*The legacy
of shame 08*

Plus

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From the *Editor*

NAOMI CAINE

Regulars

I recently read *The Burden of Heritage: hauntings of generational trauma on black lives,* by Dr Aileen Alleyne. The book explores the impact of centuries of colonial slavery and oppression on black lives – an historical trauma that is continually re-enacted in the present.

Aileen explains how the generational trauma of the past shapes black racial identity, often resulting in shame. She also offers suggestions on how to work therapeutically with the burden of heritage and heal from the trauma wounds.

> *'The book helped me to look at the effect of colonial oppression on my own, white identity'*

The book focuses on black lives, as it should. It would surely be another type of oppression if the book were to privilege the white perspective. But that doesn't mean it should be read only by black therapists. As Aileen writes: 'Black people's trauma has its genesis in white, colonial, historical oppression. Healing is therefore not a one-sided task for black people alone...'

Aileen has kindly allowed us to publish an extract from her book in this issue of the journal. It's challenging, so I encourage you to think about where and when you will read it – and to pay heed to any emotions it provokes. I hope the extract on p8 inspires you to read the book, which is bold and beautiful, a compelling mix of theory, personal reflection and practical tools.

I recognise that I am commenting from a white viewpoint, but the book not only gave me an insight into the effect of generational trauma on black lives but also helped me to look at the effect of colonial oppression on my own, white identity. The shame it aroused was certainly uncomfortable, but I am just as certain that it must be acknowledged.

Stress and burnout are common among NHS nurses, which perhaps explains why staff morale is often low and staff turnover often high. Graham Music, Jennie McShannon and Kay Trainor write on p16 about a therapeutic intervention in the acute assessment unit of an NHS hospital.

The authors describe the individual and organisational defences that were erected against the anxieties of working in a setting where death was ever present. They also explain how space was created to express and manage some of the difficult feelings and experiences, resulting in better communication within the unit and a greater appreciation of the skills of the nurses. And yes, staff retention rates improved.

Do you understand the potential impact of menopause on mental health? Do you ever discuss menopause in the consulting room? No? Perhaps we are too intently focused on the individual to attend to the context. Or maybe we overlook the impact of menopause on psychological wellbeing, as a result of ignorance, shame or even misogyny.

Dr Jane Simms advocates for change. In her article on p24, she asks us to deepen our understanding of menopause and its symptoms – and to bring menopause into therapy. We can then offer our clients empathy and compassion, supporting them to navigate this transition in their lives.

If you've ever wondered whether group therapy is effective, Natalie Wilcox's article on p29 might offer you some answers. Natalie was recently asked to evaluate a loss group run by an NHS Talking Therapies service – and the outcome data showed consistent and encouraging results.

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In touch *with your BACP*

Workshop explores race and culture

Counsellors who want to develop their knowledge and awareness of race and culture are invited to an online Professional Development Day (PDD) on Thursday 28 March, from 9.30am to 1pm.

The workshop will be led by Mamood Ahmad, a therapist, author, trainer and founder of The Anti-Discrimination Foundation (www.tadf.co.uk). The event is split into three, 45-minute sessions, which will each be followed by a live Q&A with Mamood.

The first session will introduce core concepts and challenges. It will also help you situate your own collective and intersectional position. The second session will enable you to begin reflecting on your own racial-cultural context, racial-cultural identity and attitudes towards the social construct of race. The third session will ask why core competence is essential and what it takes to be core competent, while acknowledging the continuous process of learning.

The PDD costs £35 for BACP members and £70 for non-members. For more information and to book a place, please visit: www.bacp.co.uk/events/opdd280324-online-professional-development-day-race-and-culture-core-competency-are-you-ready/

NHS guidance recommends CBT for menopause

Women should be offered cognitive behavioural therapy (CBT) to help manage problematic menopause symptoms, according to draft guidelines.

The proposed guidance to GPs from the National Institute for Health and Care Excellence (NICE) highlights evidence that CBT can help reduce menopause symptoms, including hot flushes and night sweats, depressive symptoms and sleep problems.

The draft NICE guidelines on menopause suggest CBT could be considered alongside, or as an alternative to, hormone replacement therapy (HRT). NICE adds that women should choose which treatments in its guidance work best for them, and discuss the benefits and risks with their doctor.

Dr Clare Symons, BACP's Head of Research, said: 'This is a promising start in recognising how talking therapies can have a positive impact on the lives of women going through the menopause.

'We should also be exploring and understanding the benefits of a range of types of therapy. There is limited but emerging evidence that different therapeutic approaches can also help women going through the menopause in a variety of ways. There is an urgent need for more research in this area.

'The draft guidance also requires additional investment, including the commissioning of more counsellors and psychotherapists.'

For the first time, the draft guidance specifically refers to trans men and non-binary people registered female at birth. The current guidance, which dates back to 2015, only mentions women experiencing menopausal symptoms.

How to protect against cyber risks

Many practitioners in the counselling professions are concerned about the cyber risk to confidential client data. But we often don't know how to enhance our cybersecurity skills. In a member blog, *Staying Safe in a Digital Era*, Alexandra JS Fouracres, a cybersecurity consultant, who runs her own coaching and mentoring practice, encourages us to get cyber savvy. She also offers some tips, such as setting up multiple barriers to protect our online conversations, data and systems. To read Alexandra's blog, visit: www.bacp.co.uk/news/news-from-bacp/blogs/2023/9-november-staying-safe-in-a-digital-era/

BACP joins call to address racial inequalities

BACP welcomes the call for urgent action to address ethnic inequalities in access to NHS Talking Therapies in England. Psychotherapy services need to be better tailored to meet the needs of Black and minoritised ethnic groups, according to a report by National Collaborating Centre for Mental Health and NHS Race and Health Observatory.

The report, based on 10 years of service data and patient experience, also found that, despite initiatives to redress longstanding inequalities, people from racialised communities continue to experience longer waiting times, lower rates of treatment following referral and worse outcomes from NHS Talking Therapies, compared to White British groups.

Our 2022 policy paper, *Race for the Soul of the Profession: tackling racial inequalities in the counselling professions*, highlighted inequalities in training and progression for counsellors, as well as the value of culturally appropriate therapy.

We recognise the complex and systemic factors that contribute to enduring inequalities in access and outcomes for people from racialised communities – and back the call for urgent action from Government, commissioners and services.

We also agree that the best way to address these inequalities is by making better use of local data to improve access and enhance understanding of mental health inequality. Recruiting culturally sensitive and ethnically diverse therapists should also be a priority.

Jeremy Bacon, our Third Sector Lead, said: 'We'll continue to pressure the UK Government to invest in local community-based counselling services, including high quality, accessible and culturally sensitive services to people from marginalised community backgrounds and those at greatest risk of psychological distress and mental ill health.'

Learn more about groupwork

When did you last attend a therapeutic or personal development group? Last week? During your training? Never? Do you remember what was helpful and what was not? Did you find it useful when you truly felt touched and understood by another member of the group? Was it frustrating or even soul-destroying when the facilitator kept silent, in spite of direct requests for input?

A Professional Development Day (PDD) in Manchester on Tuesday 5 March aims to broaden your knowledge of the theory and practice of working with groups.

The presenter is Dr Faisal Mahmood, a UKCP registered individual and group Gestalt psychotherapist, an accredited member of BACP and a UKCP-approved clinical supervisor. Faisal is also a senior lecturer in counselling/psychotherapy at Newman University (Birmingham) and runs a private practice in Solihull.

The main aims of the PDD are to:

- offer a critical introduction to different theoretical concepts of working with groups
- explore different types of groupwork interventions
- consider critical group concepts.

The event runs from 9.30am to 4.30pm and costs £95 for BACP members and £170 for non-members. A reduced rate of £60 is available for students, those in receipt of a state benefit or the unwaged with no personal income. For more information and to book a place, please visit: bacp.co.uk/events/pdd1010-professional-development-day-working-with-groups/

Working therapeutically with domestic abuse

Working with a person involved in domestic abuse can be challenging. Domestic abuse often extends beyond physical violence. It can involve emotional abuse, destruction of property and isolation from friends, family and support.

It is also often witnessed by children – and there might be an overlap of violence or abuse between adults and children. With divided loyalties, there can often be unwanted acceptance of domestic abuse with family members.

A Professional Development Day (PDD) at the Leonardo Hotel Leeds on Thursday 7 March will challenge your views and approach to domestic abuse. You will gain a greater understanding of domestic abuse, the dynamics of relationships and the support available. You'll develop personal confidence and be able to identify and safely manage the risks in your work.

The presenter is Gary Williams, who served in the armed forces and police service for more than 30 years. As a detective inspector, he investigated many incidents of domestic abuse and has worked with numerous agencies, introducing initiatives to raise awareness and challenge domestic abuse, including perpetrator interventions and risk management models.

Since 2008, Gary has delivered domestic abuse training to a range of therapists, as well as NHS staff and other professionals. He is committed to helping therapists develop safe practices within domestic abuse work.

Gary is a member of BACP and works in private practice, providing therapy for survivors of domestic abuse, members of the emergency services and performing artists in the entertainment industry.

The PDD runs from 9.30am to 4.30pm and costs £95 for BACP members and £170 for non-members. A reduced rate of £60 is available for students, those in receipt of a state benefit or the unwaged with no personal income. For more information and to book a place, please visit: www.bacp.co.uk/events/pdd0703-professional-development-day-working-therapeutically-with-domestic-abuse/

Conversion ban missing from King's Speech

We are disappointed that the UK Government excluded its long-promised ban on conversion therapy from the King's Speech at the end of last year. We've long campaigned for legislation to outlaw conversion practices – and the omission follows years of Government inaction and U-turns.

We remain fully committed to championing a ban on these unethical, harmful and ineffective practices. We are also proud to stand alongside sector leaders to fight for legislative change within the Memorandum of Understanding (MoU) group. Igi Moon, Chair of the MoU Group, said: 'This has to be one of the most cruel and undignified ways to treat the LGBT+ community.'

However, a proposed ban on conversion therapy had its first reading in the House of Lords in November 2023. Baroness Burt of Solihull, a Liberal Democrat peer and Vice Chair of the All-Party Parliamentary Humanist Group, tabled the Private Members' Bill, *Conversion Therapy Prohibition (Sexual Orientation and Gender Identity)*, which was selected in the House of Lords ballot. The proposal will go through several rounds of voting in the House of Lords. If it receives enough support, it will then pass to the House of Commons.

