It is evident from Figure 1 that, given the choice, LPs would make more referrals and opt for less evidence-based therapies for patients with somatised disorders. It is reflected in comments that they are aware but restricted by their health trust’s decisions over use of funds and, perhaps, confidence in therapies other than the so-called evidence-based ones. In the comments section, those LPs who chose CBT over longer term psychotherapy showed some agreement with the health trust’s decision; they stated that this was because it was evidence-based. They also felt that CBT worked well with somatic disorders and was more appropriate for patients fearful of deeper work. On another note, some LPs raised the issue of training, stating that they felt it was inadequate for patients with somatic disorders and one respondent added that, ‘it would be good to have a local register of expertise’.

A lack of funding and long waiting lists (one respondent mentioned a waiting list of 18 months) were also mentioned as concerns which worked against referrals for psychodynamic psychotherapy and some respondents commented on the difficulty in rationalizing the responsibility for these patients; medical or mental health teams?

A few commented on the suitability and need for psychodynamic psychotherapy under certain conditions; availability in the NHS, the nature of the relationships between stressor and symptom and whether it is appropriate for the relevant disorder. Other themes included issues such as the complexity of patients presenting with medically unexplainable symptoms (MUS) and the need for thorough assessment; one comment expressed a possible failure by assessors to understand fully the nature of somatisation.

When we consider the high incidence of patients presenting at their GP with MUS, it would seem that there are remarkably few referrals of somatising patients to
psychotherapy, whether it be psychodynamic, CBT or other kinds, especially when one considers that this survey was conducted among the very people supposedly responsible for this job. Of course, most patients' entry point into the healthcare system is via their GP, with 'the diagnosis of the GP decisively influenc[ing] the subsequent treatment' and Brian Broom (1997) suggests that:

‘The impact of the [LP] service is small because generally it only serves patients referred by the somatically preoccupied physician or surgeon. There is great irony in this. The somatically preoccupied are allowed to circumscribe the purview of the mind-oriented when it comes to exploring mind-body connection’.

He also criticizes ‘soma-preoccupied psychiatry’ and the trend for ‘abandoning the psyche to embrace the soma in the form of its brain and its biology’.

To conclude

Jeremy Holmes suggests that the NHS is in a ‘crisis of values in which the personal aspect of medicine competes with, rather than complements, medical technology. Like the individual somatiser, the institutional body of the NHS seems to struggle with the abstract and wants concrete evidence and ‘treatment’, a pill, an operation or a therapy that performs like one, but ‘mind’ and ‘body’ are abstractions and ‘To treat these abstractions as concrete realities is to fall into what Whitehead (1926) called “the fallacy of misplaced concreteness.”' The psychodynamically informed therapist, ‘...knows that the psychosomatic symptom, when unravelled ...[is] perfectly legible in the languages of metaphor, pun and symbol.’

While the challenge for psychotherapy is to enlarge a credible evidence base that can speak a language comprehensible to medicine, the NHS might do well to observe how the German health service, under the influence of Michael Balint’s legacy, attempts to implicate something like Balint’s ‘Patient-centred Medicine’ which considers attention to a patient’s emotions a routine part of a doctor’s work, because, in the words of McWhinney et al (1997):

‘To attend to the emotions only in certain kinds of illness, or only after diagnostic testing is negative, perpetuates the prevailing dualistic distinction between mental and physical illness. All significant illness is a disturbance at multiple levels, from the molecular to the personal and social. This implies that some of the skills that are at present considered "psychiatric" will need to be more general in all clinicians, especially those working in primary care, where so much general undifferentiated illness is seen.’

If there is to be progress it depends upon communication between the fields
of psychotherapy and general medicine; the difficulty is in mutual comprehension that allows fruitful communication and engenders mutual respect.

References:


The Mapesbury Clinic for People in Exile

Avril Johnson - Clinical Services Director - talks to Louise Buckle about running the service

The Mapesbury Clinic was established in 2001 with the aim of improving the mental health and well-being of refugees and asylum seekers. The Clinic offers culturally and linguistically appropriate counselling, psychotherapy and support services and is staffed by people from different cultures and backgrounds. Many have been refugees themselves.

The services offered are available to refugees, asylum seekers and those who are displaced, aged 17 and over, living in London. Services are free. The advocacy service offers help with a wide range of issues including housing, welfare benefits, immigration and asylum support. Where necessary clients are referred for specialist advice and representation on these and other matters. There is also a drop-in service for clients who feel isolated and links to other organisations that can provide a range of services helpful to refugees and asylum seekers.

Q: Let’s talk about you to start with. You are the clinical services manager for the Mapesbury Centre. Why did you take the role?

A: I think what attracted me to the role was that it included clinical and managerial elements and working exclusively with a particular client group.

Q: Can you tell me a bit about yourself and your journey?

A: I have a first degree in Psychology from Portsmouth University. I thought about training to become a clinical psychologist or psychoanalyst, but instead, with friends set up a company producing mainly documentary films for TV. Then around 1993-94, I decided that
I would train to be a psychotherapist. I completed my training in 2000 at the Institute of Psychotherapy and Social Studies. Since then I have worked in the voluntary and statutory sectors, and I have a private practice. From time to time, I still do some media work, but very little.

Q: And is this a full time role or do you have other commitments as well?

A: No, I work part-time. I am about to start my second year of a family therapy training and I do other things as well.

Q: How would you describe your job at the Mapesbury Clinic?

A: My role is to build upon the success of the Mapesbury Clinic, that is, in the services we provide, attracting funding to the project and expanding the Clinic’s profile. However, as a team our raison-d’être is to provide solid therapeutic and advocacy services for the client group, that is, refugees and asylum seekers. For me this means having capable counsellors/therapists from different ethnic groups, having/developing the appropriate systems so that we are efficient and effective; having an advocacy service that helps the service-user in practical ways.

Q: How would you describe the services that the Clinic provides?