Our policy team and the MoU Chair are engaging with Humanists UK to offer support to Baroness Burt, to ensure the Bill secures wide political backing.

Campaign trail

MATTHEW SMITH-LILLEY

The Scottish Government has recently published its *Mental Health and Wellbeing Strategy: delivery plan 2023-2025*, which outlines the strategy for the NHS in Scotland over the next two years. It has also published the *Mental Health and Wellbeing: workforce action plan 2023-2025*, which looks at the strategy for developing the healthcare workforce over the next two years.

The *Mental Health and Wellbeing Strategy: delivery plan 2023-2025* identifies nine, key outcomes that the Scottish Government will work towards over the next 18 to 24 months. The outcomes are:

- improved overall mental wellbeing and reduced inequalities

- improved quality of life for people with mental health conditions, free from stigma and discrimination

- improved knowledge and understanding of mental health and wellbeing and how to access appropriate support

- better equipped communities to support people's mental health and wellbeing and provide opportunities to connect with others

- more effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing

- increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs

- better informed policy, support, care and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery

- better access to and use of evidence and data in policy and practice

- a diverse, skilled, supported and sustainable workforce across all sectors.

The aims of the strategy are both sensible and admirable. But the lack of detail about how the outcomes will be delivered is disappointing.

Similarly, Scotland's *Mental Health and Wellbeing: workforce action plan 2023-2025* lacks sufficient detail about the workforce expansion targets and the recruitment of professionals to meet the rising demand for services.

As part of our work with the Scottish Government, we had the opportunity to see an earlier draft of the *Mental Health and Wellbeing: workforce action plan 2023-2025*. We therefore took the opportunity to express our concerns over the lack of specific workforce targets.

We'll continue to work with our partners in Scotland on holding the Scottish Government to account for the delivery of the strategies. We will also continue to advocate for greater opportunities for counsellors and psychotherapists within the NHS workforce, as well as for a wider choice of psychological therapies to be routinely available to service users in Scotland.

Cost-of-living roundtables

We have been running a series of roundtable meetings, focusing on building a greater understanding of the impact of the cost-of-living crisis on the nation's mental health.

The roundtable meetings will inform the content of our forthcoming report on the cost-of-living crisis, which will be made available to politicians, funders of services, organisations delivering services, BACP members and the public.

We are running six roundtables in total, each with a different theme. Themes include the impact of the cost-of-living crisis on employee's mental health and on the third sector.

We recently held a roundtable meeting at the Labour Party Conference in Liverpool, where we discussed policy solutions to tackle the mental health impact of the crisis. We were joined by politicians and stakeholders from across the mental health, social services and advice sectors.

The findings from our roundtables will also help us to strengthen political support for counselling and psychotherapy, as we move towards a General Election in England, and as we continue to work to influence mental health policy in Scotland, Wales and Northern Ireland.

Changes in the Department of Health and Social Care

In the cabinet reshuffle at the end of last year, Steve Barclay was replaced as Secretary of State for Health and Social Care by Victoria Atkins, who was promoted from her post as financial secretary to the Treasury.

Other new arrivals to the Department of Health and Social Care are Andrew Stephenson and Andrea Leadsom, who replaced Will Quince and Neil O'Brien. Maria Caulfield retains her position as Minister for Mental Health and Women's Health Strategy.

Counselling in schools in Northern Ireland

We have recently published a policy report, *The Case for Investing in Therapeutic Interventions in Northern Ireland's Schools*, which highlights evidence for the need to re-establish counselling services in Northern Ireland's primary schools.

The report brings together the voices of children, parents, teachers and school leaders, who back up the data on the demand, uptake and positive impact of counselling on children. The report is testament to the widespread support for accessible counselling and psychotherapy to be routinely available within schools across Northern Ireland. It also demonstrates a level of political unity, which is rarely seen.

You can read the report online at: www.bacp.co.uk/news/news-from-bacp/2023/20-november-charities-call-on-northern-ireland-s-political-leaders-to-prioritise-primary-school-counselling/

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The
legacy
of shame

Dr Aileen Alleyne explores the impact
of white, colonial oppression on black lives and
suggests how we can all work to heal from the
collective trauma of a shameful past

The black experience of transgenerational trauma has occurred over hundreds of years, rendering a group of people subjugated and enslaved for four centuries. The devastating impact of this insidious trauma and its negative transmissions are still being re-enacted in many aspects of black life.

The history of slavery is mostly argued from the point of view that it happened a long time ago and that we must learn to forget, leave it where it is and move on. Its present-day beneficiaries feel that they need not concern themselves with their ancestors' crimes and should be allowed to exist with no reminders of its presence, as being reminded risks both shame and guilt.

My contention is that this very disavowal is a great hurt, one that contributes to the ongoing nature and damage of transgenerational trauma, as having one's trauma recognised is the first step towards reconciliation and healing.

The non-recognition of black people's historical trauma by the white colonising world – and the rest of the world's non-acknowledgement of its impact on a human race – contribute deeply to an arrested state of being and thus development for the black diaspora. The continuation of this historical wound into present-day struggles is the hallmark of intergenerational trauma.

A major legacy of transgenerational and intergenerational trauma is shame and its impact on black identity wounding. Internalising the negative impact of racial oppression takes its toll and contributes to a general malady of the self.

Toxic shame
A particularly painful form of shame is one that, if left unaddressed, can become toxic and archaic. Unlike single-incident, shame-based situations, toxic and archaic shame stays buried within and becomes part of our self-identity. A person suffering from toxic shame will experience a chronic sense of worthlessness, low self-esteem and self-loathing – all connected to the belief that they are innately shameful or bad.

Toxic shame that stems from transgenerational trauma can be constantly aroused in the here and now, through repeated experiences of rejection and betrayal by a society that relegates minorities to the margins of humanity. It is a powerful internal enemy that acts to diminish the self and leads to either the individual or the group becoming apathetic and compliant with the status quo.

Working with toxic, archaic shame is challenging, principally because the practitioner will be working with both the individual and the collective aspects of shame trauma. For white therapists in particular, a mindfulness will be crucial, to avoid the rupture caused by re-shaming the shamed.

Shame cycle
I suggest that shame-based individuals have difficulty in achieving healthy individuation (the process of coming into and maturing into one's full identity), as they are locked in a damaging shame cycle. I suggest that such a cycle has four stages:

- shame is induced in individuals through interpersonal interactions that lead to the production of shame
- shame is internalised and eventually consumes our inner core
- the internalisation of shame creates a process of internally disowning parts of the self. Gershen Kaufman[1] labelled this 'splitting'
- splitting creates painful internal discrepancies that we attempt to correct, without much success, because the self-hate associated with the disowned, fragmented part creates repeated patterns and cycles, any time shame is triggered.

As practitioners, we need not only to understand these stages for ourselves but also to help clients develop a full awareness of their behavioural patterns. They can then gain an understanding of the work of letting go, reframing and using new and more effective tools for healthier living. To see how this works in practice, I wish to share an example of shame from my childhood.

On a bitterly cold winter's day, during the first week of my father's visit to England in 1963 – his maiden overseas trip – he took my baby sister out to the Caribbean market area of Peckham, south London.

'Working with toxic, archaic shame is challenging'

The story goes that my dad did not dress my sister adequately for this expedition, having, of course, no previous knowledge or experience of winters in a Western climate. He was apparently accosted by a group of white women, who were outraged at seeing a baby in a pram, without mittens and earmuffs.

My father meekly recalled the experience of being loudly chastised in the streets of Peckham, accused of child neglect, and marched down the street to purchase a new winter jacket, gloves and earmuffs for my baby sister. He recounted how the bunch of pushy women refused to leave the store until he had bought the items, dressed my sister in the warmer garments and listened to their rebuke to never ever do such a thing again.

While writing about this, I bristle with indignation at this missionary group of busybodies. I thought (and still believe) that the intent was honourable, maybe even loving. But the way it was done was humiliating to a black man newly arrived in England at that time.

When I recall my father's retelling of this story, his grovelling gratitude and indebtedness to the white women infuriated me. His crawling humility was typical of his generation of black people and their relationship to the colonial

'mother country' – a brainwashing into thinking and believing a superior morality and authority in the English. It's a mindset that leads the groveller to adopt an excessively subservient attitude, to the point where they become the inferior, bad and stupid one.

The mere recollection of this shame incident is potent enough to arouse again the powerful and familiar presence of 'racial hauntings', which occur after the actual experience of something injurious. The injury can come in the form of microaggressions, racism in any form, social injustice and the continual displacements, denials, projections and disavowed material of the white other onto black others.

The familiarity of these experiences for black people means they also open up something that is supposed to be in the past, namely the pain of brutal, historical, black/white relations, so it is experienced in the present – and it haunts the soul.

Linking this shame experience to the four-stage process of shame, it is important for therapists – especially white therapists working with black clients – to recognise that they will be working with some key elements of toxic shame. The risks of re-shaming the client are high, when trying to interrupt and break the cycle of the shame process.

Constant trigger
At the simplest level, the mere presence of the white face or the black face of the therapist might serve as a constant trigger for the client's shame. Therefore, the therapist's relationship with their own racial identity – and what this represents for the client in the transference – will have to be addressed.

At the more profound level, the therapist will re-shame and burden the client, if the work falls short of an engaged, attuned curiosity, an adequate working through and holding of the client's vulnerabilities.

Fostering an effective working alliance is key, and guards against any unconscious dynamics being acted out in the therapy. In addressing toxic shame and black identity wounding, it is even more important to make the unconscious element of the working relationship conscious, so that relational dynamics are not left unaddressed, to fester and produce more shame that invariably re-shames the shamed.

The main aim in addressing the shame trauma cycle that wounds identity is to enable the client to disentangle from the familiar destructive patterns of internalised shame, which keep the burden of heritage (the historical past) and generational hauntings (present-day racialised triggers) alive and impactful.

Wearing my therapist's hat today, I can make sense of how my father handled the trauma. The proud black man removed himself from his humiliation and emasculation through the unconscious mechanism of disavowing. But, in the disavowal, he unconsciously handed over his shame to me for safekeeping.

Identity trauma

Race-based shame exposes both blacks and whites, albeit in different ways. Black shame is essentially about identity trauma (hurt and loss). White shame triggers fear of identity exposure (guilt and vulnerability). When these unheeded dimensions are lived out (consciously or unconsciously) in the therapeutic encounter, it is often the case that the white therapist's shame disavowal is handed over to the black client for safekeeping.

Shame overarches much of what is difficult in black/white relations, and I believe the ubiquitous nature of shame is a driving force that brings clients to therapy. Shame resides wherever there is psychological pain.

Were I an adult client relaying my six-year-old first shame experience to a therapist, and specifically a white therapist, I would hope for several things to take place in the therapeutic processing that would make the experience an effective and healing intercultural encounter.

Here are some guidelines for therapists to meet this adult client in her early shame.

First, pick up the intergenerational trauma dynamic, so that I can see what I was carrying for my father, where I might be burdening myself and how I might be caretaking unnecessarily. The following interventions would focus the therapist's engagement with the client's shame experience and help strengthen the relational dynamics:

- what kind of man was your father? What were his views about white people before he visited England?

- tell me about your relationship with him and you being his first born

- what is your role in your family and what do you feel you hold for the other family members?

- how did the rest of your family respond to your father's encounter with the white women?

- which positive and negative characteristics of your shame heritage do you feel you hold onto, and which have you reframed?

- how does it feel to share and reflect on these painful experiences with me, your white therapist?

A full exploration using the above facilitation will signal to the client that the therapist is interested in them as a person and able to engage, hover and be curious, even when it is uncomfortable. It will also show that the therapist takes time to show genuine concern and offer encouragement for the full expression of feelings and experiences – and knows when to give primacy to important issues in the moment.

In addition, the therapist will demonstrate that they possess the intercultural stamina to go where other white therapists might fear to tread – and that they are comfortable enough in their own white skin to foster the transference at such close quarters and at a deep level.

My second guideline is to fully excavate the centrality of conflict in the shame experience. Clinically, it is paramount to give space to the 'wounded' shame-teller to fully exhume, retell and exhaust the shame experience at her own pace. The retelling should be allowed for however long is needed, so the client can spend time with the minutiae.

The most important person in the story is the client – not the colonial party. A therapist who cannot look the client's obvious race-wound in the eye, who alludes to a good deed by the white women or who equates the women's actions with strident feminists telling useless men how to get it right, would not provide the necessary holding and containment. The client would experience these interventions as deflection and avoidance. They would also highlight the therapist's own discomfort, disinterest or even unconscious racial bias, damaging the alliance and, ultimately, the therapy.

'Race-based shame exposes both blacks and whites'

Although adequate space is therapeutically necessary for the client to keenly feel the pain of the shame wound, the third guideline is to remember that the healing process can be achieved through being heard and understood by a holding and non-judgmental therapist.

It is important, however, that the white therapist is able to listen without appearing overburdened, overly shocked, disgusted or overzealous in their

The internal oppressor

Black internalised oppression is the process or action of absorbing (consciously or unconsciously) the values and beliefs of the oppressor and subscribing to stereotypes and misinformation about one's group. Such a process leads to low self-esteem, self-hate, the disowning of one's own and other minority groups, as well as other complex, defensive interpersonal behaviours that influence and impair quality of life.

I maintain that the internal oppressor – an aspect of self that becomes the inner tyrant or enemy – is distinct from internalised oppression. Like shame, the internal oppressor is an aspect of the self that holds onto historical and intergenerational baggage and re-enacts the trauma transmission through the generations.

Shame is inextricably linked to the internal oppressor. Shame says: 'I am bad, unworthy, not good enough, not lovable.' The internal oppressor is my internal adversary, my own enemy, my discrediting self.

In terms of black/white relations, the internal oppressor creates a post-slavery/post-colonial mindset that colours black people's dealings with the white other. It influences our inter-relational dynamics and attachment with this other – and may even collude unconsciously with the prevailing, external difficulties.

Crucially, the internal oppressor seems to be ever present but lies dormant for the most part. It is only when it is in contact with the external oppressive situation – real, perceived or a mixture of both – that the historical memories are reawakened, opening up old wounds that can lead to silent, invisible re-wounding of the self and identity.

Prejudices, projections, intergenerational wounds and the vicissitudes of our historical past are all aspects of this inner tyrant. They are kept alive within the transgenerational transmission of trauma, suggesting a degree of persistent, post-traumatic syndrome in black people's existence.

The legacy of black people's historical past, along with the burden of internalised oppression, both seem to play a crucial part in shaping pre-transference relationships and attachment patterns to the white other.

The picture being created here is one of the past and present, as well as external and internal factors, being inextricably linked and fused. The fusion can lead to forms of co-dependence, which I refer to as cultural enmeshment.

Societal perceptions of blackness carry many negatives and the impact on black people is varied. Some have come to expect this negativity and have adjusted to it through a process of transcendence. Others are constantly triggered into angry responses and act out their feelings. For others, the discomfort of living with this ever-present split (discrepancies between public and private identity) takes its toll and leads to inner disturbance, particularly if compounded by other present or latent personal difficulties and life struggles.

The puncturing of a black person's identity – their truth about how they truly know themselves and the contrasting negative ways in which society treats them – can destabilise a person's ontology, their mental balance and rootedness in being in the world. When it comes to race relations, the battleground is both personal and political.

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wish to repair wrongdoings on behalf of their white tribe. The chances are that the reactions will be picked up by the client as 'damaging' the therapist or, worse, a prohibition – something that is not welcomed in the work. In such circumstances, the client's own shame will be heightened. The client could also be left holding an unconscious servitude, the white therapist's shame-trigger and fragility.

Returning to my six-year-old shame experience, a therapist will fall foul of the shame disavowal dynamic by instantly jumping in and castigating the white women who shamed my father. Conversely, a therapist might feel the need to create a so-called balanced response, by trying to rationalise or prove the white women meant no harm and were being good citizens, while also giving space for the story to be told. Either of these responses on the part of the therapist is a therapeutic faux pas, which has the potential to re-shame the shamed.

The fourth guideline is that the therapist is able to show genuine curiosity and interest in exploring the psychological impact on a child who is left to hold – or who chooses to hold – a parent's shame, and how this continues to affect the parent-child relationship dynamics in different ways.

Number five – the therapist sensitively, and in a timely manner, explores whether there has been the potential for shame resonances in my outside world. An example of this would be in my interactions with white authority, checking for triggers or the activation of pain when being told what to do by figures of white authority. The therapist would be working with the activation of racial hauntings in this regard.

Finally, the therapist recognises his or her own triggers, and deals with what is activated in the rightful place, namely clinical supervision.

I see these guidelines as forming a three-stage approach to working with the shame wound from racialised trauma.

The first stage is to allow permission for the exhaustive retelling of the manifest or immediate and fresh content of the shame. The process of replaying the minutiae of events serves to unburden the shame-teller, validate them and ground their experiences in a safe space.

The crucial first stage also carries an additional importance and significance in black/white and cross-cultural encounters. People of colour who present with racialised shame trauma have a strong need to be believed in their experiences; for the white therapist, this requires an engaged stillness to be able to empathise.

The second stage is to facilitate the processing of the manifest shame content. The processing is the active work that allows the therapist's enquiries and other facilitative interventions to be heard and emotionally engaged with, for the purpose of making sense of the trauma impact.

The third stage moves the client slowly towards recovery from the shame wound, through the process of regaining their sense of mental balance from the dislocation of shame. I refer to this therapeutic facilitation as enabling the return to a state of ontological security – being grounded in our own skin and surroundings.

Sublimation

Sublimation is perhaps the single most important concept in understanding the work of healing and managing shame. Sublimation is the act of using energies that stem from this place of deep shame, rage, chronic anxiety and negativity, and redirecting them towards a creative endeavour, as in artistic creation or intellectual enquiry or pursuit.

In this phase of therapy, the practitioner facilitates movement towards the integration of the disrupted selves, by creating an encouraging and proactive environment for effective restoration, leading to hope and empowerment. The client will be stronger for having had the opportunity to create straighter lines of narrative about their experiences, instead of holding onto split, disjointed and untreated areas, where pain resided.

Through the healing powers of therapy, clients can be helped to reframe negative internalisations of their trauma, to reshape and build a more meaningful existence through vulnerability. The therapist actively encourages the client's sublimation through their engagement in their choice of activities for healing.

Identity shame arises in many contexts: when we are not seen or appreciated for who we are; when we feel the absence or loss of the positive gaze from loved ones or the outside world; when we are denied the positive mirroring of who we truly see ourselves to be.

'*Fostering an effective working alliance is key*'

Identity shame is connected to historical wounding. At its deepest level, however, identity shame results from the loss of not having a rightful place in the human world.

I posit the notion that, at an unconscious level, black people are still not perceived as fully actualised human beings; the black male is not only subhuman but also dangerous and to be feared. The unspoken nature of this dimension of race means that, at a collective level, the dominant other holds this irrational belief somewhere within the collective psyche. And, as with all unheeded phenomena, an element of acting out (namely the perpetuation of racism and identity shaming) and acting in (namely the shame wound and ongoing feelings of incompleteness and feeling not 'normal') thrive and continue.

Shame in this context stems from the internalised conflict that arises when the self finds itself having to deal with aspects of external authority (society) and the need to protect the innermost and vulnerable parts of the self. The function of this shame is to defend against anxiety that threatens to destroy an integral image of the self. But, in so doing, it shrouds full actualisation and integration of these positive aspects of the self.

Although a universal experience, shame has different dimensions when applied to the black and white context of history, heritage and identity. Black identity shame is the burden of carrying deep-rooted wounds and ongoing struggles, which are borne in relation to the dominance of the white other.

White identity shame seems to be managed by harping back to the accomplishments of Empire or by 'world-beating' blustering, which have become the current default political stance. Superiority and dominance act as masks to cover the exposure and terror of white identity shame and white fragility.

Defence against white shame invariably interferes with the quality of engagement in race conversations, as the shamed person becomes self-absorbed and overly concerned with protecting themselves. These dynamics stymie race conversations and they suffer constant ruptures. A retreat to old social scripts leaves the great weight and heft of race work to be carried and held by the black other. A key takeaway message here is for the white other to own the primitive in you.