A: The Mapesbury Clinic provides culturally and linguistically appropriate counselling/therapy. Our clients have complex issues some of which are practical in nature, hence the need for an advocacy service. Ours is ably operated by Agata Kupis. The Mapesbury Clinic was established in 2001 and was set up by the previous director and students studying at the Minster, some of whom were also refugees. They saw the need for the service and set about making it happen.

Q: You’ve mentioned the advocacy service. What other staff do you have?

A: Lemma Jembere generally manages the clinic and, of course, there are our counsellors who are a very dedicated and important part of the Clinic. This is a voluntary organisation and, particularly in the present climate, there are always issues around financing, or the lack of it.

Q: Now that we have a feel for the aim of the Clinic and its staff, can you tell me a little bit about your clients?

A: Our clients are men and women who are or have been refugees/asylum seekers. They usually present with complex issues that are a combination of psychological/mental health and social problems. We provide a service to those people who have experienced all sorts of problems as a result of war and/or upheaval in their country of origin and resettlement in a new environment. The Clinic needs to keep abreast of the languages new refugees speak, and to find ways of encouraging communities who do not consider counselling as an option to access the service. It should seize the opportunity whenever it is presented to expand the languages in which counselling takes place. The Clinic needs to be able to attract new funding. We need to think about the range of therapeutic interventions offered, for example, couples, groups and families.

Louise: I find it amazing that you are still actively expanding the number of languages that you offer when I am aware that you already offer counselling and psychotherapy in Albanian, Arabic (North African, Middle East and all dialects), Bosnian, Dari, Farsi, French,
You are a psychotherapist as well as a manager. How do you see the role of therapy in your work and the work of the Clinic.

Therapy is central. It is the Mapesbury Clinic’s raison-d’être. I think, as the clinical services manager, it is very important to separate the therapeutic from the managerial. This means not offering interpretations when a situation needs to be managed. In the Mapesbury Clinic the kind of ethos I certainly want to encourage, in terms of our relationships with each other and our clients is respect, empathy, a boundaried approach to clinical and advocacy services and a willingness to try and think about our practices.

And the role of therapy in society?

Since Freud published ‘Studies in Hysteria’ in the late nineteenth century psychotherapy, and our understanding of the psychological has increased to the extent that it is now embedded in the western social and cultural societies, I hope that continues.
What are the difficulties psychotherapists face when working with asylum seekers? Lucy Kralj offers an observation and a personal opinion?

Lucy Kralj

This paper addresses the difficulties faced by asylum seekers and the potential consequences of the processes that they encounter. It does not aim to deal with the right (or otherwise) to migrate, but instead focuses upon the possible realities of the asylum seeking process within the UK and the potential impact that this has on both the mental health of the individual seeking asylum and the therapeutic relationship.

A fundamental tenet of the psychotherapeutic relationship is the notion of safety. This concept is thrown into disarray when working with people seeking asylum in many Western countries. The asylum process can frequently re-enact the cycle of de-humanisation experienced by refugees in their original countries. The term “asylum seeker” is often used interchangeably and erroneously with “illegal immigrant” or is qualified with adjectives such as “bogus”, “genuine”, “failed”, suggesting that many people choose to leave their homes, livelihoods, families, and possessions and make an, often long and treacherous, journey to Western countries in search of “a better life” or even “a free lunch”. In reality, the term “asylum seeker” (a comparatively recent concept) means, precisely, a person seeking asylum, seeking refuge.

The term refugee was defined after World War Two as: “A person who, owing to a well-founded fear of persecution for reasons of race, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (United Nations, 1951 Convention Relating to the Status of Refugees). An asylum seeker is an individual who is applying to a foreign state for refugee status. The European Convention of Human Rights (to which the UK is a signatory) sets out minimum living standards for all human beings, for example, the right to a private and
family life, and to live a life free from torture, inhuman or degrading treatment.

Seeking asylum in the UK and its impact on health

Patterns of migration tend to mirror patterns of global conflict. There are varied reasons why a person may be forced to flee his or her homeland, including war, genocide, state-sponsored (political) torture, trafficking for sexual or labour exploitation, domestic violence, female genital mutilation, or threatened honour killings. Once people seeking asylum arrive in the UK they must navigate the complexities of our asylum system and its interpretation of international and domestic refugee and human rights legislations.

Research has repeatedly demonstrated that the mental and physical health of asylum seekers deteriorates following arrival in the UK (Burnett & Peel, 2001). Many asylum seekers arrive in Western countries in extreme poverty and vulnerable health. However, health (neither physical nor mental) is often not a priority on arrival and there are numerous barriers to accessing effective healthcare. Denial of access to public funds and health and social care compound existing health problems. Asylum seekers can find themselves utterly destitute with no recourse to statutory services. Many clients referred to the Helen Bamber Foundation (a UK-based human rights organisation, formed in April 2005) are destitute at the point of referral, having been refused asylum despite coherent histories and evidence of extreme human rights violations.

The Asylum Process

Asylum seekers must attend three Home Office interviews; these are conducted by government officials sometimes with little regard for gender, or sensitivity towards issues likely to affect the communicative ability of the claimant. For instance, a woman who has been tortured and raped by government militia, may find herself interviewed by a male government official with a male interpreter from the very faction, clan or tribe that tortured her in her homeland. She is expected to provide graphic details of her experiences to the interviewing officer. Failure to do so can cast doubt upon the credibility of her claim and late disclosure can be regarded negatively at subsequent stages in the asylum process.

Despite media claims to the contrary the overwhelming majority of initial asylum applications are refused (73% in 2007, with only 10% being granted refugee status, Home Office, 2007). Critically, 23% of appeals (most recent 2007 statistic, Home Office, 2007) are allowed. This highlights the weakness of initial decision-making and has been documented by Amnesty International (2004). Claims are generally rejected on credibility grounds or alternatively “risk on return”. Under normal circumstances there is one right of appeal. The tribunal environment is frequently experienced by the asylum appellant as intensely persecutory.

When a claim fails, the applicant faces an existence of abject poverty, depending upon charity hand-outs and begging from community members or faith groups. These conditions are fraught with hazards; personal relationships tend to break down, mental and physical health deteriorates and the person lives in constant dread of detention and deportation, or abuse at the hands of exploitative black-market traders. Confusion prevails regarding access to healthcare. Asylum applicants are frequently erroneously denied access to primary care while access to secondary and tertiary care remains restricted or prohibited.

Dehumanisation

Many of the terms used in relation to asylum seekers might be seen as dehumanising. For instance “dispersal”, “processing” and “trafficking” are words used in farming,
animal and the meat trade whilst “claimant” and “appellant” are part of the language used within the criminal justice system. Asylum seekers are all issued with photo ID cards and are assigned a registration number which is often used instead of their name. All asylum seekers are finger-printed at the point of claiming asylum, and contrary to immigration guidelines many individuals with a longstanding history of torture are detained for indefinite periods in immigration removal centres. Release from a detention centre is contingent upon good quality legal representation and former detainees are frequently electronically tagged following release and subject to stringent reporting requirements. These people have committed no crime and have been through no trial. It is worth noting that in many languages there is no differentiation in vocabulary between “trial” and “process”.

Access Denied

Given the above strains upon the individual, deterioration of mental health is hardly surprising. The search for asylum, sanctuary and a sense of home is both internal and external. People are commonly referred from one voluntary organization to another, in a desperate and, by now, perennial search for asylum, sanctuary, acceptance and belief. Practical needs and emotional needs can go unmet throughout the asylum process and many agencies to which these people turn feel overwhelmed by the level of need, the complexity of the situation and their inability to assist with the most basic of human necessities. Forward referrals are sometimes made in desperation to assist; the asylum seeker being sent to yet another stranger, hoping for “help”. “Help” can be an ambiguous word for this client group. Huge amounts of energy can be poured into securing some kind of accommodation, ensuring that a person is able to eat at least once a day, obtaining clothes, or a sleeping bag, searching for new legal representation, or simply being there, bearing witness to the unbearable difficulties of continued existence. Although “help” may be needed with all aspects of life, once in receipt of this “help” people often experience increasing despair as they realise that the internal trauma, grief and desolation does not abate.

Re-enactment: Revictimisation

Well-meaning professionals may encourage asylum seekers to seek out experts with whom to “talk about your past, talk about your problems”. Referrals are often made to specialist post traumatic stress disorder services who rarely accept failed asylum seekers precisely because their lived reality is so fraught with danger that there is no hope of achieving the sense of safety and security necessary for trauma-focused work. Although agencies coming into contact with the asylum seeker may refuse treatment or assistance for eminently sensible and ethically appropriate reasons, the individual experiences repeated refusals, rejections, rebuttals and an unacceptably high level of exposure as their story is shared time after time. This repeated exposure seems to enhance the already highly disassociated state of many traumatized people who have been compelled to tell their story but lack the emotional support network to contain the acute distress levels that are triggered (Henry, 2005).

There is considerable debate surrounding the diagnosis of post traumatic stress disorder when working with populations who are, by
definition, both victims and survivors. Summerfield (2001) rebutts the diagnosis of PTSD amongst asylum seekers and refugees, arguing that this psychiatric diagnosis undermines the resilience of individuals that should be celebrated. Others (eg de Zulueta, 2005) concur with the resilience model but also offer PTSD as an extremely useful diagnosis when working with feelings and experiences of disequilibrium following gross trauma. Herman (1992) offers the diagnosis of complex traumatic stress in the aftermath of a prolonged period of totalitarian control, taking account of the complexities of abuses experienced by many asylum seekers. Le Feuvre (2005) suggests the notion of “ongoing traumatic stress disorder” which neither negates the asylum seeker’s experiences nor confines the traumatisation to the past.

Many survivors speak of deep-seated feelings of being “not human”. The denial of public systems to which all other citizens have access serves to emphasise this feeling and belief. Acts of torture and extreme abuse necessitate the passivity of the victim and lead to a sense of helplessness. The individual is similarly forced into a position of passivity during the asylum process, repeatedly uttering the words, “I have no choice” as an explanation of their physical and emotional destitution. In this position, homelessness, destitution and disenfranchisement often become internalized, adding to pre-existing psychic disturbance (Adlam, 2005).

The survivor, caught up in the process commonly finds him/herself in the position of passive recipient, having things done to, or done for, him/her, resulting in an ongoing lack of autonomy and potential vulnerability to further abuse. The impact of disbelief has a deeply damaging effect and accusations of fabrication are devastating, reinforcing a sense of silent passivity and giving rise to a sense of madness, both internal and external, to which words cannot do justice. Such a climate of disbelief has a profoundly disturbing impact upon a person’s ability to trust and to engage in meaningful relationships, disrupting a sense of meaning and faith in self and other.

Beneficence/Non-malfeasance

The principles of beneficence and non-malfeasance are fundamental ethical principles of all health and social care and are key to the establishment of any therapeutic relationship. The start of any therapeutic work with this client group begins with a gradual process of re-humanisation that may or may not involve sophisticated therapeutic interventions. Due to the complexities of the asylum seeker’s daily existence, the therapist will often be required to work in new and creative ways, confronting difficulties that may not ordinarily be encountered.