In making distinctions for shame in the black/white relational context, one can conclude that white shame is a complex affective and cognitive reaction pattern that shapes character attitude, to prevent dangerous exposure. On the other hand, black identity shame can be seen as a complex affective and cognitive reaction to black identity wounding.

Only we (black folk) can heal our own wounds. However, as with the universal experience of trauma, there exists the relational dynamic of the wounded and the violator (my preferred choice of terms). Experiences of this profound nature and level of psychological injury require repair involving both sides – the sufferer and the contributor.

Black people's trauma has its genesis in white, colonial, historical oppression. Healing is, therefore, not a task for black people alone, but a process involving a formal act of reckoning of the impact of the wrongdoings by the oppressor. It is in the omission of the moral imperative to manage colonial legacies that the hidden white identity shame lies – and the burden of heritage for black lives.

Atonement work is necessary, not only to offer black people a profound public gesture of recognition of their historical trauma but also to enable the dominant collective to manage its own generational guilt and shame, which lies suppressed and repressed within white collective unconscious. It feels important to qualify that the atonement that I speak about is not financial compensation. A true atonement would be properly acknowledging the collective trauma of a shameful past, which should no longer be left out of conscious recognition and conveniently carried by others.
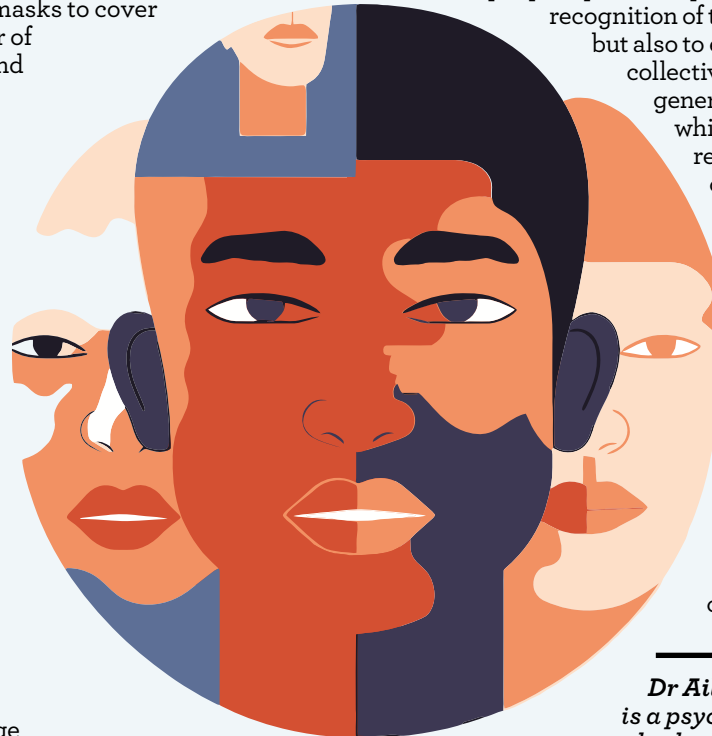
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Extracted from *The burden of heritage: hauntings of generational trauma on black lives,* published by Karnac Books in 2022. Readers of *HCPJ* can enjoy a 20% discount off the retail price, when they buy a copy direct from karnacbooks.com, using the code HCPJ-Burden. Offer ends 29 February 2024.

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Viewpoint

JUDY STAFFORD

My feet have recently been swollen and painful, so I bought over-the-counter anti-inflammatory drugs, which were effective for pain relief. But I was told by my GP to stop taking them, as they are bad for my heart.

Unfortunately, the prescribed painkillers didn't touch the pain; they only affected my brain. And if my brain wasn't working properly and there was no diminution of the pain in my feet, I couldn't justify taking the medication. So, I ended up suffering pain and swelling in my feet for about eight months. Then, remarkably, the swelling just disappeared. Joy of joys, I can get my shoes on again!

Do I know the cause of the pain and swelling in my feet? No. Over the course of the eight months, I had a phone call from a GP, who told me they weren't a foot specialist. I also had an appointment with a physiotherapist, who suggested I might have gout. But since my diet is beyond reproach and there was no discoloration of my toe, this seemed unlikely.

I was booked in for an X-ray of my right foot. I had already had an X-ray and an MRI scan of the other foot – and I was due a CT scan, too. Could I have the CT scan on the right foot and save some time? Er, no.

The pain then decided to migrate from my toe to my heel. I managed to get an out-of-hours GP appointment in a nearby neighbourhood, which was in-person and quite useful. They did a simple test, there and then, to rule out a torn Achilles tendon.

I was sent a consultant's appointment in August, which they then re-arranged for the end of October. But after a COVID booster and a flu jab, I came down with a non-COVID sore throat, cough and cold, so I had to cancel.

I had a similar experience about four years ago, when I developed a cough. A series of tests to try to find the cause of my cough didn't reveal anything conclusive. Perhaps it was my blood pressure tablets? So, I could either put up with the cough or die of a stroke. I chose to carry on with my blood pressure medication – and I still have the cough.

'*A diagnosis doesn't always offer relief, comfort or treatment*'

Why do I want to know the cause of my health problems? I sought a diagnosis, primarily in the hope that it would lead to effective treatment. A diagnosis might also have offered me relief from the 'not knowing', as well as the comfort of putting myself in the hands of 'experts'.

Of course, counsellors and psychotherapists are not able to diagnose. And a diagnosis doesn't always offer relief, comfort or treatment. It can sometimes arouse feelings of shame and hopelessness. Plus, the recommended treatment doesn't always work.

But maybe our clients look upon us as experts. They perhaps don't understand what they are feeling, or why, and they want us to identify and solve the problem for them.

When I was doing my research project on person-centred counselling, it became clear that clients sometimes want an 'answer', even if that means labelling their condition. 'Some clients take great comfort in being diagnosed.'[1]

Who are the experts, anyway? As my experience with the medical profession illustrates, they are fallible human beings, not omnipotent gods. The doctors could not diagnose my painful feet or my troublesome cough. They also now want to put me on a statin, to lower cholesterol. But there is no evidence that my cholesterol is high.

Are counsellors and psychotherapists experts? We certainly have knowledge, training and experience. It can also be tempting to play the role of the expert, to answer the client's need to surrender autonomy. Maybe it also satisfies our own need to be the confident and knowledgeable professional, and boosts our own morale.

But surely the client is the only true expert on their own life? And it's the aim of the therapeutic practitioner to empower the client, to respect and foster client autonomy. A client reaches self-awareness with the therapist alongside them on their journey of discovery as an equal, not as an expert.

Judy Stafford works in the Healthcare, Journals and Professional Standards departments of BACP. Until recently, Judy was also a registered member of BACP and a person-centred counsellor.

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Nursing
the
nurses

Stress and burnout are common among nurses. What happened when ***Graham Music***, ***Jennie McShannon*** and ***Kay Trainor*** delivered a therapeutic intervention in an acute assessment unit of an NHS hospital?

The news and social media are awash with reports of a collapse of the NHS. A recent Nuffield study[1] found that, in the year to 2022, more than 40,000 nurses left the NHS, a ninth of the entire workforce – and many more are disaffected. There is no doubt that we are facing a serious crisis.

In this article, we hope to shed light on how some of these issues play out on the frontline. We describe an intervention that we delivered in the acute assessment unit (AAU) of a major hospital, approximately two years before the pandemic. Staff morale in the unit was low and there was a high level of sick leave and staff turnover.

The 50-bed unit's primary role is to provide urgent assessment, mostly for patients from the emergency department. Patients were admitted 24 hours a day, seven days a week. In theory, they were either discharged after assessment and immediate treatment or transferred to another ward within 72 hours. In reality, the unit was often left holding onto patients for longer than 72 hours, as finding beds in the main wards was a constant problem.

We soon realised that nursing on an AAU is different from nursing on other wards. A patient's very presence is an indication of an unpredictable state of health. In any shift, there might be several cardiac arrests and a number of patients might die. Many of the patients were elderly, often with late-stage dementia. Nurses had to deal with stressed and worried relatives and often felt blamed for the situation. As Anton Obholzer and Vega Zagier Roberts observe, the NHS is perceived as a service to prevent death, often at any cost.[2]

Nurses were overstretched and often felt they were failing, knowing that patients needed more help, resources and time than they could give. When a patient died, the body was swiftly taken away and the bed changed for the next patient, if they were on a bed and not on a trolley, as occasionally happened if no bed was available. There was barely a moment to reflect on or process a life lived and lost or the feelings of the patient's family and friends, let alone their own feelings as professionals and as human beings.

Our intervention grew out of an idea from senior nurse managers that the low morale, burnout, high levels of staff turnover and absence due to sickness might be alleviated by training staff in mindfulness. Indeed, a sum of money had been raised by a nursing charity to implement mindfulness training.

We soon realised that we had underestimated the negative effect of moral injury on the nurses' state of mind and sense of competence.[3] Moral injury, sometimes referred to as moral distress,[4] has been used with reference to professionals, including the armed forces, to denote an expectation that staff should carry out actions that do not fit with their moral codes and beliefs.

'Nurses were overstretched and often felt they were failing'

Moral injury among nurses might include witnessing trauma and illness, as well as an inappropriate expectation that they should alleviate suffering and prevent death, despite a lack of resources, equipment or support. Well before COVID-19, healthcare workers of all kinds were known to be suffering the effects of moral injury or distress; research has shown it to be a leading cause of burnout, absenteeism, traumatic stress and staff turnover.[5]

In such environments, perhaps rather like children who suffer maltreatment, professionals tend to blame

themselves, rather than the system in which they work. When we realised the impact of moral injury, we broadened the remit of the programme, so the focus was not solely on the resilience of individual nurses. Mindfulness-informed interventions were used in an adapted form, and as only one arm of the intervention, which overall took a structural and systemic stance.

Defences against anxiety
Any Tavistock approach to organisational intervention inevitably has the work of Isobel Menzies Lyth[6] at its heart, as well as the many who have developed her theories.[7] It seemed appropriate that we were placed in the AAU, almost certainly the hospital's hotbed of stress and uncertainty, where nurses often cited anxiety and overwhelm as their reasons for leaving.