Thus working with this client group raises any number of ethical questions and hurdles; one key aspect of many asylum claims is medical evidence. Although the standard of proof is low, the burden to achieve this standard of proof lies with the individual asylum seeker who has to prove his/her experiences of atrocity and loss and fear of future persecution. Mental health evidence, indicative of a person’s extreme distress and traumatisation, is often heavily relied upon by Home Office and tribunal decision-makers. Ordinarily the content of the therapeutic relationship remains strictly confidential but
therapists working with asylum seekers are routinely asked to supply medico-legal reports as essential components of the asylum seeker’s claim. To submit this evidence by definition involves disclosing deeply personal and sensitive information; to withhold this information could be to risk the person’s success in their asylum application. Credibility can be called into account and a claim disbelieved where a psychotherapist has refused to provide evidence of mental distress/trauma. Ethical principles of confidentiality, beneficence and non-malfeasance become deeply intertwined and perplexing. The asylum seeker will often be prepared to disclose any personal information in order to save their lives and secure future safety; the therapist may feel deeply uneasy about such disclosure. The client often enters the relationship in a state of extreme desperation, but with a tentative degree of hope that the therapist can offer a cure or resolution. When faced with such extraordinary needs, the therapist may feel inadequate, while the client may be inherently sceptical, full of mistrust and fear. The Western therapist may feel suddenly conscious of his or her nationality and skin colour and may experience a range of counter-transferential responses including inadequacy, impotence, shame, guilt and responsibility. The client may need much, much more than the therapist feels able to offer. Does this render the relationship impossible?

This article has endeavoured to point to the complexity of the work involved and the potential issues that may confront the therapist working with asylum seekers. The therapeutic relationship may be the only place in which the client experiences a sense of safety, belonging and beneficence. Should this be denied simply on the basis that the complexities are too great?

The terms asylum seeker and refugee are not used interchangeably within this article. However the terms victim and survivor are interchangeable and synonymous also with the terms asylum seeker and refugee.

References:

A pack of slavering, tautly muscular, yellow-eyed dogs run wild through an urban landscape, spreading fear and destruction in their wake. From where does this image come? Director Ari Folman’s quest to recover memories of the Lebanon war of 1982, in which he participated as a young Israeli soldier, begins with this dream vision. The film uses animation to tell his story and those of the ex-comrades whom he tracks down and interviews. He remembers that his first task was to shoot all 22 dogs in a Palestinian village, so that they would not raise the alarm as Israeli troops approached. In conversation with a psychologist friend, Ari realises that he has blanked out most of this period of his life - but the memories are beginning to re-surface in his dreams. The quest to recover his memories and the making of the film can be a kind of therapy for himself.

For anyone interested in the concept of traumatic re-enactment (what Freud called ‘the compulsion to repeat’) and its potential re-negotiation in psychotherapy (more of this below), this is a fascinating film. It is the use of animation that makes this film such a powerful testimony. The story is told using voiceovers, scenes of Folman talking with his ex-comrades, and flashbacks to their remembered war stories. Their memories and inner emotional states come to life before our eyes as cartoon images so that, as they speak, we are drawn into the landscape of their experience. We are there with one young soldier as he travels by boat to Lebanon - a young man of 18 travelling into a war zone. We are with him as he vomits with fear on the troop boat, as he enjoys high-spirited banter with his comrades, taking photos of themselves in their seemingly invulnerable tank. And then with him as his tank, incongruous on a beach, is hit by rocket-propelled grenades, his comrades suddenly killed before his eyes. Seemingly a lone survivor of the ambush, he hides behind a rock until darkness falls, then swims south under the stars until, at the point of total exhaustion, he swims up on to a beach and is, incredibly, re-united with his own brigade.

The animation has the counter-intuitive effect of making these experiences more...
real - or perhaps of communicating how surreal they are, how war destroys every attempt to narrate and make sense. We are told how the young soldier keeps himself psychically intact - by maintaining himself in dissociation, in a kind of camera perspective: he frames what is happening in front of him as scenes, as if from a film.

Peter Levine, well known for his pioneering psychotherapy work with trauma, suggests that traumatic experiences, if unprocessed, will press into our lives as (occasionally uncanny or synchronistic) re-enactments:

'The drive to complete and heal trauma is as powerful and tenacious as the symptoms it creates. The urge to resolve trauma through re-enactment can be severe and compulsive. We are inextricably drawn into situations that replicate the original trauma in both obvious and unobvious ways. The prostitute or “stripper” with a history of childhood sexual abuse is a common example.... Re-enactments may be played out in intimate relationships, work situations, repetitive accidents or mishaps, and in other seemingly random events.... Much of the violence that plagues humanity is a direct or indirect result of unresolved trauma that is acted out in repeated unsuccessful attempts to re-establish a sense of empowerment.'

Levine, 1997: 173-1752

After returning to the States, every July 5th (that he did not spend in jail), the man had re-enacted the anniversary of his friend's death. In the therapy session the vet experienced grief over the loss of his friend; he then made the connection between Jim's death and the compulsion he felt to commit the robberies. Once he became aware of his feelings and the role the original event had played in driving his compulsion, the man was able to stop re-enacting this tragic incident.

Ibid: 82

In Waltz With Bashir the use of animation foregrounds both the process of dissociation and the route back to remembering and re-negotiating trauma. We are drawn into something much more clearly personal, constructed, and therefore intimate, than the apparent ‘reality’ of cine photography. There is also an implicit reference to Art Spiegelman’s graphic book Maus (1995), which uses the cartoon or graphic novel format to describe the experience of a family of mice in Hitler's Germany, with the Nazis depicted as cats.

One of the most striking stories in Levine’s book is that of a Vietnam veteran. At 6.30 am on July 5th in the late 1980s, this man was arrested for ‘armed robbery’. Holding his finger in his pocket to simulate a gun, he attempted to rob a convenience store. At the police station it emerged that he had committed 6 other robberies over the past 15 years, all of them at 6.30 in the morning on July 5th. He was admitted to a veteran's hospital where he was seen by a psychiatrist, who specialised in post-traumatic stress disorder. They discovered that his platoon was ambushed in Vietnam, with all his comrades being killed, except him and his friend Jim:

'But darkness fell and helicopters were unable to evacuate them. They spent a terrifying night together huddled in a rice paddy surrounded by the Viet Cong. At about 3.30 in the morning, Jim was hit in the chest by a Viet Cong bullet; he died in his friend's arms at 6.30 on the morning of July 5th.'

As the story of the massacre of 3,000 Palestinian civilians by Phalangist militias, ostensibly avenging the assassination of their revered President Bashir Gemayel – and the Israeli army's unconscious and passive complicity in this massacre – unfolds before us, the link between the Jewish experience of atrocity and trauma is made: as those Palestinian women and children streamed out of their refugee
camp, ‘it looked just like those photos of the Warsaw Ghetto’, says one of the Israelis interviewed by Folman.

At this point, the cartoon suddenly changes into cine film. But our usual dissociative distancing has been removed, so that we now encounter these images in a shockingly immediate way. Like soldiers, we are numb to the images on our TV screens because they register in much the same way as any other screen killings, whether ‘real’ or fictional. For these survivors of atrocity there will be, as yet, no comparable process of therapeutic remembering and coming to terms.

Of course there are more than individual and collective psychological factors at stake in the conflict between Israel and its neighbours – there are also deep-rooted and intractable religious, cultural, historical, political and economic obstacles in the way of finding a peaceful resolution to the problems. But this is an intensely powerful and moving film, which brings home the psychological mechanism of war - in particular the cycle of trauma and revenge and its devastating human consequences. Yet the message of the film is not dispiriting. For me – a secular Jew- the film is hopeful: for here we have an Israeli Jew who is doing the work of conscious remembering, making the link between the Jewish experience as victims of atrocity, and the Israeli army’s inaction in Sabra and Shatila, which did nothing to prevent a parallel atrocity against Palestinian civilians (Kahan Commission).

As I’m writing this review, Israeli jets are again bombing Gaza. The tragic cycle of trauma and retaliation continues. If there is a way forward, it might be through remembering our common fragile and mortal humanity. This humane and thoughtful film makes an important contribution to that remembering.

Steve Silverton

References


The Kahan Commission of enquiry into the events, established by the Israeli Government, found the Israeli authorities indirectly responsible for the massacre, having ignored ‘the danger of bloodshed and revenge when [they] approved the entry of the Phalangists into the camps as well as not taking appropriate measures to prevent bloodshed’. The full report can be read at:
Set in 1980, the film opens on a sprawling and primitive West Texas landscape. From his perch high up in the rocks, welder, hunter and Vietnam veteran, Llewelyn Moss (Josh Brolin), sets his sights on the antelopes grazing below. When he goes down to track the wounded animal, he stumbles on a scene of carnage and mayhem: abandoned pick-up trucks, a dead pit bull and several dead Mexicans; a drug deal gone horribly wrong. Moss knows that where there is heroin, there is money - $2,000,000 to be exact – which he finds. The lucky/unlucky soft-spoken Texas cowpoke/hunter stumbles across a veritable fortune in drug money only to be relentlessly pursued by a psychopathic killer.

What has been described as horror/comedy/chase, this film has all the hallmarks of the Coen brothers at their best. In the traditions of Blood Simple (1984) and Fargo (1996), this is a story of violence, humour, bungled crimes and simple people getting involved beyond their capacity.

Sheriff Ed Tom Bell (Tommy Lee Jones) is a small-town country sheriff, following in the footsteps of his deceased sheriff father. He is a product of earlier and simpler times and seems jaded, wistful and bewildered by what he discovers. When his deputy remarks on the bodies in the desert: ‘It’s a mess, ain’t it Sheriff’ he replies: ‘If it ain’t, it’ll do ‘til the mess gets here’.

Meanwhile, psychopathic killer Anton Chigurh (Javier Bardem) wants his money and nothing or no one can stop him. Within the first five minutes of the film, he has violently strangled a policeman, and shot an innocent driver. He remains both a dominant and elusive character throughout the film and his connection to the money, drugs and murders in the desert is never made clear. He cuts an alien and chilling figure – dressed in black and sporting a strange and decidedly creepy page-boy hair cut – in a landscape of cowboy boots and Stetsons. The adage of the old Wild West was that life is cheap; this is certainly borne out in the brutality and seeming senselessness of Chigurh’s bloody rampage. Sheriff Bell is the antithesis of Chigurh. He doesn’t understand all of the death and destruction laid at his feet. He longs for a time when murders were easy to track and solve; a time when crime made sense.

The cinematography, by Roger Deakins (a staple of the Coens’ films), is sumptuous and acts as a backdrop to
the relentless tension of the film, evoking images reminiscent of Edward Hopper’s paintings of lonely gas stations and hotel rooms, and the panoramic landscapes of Ansel Adams’ America. That there is no soundtrack to this film adds to its tension.

Performances by Tommy Lee Jones, Javier Bardem and Josh Brolin are outstanding. Jones and Brolin embody the quintessential Texan, at either end of the spectrum (both actors are originally from Texas and identified very strongly with their characters). The Spanish actor Javier Bardem, (a relative unknown in the US) plays the ultimate outsider, and deservedly won Best Supporting Actor at the 2008 Academy Awards. Supporting roles by Woody Harrelson (as Carson Wells, the spookily intelligent Private Detective) and Kelly Macdonald (as Moss’s feisty wife, Carla Jean), both deserve mention. Adapted by the Coens from the novel by Cormac McCarthy, this was a book deemed impossible to rework for the screen. Notwithstanding, they have done a sterling job.

This is a very violent film but it is not a film about violence or the nature of evil, nor is it a film about the inner workings of the psychopathic mind. Most striking to me – and also a Coen brothers’ trademark – was the banality, randomness and ‘ordinariness’ of violence. Innocent people simply in the wrong place at the wrong time; hapless bystanders caught up in something they never could, nor would, understand. It is a very one-to-one violence where the victim and killer are in relationship, albeit very briefly. This is very chilling to watch.