Lyth is well known for highlighting how defences develop into institutional rituals and ways of organising work, so that anxieties do not have to be faced – and this was clearly the case in the AAU. The unit could be thought of as defending against the constant fear of sudden death and the powerfully disturbing feelings this could evoke in the nurses.

'There was a high level of sick leave and staff turnover'

A typical structural defence was the way in which nurses often worked alone in a bay. At a conscious level, the system was designed to ensure the nurses were close to the six patients in their care. However, at an unconscious level, the isolation functioned to defend against the possibility that their distress might be seen or shared. The work generated powerful emotional responses and there was a fear that sharing would amplify, rather than relieve, distress.

The demand for ongoing audits and repeated checks was a defence instituted by management – and is common in stressed, public-sector settings. Of course, managers were trying to deal with their own anxiety, but it left the nurses feeling constantly over-responsible, both as individuals and as a unit. Nurses also doubted the benefit of the repeated checks and form-filling, which were neither efficient nor likely to prevent mistakes.

Managers would also defend against their anxieties by becoming more disciplinarian, driving nurses to work ever harder. It was as if they believed that pushing more might stop the inevitability and unpredictability of patient death. Senior nurses shared a culture of over-working, staying late and checking in while on holiday. A dominant, pervasive feeling was that death, always imminent, could and should be prevented, a Sisyphean and burdensome myth.

Another classic defence, pointed out by Wilfred Bion,[8] was that of splitting into gangs and cliques that could defend temporarily against the distress, but which also created a powerful inclusion/exclusion dynamic. The threat of being excluded tends to exacerbate stress. It also increases the likelihood of projections, such as placing blame or inadequacy elsewhere.

On top of the structural defences, nurses tried to push away any personal experience of pain. It was our job, in part, to help create a climate in which feelings could be contained, borne and managed, not defended against.

The unit was teeming with defensive processes, which is not uncommon in busy, stressful environments. So, it was perhaps not surprising that we, too, were drawn into projections and enactments. We aimed to be both part of and outside the system, to be able to receive projections, make sense of and metabolise them, rather than act them out.

Our team supervision was fascinating. About 12 weeks into the programme, our supervisor commented that little, if anything, had been shared about the patients and their plights, which was clearly a defence on our part. When we focused more on the experience of the AAU's primary task and patient group, we were confronted with what the nurses, and we, had been defending against. Sudden, unpredictable, life-threatening, anxiety-provoking crises seemed to assault the nurses from all sides. As our supervisor put it: 'The place is awash with beta elements.'[9]

Our supervision certainly showed the importance of a reflective space to try to metabolise some of the most challenging experiences, our own and those of the nurses, so that they were not defended against in unhealthy and unhelpful ways.

Innovative intervention
Our intervention was innovative, as it was possibly the first to combine a focus on institutional dynamics – in this case, the Tavistock 'systems-psychodynamic' approach – with an intervention based on mindfulness, compassion-focused therapy (CFT) and a

neurobiological/developmental and trauma-focused understanding.

Unusually, we were funded to train all 72 of the ward nurses over a 10-month period; the funding included money for agency staff to cover the nurses attending the programme. We divided the nurses into three groups, each with 24 participants. Nurses attended one full day a week for eight weeks, during normal working hours. They did not wear uniforms, which denote seniority and pay grades. Sessions were held off site in a small hotel, which provided catering. The nurses felt valued by such a concrete, clear investment in their wellbeing, many expressing surprise and pleasure that their needs and issues were being taken seriously.

Discussion groups

The intervention included coaching for senior nurse managers, as well as discussion groups, using the Tavistock 'work discussion' mode, where the emotional impact of the work could be shared and processed in detail, particularly the responses to patient suffering and the processes of splitting, projection and scapegoating.

Initially, our work was split, perhaps unhelpfully. Graham's main role, alongside running a supervisory work discussion group, was to deliver the mindfulness programme, which consisted of a mixture of mindfulness exercises, CFT interventions and psychodynamic and trauma-informed understanding, including an awareness of the somatic effects of traumatic experiences.

Space was created for the nurses to disclose personal issues and concerns, and an attempt was made to create an atmosphere that was non-judgmental, mutually supportive, curious, understanding and compassionate. We aimed to ensure the unique personal and professional skills of the nurses were seen and valued.

Although Graham had written a manual, the programme was adapted as we went along. For example, given the powerful self-judgments and persecutory superegos, one early session was devoted to asking each member to tell the group about something they were proud of in their career; other nurses were then asked to comment. Time and again, nurses were taken aback by the appreciation others showed for their skills, care, compassion and courage.

In the first, pilot cohort, the nurses only came together during the large plenaries and meal breaks. We realised that we had designed a structure that reflected the way they worked on the ward, where they were divided into bays, creating, at best, small, exclusive groups.

'Nurses often cited anxiety and overwhelm as their reasons for leaving'

For the next cohort, rather than running two, different mindfulness groups, we brought them all together in one large group. The effect was noticeable, with more engagement and interest. Nurses began to introduce reflective moments into their days on the unit, as well as some mindfulness into the handovers on the ward. Staff were encouraged to outline in handovers not only problems and anxieties but also what had gone well in their shifts, allowing them to leave feeling better about the work they had done.

There were more mindful pauses, even pauses to take in the effect of a patient's death, sometimes called a 'sacred pause', a ritual for medical staff to briefly honour the life of someone who has just died[10] – an intervention with good evidence for helping burnout.

Somatic awareness

An additional and important gain of the mindfulness-informed part of the programme was the development of increased somatic awareness and understanding of how traumatic and stressful experiences impact people's bodies.[11] With somatic awareness in mind, each session included some yoga and mindful breathing, which helped nurses to step outside of their usual anxious responses, such as tense muscles and shallow breathing, driven by reactivity of the sympathetic nervous system.

The discussion groups were deliberately smaller and more intimate, giving an opportunity for nurses to present and understand their work in more detail. Nurses described the extreme emotional and technical challenges of working with the most demanding patients, especially those with dementia.

The group members could air their feelings about the lack of support and sense of isolation, especially new nurses, and particularly if they had recently arrived from abroad. It was in these meetings that nurses were supported to believe that, despite working in a system under constant pressure, they were doing a really good job under very difficult circumstances.
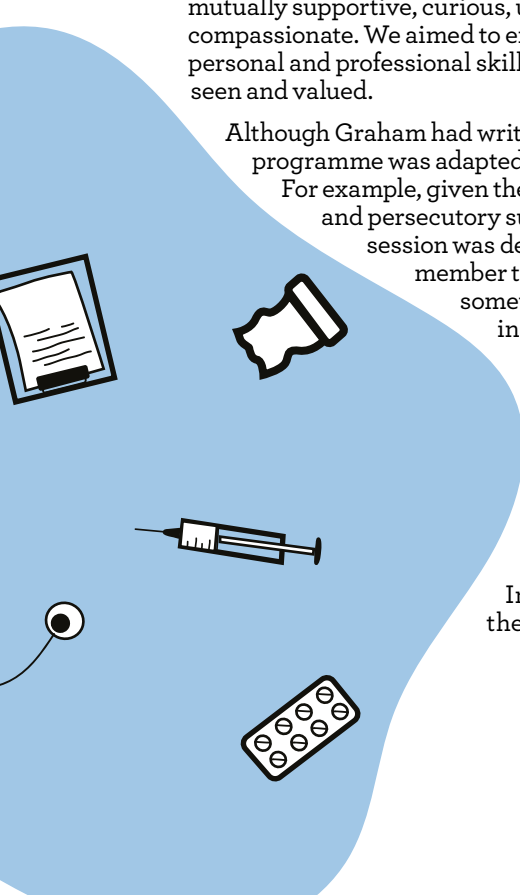
The mindfulness had a strong impact. In particular, there was an emphasis on building compassion and self-appreciation for work they had done well. It was clear that nurses, management, patients and families focused largely on what went wrong or was not good enough, losing sight of their quite extraordinary accomplishments.

'It was our job to create a climate in which feelings could be contained'

These sessions helped the nurses to reconnect with their achievements, and they reported feeling supported. The lack of good feedback or acknowledgement of their hard work had been stark. The linked fears of relatives' complaints, getting it wrong, reprimand, even losing their registration exacerbated the pressure.

Whole-group sessions allowed the different parts of the unit to see and be seen by each other. Systemic-psychodynamic exercises, led by Jennie and Kay, reinforced the value of expressing and sharing personal experiences, especially the sense of vulnerability and personal failure that, at the outset, had been located in the newly qualified nurses.

The exercises, which included self-disclosure, took place within groups made up of differently banded nurses, which allowed all the nurses to witness the loneliness of leadership. When the senior nurse manager courageously disclosed her own feelings, allowing the group to see her vulnerability, the nurses, perhaps for the first time, could empathise with her experience. Now, vulnerability could be owned across the system.

The experience possibly allowed the nurses to acknowledge that some procedures were not as helpful as hoped. For example, the senior nurse manager had insightfully noticed that the fixed structure of allocating individual nurses to separate bays had the effect of reinforcing divisions. But she had been unsuccessful in her attempts to change things, up until now.

We identified that the structure might be a social defence against the anxiety of the work; if the nurses worked more closely together in a patient bay, the distress would surface. We invited the senior nurse manager to discuss her idea with the group, in a fishbowl format, where she allowed herself to ask for help, rather than give directives.

Resistance to change
The staff shared their concerns and unpacked their resistance to the change. It was a shift from command and control to a more inclusive leadership approach, and staff responded with more curiosity, openness and willingness to trial change.

Through these and other processes, the culture began to shift. Nurses felt valued, less judged, more confident about their skills and their extraordinary, life-saving work. The group opened up and there was less splitting, helped by spending more ordinary time together, getting to know and trust each other.

Vulnerability, fragility and anxiety no longer needed to be defended against, but could be seen as part of the work, even if it meant opening up to difficult feelings. Each element of the programme contributed to the result, but it seemed clear that creating a compassionate and reflective culture led to transformations.

We remain constantly surprised by the way countertransference feelings and parallel processes feed into and sometimes hijack the work we do. Particularly at the start of the programme, all three of us experienced

responses that uncannily mirrored the feelings of the staff, not least a sense of personal inadequacy and a dread of turning up to deliver the programme, as well as some splitting, pairing and rivalry within our team and projecting in our judgment of others.

We even questioned the usefulness of continuing the programme at all. Supervision and our own reflective processes rescued us. When we made sense of the experiences and changed tack somewhat, our powerful countertransference responses receded.[12]

Fishbowl exercise

Sometime into the programme, we set up a new fishbowl exercise in the large group. We placed three chairs in the middle, which we sat on ourselves, and we talked through our own process in supervision as honestly as we could, exploring what it might mean that we had lost sight of the patients and their central importance to the AAU story.

We shared our dynamics, how often one of us had felt excluded and criticised by the other two. We spoke of how moved we were by the unit's work, especially of how much admiration we felt for the skills and courage of the nurses.

After sharing, we rejoined the big circle, giving the nurses a chance to respond. They were clearly moved. They had no idea how much we had heard them or how much we were touched by them and their work with patients. The atmosphere changed. In good Winnicottian[13] fashion, we had survived their attacks and they could now 'use' us. We had modelled an ability to be fragile and vulnerable, yet also strong, courageous and compassionate.

The project was well researched[14] and showed favourable results. Overall, the programme had a positive impact on the organisational culture in the AAU. It also had a significant effect both on the experience of work and on the original difficulty of staff retention, which, after an initial lag, saw sustained improvements that were still evident two years on.

At an individual level, the data suggest that participants developed a better understanding of themselves, including a greater insight into their own somatic responses to stressful situations and a greater appreciation of their worth and capacities. There was a deepening understanding and tolerance of colleagues' behaviour, including the behaviour of more senior colleagues.

There were noticeably hopeful changes in the quality of communication, interaction and relationships between staff and an easing of intra-AAU group boundaries, which had a positive impact on how groups perceived and related to each other, including how they resolved conflict and coped with stress.

The nurses were clear about the value of spending time together away from the ward to discuss their experiences, without hierarchy-defining uniforms, in a pleasant venue with good food. Despite the consequences for ward organisation and rota systems, staff felt nurtured by the hospital's investment in them, which facilitated engagement.

A key outcome was a better sense of shared experience, summed up by the common refrain: 'I thought it was just me who was feeling this.' Instead of feeling isolated, stressed and overwhelmed by the pressure of the work, nurses found common ground, which helped to build better fellow feeling on the unit.

Possibly the most significant impact was the increased two-way dialogue between managers and nurses. On the programme, the senior nurse manager frequently heard and took seriously the distress caused by working with sick, traumatised and dying patients. And in the fishbowl exercise, she herself felt listened to and could respond thoughtfully to feedback.

As clinicians and facilitators, we learned the value of flexibility and how we could sometimes risk stepping outside a typical consultative frame. Our flexibility helped the group of nurses engage more authentically with their own experiences. It also enabled the walls between us and the nurses, as well as between the nurses, to come down, making way for connection and renewed understanding.

We also developed a more critical and systemic understanding of the concept of resilience, of the idea of burnout or stress as a problem in the system, rather than an individual failing.

'Our supervision certainly showed the importance of a reflective space'

The different aspects of the programme generated an outcome greater than the sum of the parts. The interplay between coaching, mindfulness, whole-system learning and discussion groups allowed the nurses and management to be sufficiently contained to explore complex issues and difficult feelings. The defences against these feelings had been having a detrimental impact on their work, on their capacity to support each other and even on how the work was structured.

Interestingly, there was almost as much defence against the things they did well as against the stress of their work, and there were often tears and relief when their skills and achievements were acknowledged by others. In general, the programme facilitated a lowering of defences in a safe and supportive context.

'The programme facilitated a lowering of defences in a safe and supportive context'

The mindfulness aspect had an important role in helping loosen defensiveness against the emotions stirred up by their work and against potential criticism. Creating a culture of valuing feelings, positive and negative, enabled an atmosphere of openness and sharing that also helped the nurses make more use of the whole programme.

In addition, an understanding of individual responses to stress, in the brain and in the body, and a more mindful and self-compassionate attitude offered them skills or tools they could continue to access after work or even, occasionally, together on the ward. However, as is so often the case, the main gains came from enabling genuine emotional connection, openness to vulnerability and compassion for themselves and each other, which aided their work with patients.

Senior management was also happy with the programme, as sick leave and staff turnover reduced. The unit even won an NHS staff retention award.

If you had asked any of us in the early weeks of the intervention, we would have been unlikely to expect a successful outcome, especially given how weighed down we were with projections that left us feeling hopeless, inadequate and, at times, somewhat rancorous.

If we had to highlight one lesson, it was one we should have expected but that so often catches therapists and consultants unawares: the importance of bearing and making sense of difficult countertransference and parallel process reactions. It was the processing of these reactions that helped us to understand from the inside some of the challenging experiences faced daily by these nurses, to whom we could then show more compassion and empathy, which they in turn could show to themselves and to their patients.

Acknowledgment

© **Graham Music, Jennie McShannon, Kay Trainor**

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Jennie McShannon *is a senior organisational consultant at Tavistock Consulting. She works with leaders and teams across various sectors, including health and social care, education, government and business. Jennie teaches on Tavistock's master's programme, 'Consulting and Leading in Organisations: psychodynamic and systemic approaches'.*

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On the couch

with **Alison O'Connor**

What are your current roles and responsibilities?
I work as an associate therapist and supervisor at Talk in the Bay, Cardiff. I am also Company Supervisor for Re-Live, an arts in health charity, which I co-founded 17 years ago, with my best friend, Karin Diamond. I am currently writing a book with Karin, and our friend and colleague, Clark Baim, *Creating Life Story Theatre: a guide for practitioners,* which will be published by Methuen this year. I recently set up a social enterprise, Moral Injury Partnership, with two colleagues, developing restorative retreats for frontline staff impacted by moral injury and burnout.

Can you describe a typical working day?
At the moment, I dedicate a couple of days a week to writing, which I love. Other days, I go to Talk in the Bay, which is a 45-minute walk by the sea. I appreciate that I am very lucky with my commute – and I don't miss the days of early-morning trains. A more mindful pace feels good for me right now. A lot of my work in recent years has been around burnout, and I feel an ethical pull to try to practise what I preach.

What are the highs and lows of your working life?
It is a privilege to have the diversity of writing, therapeutic work and project development in my professional life – and that is definitely a high. The experience of witnessing someone's inner world, as they reflect and make sense of their life, is also a gift that I will never take for granted. The lows are the awareness of the injustice and unmet need in the world, and the realisation that there is so much more to be done than I will ever have time for.

How did you get to where you are today?
While I was studying drama at Bristol University, my friend and I went to volunteer in a Romanian orphanage, where we met – and fell in love with – children surviving in unimaginable conditions. Witnessing such deprivation and injustice at the age of 18 changed me. I became determined to find a way to combine my love of theatre with helping others recover and heal. I worked for several years at Geese Theatre Company,

a fantastic organisation that works in the criminal justice system. In prisons and secure settings, I developed groupwork skills and a deep respect for the way our early life experiences shape our paths. Karin and I then formed Re-Live, developing a methodology of therapeutic life story work. I trained as a therapist while at Re-Live, then as a supervisor, because I became aware of my need and desire to connect more deeply with people on change and recovery.

How do you look after yourself?
Balancing self-care with care for others is a life-long practice. My upbringing instilled a sense of 'others first'. I now accept this might always be my default position, so I work proactively to prioritise my own wellbeing. Yoga, exercise, long walks with my husband and our dog, time with family and friends are all in the mix. Solitude is a need I increasingly attend to.

What's the most useful thing you have learned?
Self-compassion. It's not an exaggeration to say that discovering Kristen Neff's work and engaging with mindful self-compassion training have been life-changing for me, as they led to the visceral realisation that I can offer myself unconditional acceptance and choose to free myself from self-criticism. I am aware that I am slightly evangelical about this now.

If you could make one change, either in your professional or personal life, what would it be?
I would do more groupwork. At heart, I am a group practitioner and yearn to create more spaces where people can experience the restorative connection of a kind, supportive group. I think the model of therapy where two individuals sit for an hour and talk, once a week, is becoming outdated and unsustainable. I would love to see group therapy embedded across the NHS, third sector and private practice, as well as lots more training opportunities in this area. Karin and I are developing a group programme of life review, where people in midlife can pause and take stock, and people near the end of their lives can reflect and make sense of the life they have lived.

My dream is to subsidise the programme, so it can be accessible to people from all walks of life. It would offer a chance to step off the treadmill and share your life story in a supportive, compassionate group.

Who or what is your inspiration?
So many to choose from. But, ultimately, it's my three children. Watching them grow and become young adults is a humbling reminder that, as much as I love my professional life, my family is my life's work.

What would you tell your younger self?
That your worth does not depend on your productivity and achievements.

What book would you recommend to other therapists?
The Resilient Practitioner, by Thomas Skovholt and Michelle Trotter-Mathison.[1] I came across it by chance in a library several years ago, and have recommended it to all students and supervisees since. It's a wonderful, compassionate guide to looking after yourself while working in the helping professions. It includes reflective exercises and strategies to help sustain your professional and personal vitality – and their concept of 'boundaried generosity' is a gift.

Do you have a favourite song?
Losing My Religion, by REM. It transports me back to 1991, healing from the death of my father, who I was very close to, with the support of good friends, youth theatre and the freedom of music.

Who is your fantasy client?
My mother.

In your dreams, you are…
Writing in a small cottage on a quiet Greek island, swimming in the blue sea every morning.

Alison O'Connor is a BACP accredited counsellor, supervisor and trainer.

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Menopause
in the
therapy room

An understanding of menopause can help support
clients as they manage the challenges
of midlife, writes **Dr Jane Simms**

Menopause is a normal life event that leads to physical, psychological and emotional changes for women. In recent years, there has been an increasing awareness of menopause, as a result of wider media coverage and improved treatments.

Women's health issues have long been of interest to me in the counselling room. I have often been intrigued by the lack of client awareness of hormonal health and of the effect of hormones on mental and physical wellbeing. So, I always take time to explore this aspect of health during the counselling process, especially in the early stages, when I am trying to get a better understanding of the client.