Whilst totally engaged throughout, I was surprisingly undisturbed by this film. Despite the gorgeous lighting and scenery, powerful performances by a very tight cast and a great script peppered with humble, down-home humour, I was left unmoved and a little disappointed. Not by the ambiguous ending, but by the stark lack of humanity. Perhaps this is the point.

If this is anyone’s story, it is the Sheriff’s. A man confused, distressed and saddened by the dichotomy between the old and simpler ways of the West and the brutality of modern life. His is the only human face in a landscape of greed, violence and purposelessness.

Ultimately, he is crushed by it, as is evidenced by the two dreams he tells his wife in the closing moments of the film.

In the end, I was left feeling this is a powerful film that should have been ripe with poignancy; a film that thinks it is deeper than it actually is. I would highly recommend it, but like many Coen brothers’ films, I wouldn’t look too hard for meaning. Just enjoy the ride.

Nancy Browner

… a character study …..

The Coen brothers have taken the classic cowboy archetype - a loner with a wrong to right - and spun it on its head. We do not know anything about Chigurh’s past. His actions tell us he is a psychopathic mercenary with paranoid delusions. He represents an anathema to those of us who seek to make meaning or find connections with the past; and yet he remains an object (a clever trick of projective identification) onto which we can project and fantasise about. His violent actions drive the plot.

(continued)
Psychopaths are eternally fascinating mostly because they operate in a world with no rules and no fear of consequences. They do exactly what they want and have no compunction about manipulating and forcing others to achieve their end. This need to be in control, to have power, is vital to their existence. People become things or, in the case of Chigurh when he kills, lowly animals, like cows going to slaughter. Chigurh plays a game with himself and his victims and uses the toss of a coin (signifying fate) to disown and defend against taking responsibility for the murderous acts he commits. He argues that he does not decide who lives or dies but that fate or God determines it when the coin is tossed. "I got here the same way the coin did", he tells Llewellyn's wife when she refuses to choose heads or tails to determine whether she lives or dies. Chigurh's omnipotence demands "respect" from whoever he meets. A harrowing exchange between him and the owner of a gas station allows the audience to witness the apparent random sensitivity of Chigurh's narcissistic rage. He is no-one's "riendo". He is above that. And my fantasy might have me believe that as God's messenger, he experiences himself as safe and able to live out a grandiose defense.

Deborah Davies
Bodies in Treatment: The Unspoken Dimension
Frances Sommer Anderson (editor)

The Analytical Press 2007 (Relational Perspectives Book Series)
pp273 £27.99 (Hardcover)
ISBN 978-0-8816-3448-8

*Bodies in Treatment* is a follow-up to *Relational Perspectives of the Body* (Analytic Press 1998) that introduced working with the body and emotions from a relational perspective. The central theme in this new book is the body in relation to trauma and it felt at times like reading a Body Psychotherapy book - especially the essay by Graham Bass who describes using a ‘hands on approach’ in a session with a client. Touching a patient in psychoanalysis is, at least in this book, no longer a taboo! The reader is introduced to a range of body-based treatments that are used either to complement or as an integral part of psychoanalytic treatment. This is a step-change, signifying a shift both from traditional psychoanalytic practice and from psychodynamic and humanistic approaches. Throughout the book we are introduced to an approach that does not favour verbal over non-verbal communication; furthermore, experiences in the non-verbal domain are seen as essential steps in the process of reintegration.

The editor gives a personal account of being at the receiving end of body-based treatments while undergoing psychoanalysis. Her remark that many of the body practitioners did not have sufficient interpersonal skills to work at a relational depth that, in her view, is necessary in trauma work, is food for thought. Nonetheless, treatments like the Alexander Technique, bioenergetic techniques combined with Kundalini yoga, biofeedback etc played an important part in her quest to uncover and integrate her traumatic experiences in a way that psychoanalysis was not able to do. It was her experience of the limitations of traditional psychoanalysis that motivated her to produce this book.

**Part One** explores ways of attending to ‘bodily experience’ that serve to support
and strengthen a client’s bodily or ‘core’ self. William Cornell shows how this aspect of self can be strengthened in therapy: for example, he had a client mimic different characters from one of her own drawings she brought to a session. This enactment enabled her to grasp feelings and sensations which she had previously forbidden and which had therefore been out of her awareness. The acting of different characters awakened feelings that had been stored in her ‘implicit memory’. This vignette demonstrates the undoing of another common analytic taboo: getting a client to act as opposed to talking in a disconnected way. Wilma Bucci’s essay provides theoretical underpinning for this new way of working. She relates ‘the unspoken dimension’ to multiple code theory: for example she suggests that experiences are stored on symbolic and sub-symbolic levels and regards these as being on an equal footing rather than lower and higher brain functions. This non-hierarchical way of looking at experience seeks to use language that connects intuitive and visceral levels in contrast to traditional, rational ways of using language.

Part Two introduces the reader to body-oriented techniques such as Pat Ogden’s and Peter Levine’s trauma work, dance and authentic movement, yoga, cranio-sacral therapy, and polarity therapy. This part of the book is very useful for psychotherapists who are seeking to integrate a body-based therapy into their clinical work. Christopher Eldredge and Gilbert Cole present trauma work that concentrates on tracking body sensation, arguing that ‘memory, affect, and image arise from a deep somatic source, not a verbal or narrative source’ (p.80). They present five different techniques that can help a client to focus on bodily experience. Maria Paola Pacifi’s essay describes long-term analytic work with an anorexic young woman, where dance and movement was crucial in helping to enliven her depleted, lifeless body and enabled her to build a new authentic self. Patricia Gerbarg introduces a wealth of research on yoga in connection with trauma. The benefit of using Sudarshan Kriya Yoga (SKY) as an adjunct to psychoanalytic treatment is illustrated in her long-term work with a client who suffered from PTSD. She suggests that yoga could play a vital part in a therapeutic plan because:

‘therapeutic breakthroughs may be catalyzed, particularly in cases where trauma-related schemas have remained inaccessible to persistent psychoanalytic approaches.’ (p.143)

Continuing with trauma work, Graham Bass, as mentioned above, uses cranio-sacral therapy as a means of helping a client become aware of, and learn to integrate, traumatic experiences. He also says that the same form of bodily integration of dissociated affects can be facilitated in an attuned psychoanalytic setting; however, based on my personal experience of having received touch, as well as using touch as an integral part of my client work, this does not ring true and the question as to whether or not touch adds another dimension is an interesting debate. Helen Newman’s essay, the last in part two, introduces the reader to polarity therapy in conjunction with psychoanalysis. She works with the five elements: ether, air, fire, water and earth. Her clinical vignettes demonstrate how these elements can be applied to individuals’ histories: for example, ‘a person whose parents died during childhood might have suffered a blow to his earth element and the work may consequently centre on helping him to feel more grounded.