It is almost 20 years since Paula Derry[1] highlighted how important it is for therapists to understand the impact of menopause on the client, to actively engage in discussion with the client about potential links between their distress and menopause, and to support the client with psychoeducation and coping strategies.

However, little information, teaching or training for therapists is routinely available.[1] In this article, I aim to provide an understanding of menopause, explaining the range of possible symptoms. I also hope to support the counsellor to identify and discuss issues related to menopause that they might encounter in the therapy room.

I refer to women in the article, but I include people with functioning ovaries, who do not identify as female.[2]

The word menopause originates from the Greek *meno*, meaning month, and *pausis*, meaning to cease or halt. Menopause is described by the World Health Organisation as the permanent cessation of the menstrual cycle.[3] You reach menopause when you have not had a period for 12 months, hence it is regarded as a retrospective event.[4]

'*Menopause is not a disease, illness, pathology or a state of being ill*'

When we refer to menopause, we are often talking about the time leading up to the cessation of periods, known as perimenopause, which can last for many years. In this article, the terms menopause and perimenopause are used interchangeably.

Menopause is not a disease, illness, pathology or a state of being ill, but a normal physiological phenomenon. It happens to every female, irrespective of race, social or economic background. The average age of menopause is 51. The age is consistent across all countries and has not varied over time.[5]

What has changed is average life expectancy. Women in England and Wales can now expect to live to 82.6,[6] so around one third of their life will be spent in the post-menopausal stage.[2]

Life does not stop because periods stop. Indeed, menopausal women might be dealing with other life events, such as redundancy, retirement, bereavement, caring for elderly parents and adjusting to children leaving home.[7]

A counsellor can help the client to understand and differentiate their menopausal symptoms from other symptoms, supporting them therapeutically and helping them to manage more effectively.

The reduction in oestrogen levels at menopause leads to a broad range of symptoms. Other hormones, including progesterone and testosterone, are also in flux and decline during this stage.[8]

A common feature of menopause is hot flushes or flashes, typically described as a sensation of heat spreading along the upper part of the body, which can last from a few seconds to several minutes. About 80% of women experience hot flushes,[9] typically for five years. However, 10% to 15% of women continue to experience hot flushes 10 or more years post menopause.[8]

Hot flushes are associated with night sweats, which can result in disturbed sleep.[10] Other vasomotor symptoms include palpitations, nausea and dizziness.[9]

Features of menopause			
Vasomotor	**Psychological**	**Genitourinary**	**Other**
Hot flushes	Nervousness	Stress incontinence	Dry eyes
Night sweats	Anxiety	Urge incontinence	Joint pain
Sweating	Irritability	Urinary frequency	Weight gain
Shivering	Tearfulness	Vaginal irritation	Bloating
Increased pulse	Emotional lability	Vaginal infections	Dental issues
Palpitations	Panic attacks	Thinning of the vaginal tissue	Headaches
Feeling faint	Forgetfulness	Painful sexual intercourse	Lethargy
Weakness	Difficulty concentrating	Bleeding	Brittle hair and nails
Jitteriness	Disrupted sleep	Decreased libido	Skin thinning/loss of elasticity
Dizziness/vertigo	Confusion/brain fog	Dysuria (burning/stinging sensation during urination)	Changes in cycle and bleeding patterns
Nausea	Cognition issues (poor recall, slower information processing)		
Insomnia	Psychosexual problems		
Fatigue/lack of energy	Low self-esteem, reduced self-confidence		
	Body-image issues		
	Embarrassment and shame		

The vagina, lower urinary tract and pelvic floor all contain oestrogen receptors, and the decline of hormones can lead to progressive loss of collagen, resulting in loss of tissue elasticity. For some women, vaginal dryness, reduced libido, painful intercourse, urinary incontinence, all of which are related to the decline in oestrogen and progesterone, can be particularly distressing.[11] Women can also find themselves prone to urine infections and irritation.[8]

Genitourinary symptoms can have a negative impact on body image, self-confidence and intimate relationships.[8]

Counselling can provide a safe, non-judgmental, supportive space for women to talk openly about the impact on their femininity, sexuality and relationships, which can help normalise and alleviate feelings of embarrassment, shame and guilt.

Psychological features
Common psychological features of menopause include cognitive issues, such as forgetfulness and brain fog, which is characterised by difficulty concentrating and retrieving information. Poor sleep can also affect cognitive function.[12]

Cognitive symptoms can be confused with symptoms of a serious illness, such as Alzheimer's. Psychoeducation can therefore be helpful, to enable women to normalise some of their symptoms and reactions.

The changing hormonal levels during perimenopause have been noted to make

some women vulnerable to mental health problems.[13] The perimenopause, which can last between four and nine years, is a '… window of increased risk for new onset or recurrence of depression', as well as anxiety, although not anxiety disorders.[10]

Furthermore, women with a history of other mental health problems, such as bipolar disorder and schizophrenia, are at increased risk of exacerbation or recurrence of symptoms.[14]

For some women, this stage of life can lead to severe episodes of low mood, triggering suicidal thoughts. Sadly, suicide during menopause is not uncommon; among females in England and Wales, the age-specific suicide rate is highest in those aged 50 to 54 years (7.8 deaths per 100,000).[15]

Perimenopausal symptoms are not always the main presenting issue, perhaps

because the client does not fully appreciate or understand the impact of menopause on their wellbeing. Disentangling menopausal symptoms and their impact from other difficulties can be challenging, but is nonetheless worthwhile.

Biopsychosocial event
Menopause does not only affect physical and psychological health; it also impacts other areas of a woman's life. In a survey by the British Menopause Society, more than a third of women reported that menopause interfered with their work and social life, and around half reported a negative impact on their sex and home lives.[16]

An awareness and understanding of the potential impact of perimenopause on women's physical, psychological and emotional health – and how this influences their day-to-day functioning – can enhance empathy and compassion in the therapist, which can help the client feel understood. It can also normalise the client's difficulties and facilitate signposting to other services or professionals.

The number of prescriptions for hormone replacement therapy (HRT) in England doubled in the five years up to 2022, to around 500,000 a month.[17]

Guidelines by the National Institute for Health and Care Excellence (NICE) recommend offering HRT to women experiencing vasomotor symptoms, such as hot flushes. NICE also recommends that women should be able to access advice on how to transition through menopause in the optimal way, that treatments should be holistic and individualised, and that women who wish to commence HRT should be provided with information on the associated benefits and risks.[18]

There is no dispute that, for some women, HRT is an important treatment option, which can lead to a better quality of life. But I wonder if there is a danger of medicalising a natural phenomenon. Menopause is not, after all, an illness.

Furthermore, medicalisation of menopause can lead to an emphasis on the negative aspects of the experience, perhaps colluding with the idea of menopause as a sign of disease. It can also lead some women to feel disempowered, believing they have no control over how their body responds and how they can manage this transitional phase.[2]

The medical approach perhaps also places the woman in a 'cultural vacuum'.[19] But research shows that menopause experience is influenced by a range of factors, such as social values and cultural beliefs. For example, in countries that privilege youth and fertility, women have a more negative experience of menopause.[2] Income and diet are also implicated in how a woman experiences menopause.[20]

Each woman needs to be understood in the context of her own, unique circumstances and experiences, which include life events, family background, coping style, body image, self-esteem, relationship history, social expectations, cultural influences and psychological profile.[21]

Positive psychology
Menopause can be a time of positive change and freedom. Many women gain an appreciation and acceptance of their body, a sense of independence, more self-confidence and a greater capacity to express their own needs and wants, rather than focus on pleasing others.[19,22] And a positive attitude to menopause is associated with less severe symptoms, better quality of life, positive body image and lower incidence of depression.[23]

However, the UK has one of the most negative attitudes towards menopause, sometimes referred to as the 'Western medicalization hypothesis'.[23] In addition, media and drug company depictions of menopause have been shown to be more negative than the reality for many women.[19]

Counsellors who understand the features of menopause

> **Practice points when working with women in midlife**
>
> How does the client feel about getting older?
>
> What stressors are in the woman's life? Stressors can include grief, loss, children leaving home, relationship issues and caring responsibilities.
>
> Are there any events in the past, such as traumas or losses, that might be reactivated at this stage in life?
>
> Is there a history of depression, anxiety or other mental health issues? Remember to check for suicidal ideation, given the increase in suicide in this age range.[15]
>
> How does the client generally cope with change?
>
> Consider self-esteem, self-worth and any changes to confidence levels, including any body-image issues, past or present.
>
> Pay attention to the client's diet and other aspects of self-care.
>
> Explore current relationships with partner and children, if relevant.
>
> Are there any psychosexual issues?
>
> Look at social support levels.
>
> Bear in mind that culture, values and beliefs can influence how a woman experiences menopause.

are uniquely placed to identify issues that might arise from the transition, normalise the client's feelings and disentangle menopause from other issues in the client's life.

The counselling room also offers a non-judgmental space for clients to reflect on their own experience of menopause and its personal meaning. The counsellor can explore with the client any positive and even transformative aspects of this stage in life. They can also consider with the client ways to navigate menopause, with or without medical intervention.

Drawing upon positive psychology and a biopsychosocial framework can help counsellors explore menopause in a way that can support the client to recognise strengths, create new meaning and

'Sadly, suicide during menopause is not uncommon'

identify new possibilities, as well as manage and cope with the symptoms associated with perimenopause.

Counselling approaches based on acceptance and compassion, such as acceptance and commitment therapy (ACT), have been shown to improve mood.[24] Cognitive behavioural therapy (CBT) has also proved effective in alleviating hot flushes and night sweats.

And mindfulness-based stress reduction and relaxation strategies are potentially effective for vasomotor symptoms.[25]

A complete understanding of the woman and the challenges she faces at this stage in life is essential, if we are to fully support women to navigate and cope with menopause effectively. Ultimately, an understanding of menopause can facilitate a conversation between the counsellor and client that seeks to empower the client, improve her wellbeing and enable her to embrace this next stage in life.