Part Three explores yet other ways into the ‘unspoken dimension’, paying attention to bodily experience in the form of movement, vocal rhythms and facial expressions. Steven Knoblauch describes a mutually transformative moment in a piece of client work which he calls the
helping a client to feel more grounded. ‘tipping point’; by this he means a moment of unusual emotional intensity that marks a shift in consciousness - the equivalent to Daniel Stern’s concept of a ‘now moment’. Gianni and Susanna Nebbiosi focus their analytic work by observing clients’ rhythmic movement patterns. They found that miming a client’s postural pattern in a supervision context has helped them to encode and understand the non-verbal communication. This approach is based on contemporary parent-infant research and the recent discovery of mirror neurons in the brain.

‘Based on these studies, it appears that the sharing and communication of emotions takes place largely through our patients’ body movements, and this process is mainly relational.’ (p. 223)

Part Four outlines ways of bringing the body into therapeutic dialogue, and suggests that this approach challenges many mainstream methods. Jean Petrucelli advances the topic from a clinical perspective and raises awareness of the simple truth that we all have feelings about our physical body as well as our therapist’s body. This is often difficult to talk about and she suggests that:

‘By bringing a consciousness of the therapist’s body into the therapeutic dialogue, we have a chance to recognise how patients disown their bodies: their feelings of insecurity, shame, humiliation, self-hatred.’ (p. 242)

Adrienne Harris and Kathy Sinsheimer write on the topic of the analyst’s self-care. Both authors point out that listening to our clients’ emotional distresses and fantasies, often for several hours a day, may affect the practitioner’s emotional and physical health. They recommend that psychotherapists seek self-care in the form of peer support and/or find ways of nurturing their bodies in massage, yoga or writing.

Overall, I found Bodies in Treatment a well-written and well-structured book in which there is a good balance between theoretical concepts and clinical examples. The vignettes bring the often quite complex theories alive. The book’s main message is that, in order to promote integration and healing, trauma work needs to happen not only on a relational level, but also on a bodily level. The variety of body treatments that are explored in the context of psychoanalysis is at the cutting edge of integration. I wholeheartedly recommend this book to psychotherapists, educators and body-based health practitioners who seek to find effective ways of working with trauma.

Brigitta Mowat

References
Sheila Haugh and Stephen Paul have done an excellent job of bringing together in one book nineteen separate discussions on how different modalities consider the therapeutic relationship. Yet, however particular the theory might be, the common denominator remains the client. "[The] therapist becomes less reliant on 'external' theory and more reliant on their immediate interaction with a client." Each chapter considers a particular modality from the perspective of a well-established, inspired practitioner; for instance, Ernesto Spinelli engages the reader in a discussion on his view of how the client-therapist relationship sits within existential psychotherapy. The book embraces a broad spectrum of approaches - Gestalt, CBT, transpersonal, non-western, group, political – and, by providing an informative historical, theoretical exploration of a particular school and how it applies to the therapeutic relationship, is an excellent resource for understanding different modalities of practice. Also provided within each chapter is a section on recent theoretical developments and where a particular approach stands with regard to research. Since most chapters consider what their growing edge or "challenge" might be, I felt, as a practitioner, reinvigorated and reconnected with core humanistic approaches and up to speed in a variety of different modalities. The relational quality of the writing pulled me into a discussion with myself, one that I now bring to colleagues. A useful bibliography accompanies each chapter.

Embedded at the heart of the book, and in harmony with the
other viewpoints expressed, is a chapter written by Geoff Pelham on *The Relational Approach*. Emerging in the 1980s from psychoanalytical thinkers, the relational approach focuses on "two-person" therapy, a therapy which is co-constructed between therapist and client and which considers questions of countertransference and "who does that feeling belong to? me? or the client?" as not recognizing the mutuality of the relationship. Pelham warns that even as the focus is on the co-created relationship, the wider social reality must not be lost – a concern echoed by other contributors. The external reality of the clients must not be overlooked; questions of power (whether within the room between therapist and client or in the external life of the client) and diversity (culture, gender, sexuality, race, class) must be made conscious and worked with. Haugh and Paul identify questions of power and diversity as central to their joint project, and indeed if there is a theme running through these chapters I would say it was this and a push for a more "actualizing paradigm" as opposed to a "reactive paradigm". Nick Totton, in his chapter on *Therapy in its Social and Political Context*, recognizes the extent of these under-considered issues within the psychotherapy community when he describes how many therapies seem to happen in a social and political vacuum; Yukishige Nakata offers us an opportunity to consider diversity in his essay on *A Japanese Perspective*, revealing a viewpoint that acknowledges how helpful psychotherapy can be for Japanese clients while still being viewed as "culturally-distant" to Japanese culture. Indeed there is an opportunity to acknowledge a different, even foreign perspective within psychotherapy. This collection of essays offers us such an opportunity.

**Deborah Davies**
This book offers fascinating information about the use of prayer in the world of counselling and psychotherapy; it is based on the author’s qualitative research - interviews for the most part - and summaries of existing literature on the subject.