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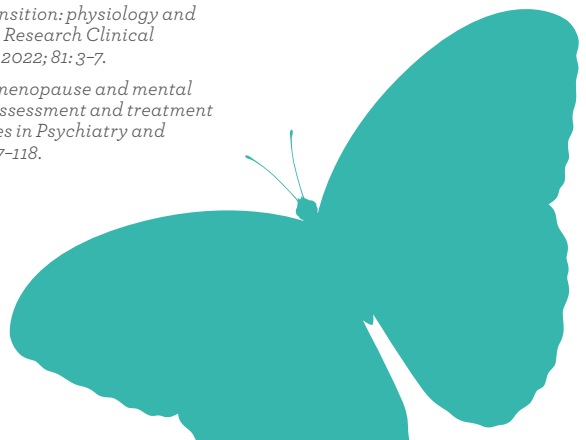
Group therapy
for loss:
does it work?

When ***Natalie Wilcox*** was asked to evaluate the effectiveness of a short-term counselling group, the results were encouraging

Talking Change* is an NHS service in Portsmouth that provides individual and group therapy for people suffering from a range of mental health issues. It follows the stepped care model, offering counselling and cognitive behavioural therapy (CBT) at step 2 and 3. The number of sessions is typically six to 12 at step 2, and 16 at step 3. There is a maximum of three treatments per referral episode and people can be stepped up or down, depending on their needs.

The service also offers interpersonal therapy, dynamic interpersonal therapy, counselling for depression, couples therapy and eye movement desensitisation and reprocessing (EMDR). In addition, Talking Change has a research team,

comprised of therapists from different modalities, including CBT therapists, psychological wellbeing practitioners and a counsellor.

I joined Talking Change in August 2021, after a period of maternity leave. I had previously worked there as a trainee counsellor and felt drawn back to the service, which aims to meet the mental health needs of a diverse, local population.

The service runs a range of counselling groups, including a loss group, a relationship group and a stress management group. The loss group was developed by a counsellor at the service in 2017 – and is one of the longest-running groups at Talking Change. Loss includes non-bereavement loss, such as loss of employment or health.

Talking Change regularly conducts evaluations, to develop and improve the services available. I was recently asked to evaluate the effectiveness of the groups, and after a review of the initial data, we decided to focus the evaluation on the loss group.

Effectiveness is routinely measured in NHS Talking Therapies services by assessing 'reliable recovery', when scores on the Patient Health Questionnaire (PHQ-9) and General Anxiety Disorder Assessment (GAD-7) fall below 'caseness' (10 on the PHQ-9 and 8 on the GAD-7), indicating that symptoms are below clinical significance.

Effectiveness is also measured by assessing 'reliable improvement', when scores reduce by four on the GAD-7[1] and

'The outcome data for the loss group showed strikingly consistent results'

by six or more on the PHQ-9.[2] I would like to acknowledge that the term 'recovery' is limited in the context of bereavement, as it is '... doubtful whether anyone fully resolves the loss of people or is ever totally free of the effects of such losses.'[3]

Talking Change collects data at triage, prior to assessment and in each session, using the PHQ-9 and GAD-7 measurement scales. The outcome data for the loss group showed strikingly consistent results – all were well above the target recovery rate of 50% set out by NHS England. The loss group also continued to exceed the target 50% recovery rate, despite the switch from in-person to remote working in 2020, as a result of the pandemic.

As we were in the middle of a global pandemic, it is perhaps no coincidence that the loss group stood out. As Pauline Boss states: 'We suffered the ultimate loss: the loss of trust in the world as a safe and predictable place. This is the crucible for high anxiety and distress.'[4]

The Talking Change loss group is made up of eight to 10 patients, aged 17 and above, who have experienced a loss at least six months ago, but within three years. There are usually eight, weekly sessions, each lasting an hour and a half.

If the loss is more recent than six months, people can be referred to the stress management group, owing to the shock and chaos that can be experienced early in the grieving process.[5] After the three-year period, a different course of treatment might be indicated.

The loss group offers the opportunity to share stories and experiences. The group uses the 'grief wheel'[5] model, which suggests that people might experience grief in terms of trauma, anguish, exasperation, haggling, sorrow, readjustment and looking forward. It is emphasised that the grief wheel is non-linear; people can pass back and forth through each stage.

It is recognised that grief can impact different aspects of people's lives, including identity, family dynamics, ideology and finances.[5] It is also acknowledged that there are many ways to grieve, and people might not relate to the model.

At the end of the group sessions, flowers are brought in and laid in a circle, as a symbol of what and who has been lost. The ritual was sustained when the group switched online in July 2020.

A colleague, who has worked in the NHS for more than 30 years and is a facilitator of the loss group, said: 'The power of shared experience is phenomenal. Loss is not a mental illness or mental health condition... loss is part of life. We might not all experience depression; all feelings are normal; it is unique.'

Evaluation approach
The service evaluation was done at a local level, using existing data from the PHQ-9 and GAD-7 measures, which were supplemented with a survey and interviews about people's experiences, using a reflexive[6] and iterative[7] approach.

I started the interviews by asking participants to tell me about their experience of the loss group. Themes that were generated subsequently informed further interview questions.

I took notes during the interviews, making interpretations and checking my interpretations with the participants for accuracy. I decided to take notes rather than record the interviews, as the presence of a recording device – visible or not – can influence the interaction.[8]

Interview notes were used to extract initial themes, which were checked with the Talking Change research and therapy teams, as a form of triangulation. The initial themes were then funnelled into eight, overarching themes. Again, these themes were checked, as a further form of triangulation and to minimise bias.

The aim was to generate a rich and confirmable set of data in a relatively short time – two months in total for the interviews. It would be interesting to develop this work further, by conducting a narrative inquiry[9] of people's experience of the loss group.

### Data findings on outcome measures
The service uses the online data system, IAPTUS, to ensure maximum levels of confidentiality and data protection compliance. The following data reflect patients who completed the group or attended a minimum of two sessions.

In 2019, 76.8 % were reliably recovered or reliably improved and 44.2 % recovered without other intervention. In 2021, 81.3% were reliably recovered or reliably improved and 50% recovered without other intervention.

People who did not make a recovery or reliably improve were able to access further treatment, either prior to or after the group.

The results for 2020 were not included in the evaluation, as it was the height of the pandemic.

The high recovery rates in 2019 and 2021 suggest that, overall, the group made a significant difference to people's lives. I was also struck by the higher rates of recovery in 2021, when the group had moved from in-person to online. Perhaps
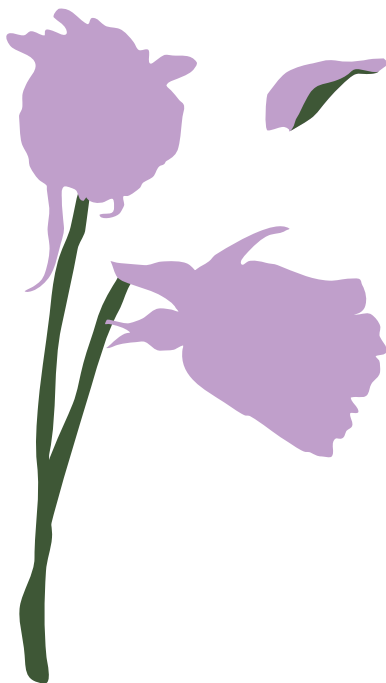
the online provision made therapy more easily accessible, creating connection at a time of isolation.

Data findings on the survey

It can be difficult to incentivise people to fill out and return surveys. Out of 59 sent out, a total of 23 were returned, with 13 fully completed. Although disappointing in terms of numbers, the survey generated some key themes that could be expanded on in the interviews.

The surveys suggested that the group offered a comforting and safe space, where people could feel less alone, talk about their loss and learn from one another. The group gained insight into the uniqueness of everyone's journey, understanding that every feeling is OK and that the process is not linear.

The group also enabled participants to develop different perspectives, especially regarding living alongside grief and loss.

Some survey responses also suggested the existence of a hierarchy of loss, which led to feelings of resentment. For example, one participant disclosed that she had been going through multiple losses. She used the group to work through the death of a loved one, but she would not have felt comfortable bringing the loss of her marriage to the group. She subsequently received further therapy to address this issue.

There were several, moving survey responses. For example, one group member described the group as 'life changing', because it had created vital new connections and ongoing supportive friendships. Another participant made the following statement: 'When you experience profound loss and have no previous life experience from which to draw coping mechanisms, you feel incredibly alone. Therefore, to be amongst others who are also going through the same sense of abandonment is, in itself, comforting, knowing that a shared experience can help you find strategies to keep yourself afloat.'

The service evaluation also found that people whose initial preference was for one-to-one therapy, went on to benefit from the group.

Data findings on interviews

A total of nine interviews were conducted. The support offered by the group emerged as particularly effective, easing the sense of isolation. The loss group also provided an appropriate boundary and holding space to contain the stories and expressions of pain, loss and grief that could be shared and validated.

Many members of the group kept in contact and met up after the group sessions had finished. The continued support enabled people to accept, or begin to accept, their losses and move forward with greater emotional freedom and fluidity, potentially opening doors to new relationships and paths in life.

The process of sharing offered different perspectives of grief, but also allowed for connection, which was an important aspect of the healing process.[10,11]

Of the nine people interviewed, two found the exposure or vulnerability to be a barrier. However, one participant commented that, even though she felt uncomfortable when she was in the spotlight, the overall impact was beneficial. Another found it difficult to open up, but was aware that this was an existing trust issue, as a result of complex trauma.

Interestingly, despite the higher recovery scores in 2021, people reported issues with online delivery. For example, online connectivity was sometimes disrupted. Some people also found it harder to read non-verbal cues, or felt more vulnerable if other members of the group did not turn on their cameras. There was also the issue of privacy and confidentiality when the group was online.

> *'The loss group offers the opportunity to share stories and experiences'*

The service evaluation was admittedly limited to a small sample, but it seems conclusive that short-term group therapy can be effective for loss in an NHS Talking Therapies service. Additionally, the effectiveness of the loss group was maintained during the move to online provision and can be therapeutic without other intervention for some people.

Connection, togetherness and support emerged as the key themes and therapeutic components of the group. It is also my experience that these themes are paralleled by staff and embodied in the delivery of the service. The relationships that are fostered in the team enable something unique and special to be co-created, forming an essential foundation for the healing process, both for therapists and clients.

As a result of the evaluation, the loss group is now delivered in-person, not online. Talking Change is also considering whether distinct groups are needed for loss and bereavement.

*Talking Change has now been renamed, NHS Talking Therapies Portsmouth.

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