While more than fifty percent of BACP accredited counsellors and psychotherapists use prayer as part of their practice, they do not necessarily invoke prayer as an intervention during a session. Thirty-seven percent reported praying quietly for guidance during a session and others have used prayer as a source of personal strength or as an intercession on behalf of a client; only six percent said that they had on occasion used prayer as a psychotherapeutic intervention. These are just some figures Gubi provides from his research but he is truly inspiring when he discusses questions of human relatedness and the spiritual dimension in the counselling relationship.

The book includes a wide range of examples on how prayer influences counselling practice and discusses in great detail its benefits and dangers as a therapeutic intervention. For example, as a feminist theologian, I was struck by comments on the use of ritual; some feminist theologians have emphasised the importance of ritual in order to deal with the loss of a child during pregnancy or a miscarriage and my own research provided evidence that Anglican women priests, other Christian female ministers and women rabbis have, on occasion, been involved in creating rituals for life cycle events that particularly - but not
exclusively - affect women (Blohm, 2006). This book advises that while ritual may be helpful when dealing with loss, it carries the risk of providing people with false hope for final closure or serving to discourage them from talking about their loss.

I agree with the author that psychotherapy has at its origin spiritual roots and many people who previously may have felt drawn to ministry are now seeking psychotherapy training instead. The Jewish and Christian roots of major psychotherapeutic schools are in my view obvious to anyone familiar with these traditions. Nevertheless, the fact that psychotherapy’s founding fathers and mothers had often turned their back on their religious roots impacts on the profession to this day; research suggests that practitioners who do use prayer often decide not to bring this to supervision because they feel that it goes against the culture of what is accepted in psychotherapy circles. This is worrying since prayer like any other intervention can be very destructive when used without peer review. Even though Gubi’s interviewees on the whole appeared to be very thoughtful in their practice there were examples when I found the use of prayer inappropriate.

When working in Christian ministry I have always been cautious about the use of prayer in pastoral situations; I feel when praying with people it is important to ensure that they feel comfortable. In my own view, using prayer to send messages to other people rather than a deity is inappropriate and I therefore felt very uncomfortable when I read that some counsellors do just that. During my pastoral training course in a hospital setting I learned that prayer, performed with sensitivity and sincerity, may sometimes indeed be helpful and welcome and this book quotes research on the benefits of prayer for general well being. This should not be taken to mean that prayer offers instant healing, rather that it can enable people to live their lives from a new perspective.

Having read Gubi’s book, I am still not convinced that I will use prayer when working as a counsellor or psychotherapist in a secular setting. In a pastoral capacity, however, I will continue to pray with people. Interestingly, the author has not used prayer as part of his practice even though he respects the integrity of those counsellors who do.

This book is important for anyone who uses prayer as an intervention and for supervisors and people working in training. It is vital to create an atmosphere in training and supervision where practitioners feel free to discuss issues of spirituality and religious practice in their work. Even though predominantly Christian, the book is a worthwhile read for anyone involved in pastoral care in a religious setting as it highlights the dangers and benefits involved in using prayer as a pastoral tool.

Uta Blohm

References
Patrick McGrath’s new novel *Trauma* continues a longstanding preoccupation with madness, incarceration and psychiatry most familiar from his earlier works *Dr Haggard’s Disease* and *Asylum*. Billed as a psychological thriller, McGrath’s skills lie in the cool and polished way he peels away the layers of confusion and disturbance in his characters. Added to this, his ‘unreliable’ narrator and trademark gothic touches lead to an assured tale in which the reader feels in safe hands from the start.

Set in the New York of the 1970s *Trauma* features Charlie Weir, a psychiatrist specialising in trauma with Vietnam veterans, in which the stories of Weir’s clients and that of himself unfold in parallel narratives. In the wrecked lives of the veterans he treats, war experiences are re-lived daily, years later. The focus is on the spiralling downwards of two of his clients, one the brother of Weir’s wife, who commits suicide while in group therapy and another who jumps from a building and survives. Weir’s own life mirrors this downward path. Unable to shed his fixation on his early family history we learn of his hatred of his drifter father, love and loathing for his mother and his complex relationship with his older brother, now a successful artist. Muddled memories and hazy dreams of his own childhood trauma continue to plague Charlie as his marriage collapses, his clients disintegrate and his girlfriend falls prey to nightmares and violent outbursts.

A Manhattan backdrop, references to the squalor of New York and frequent nods and reminders of the Twin Towers (even though the action takes place in the 1970s) lead us into street-scapes of rubbish and decay and the sense of incipient collapse. Charlie’s own demise is signalled by his brother-in-law’s suicide, although there is an abiding sense of the precarious nature of sanity and the possibility that at any moment any one of the characters could slip, or jump, into an abyss.

McGrath’s Freudian pointers are somewhat clunky; for example the air in...
Charlie’s mother’s basement ‘smelled stale and slightly rancid’. He adds: ‘It would have been a dull-witted psychiatrist who failed to recognise this as a representation of the unconscious mind’. In fact the psychological back story in which issues around trauma therapy are explored is weaker than that of Charlie’s own web of dysfunctional relationships, and as the novel proceeds we realise we are reading about his own unpicking of a personal trauma narrative rather than that of his clients.

The book’s strength is in the escalation of a steamy claustrophobic atmosphere and deft, careful characterisation along with the developing parallel worlds of his characters. This is not to discount the unsavoury pleasure to be derived from watching a man who trades in psychological insight unravelling through lack of self-knowledge; *Trauma* delivers this in spades. From his attempt to be his girlfriend’s therapist to the final revelation about what really happened to him as a child, Charlie Weir stumbles downwards within his own alienated mind-scape. Oddly, given the restrained and accomplished tone of the novel, it failed to deliver a sense of true threat and menace. This reviewer simply did not care too much about what happened to Charlie, and found the gothic ‘reveal’ at the end somewhat unsatisfying and hurried. Nonetheless, this is a rewarding and interesting novel from an assured writer.

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